

Maine Bureau of Insurance
Form Filing Review Requirements Checklist
Group Specified Disease - H07G
(Revised 6/24/2015)

Confirm compliance and IDENTIFY the LOCATION (page number, section, paragraph, etc.) of the STANDARD IN FILING 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	STATE LAW/ RULE	DESCRIPTION OF REQUIREMENT	N/A →	CONFIRM COMPLIANCE AND IDENTIFY LOCATION OF STANDARD IN FILING MUST EXPLAIN WHY REQUIREMENT IS NOT APPLICABLE
GENERAL SUBMISSION REQUIREMENTS				
Electronic (SERFF) Submission Requirements	24-A M.R.S.A. §2412 (2) Bulletin 360	All filings must be filed electronically, using the <u>NAIC</u> System for Electronic Rate and Form Filing (SERFF). See http://www.serff.com .	<input type="checkbox"/>	
FILING FEES	24-A M.R.S.A. §601(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.	<input type="checkbox"/>	
Grounds for disapproval	24-A M.R.S.A. §2413	Seven categories of the grounds for disapproving a filing.	<input type="checkbox"/>	

Readability	24-A M.R.S.A. §2441	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.	<input type="checkbox"/>	
Variability of Language	24-A M.R.S.A. §2412 §2413	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"/>	
GENERAL POLICY PROVISIONS				
Classification of Coverage, Disclosure, and Minimum Standards	24-A M.R.S.A. §2694 Rule 755	These rules establish minimum standards for benefits under individual and group health insurance. These rules clarify the meaning of limited benefits health insurance as referred to in chapters 33, 35 and 56-A. The rules also set minimum standards for benefits for specified disease coverage.	<input type="checkbox"/>	
Designation of Classification of Coverage	Rule 755, Sec. 6	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.	<input type="checkbox"/>	
Explanations for any Exclusion of Coverage for work related sicknesses or injuries	24-A M.R.S.A. §2413	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.	<input type="checkbox"/>	

Explanations Regarding Deductibles	24-A M.R.S.A. §2413	All policies must include clear explanations of all of the following regarding deductibles: <ol style="list-style-type: none"> 1. Whether it is a calendar or policy year deductible. 2. Clearly advise whether non-covered expenses apply to the deductible. 3. Clearly advise whether it is a per person or family deductible or both. 	<input type="checkbox"/>	
Extension of Benefits	24-A M.R.S.A. §2849-A	Must provide an extension of benefits of at least 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.		
Notice Regarding Policies or Certificates Which are Not Medicare Supplement Policies	Rule 275, Sec. 17(D) Rule 755, Sec. 7(A)13	There must be a notice predominantly displayed on the first page of the policy that states: "THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."	<input type="checkbox"/>	
Rate Filing	24-A M.R.S.A. §2839	1. Filing of rate information. Every insurer shall file for approval by the superintendent every rate, rating formula, classification of risks and every modification of any formula or classification that it proposes to use in connection with individual health insurance policies and certain group policies specified in section 2701. 2. Filing; information. When a filing is not accompanied by the information upon which the	<input type="checkbox"/>	

		insurer supports such filing, or the superintendent does not have sufficient information to determine whether such filing meets the requirements that rates not be excessive, inadequate or unfairly discriminatory, the superintendent shall require the insurer to furnish the information upon which it supports the filing.		
Renewal provision	24-A M.R.S.A. §2820	Policy must contain the terms under which the policy can or cannot be renewed	<input type="checkbox"/>	
Representations on Applications	24-A M.R.S.A. §2411	There shall be a provision that all statements contained in any such application for insurance shall be deemed representations and not warranties.	<input type="checkbox"/>	
Time for suits	24-A M.R.S.A. §2828	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"/>	
EXCEPTED BENEFIT REQUIREMENTS				
Required Disclosures	79 FR 30240 45 CFR §148.220(b)(4) (v) Bulletin 396	The requirement of paragraph (b)(4)(iv) of this section applies to all hospital or other fixed indemnity insurance policy years beginning on or after January 1, 2015, and the requirement of paragraph (b)(4)(i) of this section applies to hospital or other fixed indemnity insurance policies issued on or after January 1, 2015, and to hospital or other fixed indemnity policies issued before that date, upon their first renewal occurring on or after October 1, 2016. This applies to all insurers writing hospital indemnity policies or other fixed indemnity	<input type="checkbox"/>	

	Appendices A and B	<p>policies sold in the individual market in Maine, including association coverage and other coverage that is issued through non-employer groups.</p> <p>All policies and certificates with effective dates on or after January 1, 2015, are subject to the Final Rule. In addition, the notice requirement applies to renewals for all policy years beginning on or after January 1, 2015.</p>		
New Sales Application Materials Notice	45 CFR § 148.220(b)(4) (iv)	<p>A notice is displayed prominently in the application materials in at least 14 point type that has the following language:</p> <p>“THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.”</p> <p>This notice can be a separate sheet in the application package. It does not need to be in the application or in the policy or certificate.</p>	<input type="checkbox"/>	
Renewal Notice	45 CFR § 148.220(b)(4) (iv)	<p>A notice is displayed prominently in the application materials in at least 14 point type that has the following language:</p> <p>“THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.”</p>	<input type="checkbox"/>	

	<p>Bulletin 396</p>	<p>This notice can be a separate sheet in the application package. It does not need to be in the application or in the policy or certificate.</p> <p>If no application for renewal is required because the policy or certificate renews automatically upon continued payment of premiums, then no later than October 1, 2016, the carrier shall send notice to each insured who was not given notice at the point of sale. The Bureau suggests that carriers use language substantially similar to the following notice:</p> <p>“THIS INSURANCE POLICY DOES NOT MEET THE AFFORDABLE CARE ACT’S REQUIREMENT THAT YOU MAINTAIN MINIMUM ESSENTIAL COVERAGE, ALSO KNOWN AS MAJOR MEDICAL INSURANCE. FAILURE TO MAINTAIN MINIMUM ESSENTIAL HEALTH COVERAGE MAY RESULT IN ADDITIONAL PAYMENT WITH YOUR TAXES. THIS INSURANCE COVERAGE WILL REMAIN IN FORCE AS LONG AS YOU CONTINUE TO PAY YOUR PREMIUMS.”</p> <p>The attestation requirement applies to all renewal applications for coverage effective on or after October 1, 2016.</p>		
Coordination of Benefits	<p>45 CFR § 148.220(b)(4) (ii)</p>	<p>There is no coordination between the provision of benefits and an exclusion of benefits under any other health coverage.</p>	<p><input type="checkbox"/></p>	

CLASSIFICATION OF COVERAGE, DISCLOSURE, AND MINIMUM STANDARDS – RULE 755

Minimum standards for benefits	24-A M.R.S.A. §2694	These rules establish minimum standards for benefits under individual and group health insurance. These rules clarify the meaning of limited benefits health insurance as referred to in chapters 33, 35 and 56-A. The rules also set minimum standards for benefits for specified disease coverage.	<input type="checkbox"/>	
Definitions	Sec. 4	<p>A. Except as provided in this rule, an individual health insurance policy or group health insurance policy or certificate delivered or issued for delivery to any person in this state and to which this rule applies shall contain definitions respecting the matters set forth below that comply with the requirements of this section. Definitions may need to be modified to comply with other requirements specified in Section 3(D). Including but not limited to:</p> <p>C. “Accident,” “accidental injury,” and “accidental means” shall be defined to employ “result” language and shall not include words that establish an accidental means test or use words such as “external, violent, visible wounds” or similar words of description or characterization. The definition shall not be more restrictive than the following: “accident,” “accidental injury,” or “accidental means” means accidental bodily injury sustained by the insured person that is the direct cause of the condition for which benefits are provided and that occurs while the insurance is in force.</p> <p>M. “Sickness” shall not be defined to be more restrictive than the following: “Sickness means</p>	<input type="checkbox"/>	

		illness or disease of an insured person.”		
Probationary or Waiting Periods	Sec. 5	<p>A. A policy shall not contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy, except:</p> <p>(1) A policy may specify a probationary or waiting period for sickness not to exceed 30 days from the effective date of the coverage of the insured person; and</p> <p>(2) A policy may specify a probationary or waiting period not to exceed six months for specified diseases or conditions and losses resulting from disease or condition related to hernia, disorder of reproduction organs, varicose veins, adenoids, appendix, and tonsils. However, the permissible six-month exception shall not be applicable where the specified diseases or conditions are treated on an emergency basis.</p>	<input type="checkbox"/>	
Pre-existing Condition Exclusions	<p>Rule 755, Sec. 5(B)</p> <p>Rule 755, Sec. 7(A)(8)</p>	<p>A policy shall not exclude coverage for a loss, due to a preexisting condition, that occurs beyond the 12 months following the issuance of the policy or certificate where the application or enrollment form for the insurance does not seek disclosure of prior illness, disease, physical conditions, medical care, or treatment and where the preexisting condition is not specifically excluded by the terms of the policy or certificate.</p> <p>If a policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and be labeled as</p>	<input type="checkbox"/>	

		“Preexisting Condition Limitations.”		
Limitations and Exclusions	Rule 755, Sec. 5(E)	A policy shall not limit or exclude coverage except as provided in this subsection.	<input type="checkbox"/>	
Minimum Standards Guaranteed Renewable or Noncancellable	Sec. 6(A)	<p>General Rules:</p> <p>(1) A “noncancellable,” “guaranteed renewable,” or “noncancellable and guaranteed renewable” individual health insurance policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. In addition, the policy shall provide that in the event of the insured’s death, the spouse of the insured, if covered under the policy, shall become the insured.</p> <p>(2)(d) A policy that is subject to the renewal requirements of 24-A M.R.S.A. § 2850-B and that permits the insurer to nonrenew for any reason other than nonpayment of premiums must be labeled “guaranteed renewable with limited exceptions.”</p> <p>(7) A policy may contain a provision relating to recurrent disabilities, but a provision relating to recurrent disabilities shall not specify that a recurrent disability be separated by a period greater than six months.</p> <p>J. Specified Disease Coverage</p> <p>(1) “Specified disease coverage” pays benefits based on diagnosis and/or treatment of a</p>	<input type="checkbox"/>	

specifically named disease or diseases. A specified disease policy must meet the following rules and one of the following sets of minimum standards for benefits:

(a) Insurance covering cancer only or cancer in conjunction with other conditions or diseases must meet the standards of Paragraph (4), (5) or (6) of this subsection.

(b) Insurance covering only specified diseases other than cancer must meet the standards of Paragraph (3) or (6) of this subsection.

(2) General Rules

The following rules shall apply to specified disease coverages in addition to all other rules imposed by this Rule. In cases of conflict between the following and other rules, the following rules shall govern.

(a) Policies covering a single specified disease or combination of specified diseases may not be sold or offered for sale other than as specified disease coverage under this section.

(b) Any policy issued pursuant to this section that conditions payment upon pathological diagnosis of a covered disease shall also provide that if the pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted instead.

(c) Notwithstanding any other provision of this rule, specified disease policies shall provide benefits, with the exception of any lump-sum

<p>Probationary period</p>		<p>benefit based on diagnosis of a specified disease, to any covered person not only for the specified diseases but also for any other conditions or diseases, directly caused or aggravated by the specified diseases or the treatment of the specified disease.</p> <p>(d) Individual specified disease coverage shall be guaranteed renewable or noncancellable.</p> <p>(e) A specified disease policy may contain a waiting or probationary period of no more than 30 days following the issue or reinstatement date of the policy or certificate.</p> <p>(f) An application or enrollment form for specified disease coverage shall contain a statement above the signature of the applicant or enrollee that a person to be covered is not covered also by any Title XIX program (Medicaid). The statement may be combined with any other statement for which the insurer may require the applicant's or enrollee's signature.</p> <p>(h) Except as permitted under 24-A M.R.S.A. §§ 2722 and 2723, benefits for specified disease coverage shall be paid regardless of other coverage.</p> <p>(i) After the effective date of the coverage (or applicable waiting period, if any) benefits based on care or confinement shall begin with the first day of care or confinement if the care or confinement is for a covered disease even though the diagnosis is made at some later date.</p>		
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<p>Preexisting condition</p>	<p>(j) Policies providing expense benefits shall not use the term “actual” when the policy pays up to only a limited amount of expenses. Instead, the policy should use language that does not have the misleading or deceptive effect of the phrase “actual charges.”</p> <p>(k) “Preexisting condition” shall not be defined more broadly than the following: “Preexisting condition means a condition for which medical advice, diagnosis, care, or treatment was recommended or received from a physician within the six (6) month period preceding the effective date of coverage of an insured person.”</p> <p>(l) Coverage for specified diseases will not be excluded due to a preexisting condition for a period greater than six (6) months following the effective date of coverage of an insured person.</p>		
<p>Minimum benefits</p>	<p>(3) Expense-incurred non-cancer coverages must provide the minimum benefits specified in either subparagraph (a) or subparagraph (b):</p> <p>(a) Coverage for each insured person for a specifically named disease (or diseases) with a deductible amount not in excess of \$250 and an overall aggregate benefit limit of no less than \$10,000 and a benefit period of not less than two years. The policy may provide coverage for any expenses necessarily incurred in the treatment of the disease but must cover at least the following incurred expenses:</p> <p>(i) Hospital room and board and any other</p>		

	<p>hospital furnished medical services or supplies;</p> <p>(ii) Treatment by a legally qualified physician or surgeon;</p> <p>(iii) Private duty services of a registered nurse;</p> <p>(iv) X-ray, radium, and other therapy procedures used in diagnosis and treatment;</p> <p>(v) Professional ambulance for local service to or from a local hospital;</p> <p>(vi) Blood transfusions, including expense incurred for blood donors;</p> <p>(vii) Drugs and medicines prescribed by a physician;</p> <p>(viii) The rental of an iron lung or similar mechanical apparatus;</p> <p>(ix) Braces, crutches, and wheel chairs as are deemed necessary by the attending physician for the treatment of the disease; and</p> <p>(x) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease.</p> <p>(b) Coverage for each insured person for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than \$25,000 payable at the rate of not less than \$50 a day while confined</p>	
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in a hospital and a benefit period of not less than 500 days.

(4) A policy that provides coverage for cancer-only coverage or in combination with one or more other specified diseases on an expense incurred basis shall cover at least the usual, customary, and reasonable charges, as determined consistent with § 7(A)(7) or a maximum allowance based on the Medicare Resource Based Relative Value Scale with appropriate adjustments for market conditions, for the following services and supplies for the care and treatment of cancer. The policy may provide for a deductible amount not in excess of \$250 for each insured person, an overall aggregate benefit limit of not less than \$10,000 for each insured person, and a benefit period of not less than three years. With the exception of subparagraphs (c) and (f), services and supplies provided on an outpatient basis may be subject to copayment by the insured person not to exceed 20% of covered charges. The requirements of this paragraph apply unless the Superintendent approves different minimum benefits based on a determination that the minimum benefits provided by the insurer are in the interest of the consumer.

(a) Treatment by, or under the direction of, a legally qualified physician or surgeon;

(b) X-ray, radium chemotherapy and other therapy procedures used in diagnosis and treatment;

(c) Hospital room and board and any other hospital furnished medical services or supplies;

- (d) Blood transfusions and their administration, including expense incurred for blood donors;
- (e) Drugs and medicines prescribed by a physician;
- (f) Professional ambulance for local service to or from a local hospital;
- (g) Private duty services of a registered nurse provided in a hospital;
- (h) Braces, crutches, and wheelchairs deemed necessary by the attending physician for the treatment of the disease;
- (i) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease;
- (j) (i) Home health care, which is necessary care and treatment provided at the insured person's residence by a home health care agency or by others under arrangements made with a home health care agency. The policy may require that the program of treatment be prescribed in writing by the insured person's attending physician and that the physician approve the program prior to its start. The policy also may require that the physician certify that confinement in a hospital or a skilled nursing facility would be otherwise required. A "home health care agency" is an entity that (1) is an agency approved under Medicare, (2) is licensed to provide home health care under applicable state law, or (3) meets all of the

following requirements:

(I) It is primarily engaged in providing home health care services;

(II) Its policies are established by a group of professional personnel (including at least one physician and one registered nurse);

(III) It is available to provide the care needed in the home seven days a week and has telephone answering service available 24 hours per day;

(IV) It provides, either directly or through contract, the services of a coordinator responsible for case discovery and planning and for assuring that the covered person receives the services ordered by the physician;

(V) It has under contract the services of a physician-advisor licensed by the State or a physician; and

(VI) It maintains clinical records on all patients.

(ii) Home health care includes, but is not limited to:

(I) Part-time or intermittent skilled nursing services provided by a registered nurse or a licensed practical nurse;

(II) Part-time or intermittent home health aide services that provide supportive services in the home under the supervision of a registered nurse or a physical, speech or hearing occupational

	<p>therapists;</p> <p>(III) Physical, occupational or speech and hearing therapy; and</p> <p>(IV) Medical supplies, drugs and medicines prescribed by a physician and related pharmaceutical services, and laboratory services, to the extent the charges or costs would have been covered if the insured person had remained in the hospital.</p> <p>(k) Physical, speech, hearing and occupational therapy;</p> <p>(l) Special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, chux, oxygen, surgical dressings, rubber shields, and colostomy and eleostomy appliances;</p> <p>(m) Prosthetic devices including wigs and artificial breasts;</p> <p>(n) Nursing home care for noncustodial services; and</p> <p>(o) Reconstructive surgery when deemed necessary by the attending physician.</p> <p>(p) Policies that offer transportation and lodging benefits for an insured person may not condition those benefits on hospitalization.</p> <p>(5) The requirements of this paragraph apply unless the Superintendent approves different minimum benefits based on a determination that</p>	
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the minimum benefits provided by the insurer are in the interest of the consumer.

(a) The following minimum benefits standards apply to cancer coverages written on a per diem indemnity basis. These coverages shall offer insured persons:

(i) A fixed-sum payment of at least \$100 for each day of hospital confinement for at least 365 days;

(ii) A fixed-sum payment equal to one half the hospital inpatient benefit for each day of hospital or nonhospital outpatient surgery, chemotherapy, and radiation therapy, for at least 365 days of treatment; and

(iii) A fixed-sum payment of at least \$50 per day for blood and plasma, which includes their administration whether received as an inpatient or outpatient for at least 365 days of treatment.

6) The following minimum benefits standards apply to lump-sum indemnity coverage of any specified disease:

(a) These coverages must pay indemnity benefits on behalf of insured persons of a specifically named disease or diseases. The benefits are payable as a fixed, one-time payment made within 30 days of submission to the insurer of proof of diagnosis of the specified disease.

(b) Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, the same dollar amounts shall be

		<p>payable regardless of the particular subtype of the disease with one exception. In the case of clearly identifiable subtypes with significantly lower treatments costs, lesser amounts may be payable so long as the policy clearly differentiates that subtype and its benefits.</p>		
<p>Required Disclosure Provisions</p>	<p>Sec. 7(A)</p>	<p>4) Each policy of individual health insurance and group health insurance shall include a renewal, continuation, or nonrenewal provision. The language or specification of the provision shall be consistent with the type of contract to be issued. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.</p> <p>(5) The following requirements apply to riders or endorsements added to a policy after date of issue, except as provided in subparagraph (e).</p> <p>(a) Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all riders or endorsements added to a policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder.</p> <p>(14) Insurers, except direct response insurers, shall give a person applying for specified disease insurance that covers cancer the NAIC Buyer's Guide to Cancer Insurance at the time of application enrollment and shall obtain the</p>		

		<p>recipient's written acknowledgement of the guide's delivery. Direct response insurers shall provide the Buyer's Guide upon request, but not later than the time that the policy or certificate is delivered.</p> <p>(15) All specified disease policies and certificates shall contain on the first page 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], a prominent statement as follows:</p> <p>Notice to Buyer: This is a specified disease [policy] [certificate]. This [policy] [certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. [If the policy covers cancer, include the following sentence.] Read your [policy] [certificate] carefully with the outline of coverage and the Buyer's Guide to Cancer Insurance.</p>		
General Outline of Coverage Requirements	Rule 755, Sec. 7(B)	This subsection contains general requirements and disclosures for Outlines of Coverage.	<input type="checkbox"/>	
Specified Disease Coverage (Outline of Coverage)	Rule 755, Sec. 7(K)	This subsection describes the required provisions and disclosures for the Outline of Coverage for Specified Disease coverage.	<input type="checkbox"/>	
ELIGIBILITY/ENROLLMENT				
Children of Unmarried Women	24-A M.R.S.A. §2832	Coverage of children must be made available to unmarried women on the same basis as married women.	<input type="checkbox"/>	
Definition of Dependent	24-A M.R.S.A. §2833	Children (including stepchildren, adopted children or children placed for adoption) under the age of 19. Cannot use financial dependency as a	<input type="checkbox"/>	

		requirement for eligibility. Adopted, or placed for adoption children are to be provided the same benefits as natural dependent children and stepchildren.		
Dependent Children Up to Age 25	24-A M.R.S.A. §2833-B	An individual health insurance policy that offers coverage for dependent children must offer such coverage until the dependent child is 25 years of age. 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 health policy/contract or federal or state government program.	<input type="checkbox"/>	
Dependent children with mental or physical illness	24-A M.R.S.A. §2833-A	Requires health insurance policies to continue coverage for dependent children 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"/>	
CLAIMS & UTILIZATION REVIEW				
Assignment of benefits	24-A M.R.S.A. §2827-A	All policies providing benefits for medical or dental care on an expense-incurred basis must contain a provision permitting the insured to assign benefits for such care to the provider of the care. An assignment of benefits under this section does not affect or limit the payment of benefits otherwise payable under the policy.	<input type="checkbox"/>	
Calculation of health benefits based on actual cost	24-A M.R.S.A. §2185	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	<input type="checkbox"/>	

		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	24-A M.R.S.A. §2413	All policies must include clear explanations of all of the following regarding deductibles: <ol style="list-style-type: none"> 1. Whether it is a calendar or policy year deductible. 2. Clearly advise whether non-covered expenses apply to the deductible. 3. Clearly advise whether it is a per person or family deductible or both. 		
Examination, autopsy	24-A M.R.S.A. §2826	There shall be a provision that the insurer has the right to examine the insured as often as it may reasonably require during the pendency of claim and also has the right to make an autopsy in case of death where it is not prohibited by law.	<input type="checkbox"/>	
Forms for proof of loss	24-A M.R.S.A. §2825	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	<input type="checkbox"/>	

		filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made		
Limits on priority liens/subrogation	24-A M.R.S.A. §2836	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"/>	Yes <input type="checkbox"/> Please provide citation for section in policy <hr/> No <input type="checkbox"/>
Notice of claim	24-A M.R.S.A. §2823	There shall be a provision that written notice of sickness or of injury must be given to the insurer within 30 days after the date when such sickness or injury occurred. Failure to give notice within such time shall not invalidate nor reduce any claim, if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.	<input type="checkbox"/>	
Payment of Claims	24-A M.R.S.A. §2436	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"/>	
Penalty for failure to notify of hospitalization	24-A M.R.S.A. §2847-A	No penalty for hospitalization for emergency treatment.	<input type="checkbox"/>	
GRIEVANCES & APPEALS				
Grievance procedure	24-A M.R.S.A. §2816	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"/>	
PRESCRIPTION DRUGS				
Off-label use of prescription drugs for cancer, HIV or AIDS	24-A M.R.S.A. §2837-F	Coverage required for off-label use of prescription drugs for treatment of cancer, HIV, or AIDS.	<input type="checkbox"/>	

	24-A M.R.S.A. §2837-G			
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