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

**QUALIFIED STAND ALONE DENTAL – GROUP (H10G.001) and INDIVIDUAL (H10I.001)**

**Inside and Outside the Marketplace**

**For Plans Issued On or After January 1, 2024**

**(Revised 04/13/2023)**

**Confirm compliance and IDENTIFY the LOCATION (Page Number, Section, Paragraph, etc.) of the STANDARD in the last column.**

**N/A: Check this box if a contract does not have to meet this requirement and EXPLAIN WHY in the last column.**

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| State Benefit/Provision and/or ACA Requirement | **State  Law/Rule and/or  Federal Law** | State Description of Requirement and/or ACA Description of Requirement | N/A 🡪 | **CONFIRM COMPLIANCE**  **AND IDENTIFY LOCATION OF STANDARD IN FILING**  **& EXPLAIN IF REQUIREMENT** IS NOT APPLICABLE |
| **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.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** | | | | |
| Death with Dignity | [22 M.R.S. § 2140(19)](http://www.mainelegislature.org/legis/statutes/22/title22sec2140.html) | The sale, procurement or issuance of any health or accident insurance or the rate charged for any health or accident policy may not be conditioned upon or affected by the making or rescinding of a request by a qualified patient for medication that the patient may self-administer to end the patient's life in accordance with this Act. | ☐ |  |
| Dental benefit waiting period | 24-A M.R.S. §2766-A  24-A M.R.S. §2847-W | Coverage for dental services may not impose a waiting period for any dental or oral health service or treatment, except for orthodontic treatment, for an enrollee if the enrollee is under 19 years of age.  For purposes of this statute, “waiting period” means a period of time after the date of enrollment during which a health insurance plan excludes coverage for the diagnosis or treatment of any or all medical conditions.  [24-A M.R.S. § 2848(5)](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2848.html). | ☐ |  |
| Free look period (Individual Only) | [24-A M.R.S.A. §2717](http://legislature.maine.gov/statutes/24-A/title24-Asec2717.html) | 10 day free look. | ☐ |  |
| General format | [24-A M.R.S.A. §2703](http://legislature.maine.gov/statutes/24-A/title24-Asec2703.html) | Readability, term of policy described, cost disclosed, form number in bottom left corner. | ☐ |  |
| Genetic Information Protections | [24-A M.R.S.  § 2159-C(2)](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2159-C.html) | A carrier may not discriminate against an individual or eligible dependent on the basis of genetic information or the refusal to submit to a genetic test or make available the results of a genetic test or on the basis that the individual or eligible dependent received a genetic test or genetic counseling in the issuance, withholding, extension or renewal of any hospital confinement or other health insurance, or in the fixing of the rates, terms or conditions for insurance, or in the issuance or acceptance of any application for insurance.  A carrier may not request, require or purchase genetic information for purposes of determining eligibility for benefits, computing premium or contribution amounts, applying any preexisting condition exclusion or any other activities related to the creation, renewal or replacement of a health insurance contract.  A carrier may not request, require or purchase genetic information with respect to an individual prior to the individual's enrollment under the plan or coverage in connection with the enrollment. |  |  |
| Grace Period | [24-A M.R.S.A. §2809-A](http://legislature.maine.gov/statutes/24-A/title24-Asec2809-A.html)  [§2707](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2707.html)  [Bulletin 288](https://www.maine.gov/pfr/insurance/themes/insurance/pdf/288.pdf) | There shall be a provision that a grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force. | ☐ |  |
| Legal actions | [24-A M.R.S.A. §2828](http://legislature.maine.gov/statutes/24-A/title24-Asec2828.html)  [§2715](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2715.html) | No action can be brought to recover on the policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of the policy. No such action shall be brought after the expiration of 3 years (for individual plans) (2 years for group plans) after the time written proof of loss is required to be furnished. | ☐ |  |
| Notice of Rate Increase | [24-A M.R.S.A. §2839](http://legislature.maine.gov/statutes/24-A/title24-Asec2839.html)  [§2735-A](http://legislature.maine.gov/statutes/24-A/title24-Asec2735-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. | ☐ |  |
| Outline of Coverage – Dental Requirements | [Rule 755, Sec. 7(N)](http://www.maine.gov/sos/cec/rules/02/031/031c755.doc)  [24-A M.R.S.A. §2695](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2695.html) | An outline of coverage in the form prescribed below shall be issued in connection with dental plan policies and certificates. The items included in the outline of coverage must appear in the sequence prescribed:  (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) [A brief specific description of the benefits. 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.]  (3) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or, in any other manner, operate to qualify payment of the benefits described in Paragraph (2) above.]  (4) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]  **FOR GROUPS**: An outline of coverage for group health insurance, a group dental plan or a group vision care plan is not required to be delivered to certificate holders if the certificate contains a brief description of:  A. Benefits;  B. Provisions that exclude, eliminate, restrict, limit, delay or in any other manner operate to qualify payment of the benefits;  C. Renewability provisions; and  D. Notice requirements as provided in rules adopted pursuant to this chapter.  Carriers must attest in the far left column of this checklist that the certificate contains the above required provision/descriptions. |  |  |
| PPO Benefit level differential | 24-A M.R.S.A. [§2677-A](http://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.** | ☐ |  |
| Renewal provision | 24-A M.R.S.A. [§2820](http://legislature.maine.gov/statutes/24-A/title24-Asec2820.html)  [§2738](http://legislature.maine.gov/statutes/24-A/title24-Asec2738.html) | Policy must contain the terms under which the policy can or cannot be renewed. | ☐ |  |
| Required disclosure statements on policies/certificates | [Rule 755, Sec. 7(A)(22)](http://www.maine.gov/sos/cec/rules/02/031/031c755.doc) | All dental plan policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:  “Notice to Buyer: This [policy] [certificate] provides dental benefits only.” | ☐ |  |
| Third Party 10 Day Notification prior to cancellation; restrictions on cancellation, termination or lapse due to cognitive impairment or functional incapacity | [24-A M.R.S.A. §2847-C](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2847-C.html)  24-A M.R.S.A. [§2707-A](http://legislature.maine.gov/statutes/24-A/title24-Asec2707-A.html)  [Rule 580](http://www.maine.gov/sos/cec/rules/02/031/031c580.doc) | An insurer shall provide for notification of the insured person and another person, if designated by the insured, prior to cancellation of a health insurance policy for nonpayment of premium.  **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 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.   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 (Group Only) | [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 3-year period. | ☐ |  |
| Time limit on defenses (Individual Only) | [24-A M.R.S.A. §2706](http://legislature.maine.gov/statutes/24-A/title24-Asec2706.html) | After 3 years from the date of issue of policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability, commencing after the expiration of such 3-year period. | ☐ |  |
| **ELIGIBILITY/ENROLLMENT** | | | | |
| Annual Open Enrollment/Special Enrollment Periods - *INDIVIDUAL* | 45 CFR §155.410  45 CFR §155.420 | A carrier may restrict enrollment in individual health plans to open enrollment periods and special enrollment periods to the extent not inconsistent with applicable federal law.  Must provide an annual open enrollment period that begins November 1, and extends through December 15, annually.  Must also provide a written annual open enrollment notification to each enrollee no earlier than September 1, and no later than September 30.  Must provide special enrollment periods consistent with this section, during which qualified individuals may enroll. A qualified individual or enrollee has 60 days for individuals from the date of a triggering event to select a plan.  **Also applies to off-marketplace plans.** | ☐ |  |
| Annual Open Enrollment/Special Enrollment Periods - *SHOP* | 45 CFR §155.725  45 CFR §155.725(g) | Enrollment periods under SHOP for plan years beginning on or after January 1, 2018.  (a) General requirements. The SHOP must ensure that issuers offering QHPs through the SHOP adhere to applicable enrollment periods, including special enrollment periods.  (b) Rolling enrollment in the SHOP. The SHOP must permit a qualified employer to purchase coverage for its small group at any point during the year. The employer's plan year must consist of the 12-month period beginning with the qualified employer's effective date of coverage, unless the plan is issued in a State that has elected to merge its individual and small group risk pools under section 1312(c)(3) of the Affordable Care Act, in which case the plan year will end on December 31 of the calendar year in which coverage first became effective.  (c) Special enrollment periods. (1) The SHOP must ensure that issuers offering QHPs through the SHOP provide special enrollment periods consistent with the section, during which certain qualified employees or dependents of qualified employees may enroll in QHPs and enrollees may change QHPs.  (2) The SHOP must ensure that issuers offering QHPs through a SHOP provide a special enrollment period for a qualified employee or a dependent of a qualified employee who;  (i) Experiences an event described in §155.420(d)(1) (other than paragraph (d)(1)(ii)), or experiences an event described in §155.420(d)(2), (4), (5), (7), (8), (9), (10), (11), or (12);  (ii) Loses eligibility for coverage under a Medicaid plan under title XIX of the Social Security Act or a State child health plan under title XXI of the Social Security Act; or  (iii) Becomes eligible for assistance, with respect to coverage under a SHOP, under such Medicaid plan or a State child health plan (including any waiver or demonstration project conducted under or in relation to such a plan).  (3) A qualified employee or dependent of a qualified employee who experiences a qualifying event described in paragraph (j)(2) of this section has:  (i) Thirty (30) days from the date of a triggering event described in paragraph (c)(2)(i) of this section to select a QHP through the SHOP; and  (ii) Sixty (60) days from the date of a triggering event described in paragraph (c)(2)(ii) or (iii) of this section to select a QHP through the SHOP;  (4) A dependent of a qualified employee is not eligible for a special enrollment period if the employer does not extend the offer of coverage to dependents.  (5) The effective dates of coverage for special enrollment periods are determined using the provisions of §155.420(b).  (6) Loss of minimum essential coverage is determined using the provisions of §155.420(e).  (d) Limitation. Qualified employees will not be able to enroll unless the employer group meets any applicable minimum participation rate implemented under §155.706(b)(10).  (e) Applicability date. The provisions of this section apply for plan years beginning on or after January 1, 2018.Must provide notification to a qualified employee of the annual open enrollment period in advance of such period. Also applies to off-marketplace plans. | ☐ |  |
| Dependent Children - Offer | [24-A M.R.S.A. §2847-R](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2847-R.html)  §2766 | All group dental insurance policies, contracts and certificates that offer dependent coverage must offer the opportunity to enroll a dependent child in the dental insurance coverage during the following periods:  A. From birth to 30 days of age; and  B. Any open or annual enrollment period. | ☐ |  |
| Dependent Children Up to Age 25 | [24-A M.R.S.A. §2833-B](http://legislature.maine.gov/statutes/24-A/title24-Asec4233-B.html)  [§2742-B](http://legislature.maine.gov/statutes/24-A/title24-Asec4233-B.html) | An individual or group health maintenance organization contract that offers coverage for dependent children must offer such coverage until the dependent child is 25 years of age. | ☐ |  |
| Dependent children with mental or physical illness  Dependent student on medically necessary leave of absence | [24-A M.R.S.A. §2742-A](http://legislature.maine.gov/statutes/24-A/title24-Asec2742-A.html)  PHSA §2728  (45 CFR §147.145) | Requires health insurance policies to continue coverage for dependent children up to 24 years of age who are unable to maintain enrollment in college due to mental or physical illness if they would otherwise terminate coverage due to a requirement that dependent children of a specified age be enrolled in college to maintain eligibility.  Issuer cannot terminate coverage of dependent student due to a medically necessary leave of absence before:   * The date that is 1 year after the first day of the leave; or * The date on which coverage would otherwise terminate under the terms of the coverage.   “Medically necessary leave of absence” means: a leave of absence or change of enrollment of a dependent child from a post-secondary education institution that:   1. Commences while the child is suffering from a serious illness or injury; 2. Is medically necessary; and 3. Causes the child to lose student status for purposes of coverage under the terms of coverage.   Issuer must include with any notice regarding a requirement for certification of student status for coverage, a description of the terms for continued coverage during medically necessary leaves of absence. | ☐ |  |
| Extension of dependent coverage to age 26  Dependent coverage must be available up to age 26 if policy offers dependent coverage. | [24-A M.R.S.A. §4320-B](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4320-B.html)  PHSA §2714  (75 Fed Reg 27122,  45 CFR §147.120) | A carrier offering a health plan subject to the requirements  of the federal Affordable Care Act that provides dependent  coverage of children shall continue to make such coverage  available for an adult child until the child turns 26 years of  age, consistent with the federal Affordable Care Act.  An insurer shall provide notice to policyholders regarding the availability of dependent coverage under this section upon each renewal of coverage or at least once annually, whichever occurs more frequently. Notice provided under this subsection must include information about enrolment periods and notice of the insurer’s definition of and benefit limitations for preexisting conditions.  Eligible children are defined based on their relationship  with the participant. Limiting eligibility is prohibited based  on: financial dependency on primary subscriber, residency,  student status, employment, eligibility for other coverage, marital status.  Terms of the policy for dependent coverage cannot vary based on the age of a child. | ☐ |  |
| Ensure Health Insurance for Certain Adults with Disabilities | [24-A M.R.S.A. §2742-C](https://legislature.maine.gov/statutes/24-A/title24-Asec2742-C.html) | The act requires health insurance polices that offer coverage for a dependent child to offer coverage for adults with disabilities who are unable to sustain themselves through employment in the same manner as for a dependent child on a parent’s police. The law clarifies that an insurer is required to offer coverage for a dependent child with a disability, at the option of the policyholder, regardless of age. | ☐ |  |
| 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. | ☐ |  |
| **CLAIMS** | | | | |
| Assignment of Benefits | [§2827-A](http://legislature.maine.gov/statutes/24-A/title24-Asec2827-A.html)  24-A M.R.S.A. [§2755](http://legislature.maine.gov/statutes/24-A/title24-Asec2755.html) | Permits insureds to assign benefits directly to their provider of care. Applies to medical and dental expense incurred plans. Does not include indemnity plans. | ☐ |  |
| Calculation of health benefits based on actual cost | [24-A M.R.S.A. §2185](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2185.html) | 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. | ☐ |  |
| Claim forms (Individual Only) | [24-A M.R.S.A. §2710](http://legislature.maine.gov/statutes/24-A/title24-Asec2710.html) | The insurer will furnish claim forms to the claimant. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy for filing of claim forms. | ☐ |  |
| Coordination of Benefits and Evidence of Coverage | [24-A M.R.S.A.§2844](http://legislature.maine.gov/statutes/24-A/title24-Asec2844.html)  [§2723-A](http://legislature.maine.gov/statutes/24-A/title24-Asec2723-A.html)  [Rule 191(§9-A and §9-D)](http://www.maine.gov/sos/cec/rules/02/031/031c191.doc)  [Rule 790](http://www.maine.gov/sos/cec/rules/02/031/031c790.doc) | Lists items that are required to be placed in an Evidence of Coverage. Also §9 states:  Evidences of coverage may contain a provision for coordination  of benefits, provided that such provision shall not relieve an  HMO of its duty to provide or arrange for a covered health care  service to an enrollee solely because the enrollee is entitled to  coverage under any other contract, policy or plan, including  coverage provided under government programs. | ☐ |  |
| Forms for proof of loss (Group Only) | [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  Lifetime or annual limits on the dollar value of Essential Health Benefits (EHB):  Cost Sharing Limitations  **\*2023 Plan Year Limits:**  Use current maximum limits as prescribed by CMS final rule. | [24-A M.R.S.A. §4318](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4318.html)  PHSA §2711  (75 Fed Reg 37188,  45 CFR §147.126);  45 §155.1065(a)(2)  45 CFR § 156.150(a) | 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.  Stand-alone dental plans must cover at least the pediatric dental EHB. 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.  A stand-alone dental plan covering the pediatric dental EHB must demonstrate that it has a reasonable annual limitation on cost-sharing as determined by the Exchange. Such annual limit is calculated without regard to EHBs provided by the QHP and without regard to out-of-network services**.** “Reasonable” to mean any annual limit on cost sharing that is at or below **$350** for a plan with one child enrollee or **$700** for a plan with two or more child enrollees. | ☐ |  |
| Limits on priority liens/Subrogation | [24-A M.R.S.A. §2836](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2836.html)  [§2729-A](http://legislature.maine.gov/statutes/24-A/title24-Asec2729-A.html) | Does this policy have subrogation provisions? If yes, see provisions below:  Subrogation requires prior written approval of the insured and allows such payments only on a just and equitable basis and not on the basis of a priority lien. | ☐ |  |
| Notice of claim | [24-A M.R.S.A. §2823](http://legislature.maine.gov/statutes/24-A/title24-Asec2823.html)  [§2709](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2709.html) | There shall be a provision that written notice of sickness or of injury must be given to the insurer within 20 days (30 days for group) after the date when such sickness or injury occurred. Failure to give notice within such time shall not invalidate nor reduce any claim, if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. | ☐ |  |
| 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. | ☐ |  |
| **Grievances & Appeals** | | | | |
| Grievance procedure - **Group** | [24-A M.R.S.A. §2816](http://legislature.maine.gov/statutes/24-A/title24-Asec2816.html) (non-ERISA group plans only) | The policy must contain the procedure to follow if an insured wishes to file a grievance regarding policy provisions or denial of benefits. | ☐ |  |
| Review and Arbitration -**Individual** | [24-A M.R.S.A. §2747](https://legislature.maine.gov/statutes/24-A/title24-Asec2747.html) | 1. Any insurer denying medical expense reimbursement benefits on any of the grounds specified in subsection 2 for a claim filed pursuant to a policy issued under this chapter, other than a policy that is subject to section 4312, shall provide the policy or certificate holder with an opportunity to have the denial reviewed by the insurer and to arbitrate the denial if not satisfied after review. The right to review and arbitrate must be prominently set forth in any written notice sent to the policy or certificate holder denying the claim. The arbitration is nonbinding and must be carried out in accordance with procedures established by the insurer.  2. The procedure specified in subsection 1 shall apply to the denial of any medical expense reimbursement benefits based upon:  A. A health condition existing prior to the effective coverage of the policy or certificate; or  B. The lack of medical necessity. |  |  |
| **Providers/Networks** | | | | |
| Dental hygiene therapist | [24-A MRSA](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2847-U.html)  [§2847-U](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2847-U.html)    [24-A MRSA](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2765-A.html)  [§2765-A](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2765-A.html) | 1. An insurer that issues individual dental insurance or health insurance that includes coverage for dental services shall provide coverage for dental services performed by a dental hygiene therapist licensed under Title 32, chapter 16, subchapter 3-C when those services are covered services under the contract and when they are within the lawful scope of practice of the dental hygiene therapist.  2.  Limits; coinsurance; deductibles.   A contract that provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.   3.  Coordination of benefits with dental insurance.   If an enrollee eligible for coverage under this section is eligible for coverage under a dental insurance policy or contract and a health insurance policy or contract, the insurer providing dental insurance is the primary payer responsible for charges under subsection 1 and the insurer providing individual health insurance is the secondary payer.   4.  Application.   The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed on or after January 1, 2015 in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date. | ☐ |  |
| Independent Practice Dental Hygienists | [24-A M.R.S.A. §2847-Q](http://legislature.maine.gov/statutes/24-A/title24-Asec2847-Q.html)  [§2765](http://legislature.maine.gov/statutes/24-A/title24-Asec2765.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 approval | 24-A M.R.S.A. [§2673-A](http://legislature.maine.gov/statutes/24-A/title24-Asec2673-A.html)  [Rule 360](http://www.maine.gov/sos/cec/rules/02/031/031c360.doc)  [Rule 850](http://www.maine.gov/sos/cec/rules/02/031/031c850.doc) | All managed care arrangements except MEWAs must be filed for adequacy & compliance with Rule 850 & Rule 360 access standards. | ☐ |  |
| **GENERAL DENTAL SERVICES/coverage** | | | | |
| Emergency services | [24-A M.R.S.A. §2847-A](http://legislature.maine.gov/statutes/24-A/title24-Asec2847-A.html)  [§2749-A](http://legislature.maine.gov/statutes/24-A/title24-Asec2749-A.html) | No prior authorization can be required for emergency services. | ☐ |  |
| Pediatric Dental | PHSA §2707  45 CFR §155.1065 (a)(3) | Stand-Alone dental plans are only required to provide coverage for pediatric dental essential health benefits.  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. | ☐ |  |