

**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, 2017**  
**(Revised 3/25/2016)**

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.

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
<b>GENERAL SUBMISSION REQUIREMENTS</b>				
Electronic (SERFF) Submission Requirements	<a href="#">24-A M.R.S.A. §2412 (2)</a>  <a href="#">Bulletin 360</a>	All filings must be filed electronically, using the <u>NAIC</u> System for Electronic Rate and Form Filing (SERFF). See <a href="http://www.serff.com">http://www.serff.com</a> .	<input type="checkbox"/>	
FILING FEES	<a href="#">24-A M.R.S.A. §601(17)</a>	\$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.	<input type="checkbox"/>	
Grounds for disapproval	<a href="#">24-A M.R.S.A. §2413</a>	Seven categories of the grounds for disapproving a filing.	<input type="checkbox"/>	
Readability	<a href="#">24-A M.R.S.A. §2441</a>	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,	<input type="checkbox"/>	

		Group Annuities as funding vehicles. Scores must be entered on form schedule tab in SERFF.		
Variability of Language	<a href="#">24-A M.R.S.A. §2412</a> <a href="#">§2413</a>	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.	<input type="checkbox"/>	
<b>GENERAL POLICY PROVISIONS</b>				
Free look period (Individual Only)	<a href="#">24-A M.R.S.A. §2717</a>	10 day free look.	<input type="checkbox"/>	
General format	<a href="#">24-A M.R.S.A. §2703</a>	Readability, term of policy described, cost disclosed, form number in bottom left corner.	<input type="checkbox"/>	
Grace Period	<a href="#">24-A M.R.S.A. §2809-A</a> <a href="#">§2707</a> <a href="#">Bulletin 288</a>	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.	<input type="checkbox"/>	
Legal actions	<a href="#">24-A M.R.S.A. §2828</a> <a href="#">§2715</a>	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.	<input type="checkbox"/>	
Notice of Rate Increase	<a href="#">24-A M.R.S.A. §2839</a> <a href="#">§2735-A</a>	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.	<input type="checkbox"/>	
Outline of Coverage – Dental Requirements	<a href="#">Rule 755, Sec. 7(N)</a>	This subsection describes the required provisions and disclosures for the Outline of Coverage for Dental Coverage.	<input type="checkbox"/>	
Outline of Coverage - General Requirements	<a href="#">Rule 755, Sec. 7(B)</a>	This subsection contains general requirements and disclosures for Outlines of Coverage.	<input type="checkbox"/>	

PPO Benefit level differential	<a href="#">24-A M.R.S.A. §2677-A</a>	There cannot be more than a 20% differential in benefits between preferred and non-preferred providers. <b>Superintendent can grant waiver for the 20%, in particular for designated providers for cost or quality.</b>	<input type="checkbox"/>	
Renewal provision	<a href="#">24-A M.R.S.A. §2820</a>  <a href="#">§2738</a>	Policy must contain the terms under which the policy can or cannot be renewed.	<input type="checkbox"/>	
Required disclosure statements on policies/certificates	<a href="#">Rule 755, Sec. 7(A)(22)</a>	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.”	<input type="checkbox"/>	
Third Party Notice, Cancellation and Reinstatement	<a href="#">24-A M.R.S.A. §2847-C</a>  <a href="#">24-A M.R.S.A. §2707-A</a>  <a href="#">Rule 580</a>	Third party notice of cancellation and reinstatement for cognitive impairment or functional incapacity.	<input type="checkbox"/>	
Time for suits (Group Only)	<a href="#">24-A M.R.S.A. §2828</a>	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.	<input type="checkbox"/>	
Time limit on defenses (Individual Only)	<a href="#">24-A M.R.S.A. §2706</a>	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.	<input type="checkbox"/>	

**ELIGIBILITY/ENROLLMENT**

<p>Annual Open Enrollment/Special Enrollment Periods - <i>INDIVIDUAL</i></p>	<p>45 CFR §155.410  45 CFR §155.420</p>	<p>Must provide an annual open enrollment period that begins November 1, 2016 and extends through January 31, 2017.</p> <p>Must also provide a written annual open enrollment notification to each enrollee no earlier than September 1, and no later than September 30.</p> <p>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.</p>	<p><input type="checkbox"/></p>	
<p>Annual Open Enrollment/Special Enrollment Periods - <i>SHOP</i></p>	<p>45 CFR §155.725  45 CFR §155.725(g)</p>	<p><u>Employer:</u></p> <p>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.</p> <p>Must provide qualified employers with a period of no less than 30 days prior to the completion of the employer’s plan year and before the annual employee open enrollment period, in which the qualified employer may change its participation in the SHOP for the next plan year.</p> <p>Must provide notification to a qualified employer of the annual election period in advance of such period.</p> <p><u>Employees:</u></p> <p>Must establish a standardized annual open enrollment period of no less than 30 days for qualified employees prior to the completion of the applicable qualified employer's plan year and after that employer's annual election period. Must provide notification to a qualified employee of the annual open</p>	<p><input type="checkbox"/></p>	

		<p>enrollment period in advance of such period.</p> <p>Must provide special enrollment periods consistent with this section, during which qualified individuals may enroll. A qualified individual or enrollee has 30 days for SHOP from the date of a triggering event to select a plan.</p> <p>Must provide notification to a qualified employee of the annual open enrollment period in advance of such period.</p> <p>Newly qualified employees. The SHOP must provide an employee who becomes a qualified employee outside of the initial or annual open enrollment period an enrollment period to seek coverage in a QHP beginning on the first day of becoming a qualified employee.</p>		
Dependent Children - Offer	<a href="#">24-A M.R.S.A. §2847-R §2766</a>	<p>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:</p> <p>A. From birth to 30 days of age; and</p> <p>B. Any open or annual enrollment period.</p>	<input type="checkbox"/>	
Dependent Children Up to Age 25	<a href="#">24-A M.R.S.A. §2833-B §2742-B</a>	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.	<input type="checkbox"/>	
Dependent children with mental or physical illness	<a href="#">24-A M.R.S.A. §2742-A</a>	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.	<input type="checkbox"/>	
Dependent student on medically necessary leave of absence	PHSA §2728 (45 CFR §147.145)	<p>Issuer cannot terminate coverage of dependent student due to a medically necessary leave of absence before:</p> <ul style="list-style-type: none"> <li>• The date that is 1 year after the first day of the leave; or</li> </ul>		

		<ul style="list-style-type: none"> <li>• The date on which coverage would otherwise terminate under the terms of the coverage.</li> </ul> <p>“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:</p> <ol style="list-style-type: none"> <li>1. Commences while the child is suffering from a serious illness or injury;</li> <li>2. Is medically necessary; and</li> <li>3. Causes the child to lose student status for purposes of coverage under the terms of coverage.</li> </ol> <p>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.</p>		
<p>Extension of dependent coverage to age 26</p> <p>Dependent coverage must be available up to age 26 if policy offers dependent coverage.</p>	<p><a href="#">24-A M.R.S.A. §4320-B</a></p> <p>PHSA §2714 (75 Fed Reg 27122, 45 CFR §147.120)</p>	<p>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.</p> <p>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.</p> <p>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.</p>	<input type="checkbox"/>	

		Terms of the policy for dependent coverage cannot vary based on the age of a child.		
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 19 <sup>th</sup> birthday month if non-coverage of those services after that time would negatively affect care.	<input type="checkbox"/>	
<b>CLAIMS</b>				
Assignment of Benefits	<a href="#">§2827-A</a> <a href="#">24-A M.R.S.A. §2755</a>	Permits insureds to assign benefits directly to their provider of care. Applies to medical and dental expense incurred plans. Does not include indemnity plans.	<input type="checkbox"/>	
Calculation of health benefits based on actual cost	<a href="#">24-A M.R.S.A. §2185</a>	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.	<input type="checkbox"/>	
Claim forms (Individual Only)	<a href="#">24-A M.R.S.A. §2710</a>	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.	<input type="checkbox"/>	
Coordination of Benefits and Evidence of	<a href="#">24-A M.R.S.A. §2844</a>	Lists items that are required to be placed in an Evidence of Coverage. Also §9 states:	<input type="checkbox"/>	

Coverage	<a href="#">§2723-A</a> <a href="#">Rule 191(§9-A and §9-D)</a> <a href="#">Rule 790</a>	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)	<a href="#">24-A M.R.S.A. §2825</a>	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.	<input type="checkbox"/>	
Lifetime Limits and Annual Aggregate Dollar Limits Prohibited	<a href="#">24-A M.R.S.A. §4318</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.	<input type="checkbox"/>	
Lifetime or annual limits on the dollar value of Essential Health Benefits (EHB):	PHSA §2711 (75 Fed Reg 37188, 45 CFR §147.126); 45 §155.1065(a)(2)	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.		

Cost Sharing Limitations <b>*2017 Plan Year Limits:</b> One Child: <b>\$350</b> Two or More Children: <b>\$700</b>	45 CFR § 156.150(a)	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 <b>\$350</b> for a plan with one child enrollee or <b>\$700</b> for a plan with two or more child enrollees.		
Limits on priority liens/Subrogation	<a href="#">24-A M.R.S.A. §2836</a>  <a href="#">§2729-A</a>	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.	<input type="checkbox"/>	
Notice of claim	<a href="#">24-A M.R.S.A. §2823</a>  <a href="#">§2709</a>	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.	<input type="checkbox"/>	
Payment of Claims	<a href="#">24-A M.R.S.A. §2436</a>	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.	<input type="checkbox"/>	
<b>GRIEVANCES &amp; APPEALS</b>				
Grievance procedure	<a href="#">24-A M.R.S.A. §2816</a> (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.	<input type="checkbox"/>	
<b>PROVIDERS/NETWORKS</b>				

Dental hygiene therapist	<a href="#">24-A MRSA §2847-U</a>  <a href="#">24-A MRSA §2765-A</a>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>	□	
Independent Practice Dental Hygienists	<a href="#">24-A M.R.S.A. §2847-Q</a>  <a href="#">§2765</a>	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	<a href="#">24-A M.R.S.A.</a>	All managed care arrangements except MEWAs must be filed for adequacy & compliance with Rule 850 & Rule 360 access	□	

	<a href="#">§2673-A, Rule 360</a>	standards.		
	<a href="#">Rule 850</a>			

**GENERAL DENTAL SERVICES/COVERAGE**

Emergency services	<a href="#">24-A M.R.S.A. §2847-A</a>  <a href="#">§2749-A</a>	No prior authorization can be required for emergency services.	<input type="checkbox"/>	
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.	<input type="checkbox"/>	