

**Maine Bureau of Insurance  
Form Filing Review Requirements Checklist  
H21 - Group Basic Hospital Expense (11)  
(Amended 11/2011)**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD IN FILING
Guaranteed Issue	<a href="#">24-A M.R.S.A. §2808-B</a>	Small group plans are guaranteed issue and renewed, community rated, and standardized plans.	
Dependent coverage	<a href="#">24-A M.R.S.A. §2809</a>	May not use residency as a requirement for dependents.	
Designation of Classification of Coverage	<a href="#">Rule 755, Sec. 6</a>	The heading of the cover letter of any form filing subject to this rule shall state the category of coverage set forth in 24-A M.R.S.A. § 2694 that the form is intended to be in.	
Classification, Disclosure, and Minimum Standards	<a href="#">Rule 755</a>	Must comply with all applicable provisions of Rule 755 including, but not limited to, Sections 4, 5, 6(A), 6(B), 7(A), 7(B), 7(C), and 8.	
Continuation of group coverage	<a href="#">24-A M.R.S.A. §2809-A(11)</a>	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).	
PPOs – Payment for Non-preferred Providers (as applicable)	<a href="#">24-A M.R.S.A. §2677-A(2)</a>	The benefit level differential between services rendered by preferred providers and nonpreferred providers may not exceed 20% of the allowable charge for the service rendered.	
Required provisions	<a href="#">24-A M.R.S.A. §2816 thru §2828</a>	Application statements, notice of claim, proof of loss, assignment of benefits, renewal provisions	
Child coverage	<a href="#">24-A M.R.S.A. §2833</a>	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	
Newborn coverage	<a href="#">24-A M.R.S.A. §2834</a>	Newborns are automatically covered under the plan from the moment of birth for the first 31 days	
Maternity and newborn care	<a href="#">24-A M.R.S.A. §2834-A</a>	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.	
Dependent enrollment	<a href="#">24-A M.R.S.A. §2834-B</a>	Enrollment for qualifying events.	
Limits on priority liens	<a href="#">24-A M.R.S.A. §2836</a>	No policy for health insurance shall provide for priority over the insured of payment for any hospital, nursing, medical or surgical services	
Coverage for breast cancer treatment	<a href="#">24-A M.R.S.A.</a>	Must provide coverage for reconstruction of both	

	<a href="#">§2837-C</a>	breasts to produce symmetrical appearance according to patient and physician wishes.	
Substance Abuse	<a href="#">24-A M.R.S.A. §2842, Rule 320</a>	Mandated coverage at minimum levels defined in the Rule.	
Coordination of benefits	<a href="#">24-A M.R.S.A. §2844</a>	Medicaid is always secondary	
Penalty for failure to notify of hospitalization (as applicable)	<a href="#">24-A M.R.S.A. §2847-A</a>	No penalty for hospitalization for emergency treatment	
Notification prior to cancellation	<a href="#">24-A M.R.S.A. §2847-C, Rule 580</a>	10 days prior notice, reinstatement required if insured has cognitive impairment or functional incapacity	
Penalty for noncompliance with utilization review (as applicable)	<a href="#">24-A M.R.S.A. §2847-D</a>	May not have a penalty of more than \$500 for failure to provide notification under a utilization review program	
Continuity on replacement of group policy	<a href="#">24-A M.R.S.A. §2849</a>	Continuity of coverage to persons who were covered under the replaced contract any time during the 90 days before the discontinuance of the replaced contract or policy.	
Extension of Benefits	<a href="#">24-A M.R.S.A. §2849-A</a>	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.	
Continuity for individual who changes groups	<a href="#">24-A M.R.S.A. §2849-B</a>	A person is provided continuity of coverage if the person was covered under the 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.	
Limitations on exclusions and waiting periods	<a href="#">24-A M.R.S.A. §2850</a>	A preexisting condition exclusion may not exceed 12 months, including the waiting period, if any. This section goes on to describe restrictions to preexisting condition exclusions.	
Guaranteed Renewal	<a href="#">24-A M.R.S.A. §2850-B</a>	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.	
Health plan accountability	<a href="#">Rule 850</a>	Standards in this rule include, but are not limited to, required provisions for grievance and appeal procedures, emergency services, and utilization review standards.	
Definition of UCR	<a href="#">24-A M.R.S.A. §4303(8)</a>	The data used to determine this charge must be Maine specific and relative to the region where the claim was incurred.	
Domestic Partner Coverage (Mandated <b>offer</b> )	<a href="#">24-A M.R.S.A. §2832-A</a>	Coverage must be offered for domestic partners of individual policyholders or group members. This section establishes criteria defining who is an eligible domestic partner.	
Definition of Medically Necessary	<a href="#">24-A M.R.S.A. §4301-A, Sub-§10-</a>	Forms that use the term "medically necessary" or similar terms must include this new definition	

	<u><a href="#">A</a></u>	<b>verbatim.</b>	
Health Plan Improvement Act	<u><a href="#">24-A M.R.S.A. §4301-A - §4314</a></u>	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	
Notice of Rate Increase	<u><a href="#">24-A M.R.S.A. §2839-A</a></u>	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.	
UCR Required Disclosure	<u><a href="#">24-A M.R.S.A. §4303(8)(A)</a></u>	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.	
Mental Health Coverage	<u><a href="#">24-A M.R.S.A. §2843, Rule 330</a></u>	Must provide, at a minimum, the following benefits for a person suffering from a mental or nervous condition: inpatient services, day treatment services, outpatient services, and home health care services. For groups with more than 20 employees mental health benefits can not be less extensive than for physical illnesses for the following mental illnesses: psychotic disorders (including schizophrenia), dissociative disorders, mood disorders, anxiety disorders, personality	

		<p>disorders, paraphilias, attention deficit ad disruptive behavior disorders, pervasive developmental disorders, tic disorders, eating disorders (including bulimia and anorexia), and substance abuse-related disorders.</p> <p>Mandated offer of parity for small groups – mental health benefits cannot be less extensive than for physical illnesses for the following mental illnesses: schizophrenia, bipolar disorder, pervasive developmental disorder (or autism), paranoia, panic disorder, obsessive compulsive disorder, and major depressive disorder.</p>	
Prohibition against Absolute Discretion Clauses Effective 9/13/03	<a href="#">24-A M.R.S.A. §4303(11)</a>	Carriers are prohibited from including or enforcing absolute discretion provisions in health plan contracts, certificates, or agreements.	
Extension of coverage for dependent children with mental or physical illness	<a href="#">24-A M.R.S.A. §2833-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.	
Coverage for Dependent Children Up to Age 25	<a href="#">24-A M.R.S.A. §2833-B</a>	A group health insurance policy that offers coverage for dependent children must offer such coverage until the dependent child is 25 years of age. Pursuant to §2833-B the child must be unmarried, have no dependent of their own, be a resident of Maine or be enrolled as a full-time student, and not have coverage under any other	

		<p>health policy/contract or federal or state government program.</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 enrollment periods and notice of the insurer's definition of and benefit limitations for preexisting conditions.</p>	
Timeline for second level grievance review decisions	<a href="#">24-A M.R.S.A. §4303(4)</a>	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.	
Coverage for Dental Hygienists	<a href="#">24-A M.R.S.A. §2847-Q</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.	
Telemedicine Services	<a href="#">24-A M.R.S.A. §4316</a>	A carrier offering a health plan in this State may not deny coverage on the basis that the coverage is provided through telemedicine if the health care service would be covered were it provided through in-person consultation between the covered person and a health care provider. Coverage for health care services provided through telemedicine must be determined in a	

		<p>manner consistent with coverage for health care services provided through in-person consultation. A carrier may offer a health plan containing a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation.</p>	
Childhood Immunizations	<p><a href="#">24-A M.R.S.A. §4302(1)(A)(5)</a></p>	<p>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.</p>	
Continuity of Prescription Drugs	<p><a href="#">24-A M.R.S.A. §4303 (7)(A)</a></p>	<p>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</p>	

		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.	
Continuity on replacement of group policy – Preexisting condition exclusions	<a href="#">24-A M.R.S.A. §2849</a>	An insurer or health maintenance organization may impose a preexisting condition exclusion period on a person who was subject to a preexisting condition exclusion under the replaced contract or policy. The preexisting condition exclusion period under the replacement policy or contract must end no later than the date the preexisting condition exclusion period would have ended under the replaced contract or policy.	
Calculation of health benefits based on actual cost	<a href="#">24-A M.R.S.A. §2185</a>	Policies must comply with the requirements of 24-A §2185 which requires calculation of health benefits based on actual cost. All health insurance policies, health maintenance organization plans and subscriber contracts or certificates of nonprofit hospital or medical service organizations with respect to which the insurer or organization has negotiated discounts with providers must provide for the calculation of all covered health benefits, including without limitation all coinsurance, deductibles and lifetime maximum benefits, on the basis of the net negotiated cost and must fully reflect any	

		discounts or differentials from charges otherwise applicable to the services provided. With respect to policies or plans involving risk-sharing compensation arrangements, net negotiated costs may be calculated at the time services are rendered on the basis of reasonably anticipated compensation levels and are not subject to retrospective adjustment at the time a cost settlement between a provider and the insurer or organization is finalized.	
Explanations Regarding Deductibles	<a href="#">24-A M.R.S.A. §2413</a>	All policies must include clear explanations of all of the following regarding deductibles: <ol style="list-style-type: none"> <li>1. Whether it is a calendar or policy year deductible.</li> <li>2. Clearly advise whether non-covered expenses apply to the deductible.</li> <li>3. Clearly advise whether it is a per person or family deductible or both.</li> </ol>	
Explanations for any Exclusion of Coverage for work related sicknesses or injuries	<a href="#">24-A M.R.S.A. §2413</a>	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.	
Autism Spectrum Disorders	<a href="#">24-A M.R.S.A. §2847-T</a>	All group health insurance policies, contracts and certificates must provide coverage for autism spectrum disorders for an individual covered	

		<p>under a policy, contract or certificate who is 5 years of age or under in accordance with the following.</p> <ol style="list-style-type: none"> <li>1. The policy, contract or certificate must provide coverage for any assessments, evaluations or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an autism spectrum disorder.</li> <li>2. The policy, contract or certificate must provide coverage for the treatment of autism spectrum disorders when it is determined by a licensed physician or licensed psychologist that the treatment is medically necessary.</li> <li>3. The policy, contract or certificate may not include any limits on the number of visits.</li> <li>4. The policy, contract or certificate may limit coverage for applied behavior analysis to \$36,000 per year. An insurer may not apply payments for coverage unrelated to autism spectrum disorders to any maximum benefit established under this paragraph.</li> <li>5. Coverage for prescription drugs for the treatment of autism spectrum disorders must be determined in the same manner as coverage for prescription drugs for the treatment of any other illness or condition.</li> </ol>	
Early Childhood Intervention	<a href="#">24-A M.R.S.A.</a>	All group health insurance policies, contracts and	

	<a href="#">§2847-S</a>	<p>certificates must provide coverage for children's early intervention services in accordance with this subsection. A referral from the child's primary care provider is required. The policy or contract may limit coverage to \$3,200 per year for each child not to exceed \$9,600 by the child's 3rd birthday.</p> <p>“Children's early intervention services” means services provided by licensed occupational therapists, physical therapists, speech-language pathologists or clinical social workers working with children from birth to 36 months of age with an identified developmental disability or delay as described in the federal Individuals with Disabilities Education Act, Part C, 20 United States Code, Section 1411  <a href="http://uscode.house.gov/uscode-cgi/fastweb.exe?getdoc+uscview+t17t20+4099+0++%28%29%20%20A.">http://uscode.house.gov/uscode-cgi/fastweb.exe?getdoc+uscview+t17t20+4099+0++%28%29%20%20A.</a></p>	
Coverage of prosthetic devices to replace an arm or leg	<a href="#">24-A M.R.S.A. §4315</a>	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 is also required for prosthetic devices that contain a microprocessor. Coverage for repair or replacement of a prosthetic device must also be included.	
Lifetime Limits and Annual Aggregate Dollar Limits Prohibited	<a href="#">§4318</a>	An individual or group health plan may not include a provision in a policy, contract, certificate or agreement that purports to terminate	

		<p>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.</p> <p>A carrier may however offer a health plan that limits benefits under the health plan for specified health care services on an annual basis.</p>	
Preventative Care Services	24-A M.R.S.A. <a href="#">§4320-A</a>	Coverage of preventive health services	