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| **Maine Bureau of Insurance** |
| Form Filing Review Requirements Checklist |
| TOI - H21 Other  |
| Legal Services Coverage |
| Revised – 9/9/2021 |
| Carriers must confirm compliance and IDENTIFY the LOCATION (Form number, Page number, Section, Paragraph, etc.) of the standard in the form in the last column. Any response of N/A requires that a carrier explain why the requirement is not applicable. |
| This checklist is intended to provide a summary of State and Federal requirements for the TOI listed above. Please see the laws/rules referenced in the checklist below for the full requirement. |

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| **REVIEW REQUIREMENTS** | **REFERENCES** |  | **COMPLIANCE** |
| **GENERAL SUBMISSION REQUIREMENTS** |  |  |  |
| Electronic (SERFF) Filing Requirements: | [Title 24-A § 2412](https://legislature.maine.gov/statutes/24-A/title24-Asec2412.html)(2) [Bulletin 360](https://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 | [Title 24-A § 601](https://legislature.maine.gov/statutes/24-A/title24-Asec601.html) (17) | $20.00 for Rate filings, rating rules filings, insurance policy, forms, riders, endorsements and certificates. See General Instructions page in SERFF for additional information on filing fee structure. Filing fees must be submitted by EFT in SERFF at the time of submission of the filing. All filings require a filing fee unless specifically excluded per 24-A M.R.S.A. §4222(1), and/or are a required annual report. |  |
| Grounds for disapproval | [Title 24-A § 2413](https://legislature.maine.gov/statutes/24-A/title24-Asec2413.html) | Seven categories of the grounds for disapproving a filing. |  |
| Readability | [Title 24-A § 2441](https://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 | [Title 24-A § 2412](https://legislature.maine.gov/statutes/24-A/title24-Asec2412.html)  [Title 24-A § 2413](https://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. |  |
| **ADDITIONAL RATE FILING REQUIREMENTS** |  |  |  |
| Notice of Rate Increase | [Title 24-A § 2839](https://legislature.maine.gov/statutes/24-A/title24-Asec2839-A.html)-A | Requires that insurers provide a minimum of 60 days written notice to policyholders prior to a rate filing for individual health insurance or a rate increase for group health insurance. See statute for the requirements for the notice. |  |
| **GENERAL POLICY PROVISIONS** |  |  |  |
| Attorney selection | [Title 24-A § 2886](https://legislature.maine.gov/statutes/24-A/title24-Asec2886.html)[Rule 370](https://www.maine.gov/sos/cec/rules/02/031/031c370.doc) § 5(C)(1) | Except for basic legal advice rendered by telephone or mail as described in §2883 (referenced above), beneficiaries of legal services insurance shall not be required to select an attorney other than one of the beneficiary's own choosing to provide covered legal services, provided that the attorney is properly admitted to the bar of the applicable jurisdiction. |  |
| Benefits | [Rule 370](https://www.maine.gov/sos/cec/rules/02/031/031c370.doc) § 5(B) | Policies must contain a detailed list and description of the legal services provided or the legal matters for which expenses are to be reimbursed and the amount of reimbursement. Covered services may include the legal services/matters listed in [Rule 370](https://www.maine.gov/sos/cec/rules/02/031/031c370.doc). |  |
| Childhood Immunizations | [Title 24-A § 4302](https://legislature.maine.gov/statutes/24-A/title24-Asec4302.html)(1)(A)(5) [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-A.html)-A | Childhood immunizations must be expressly covered or expressly excluded in all policies. If childhood immunizations are a covered benefit it must be expressly stated in the benefit section. If childhood immunizations are not a covered benefit then this must be expressly stated as an exclusion in the policy. |  |
| Classification, Disclosure, and Minimum Standards | [Rule 755](https://www.maine.gov/sos/cec/rules/02/031/031c755.doc) | Must comply with all applicable provisions of [Rule 755](https://www.maine.gov/sos/cec/rules/02/031/031c755.doc) including, but not limited to, Sections 4, 5, 6(A), 6(B), 7(A), 7(B), 7(C), and 8. |  |
| Continuation of group coverage | [Title 24-A § 2809](https://legislature.maine.gov/statutes/24-A/title24-Asec2809-A.html)-A(11) | If the termination of an individual's group insurance coverage is a result of the member or employee being temporarily laid off or losing employment because of an injury or disease that the employee claims to be compensable under Workers Compensation, the insurer shall allow the member or employee to elect to continue coverage under the group policy at no higher level than the level of benefits or coverage received by the employee immediately before termination and at the member's or employee's expense or, at the member's or employee's option, to convert to a policy of individual coverage without evidence of insurability in accordance with this section. See complete details in §2809-A(11). |  |
| Continuity for individual who changes groups | [Title 24-A § 2849](https://legislature.maine.gov/statutes/24-A/title24-Asec2849-B.html)-B | A person is provided continuity of coverage if the person was covered under a prior policy and the prior policy terminated within 180 days before the date the person enrolls or is eligible to enroll in the succeeding policy, or within 90 days before the date the person enrolls or is eligible to enroll in the succeeding contract. The succeeding carrier must waive any medical underwriting or preexisting conditions exclusion to the extent that benefits would have been payable under a prior contract or policy if the prior contract or policy were still in effect. |  |
| Continuity of coverage | [Title 24-A § 2849](https://legislature.maine.gov/statutes/24-A/title24-Asec2849.html)[Title 24-A § 2849](https://legislature.maine.gov/statutes/24-A/title24-Asec2849.html)-B(7) | This section provides continuity of coverage to persons who were covered under the replaced contract or policy at any time during the 90 days before the discontinuance of the replaced contract or policy. Must certify in the cover letter and/or filing description that the underlying plan will comply with Maine’s continuity law. |  |
| Coordination of Benefits provisions (requirement applicable only if policy contains a coordination of benefits provision)Coordination of Benefits with Medicare and Medicaid | [Title 24-A § 2844](https://legislature.maine.gov/statutes/24-A/title24-Asec2844.html)(1-A)(B)(4) [Rule 191](https://www.maine.gov/sos/cec/rules/02/031/031c191.docx) § 9(A)[Rule 191](https://www.maine.gov/sos/cec/rules/02/031/031c191.docx) § 9(D)[Rule 790](https://www.maine.gov/sos/cec/rules/02/031/031c790.doc) [Bulletin 440](https://www.maine.gov/pfr/insurance/themes/insurance/pdf/440.pdf) | Provisions relating to coordination of benefits payable under the contract and under other plans of insurance or of health care coverage under which a certificate holder or the certificate holder's dependents may be covered must conform to Bureau of Insurance [Rule 790](https://www.maine.gov/sos/cec/rules/02/031/031c790.doc).The statute also sets forth how coordination with Medicare and Medicaid is governed. Medicaid (MaineCare) is always secondary payer to the insurer. |  |
| Definition of Medically Necessary | [Title 24-A § 4301](https://legislature.maine.gov/statutes/24-A/title24-Asec4301-A.html)-A(10-A) | Forms that use the term "medically necessary" or similar terms must include the following definition verbatim: A. Consistent with generally accepted standards of medical practice; B. Clinically appropriate in terms of type, frequency, extent, site and duration; C. Demonstrated through scientific evidence to be effective in improving health outcomes; D. Representative of "best practices" in the medical profession; and E. Not primarily for the convenience of the enrollee or physician or other health care practitioner. |  |
| Definition of UCR | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html) (8) | The data used to determine this charge must be Maine specific and relative to the region where the claim was incurred. |  |
| Designation of Classification of Coverage | [Rule 755](https://www.maine.gov/sos/cec/rules/02/031/031c755.doc) § 6 | The heading of the cover letter of any form filing subject to this rule shall state the category of coverage set forth in [Title 24-A § 2694](https://legislature.maine.gov/statutes/24-A/title24-Asec2694.html) that the form is intended to be in. |  |
| Exclusions & Limitations | [Rule 370](https://www.maine.gov/sos/cec/rules/02/031/031c370.doc) § 5(D & E) | Policies may contain the exclusions listed in [Rule 370](https://www.maine.gov/sos/cec/rules/02/031/031c370.doc) and any other exclusions approved by the Superintendent. Certificates issued under group policies may summarize the terms of the master contract but must contain a full and clear statement of the exclusions and limitations. |  |
| Explanations for any Exclusion of Coverage for work related sicknesses or injuries | [Title 24-A § 2413](https://legislature.maine.gov/statutes/24-A/title24-Asec2413.html) | If the policy excludes coverage for work related sicknesses or injuries, clearly explain whether the coverage is excluded if the enrollee is exempt from requirements from state workers compensation requirements or has filed an exemption from the workers compensation laws. |  |
| Extension of Benefits | [Rule 370](https://www.maine.gov/sos/cec/rules/02/031/031c370.doc) § 5(C)(2) | Coverage is to be provided for costs incurred during the policy term. Coverage of services ongoing at the time coverage terminates is to be provided for an additional 90 days. |  |
| Extension of Benefits | [Title 24-A § 2849](https://legislature.maine.gov/statutes/24-A/title24-Asec2849-A.html)-A[Rule 590](https://www.maine.gov/sos/cec/rules/02/031/031c590.doc) | Provide an extension of benefits of 6 months for a person who is totally disabled on the date the group or subgroup policy is discontinued. For a policy providing specific indemnity during hospital confinement, "extension of benefits" means that discontinuance of the policy during a disability has no effect on benefits payable for that confinement. For purposes of determining eligibility for extension of benefits, "total disability" shall be defined no more restrictively than: A.in the case of an insured who was gainfully employed prior to disability, "the inability to engage in any gainful occupation for which he or she is reasonably suited by training, education, and experience;" or B.in the case of an insured who was not gainfully employed prior to disability, "the inability to engage in most normal activities of a person of like age in good health." |  |
| Forms for Proof of Loss | [Title 24-A § 2423](https://legislature.maine.gov/statutes/24-A/title24-Asec2423.html) | An insurer shall furnish, upon written request of any person claiming to have a loss under an insurance contract issued by such insurer, forms of proof of loss for completion by such person, but such insurer shall not, by reason of the requirement so to furnish forms, have any responsibility for or with reference to the completion of such proof or the manner of any such completion or attempted completion. |  |
| Grace Period/Notice of Cancellation | [Rule 370](https://www.maine.gov/sos/cec/rules/02/031/031c370.doc) § 5(C)(5 & 6) | Cancellation may be initiated by either the insurer or the policyholder by providing 30-days written notice to the other for reasons other than non-payment of premium. Any return premium shall be on a pro-rata basis. If the insurer initiates cancellation for non-payment of premium, a grace period of not less than 10 days shall be provided. Policies may contain the following exclusions: |  |
| Guaranteed Issue & Renewal | [Title 24-A § 2808](https://legislature.maine.gov/statutes/24-A/title24-Asec2808-B.html)-B[Title 24-A § 2850](https://legislature.maine.gov/statutes/24-A/title24-Asec2850-B.html)-B | Renewal must be guaranteed to all individuals, to all groups and to all eligible members and their dependents in those groups except for failure to pay premiums, fraud or intentional misrepresentation. Small group plans are guaranteed issue and renewed, community rated, and standardized plans. |  |
| Guaranteed Renewal | [Title 24-A § 2850](https://legislature.maine.gov/statutes/24-A/title24-Asec2850.html)-BPHSA § 2702 ([45 CFR § 148.122](https://www.ecfr.gov/cgi-bin/text-idx?SID=985c38eeddaa13128929637cc7ec919e&pitd=20180719&node=pt45.1.148&rgn=div5#se45.1.148_1122)) | 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. May only non-renew or cancel coverage for nonpayment of premiums, fraud, market exit, movement outside of service area, or cessation of bona-fide association membership. |  |
| Health plan accountability | [Rule 850](https://www.maine.gov/sos/cec/rules/02/031/031c850.docx) | Standards in this rule include, but are not limited to, required provisions for grievance and appeal procedures, emergency services, and utilization review standards. |  |
| Health Plan Improvement Act | [Title 24-A Chapter 56-A](https://legislature.maine.gov/statutes/24-A/title24-Ach56-Asec0.html) | These sections describe requirements for health plans offered in Maine. The requirements include, but are not limited to: access to clinical trials, access to prescription drugs, utilization review standards, and independent external review |  |
| Lifetime Limits and Annual Dollar Limits Prohibited - Lifetime or annual limits on the dollar value of Essential Health Benefits (EHB): \*2023 Plan Year Limits: Use current maximum out-of-pocket limits as prescribed by CMS final rule. | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320.html) PHSA § 2711 ([75 Fed Reg 37188](https://www.federalregister.gov/documents/2010/06/28/2010-15278/patient-protection-and-affordable-care-act-preexisting-condition-exclusions-lifetime-and-annual),[45 CFR § 147](https://www.ecfr.gov/cgi-bin/text-idx?SID=985c38eeddaa13128929637cc7ec919e&pitd=20180719&node=pt45.1.147&rgn=div5#se45.1.147_1126).126) | A carrier offering an individual, small group or large group health plan, may not establish lifetime limits on the dollar value of benefits for any participant or beneficiary; or annual limits on the dollar value of essential benefits. Plans may not establish lifetime limits on the dollar value of essential health benefits: Ambulatory patient services, Emergency services, Hospitalization Maternity and newborn care, Mental health, and substance use disorder services, including behavioral health treatment, Prescription drugs Rehabilitative and habilitative services and devices, Laboratory services, Preventive and wellness services and chronic disease management, Pediatric services, including oral and vision care Issuers are not prohibited from using lifetime limits for specific covered benefits that are not EHB; issuers are not prohibited from excluding all benefits for a non-covered condition for all covered people, but if any benefits are provided for a condition, then no lifetime limit requirements apply. |  |
| Limits on priority liens/Subrogation | [Title 24-A § 2836](https://legislature.maine.gov/statutes/24-A/title24-Asec2836.html) [Title 24-A § 2729](https://legislature.maine.gov/statutes/24-A/title24-Asec2729-A.html)-A | No policy shall provide for priority over the insured if the insured is entitled to receive reimbursement as a result of legal action or claim, except if that provision is approved by the superintendent, requires the prior written approval of the insured, and allows such payments only on a just and equitable basis and not on the basis of a priority lien. |  |
| Penalty for failure to notify of hospitalization | [Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-A.html)-A[45 CFR § 147](https://www.ecfr.gov/cgi-bin/text-idx?SID=a3bb635afd7624f532acfe878eec552b&pitd=20180719&node=pt45.1.147&rgn=div5#se45.1.147_1138).138(b) | No penalty allowed for failure to notify the insurer of insured's hospitalization for emergency treatment. (There is no specific HMO requirement for this benefit/provision, but it is a benchmark plan requirement.) |  |
| PPOs – Payment for Non-preferred Providers (as applicable) | [Title 24-A § 2677-A](https://legislature.maine.gov/statutes/24-A/title24-Asec2677-A.html) | There cannot be more than a 20% differential in benefits between preferred and non-preferred providers. Superintendent can grant waiver for the 20%, in particular for designated providers for cost or quality. |  |
| Prohibition against Absolute Discretion Clauses | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html) (11) | Carriers are prohibited from including or enforcing absolute discretion provisions in health plan contracts, certificates, or agreements. |  |
| Provider Contracts | [Rule 370](https://www.maine.gov/sos/cec/rules/02/031/031c370.doc) § 6 | Contracts between the insurer and participating attorneys or other providers of legal services must be filed with the superintendent for the purpose of enabling the superintendent to review whether the insurer has made adequate arrangements for the provision of any promised legal services. Such contracts may not become effective until 30 days after filing. |  |
| Rates | [Title 24-A § 2885](https://legislature.maine.gov/statutes/24-A/title24-Asec2885.html) | No policy of group legal services insurance may be delivered in this State until a copy of the group manual rates to be used in calculating the premium for these policies has been filed for informational purposes with the superintendent. |  |
| Representations in Application | [Title 24-A § 2411](https://legislature.maine.gov/statutes/24-A/title24-Asec2411.html) | All statements and descriptions in any application for insurance, by or in behalf of the insured, are deemed to be representations and not warranties. |  |
| Required provisions | [Title 24-A § 2816](https://legislature.maine.gov/statutes/24-A/title24-Asec2816.html)[Title 24-A § 2817](https://legislature.maine.gov/statutes/24-A/title24-Asec2817.html)[Title 24-A § 2818](https://legislature.maine.gov/statutes/24-A/title24-Asec2818.html)[Title 24-A § 2819](https://legislature.maine.gov/statutes/24-A/title24-Asec2819.html) [Title 24-A § 2820](https://legislature.maine.gov/statutes/24-A/title24-Asec2820.html)[Title 24-A § 2821](https://legislature.maine.gov/statutes/24-A/title24-Asec2821.html)[Title 24-A § 2822](https://legislature.maine.gov/statutes/24-A/title24-Asec2822.html)[Title 24-A § 2823](https://legislature.maine.gov/statutes/24-A/title24-Asec2823.html)[Title 24-A § 2824](https://legislature.maine.gov/statutes/24-A/title24-Asec2824.html)[Title 24-A § 2825](https://legislature.maine.gov/statutes/24-A/title24-Asec2825.html)[Title 24-A § 2826](https://legislature.maine.gov/statutes/24-A/title24-Asec2826.html)[Title 24-A § 2827](https://legislature.maine.gov/statutes/24-A/title24-Asec2827.html)[Title 24-A § 2828](https://legislature.maine.gov/statutes/24-A/title24-Asec2828.html) | Application statements, notice of claim, proof of loss, assignment of benefits, renewal provisions |  |
| Statements in Application | [Title 24-A § 2410](https://legislature.maine.gov/statutes/24-A/title24-Asec2410.html) | The insured shall not be bound by any statement made in an application for health insurance policy and the application shall not be admissible in evidence in any action relative to such policy or contract, unless a true copy of the application was attached to or endorsed on the policy or contract when issued as a part thereof. |  |
| Third Party 10 Day Notification prior to cancellation; restrictions on cancellation, termination or lapse due to cognitive impairment or functional incapacity | [Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-C.html)-C[Title 24-A § 2707](https://legislature.maine.gov/statutes/24-A/title24-Asec2707-A.html)-A[Rule 580](https://www.maine.gov/sos/cec/rules/02/031/031c580.doc) | An insurer shall provide for notification of the insured person and another person, if designated by the insured, prior to cancellation of a health insurance policy for nonpayment of premium. FOR INDIVIDUAL PLANS: Insurers must provide the following disclosure, notice and reinstatement rights:1. Insured has the right to elect a third party to receive notice and that the insurer will send them a third party notice request form to make that selection.2. Insured and designated individual will receive a 10 day notice of cancellation.3. Insured has the right to reinstatement of the contract if the insured suffers from cognitive impairment or functional incapacity and the ground for cancellation was the insured’s nonpayment of premium or other lapse or default on the part of the insured.4. Notice that if a request for reinstatement of coverage because of cognitive impairment or functional incapacity is denied, notice of denial shall be provided to the insured and to the person making the request, if different. The notice of denial shall include notification of the 30 day period following receipt of the notice during which a hearing before the Superintendent may be requested. FOR GROUP PLANS: Third Party Notice of Cancellation for group plans must be applied as follows: 1. If the entire cost of the insurance coverage is paid by the Policyholder, there is no requirement to send the Third Party Notice of Cancellation. 2. If the entire cost of the insurance coverage is paid by the Certificate holder and is direct billed, the insurer must include notification in the policy/certificate to advise the member of their rights. 3. If the entire cost of the insurance coverage is paid by the Certificate holder and is made via payroll deduction, then [Rule 580](https://www.maine.gov/sos/cec/rules/02/031/031c580.doc), § 5 (3) would apply and the insurer must include this notification in the policy/certificate to advise the member of their rights. 4. If a portion of the cost of the insurance coverage is paid by the Policyholder and the remainder is paid by the Certificate holder and is made via payroll deduction, then [Rule 580](https://www.maine.gov/sos/cec/rules/02/031/031c580.doc), § 5 (3) would apply and the insurer must include this notification in the policy/certificate to advise the member of their rights. Please review [Rule 580](https://www.maine.gov/sos/cec/rules/02/031/031c580.doc) and add the required language to the certificate. Additionally, pursuant to [Rule 580](https://www.maine.gov/sos/cec/rules/02/031/031c580.doc) § 6(A)(7), the requirement may be satisfied by including the notice of reinstatement right in an application that is incorporated into the contract. |  |
| UCR Required Disclosure | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html) (8)(A) | Clearly disclose that the insured or enrollee may be subject to balance billing as a result of claims adjustment and provide a toll-free number that an insured or enrollee may call prior to receiving services to determine the maximum allowable charge permitted by the carrier for a specified service. |  |
| **ELIGIBILITY / ENROLLMENT** |  |  |  |
| Coverage for Dependent Children Up to Age 26 | [Title 24-A § 2833](https://legislature.maine.gov/statutes/24-A/title24-Asec2833-B.html)-B | A group health insurance policy that offers coverage for dependent children must offer such coverage until the dependent child is 26 years of age. |  |
| Definition of Dependent | [Title 24-A § 2833](https://legislature.maine.gov/statutes/24-A/title24-Asec2833.html) | Defined as under 19 years of age and are children, stepchildren or adopted children of, or children placed for adoption with the policyholder, member or spouse of the policyholder or member, no financial dependency requirement, court ordered coverage |  |
| Dependent children with mental or physical illness. | [Title 24-A § 2833](https://legislature.maine.gov/statutes/24-A/title24-Asec2833-A.html)-A[Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-B.html)-B | Requires health insurance policies to continue coverage for dependent children up to 26 years of age who are unable to maintain enrollment in college due to mental or physical illness if they would otherwise terminate coverage due to a requirement that dependent children of a specified age be enrolled in college to maintain eligibility. |  |
| Dependent Coverage | [Title 24-A § 2809](https://legislature.maine.gov/statutes/24-A/title24-Asec2809.html) | Coverage for family members or dependents of an individual in the insured group may not exclude those minor children of the individual who do not reside with that individual.Coverage for family members or dependents of an individual in the insured group may provide for the continuation of benefit provisions after the death of the such individual. |  |
| Dependent special enrollment period | [Title 24-A § 2834](https://legislature.maine.gov/statutes/24-A/title24-Asec2834-B.html)-B[Title 24-A § 4222-B](https://legislature.maine.gov/statutes/24-A/title24-Asec4222-B.html) (11) | Enrollment for qualifying events. |  |
| Domestic partner benefits | [Title 24-A § 2832](https://legislature.maine.gov/statutes/24-A/title24-Asec2832-A.html)-A | Contracts must make available to group policyholders the option for additional benefits for the domestic partner of a certificate holder at appropriate rates and under the same terms and conditions as are provided to spouses of married certificate holders under a group policy. This section provides criteria defining "domestic partner" for purposes of this requirement and what evidence may be required as a condition of eligibility. |  |
| Newborn coverage | [Title 24-A § 2834](https://legislature.maine.gov/statutes/24-A/title24-Asec2834.html) | Newborns must be automatically covered under the plan from the moment of birth for the first 31 days. An adopted child is deemed to be newly born to the adoptive parents from the date of the signed placement agreement. |  |
| **CLAIMS** |  |  |  |
| Calculation of health benefits based on actual cost | [Title 24-A § 2185](https://legislature.maine.gov/statutes/24-A/title24-Asec2185.html) | If the insurer has negotiated discounts with providers, the insurer must provide for the calculation of all covered health benefits, including without limitation all coinsurance, deductibles and lifetime maximum benefits, on the basis of the net negotiated cost and must fully reflect any discounts or differentials from charges otherwise applicable to the services provided. With respect to policies involving risk-sharing compensation arrangements, net negotiated costs may be calculated at the time services are rendered on the basis of reasonably anticipated compensation levels and are not subject to retrospective adjustment at the time a cost settlement between a provider and the insurer or organization is finalized. |  |
| Explanations Regarding Deductibles | [Title 24-A § 2413](https://legislature.maine.gov/statutes/24-A/title24-Asec2413.html) | All policies must include clear explanations of all of the following regarding deductibles: Whether it is a calendar or policy year deductible. Clearly advise whether non-covered expenses apply to the deductible. Clearly advise whether it is a per person or family deductible or both. |  |
| Penalty for noncompliance with utilization review | [Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-D.html)-D | A policy may not have a penalty of more than $500 for failure to provide notification under a utilization review program. |  |
| Timely Payment of Undisputed Insurance Claims | [Title 24-A § 2436](https://legislature.maine.gov/statutes/24-A/title24-Asec2436.html)[Title 24-A § 4207](https://legislature.maine.gov/statutes/24-A/title24-Asec4207.html)[Title 24-A § 4222-B](https://legislature.maine.gov/statutes/24-A/title24-Asec4222-B.html)(13)[Rule 191](https://www.maine.gov/sos/cec/rules/02/031/031c191.docx)(9)(C)(4) | An undisputed 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 An ”undisputed claim” means a manually or electronically submitted claim from a health care provider or health care facility that:A. Contains all the required data elements necessary for accurate adjudication without the need for additional information;B. Is not materially deficient or improper, including lacking substantiating documentation required by the carrier; andC. Has no particular or unusual circumstances requiring special treatment that prevent payment from being made by the carrier. |  |
| **GRIEVANCES & APPEALS** |  |  |  |
| Timeline for second level grievance review decisions | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(4) | Decisions for second level grievance reviews must be issued within 30 calendar days if the insured has not requested to appear in person before authorized representatives of the health carrier. |  |
| **PROVIDERS / NETWORKS** |  |  |  |
| Coverage for Services Provided by Certified Registered Nurse Anesthetists | [Title 24-A § 4320](https://legislature.maine.gov/legis/statutes/24-A/title24-Asec4320-Q.html)-Q | Coverage for services provided by certified registered nurse anesthetists (CRNA) is required. |  |
| Independent Practice Dental Hygienists | [Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-Q.html)-Q | Coverage must be provided for dental services performed by a licensed independent practice dental hygienist when those services are covered services under the contract and when they are within the lawful scope of practice of the independent practice dental hygienist. |  |
| **GENERAL HEALTH CARE TREATMENT / COVERAGE** |  |  |  |
| Coverage for Breast Cancer Treatment and Reconstructive Surgery | [Title 24-A § 2837](https://legislature.maine.gov/statutes/24-A/title24-Asec2837-C.html)-C | Coverage with for inpatient breast cancer treatment must be provided for the duration determined by the attending physician.Must provide coverage for reconstruction of both breasts to produce symmetrical appearance according to patient and physician wishes. |  |
| Preventive health services Preventive health services without cost-sharing requirements including deductibles, co-payments, and co-insurance. | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320.html)-A[Rule 191](https://www.maine.gov/sos/cec/rules/02/031/031c191.docx) § 9(M)PHSA § 2713 ([75 Fed Reg 41726](https://www.federalregister.gov/documents/2010/07/19/2010-17242/interim-final-rules-for-group-health-plans-and-health-insurance-issuers-relating-to-coverage-of), [45 CFR § 147](https://www.ecfr.gov/cgi-bin/text-idx?SID=a3bb635afd7624f532acfe878eec552b&pitd=20180719&node=pt45.1.147&rgn=div5#se45.1.147_1130).130) | Must, at a minimum, provide coverage for, and may not impose cost-sharing requirements for, the following preventive services: The evidence-based items or services that have a rating of A or B in the recommendations of the USPSTF or equivalent rating from a successor organization; With respect to the individual insured, immunizations that have a recommendation from the federal DHHS, CDC, Advisory Committee on Immunization Practices; With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the most recent version of the comprehensive guidelines supported by the federal DHHS, HRSA; and With respect to women, such additional preventive care and screenings not described in paragraph A, provided for in the comprehensive guidelines supported by the federal DHHS, HRSA women's preventive services guidelines. If one of the recommendations referenced above is changed during a plan year, a carrier is not required to make changes to that health plan during the plan year. SEE SEPARATE CHECKLIST FOR SPECIFIC SERVICES. |  |
| Telehealth Services | [Title 24-A § 4316](https://legislature.maine.gov/statutes/24-A/title24-Asec4316.html) | Carrier must provide coverage for telehealth services if the service would be covered if it were provided through in-person consultation and as long as the provider is acting within the scope of practice of the provider’s license with regard to telehealth services. Can’t put any restriction on the prescribing of medication through telehealth that could otherwise be prescribed in-person. The availability of health care services may not be considered for the purposes of demonstrating provider network adequacy. |  |
| **WOMEN & MATERNITY** |  |  |  |
| Maternity and newborn care; newborn children coverage | [Title 24-A § 2834](https://legislature.maine.gov/statutes/24-A/title24-Asec2834.html)[Title 24-A § 2834](https://legislature.maine.gov/statutes/24-A/title24-Asec2834-A.html)-A[Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-A.html)-A[45 CFR § 148.170](https://www.ecfr.gov/cgi-bin/text-idx?SID=985c38eeddaa13128929637cc7ec919e&pitd=20180719&node=pt45.1.148&rgn=div5#se45.1.148_1170) | Benefits must be provided for maternity (length of stay) and newborn care, in accordance with "Guidelines for Perinatal Care" as determined by attending provider and mother. Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section. An issuer is required to provide notice unless state law requires coverage for 48/96-hour hospital stay, requires coverage for maternity and pediatric care in accordance with an established professional medical association, or requires that decisions about the hospital length of stay are left to the attending provider and the mother. Policies and certificates providing coverage on an expense-incurred basis must provide that benefits are payable for a newly born child of the insured or subscriber from the moment of birth for the first 31 days. This must include coverage of injury or sickness or other benefits provided by the policy, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of premium is required to provide coverage for a child, the policy may require that notice of birth and payment of the premium be furnished within 31 days after the date of birth in order to have coverage continue beyond the 31-day period. The payment may be required to be retroactive to the date of birth. |  |
| **AUTHORITY TO SELL AND DEFINITION OF LEGAL SERVICES INSURANCE** |  |  |  |
| Certificate of Authority to sell legal services insurance | [Title 24-A § 2882](https://legislature.maine.gov/statutes/24-A/title24-Asec2882.html)[Rule 370](https://www.maine.gov/sos/cec/rules/02/031/031c370.doc) § 4[Title 24-A § 410](https://www.mainelegislature.org/legis/statutes/24-A/title24-Asec410.html) | Upon application to an approval by the superintendent, an insurer incorporated by or under the laws of this State or any foreign or alien insurance company duly licensed to transact insurance in its state of domicile may make application for a certificate of authority to transact the business of legal services insurance, including reinsurance, in this State, if that company is authorized or qualified to be authorized to transact a health insurance business in this State. Carriers are asked to provide evidence of state approval to sell legal services insurance. If a carrier is already authorized for Health in Maine, the carrier needs to meet an additional stock requirement of $500,000 in addition to the $2,500,000 required as a multiple lines insurer. Please provide supporting evidence. |  |
| Definition of Legal Services Insurance; Exemption | [Title 24-A § 2883](https://legislature.maine.gov/statutes/24-A/title24-Asec2883.html)[Title 24-A § 2881](https://legislature.maine.gov/statutes/24-A/title24-Asec2881.html) | "Legal services insurance" is insurance which involves the assumption of a contractual obligation to reimburse the beneficiary against or pay on behalf of the beneficiary all or a portion of the beneficiary's fees, costs or expenses related to or arising out of services performed by or under the supervision of an attorney who is not an employee of or under the control of the insurer directly or indirectly and who is licensed to practice in the jurisdiction in which the services are performed. Legal services insurance may also include provisions for basic legal advice only rendered to the beneficiary, by telephone or mail, by one or more attorneys licensed to practice in the jurisdiction in which the advice is given; none of whom are employees of or under the control of the insurer, directly or indirectly. Legal services insurance does not include: the provision of or reimbursement for legal services incidental to other insurance coverages (§2883), or the payment by a voluntary association, other than a voluntary association which is an insurer, on behalf of one of its members of fees, costs or expenses related to or arising out of legal services performed for the member by an attorney who either is an employee of the paying association or who provides the legal services to the association's member, pursuant to an agreement with that association (§2881).   |  |
| Group Policy Basis Only | [Title 24-A § 2884](https://legislature.maine.gov/statutes/24-A/title24-Asec2884.html) | Legal services insurance may only be issued in this State on a group policy basis. Group legal services insurance is that form of voluntary legal services insurance covering employees or members, with or without their eligible dependents, written under a master policy issued to any governmental corporation, unit, agency or department or to any employer, association of employers or employee leasing company registered pursuant to Title 32, chapter 125, including the trustee or trustees of a fund established by that employer, association of employers or registered employee leasing company, a labor union or other employee organization, including the trustees of a fund established by that labor union or employee organization. The terms “employee” and “employees” have the same meaning as are given to those terms for the purposes of writing group life insurance in this State (see §2603). |  |
| **INFANTS & CHILDREN** |  |  |  |
| Autism Spectrum Disorders | [Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-T.html)-T | Group health insurance policies and certificates must provide coverage for autism spectrum disorders, as defined in this section, for a covered individual who is 10 years of age or under in accordance with the requirements set forth in this section. |  |
| Early Childhood Intervention | [Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-S.html)-S | Group health insurance policies and certificates must provide coverage for children's early intervention services in accordance with the requirements of this section. "Children's early intervention services" is defined in this section. |  |
| **MENTAL HEALTH & SUBSTANCE ABUSE SERVICES / COVERAGE** |  |  |  |
| Mental health coverage | [Title 24-A § 2843](https://legislature.maine.gov/statutes/24-A/title24-Asec2843.html)[Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-D.html)-D[Rule 330](https://www.maine.gov/sos/cec/rules/02/031/031c330.doc) | The contract must provide coverage for treatment of certain mental illnesses (including substance use disorders), as diagnosed by specific providers, and the coverage must meet the following parity requirements:• benefits for treatment and diagnosis of mental illnesses must be provided under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illness;• providers may be required to furnish data substantiating that initial/continued treatment is medically necessary, and in determining medical necessity, the same criteria must be used for medical treatment for mental illness as for physical illness under the policy;• if benefits for physical illness are provided on an expense-incurred basis, the benefits required for mental illness may be delivered separately under a managed care system;• contracts may not have separate maximums, deductibles, coinsurance amounts, out-of-pocket limits in a benefit period of not more than 12 months, or separate office visit limits, for physical illness and mental illness;• contracts may not impose a limitation on benefits for mental illness unless the same limitation is also imposed for physical illness;• copayments for mental illness must be actuarially equivalent to any coinsurance requirements or, if there are no coinsurance requirements, may not be greater than any copayment or coinsurance for physical illness; and• a medication management visit associated with a mental illness must be covered in the same manner as a medication management visit for treatment of a physical illness and may not be counted in the calculation of any maximum outpatient treatment visit limits.The contract must provide for medically necessary health care for a person suffering from mental illness, and such medically necessary health care must include, but is not limited to: • inpatient care; • day treatment services; • outpatient services; and • home health care services. |  |
| Substance Abuse Disorder Treatment | [Title 24-A § 2842](https://legislature.maine.gov/statutes/24-A/title24-Asec2842.html)[Rule 320](https://www.maine.gov/sos/cec/rules/02/031/031c320.doc) | If the contract provides coverage for hospital care, the contract must provide coverage for the treatment of substance use disorder pursuant to a treatment plan, which must, at a minimum, include: 1) residential treatment at a hospital or free-standing residential treatment center that is licensed, certified or approved by the State; and 2) outpatient care rendered by state licensed, certified or approved providers. Treatment or confinement at a facility may not preclude further/additional treatment at another eligible facility if the benefit days used do not exceed the total number of benefit days provided for under the contract. (not required for contracts issued to employers with 20 or fewer employees insured under the contract) |  |
| **PRESCRIPTION DRUGS** |  |  |  |
| Continuity of Prescription Drugs | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(7)(A) | If an enrollee has been undergoing a course of treatment with a prescription drug by prior authorization of a carrier and the enrollee’s coverage with one carrier is replaced with coverage from another carrier pursuant to section 2849-B, the replacement carrier shall honor the prior authorization for that prescription drug and provide coverage in the same manner as the previous carrier until the replacement carrier conducts a review of the prior authorization for that prescription drug with the enrollee’s prescribing provider. Policies must include a notice of the carrier’s right to request a review with the enrollee’s provider, and the replacing carrier must honor the prior carrier’s authorization for a period not to exceed 6 months if the enrollee’s provider participates in the review and requests the prior authorization be continued. The replacing carrier is not required to provide benefits for conditions or services not otherwise covered under the replacement policy, and cost sharing may be based on the copayments and coinsurance requirements of the replacement policy. |  |
| Coverage for HIV Prevention Drugs | [Title 24-A § 4317](https://legislature.maine.gov/statutes/24-A/title24-Asec4317-D.html)-D | A. If the FDA has approved one or more HIV prevention drugs that use the same method of administration, a carrier must cover at least one approved drug for each method of administration with no out-of-pocket cost. B. A carrier is not required to cover pre- or post-exposure prophylaxis drug dispensed or administered by an out-of-network pharmacy provider unless the enrollee's health plan provides an out-of-network pharmacy benefit. C. A carrier may not prohibit a pharmacy from dispensing or administering any HIV prevention drugs. |  |
| No Prior Authorization or step therapy for mental illness drugs | [Title 24-A § 4304](https://legislature.maine.gov/statutes/24-A/title24-Asec4304.html)(2-C)[Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-N.html)-N | Carrier must approve all prior authorizations for drugs to treat serious mental illness. No step therapy for such drugs. Serious mental illness means mental illness must result in serious functional impairment that substantially interferes with or limits one or more major life activities. |  |
| Prosthetic devices to replace an arm or leg. | [Title 24-A § 4315](https://legislature.maine.gov/statutes/24-A/title24-Asec4315.html)[42 USC 1395m](https://www.law.cornell.edu/uscode/text/42/1395m) | Coverage must be provided, at a minimum, for prosthetic devices to replace, in whole or in part, an arm or leg to the extent that they are covered under the Medicare program. Coverage for repair or replacement of a prosthetic device must also be included. Exclusion for micro-processors was removed effective 1/2011.1. Definition. As used in this section, "prosthetic device" means an artificial device to replace, in whole or in part, an arm or a leg. 2. Required coverage. A carrier shall provide coverage for prosthetic devices in all health plans that, at a minimum, equals, except as provided in subsection 8, the coverage and payment for prosthetic devices provided under federal laws and regulations for the aged and disabled pursuant to 42 United States Code, Sections 1395k, 1395l and 1395m and 42 Code of Federal Regulations, Sections 414.202, 414.210, 414.228 and 410.100. Covered benefits must be provided for a prosthetic device determined by the enrollee's provider, in accordance with section 4301-A, subsection 10-A, to be the most appropriate model that adequately meets the medical needs of the enrollee. 8. Health savings accounts. Benefits for prosthetic devices under health plans issued for use in connection with health savings accounts as authorized under Title XII of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 may be subject to the same deductibles and out-of-pocket limits that apply to overall benefits under the contract.(h) Payment for prosthetic devices and orthotics and prosthetics (1) General rule for payment (A) In general Payment under this subsection for prosthetic devices and orthotics and prosthetics shall be made in a lump-sum amount for the purchase of the item in an amount equal to 80 percent of the payment basis described in subparagraph (B). (B) Payment basis Except as provided in subparagraphs (C), (E), and (H)(i), the payment basis described in this subparagraph is the lesser of— (ii) the actual charge for the item; or (iii) the amount recognized under paragraph (2) as the purchase price for the item. Coverage should be applied as follows:1. Coinsurance shall NOT exceed 20%, AFTER deductible in the plan. 2. HSA’s are NOT subject to the 20% requirement but coinsurance may not exceed that for other services. 3. DME and other prosthetic devices are NOT subject to the 20%, so it would be helpful to clarify in the schedule of benefits, summary of benefits and coverage, and the plan and benefits template how each category is paid out. 4. Out Of Network is NOT subject to 20%, unless there is no in-network available then OON should be billed as in-network i.e. 20%. |  |