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| **Maine Bureau of Insurance** |
| Form Filing Review Requirements Checklist |
| TOI - H16I.004  |
| Individual Major Medical SHORT-TERM, LIMITED-DURATION  |
| Revised – 5/30/2024 |
| Carriers must confirm compliance and IDENTIFY the LOCATION (Form number, Page number, Section, Paragraph, etc.) of the standard in the form in the last column. Any response of N/A requires that a carrier explain why the requirement is not applicable. |
| This checklist is intended to provide a summary of State and Federal requirements for the TOI listed above. Please see the laws/rules referenced in the checklist below for the full requirement. |

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| **REVIEW REQUIREMENTS** | **REFERENCES** |  | **COMPLIANCE** |
| **GENERAL SUBMISSION REQUIREMENTS** |  |  |  |
| Electronic (SERFF) Filing Requirements: | [Title 24-A § 2412](https://legislature.maine.gov/statutes/24-A/title24-Asec2412.html)(2) [Bulletin 360](https://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/360_0.pdf) | All filings must be filed electronically, using the NAIC System for Electronic Rate and Form Filing (SERFF). See http://www.serff.com |  |
| FILING FEES | [Title 24-A § 601](https://legislature.maine.gov/statutes/24-A/title24-Asec601.html) (17) | $20.00 for Rate filings, rating rules filings, insurance policy, forms, riders, endorsements and certificates. See General Instructions page in SERFF for additional information on filing fee structure. Filing fees must be submitted by EFT in SERFF at the time of submission of the filing. All filings require a filing fee unless specifically excluded per 24-A M.R.S.A. §4222(1), and/or are a required annual report. |  |
| Grounds for disapproval | [Title 24-A § 2413](https://legislature.maine.gov/statutes/24-A/title24-Asec2413.html) | Seven categories of the grounds for disapproving a filing. |  |
| Readability | [Title 24-A § 2441](https://legislature.maine.gov/statutes/24-A/title24-Asec2441.html) | Minimum of 50.  Riders, endorsements, applications all must be scored. They may be scored either individually or in conjunction with the policy/certificate to which they will be attached. Exceptions: Federally mandated forms/language, Groups > 1000, Group Annuities as funding vehicles. Scores must be entered on form schedule tab in SERFF. |  |
| Variability of Language | [Title 24-A § 2412](https://legislature.maine.gov/statutes/24-A/title24-Asec2412.html)  [Title 24-A § 2413](https://legislature.maine.gov/statutes/24-A/title24-Asec2413.html) | Forms with variable bracketed information must include all the possible language that might be placed within the brackets. The use of too many variables will result in filing disapproval as Bureau staff may not be able to determine whether the filing is compliant with Maine laws and regulations. |  |
| **STATE DEFINITION** |  |  |  |
| Assessment of applicant’s eligibility for APTC or CSR under a qualified health plan | [Title 24-A § 2849](https://legislature.maine.gov/statutes/24-A/title24-Asec2849-B.html)-B(8)(E) | Upon offering an individual short-term, limited-duration policy for purchase, an insurer or the insurer's agent or broker must assess an applicant for eligibility for an advanced premium tax credit (APTC) or cost-sharing reduction (CSR) for coverage under a qualified health plan (QHP) purchased on the exchange pursuant to the federal ACA, as defined in Title 24-A § 2188(1)(A), and shall provide an estimate of the cost for coverage under a QHP after applying any APTC or CSR. |  |
| Definition; contract term | [Title 24-A § 2849](https://legislature.maine.gov/statutes/24-A/title24-Asec2849.html)-B(1)[Bulletin 438](https://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/438.pdf) | A short-term, limited-duration policy is an individual, nonrenewable policy issued for a term that does not extend beyond December 31st of the calendar year in which the policy is issued. |  |
| Sale and marketing restriction | [Title 24-A § 2849](https://legislature.maine.gov/statutes/24-A/title24-Asec2849-B.html)-B(8)(D) | An insurer or the insurer's agent or broker may not actively market or sell any short-term, limited-duration policy during any open enrollment period, except for a short-term, limited-duration policy that terminates coverage on December 31st of the calendar year in which it is sold. |  |
| Sale through in-person encounter required | [Title 24-A § 2849](https://legislature.maine.gov/statutes/24-A/title24-Asec2849.html)-B(8)(C)[Bulletin 438](https://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/438.pdf) | An insurer or the insurer’s agent or broker may not issue a short-term, limited-duration policy unless it has been sold through an in-person encounter, which means the agent or broker and the consumer must meet in the same physical location. |  |
| Short Term Policy Limitations | [Title 24-A § 2849](https://legislature.maine.gov/statutes/24-A/title24-Asec2849-B.html)-B(1) and (8)(B) | An insurer or the insurer's agent or broker may issue a short-term, limited-duration policy that replaces a prior short-term, limited-duration policy as long as the combined term of the new policy and all prior policies does not exceed 24 months and the individual has not been covered under any prior short-term, limited-duration policy for at least 12 months. All individuals making an application for coverage under a short-term, limited-duration policy must disclose any prior coverage under a short-term, limited-duration policy and the policy duration. |  |
| **STATE AND FEDERAL DISCLOSURES** |  |  |  |
| Federal notice requirement | [45 CFR § 144.103](https://www.ecfr.gov/cgi-bin/text-idx?SID=a3bb635afd7624f532acfe878eec552b&pitd=20180719&node=pt45.1.147&rgn=div5#se45.1.147_1103) | Short-term, limited duration policies must display prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the following notice with any additional information required by applicable state law: This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage. |  |
| State disclosure/notice requirements | [Title 24-A § 2849](https://legislature.maine.gov/statutes/24-A/title24-Asec2849.html)-B(8)(A)[Title 24-A § 2849](https://legislature.maine.gov/statutes/24-A/title24-Asec2849-B.html)-B(8)(F)[Bulletin 438](https://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/438.pdf)[Title 24-A § 2849](https://legislature.maine.gov/statutes/24-A/title24-Asec2849.html)-B(8)(G) | Upon offering an individual short-term, limited-duration policy for purchase, an insurer or the insurer's agent or broker must provide written disclosure, in at least 14-point type, of the following:(1) A summary of plan benefits, limits and exclusions in a standardized format similar to the format required for a qualified health plan (QHP) under the federal ACA that is specific to the exact policy being offered for purchase in this State, including, but not limited to, information about the circumstances in which covered benefits may be subject to balance billing and examples of how charges may be applied toward any cost sharing under the policy and billed to the individual policyholder. The standardized format is available online at: www.maine.gov/pfr/insurance/regulated/insurance\_companies/rate\_form\_checklists/life\_health/additional\_non\_qhp.html (2) A comparison of the short-term, limited-duration policy to a QHP in the terms, benefits and conditions of the policy, any exclusions, medical loss ratio requirements or the provisions of guaranteed renewal and continuity of coverage. The documents and information required to be disclosed by § 2849-B(8)(A) above must also be available through the insurer’s publicly accessible website. An insurer or the insurer's agent or broker shall provide, upon the purchase of a short-term, limited-duration policy; upon the expiration of the policy; and, if the policy is in effect during an open enrollment period, on November 1st of the calendar year in which the policy was sold, written notice of the following:(1) Disclosure that a short-term, limited-duration policy is not considered minimum essential coverage under the federal ACA and that termination of a policy is not a qualifying event for a special enrollment period; and(2) The dates for the next open enrollment period, the website address for the publicly accessible website of the exchange, as defined in Title 24-A § 2188(1)(A), and the toll-free telephone number for the exchange. |  |
| **GENERAL POLICY PROVISIONS** |  |  |  |
| AIDS | [Title 24-A § 2750](https://legislature.maine.gov/statutes/24-A/title24-Asec2750.html) | May not provide more restrictive benefits for expenses resulting from Acquired Immune Deficiency Syndrome (AIDS) or related illness. |  |
| Classification, Disclosure, and Minimum Standards | [Rule 755](https://www.maine.gov/sos/cec/rules/02/031/031c755.doc) | Must comply with all applicable provisions of [Rule 755](https://www.maine.gov/sos/cec/rules/02/031/031c755.doc) including, but not limited to, Sections 4, 5, 6(A), 6(F), and Sections 7(A), 7(B), and 7(G). |  |
| Death with Dignity | [Title 22 § 2140](https://legislature.maine.gov/statutes/22/title22sec2140.html)(19) | 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 the Maine Death With Dignity Act. |  |
| Examination, autopsy | [Title 24-A § 2714](https://legislature.maine.gov/statutes/24-A/title24-Asec2714.html)[Title 24-A § 2826](https://legislature.maine.gov/statutes/24-A/title24-Asec2826.html) | The following must be included:Physical examination and autopsy: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law. |  |
| Explanations for any Exclusion of Coverage for work related sicknesses or injuries | [Title 24-A § 2413](https://legislature.maine.gov/statutes/24-A/title24-Asec2413.html) | If the policy excludes coverage for work related sicknesses or injuries, clearly explain whether the coverage is excluded if the enrollee is exempt from requirements from state workers compensation requirements or has filed an exemption from the workers compensation laws. |  |
| Format of Policy | [Title 24-A § 2703](https://legislature.maine.gov/statutes/24-A/title24-Asec2703.html) | Time, place, and amount of premium payment required, Effective and Termination Date required, Name of Insured(s) required. Each form, including riders and endorsements, which comprise the contract, shall be identified by a form number in the lower left hand corner of the first page thereof. |  |
| Genetic Information Protections | [Title 24-A § 2159](https://legislature.maine.gov/statutes/24-A/title24-Asec2159-C.html)-C(2) | 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 | [Title 24-A § 2707](https://legislature.maine.gov/statutes/24-A/title24-Asec2707.html) | The policy must include a “Grace period” of not less than 7 days for weekly premium, 10 days for monthly premium, and 31 days for all other policies. |  |
| Intoxicants and narcotics | [Title 24-A § 2728](https://legislature.maine.gov/statutes/24-A/title24-Asec2728.html)[Title 24-A § 2829](https://legislature.maine.gov/statutes/24-A/title24-Asec2829.html)(3) | Policies cannot contain the following provision: “2728 and narcotics. The insurer is not liable for any loss sustained or contracted in consequence of the insured’s being intoxicated or under the influence of any narcotic or of any hallucinogenic drug, unless administered on the advice of a physician.” |  |
| Legal Actions | [Title 24-A § 2715](https://legislature.maine.gov/statutes/24-A/title24-Asec2715.html) | There shall be a provision as follows:Legal actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished. |  |
| Notice of Rate Increase | [Title 24-A § 2735-A](https://legislature.maine.gov/statutes/24-A/title24-Asec2735-A.html)[Title 24-A § 2839](https://legislature.maine.gov/statutes/24-A/title24-Asec2839-A.html)-A | Requires that insurers provide a minimum of 60 days written notice to policyholders prior to a rate filing for individual health insurance or a rate increase for group health insurance. See statute for the requirements for the notice. |  |
| Notice Regarding Policies or Certificates Which are Not Medicare Supplement Policies | [Title 24-A § 5013](https://legislature.maine.gov/statutes/24-A/title24-Asec5013.html)[Rule 275](https://www.maine.gov/sos/cec/rules/02/031/031c275.docx) § 17(E) | The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy or certificate delivered to insureds. The notice shall be in no less than twelve (12) point type and shall contain the following language: “THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company. If you have a Medicare Supplement policy or major medical policy, this coverage may be more than you need. For information call the Bureau of Insurance at 1-800-300-5000.” |  |
| Notification prior to cancellation; restrictions on cancellation, termination or lapse due to cognitive impairment or functional incapacity | [Title 24-A § 2707](https://legislature.maine.gov/statutes/24-A/title24-Asec2707-A.html)-A [Rule 580](https://www.maine.gov/sos/cec/rules/02/031/031c580.doc) | An insurer shall provide for notification of the insured person and another person, if designated by the insured, prior to cancellation of a health insurance policy for nonpayment of premium. 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. |  |
| Penalty for failure to notify of hospitalization prohibited | [Title 24-A § 2749-A](https://legislature.maine.gov/statutes/24-A/title24-Asec2749-A.html) | A policy may not include a provision permitting the insurer to impose a penalty for the failure of any person to notify the insurer of an insured person's hospitalization for emergency treatment. For purposes of this section, "emergency treatment" has the same meaning as defined in Title 22 § 1829. |  |
| PPOs – Payment for Non-preferred Providers (as applicable) | [Title 24-A § 2677-A](https://legislature.maine.gov/statutes/24-A/title24-Asec2677-A.html) | There cannot be more than a 20% differential in benefits between preferred and non-preferred providers. Superintendent can grant waiver for the 20%, in particular for designated providers for cost or quality. |  |
| Prior Authorization of Nonemergency services | [Title 24-A § 4304](https://legislature.maine.gov/statutes/24-A/title24-Asec4304.html)[Rule 850](https://www.maine.gov/sos/cec/rules/02/031/031c850.docx)(8) | A request for prior authorization of a nonemergency service must be answered within 72 hours or 2 business days, whichever is less, Both the provider and the enrollee on whose behalf the authorization was requested must be notified by the carrier of its determination. If the carrier needs additional information, it must decide within 72 hours or 2 business days, whichever is less, after receiving the requested information. If outside consultation is necessary, the carrier shall decide within 72 hours or 2 business days, whichever is less, from the time of the carrier’s initial response. If a carrier does not grant or deny a prior authorization request within these timeframes, the request is granted.In exigent circumstances, a carrier must answer a prior authorization request no more than 24 hours after receiving the request. Exigent circumstances exist when an enrollee's life, health or ability to regain maximum function is seriously jeopardized or when an enrollee is on a current course of treatment using a nonformulary drug. The carrier must notify the enrollee, the enrollee’s designee if applicable, and the provider of its coverage decision.Concurrent review determinations must be within 1 working day after obtaining all necessary information. Certification of extended stay or additional services: must notify the covered person and the provider rendering the service within 1 working day. Written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.Adverse benefit determination of concurrent review: must notify the covered person and the provider rendering the service within 1 working day. Continue the service without liability to the covered person until the covered person has been notified of the determination.Utilization Review Disclosure Requirements The carrier shall include a clear and reasonably comprehensive description of its utilization review procedures, including: Procedures for obtaining review of adverse benefit determinations; A Statement of rights and responsibilities of covered persons with respect to those procedures in the certificate of coverage or member handbook; The statement of rights shall disclose the member’s right to request in writing and receive copies of any clinical review criteria utilized in arriving at any adverse health care treatment decision. Carrier shall include a summary of its utilization review procedures in materials intended for prospective covered persons; Carriers requiring enrollees to initiate utilization review provide on its membership cards a toll-free telephone number to call for utilization review decisions. All notices to applicants, enrollees and policyholders or certificate holders subject to the requirements of the federal Affordable Care Act must be provided in a culturally and linguistically appropriate manner consistent with the requirements of the federal Affordable Care Act. Notices advising enrollees that services have been determined to be medically necessary must also advise whether the service is covered. Once a service has been approved, the approval cannot be withdrawn retrospectively unless fraudulent or materially incorrect information was provided at the time prior approval was granted. Also, if benefits are denied and the enrollee appeals, the carrier cannot deny the appeal without a written explanation addressing the issues that were raised by the enrollee. |  |
| Prohibition on preexisting condition exclusions | [Title 24-A § 2850](https://legislature.maine.gov/statutes/24-A/title24-Asec2850.html)(2) PHSA § 2704PHSA § 1255([75 Fed Reg 37188](https://www.federalregister.gov/documents/2010/06/28/2010-15278/patient-protection-and-affordable-care-act-preexisting-condition-exclusions-lifetime-and-annual), [45 CFR § 147](https://www.ecfr.gov/cgi-bin/text-idx?SID=985c38eeddaa13128929637cc7ec919e&pitd=20180719&node=pt45.1.147&rgn=div5#se45.1.147_1108).108) | A policy may not impose a preexisting condition exclusion. Prohibits the imposition of a preexisting condition exclusion by all group plans and non-grandfathered individual market plans. |  |
| Proof of loss | [Title 24-A § 2711](https://legislature.maine.gov/statutes/24-A/title24-Asec2711.html) | The following must be included: Proofs of loss: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. |  |
| Rebates | [Title 24-A § 2160](https://legislature.maine.gov/statutes/24-A/title24-Asec2160.html)[Title 24-A § 2163-A](https://legislature.maine.gov/statutes/24-A/title24-Asec2163-A.html)[Bulletin 426](https://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/426.pdf)[Bulletin 382](https://www.maine.gov/pfr/insurance/themes/insurance/pdf/382.pdf) | Are there any provisions that give the insured a benefit not associated with indemnification or loss? Yes \_\_\_No \_\_\_ |  |
| Reinstatement | [Title 24-A § 2808](https://legislature.maine.gov/statutes/24-A/title24-Asec2808.html) | If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. |  |
| Renewal provision | [Title 24-A § 2738](https://legislature.maine.gov/statutes/24-A/title24-Asec2738.html)[Title 24-A § 2820](https://legislature.maine.gov/statutes/24-A/title24-Asec2820.html) | Policy must contain the terms under which it can/ cannot be renewed. Must be placed prominently on the first page. |  |
| Required provisions | [Title 24-A § 2704](https://legislature.maine.gov/statutes/24-A/title24-Asec2705.html)[Title 24-A § 2705](https://legislature.maine.gov/statutes/24-A/title24-Asec2705.html)[Title 24-A § 2706](https://legislature.maine.gov/statutes/24-A/title24-Asec2706.html)[Title 24-A § 2707](https://legislature.maine.gov/statutes/24-A/title24-Asec2707.html)[Title 24-A § 2708](https://legislature.maine.gov/statutes/24-A/title24-Asec2708.html)[Title 24-A § 2709](https://legislature.maine.gov/statutes/24-A/title24-Asec2709.html)[Title 24-A § 2710](https://legislature.maine.gov/statutes/24-A/title24-Asec2710.html)[Title 24-A § 2711](https://legislature.maine.gov/statutes/24-A/title24-Asec2711.html)[Title 24-A § 2712](https://legislature.maine.gov/statutes/24-A/title24-Asec2712.html)[Title 24-A § 2713](https://legislature.maine.gov/statutes/24-A/title24-Asec2713.html)[Title 24-A § 2714](https://legislature.maine.gov/statutes/24-A/title24-Asec2714.html)[Title 24-A § 2715](https://legislature.maine.gov/statutes/24-A/title24-Asec2715.html)[Title 24-A § 2716](https://legislature.maine.gov/statutes/24-A/title24-Asec2716.html) | Entire contract – changes, time limit on certain defenses, reinstatement, notice of claims, payment of claims, claim forms, proof of loss, right to examine and return policy. |  |
| Right to Examine and Return Policy ("free look period") | [Title 24-A § 2717](https://legislature.maine.gov/statutes/24-A/title24-Asec2717.html) | The policy, or a separate rider attached thereto when delivered, must include a provision stating that the person being issued the policy must be permitted to return the policy within 10 days of delivery to such person and to have a refund of premium paid if not satisfied with the policy for any reason after examining it. The policy may be returned to the insurer at its home or branch office to the agent through whom it was applied for, and shall be void from the beginning, as if the policy had not been issued. The provision must be under an appropriate caption in the policy, and if it’s not printed on the face page, adequate notice of the provision must be printed or stamped conspicuously on the face page. |  |
| Time Limit on Certain Defenses | [Title 24-A § 2706](https://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** |  |  |  |
| Dependent children coverage to age 26 | [Title 24-A § 2742](https://legislature.maine.gov/statutes/24-A/title24-Asec2742-B.html)-B | An individual health insurance policy that offers coverage for dependent children must offer such coverage until the dependent child is 26 years of age. |  |
| Dependent children with mental or physical illness | [Title 24-A § 2742](https://legislature.maine.gov/statutes/24-A/title24-Asec2742-A.html)-A PHSA § 2728([45 CFR § 147](https://www.ecfr.gov/cgi-bin/text-idx?SID=985c38eeddaa13128929637cc7ec919e&pitd=20180719&node=pt45.1.147&rgn=div5#se45.1.147_1145).145) | Requires health insurance policies to continue coverage for dependent children up to 26 years of age who are unable to maintain enrollment in college due to mental or physical illness if they would otherwise terminate coverage due to a requirement that dependent children of a specified age be enrolled in college to maintain eligibility. 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: Commences while the child is suffering from a serious illness or injury; Is medically necessary; and 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. |  |
| Domestic partner benefits | [Title 24-A § 2741](https://legislature.maine.gov/statutes/24-A/title24-Asec2741-A.html)-A | Contracts must make available to policyholders the option for additional benefits for the domestic partner of a policyholder at appropriate rates and under the same terms and conditions as are provided to spouses of married policyholders. This section provides criteria defining "domestic partner" for purposes of this requirement and what evidence may be required as a condition of eligibility. |  |
| **CLAIMS** |  |  |  |
| Assignment of benefits | [Title 24-A § 2755](https://legislature.maine.gov/statutes/24-A/title24-Asec2755.html) | 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. |  |
| Calculation of health benefits based on actual cost | [Title 24-A § 2185](https://legislature.maine.gov/statutes/24-A/title24-Asec2185.html) | If the insurer has negotiated discounts with providers, the insurer must provide for the calculation of all covered health benefits, including without limitation all coinsurance, deductibles and lifetime maximum benefits, on the basis of the net negotiated cost and must fully reflect any discounts or differentials from charges otherwise applicable to the services provided. With respect to policies involving risk-sharing compensation arrangements, net negotiated costs may be calculated at the time services are rendered on the basis of reasonably anticipated compensation levels and are not subject to retrospective adjustment at the time a cost settlement between a provider and the insurer or organization is finalized. |  |
| Claim Forms | [Title 24-A § 2710](https://legislature.maine.gov/statutes/24-A/title24-Asec2710.html) | The policy must include the “Claim forms” provision set forth in Section 2710. |  |
| Claims for Office Visits that include Preventive Health Services | [45 CFR § 147](https://www.ecfr.gov/cgi-bin/text-idx?SID=a3bb635afd7624f532acfe878eec552b&pitd=20180719&node=pt45.1.147&rgn=div5#se45.1.147_1130).130 (a)(1) [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(15) | Policies and certificates must include clear explanations regarding how claims will be paid for office visits that include preventive health services, and the policyholder’s cost sharing may not be greater than the following:If an item or service described in 45 CFR §147.130 (a)(1):1. Is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan or issuer may impose cost-sharing requirements with respect to the office visit. 2. Is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then a plan or issuer may not impose cost-sharing requirements with respect to the office visit.Services related to a specific health concern, condition or injury may be separately billed as an office visit and may be subject to cost-sharing requirements as provided in the health plan. |  |
| Credit toward Deductible | [Title 24-A § 2723](https://legislature.maine.gov/statutes/24-A/title24-Asec2723-A.html)-A(3) | When an insured is covered under more than one expense-incurred health plan, payments made by the primary plan, payments made by the insured and payments made from a health savings account or similar fund for benefits covered under the secondary plan must be credited toward the deductible of the secondary plan. This subsection does not apply if the secondary plan is designed to supplement the primary plan. |  |
| Explanations Regarding Deductibles | [Title 24-A § 2413](https://legislature.maine.gov/statutes/24-A/title24-Asec2413.html) | All policies must include clear explanations of all of the following regarding deductibles: Whether it is a calendar or policy year deductible. Clearly advise whether non-covered expenses apply to the deductible. Clearly advise whether it is a per person or family deductible or both. |  |
| Limits on priority liens/subrogation | [Title 24-A § 2729](https://legislature.maine.gov/statutes/24-A/title24-Asec2729-A.html)-A | No policy shall provide for priority over the insured member of payment for any hospital, nursing, medical or surgical services, or of any expenses paid or reimbursed under the policy, in the event the insured member is entitled to receive payment reimbursement from any other person as a result of legal action or claim, except as provided in this section. A policy may contain a provision that allows such payments, if that provision is approved by the superintendent, and if that provision requires the prior written approval of the insured and allows such payments only on a just and equitable basis and not on the basis of a priority lien. A just and equitable basis shall mean that any factors that diminish the potential value of the insured's claim shall likewise reduce the share in the claim for those claiming payment for services or reimbursement. |  |
| Maximum Allowable Charges | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(8) | If benefits for covered services are limited to a maximum amount based on any combination of usual, customary and reasonable charges or other similar method, the carrier must: (1) Clearly disclose that the insured or enrollee may be subject to balance billing as a result of claims adjustment; and (2) 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. Must 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. The data used to determine this charge must be Maine specific and relative to the region where the claim was incurred. |  |
| Notice of claim | [Title 24-A § 2709](https://legislature.maine.gov/statutes/24-A/title24-Asec2709.html) | There shall be a provision that written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.In a policy providing a loss-of-time benefit which may be payable for at least 2 years, an insurer may, at its option, add additional language to the required “Notice of claim” provision, as provided in Section 2709. |  |
| Penalty for noncompliance with utilization review | [Title 24-A § 2749-B](https://legislature.maine.gov/statutes/24-A/title24-Asec2749-B.html) | A health insurance policy issued or renewed in this State after April 8, 1994 may not contain a provision that permits, upon retroactive review and confirmation of medical necessity, the imposition of a penalty of more than $500 for failure to provide notification under a utilization review program. This section does not limit the right of insurers to deny a claim when appropriate prospective or retroactive review concludes that services or treatment rendered were not medically necessary. |  |
| Protection from Balance Billing | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html) (8-A) | If the carrier has a provider network, an enrollee's responsibility for payment under a managed care plan when covered health care is rendered by participating providers must be limited to the cost-sharing provisions expressly disclosed in the contract, such as deductibles, copayments and coinsurance. If the enrollee has paid their share of the charge as specified in the plan, the carrier shall hold the enrollee harmless from any additional amount owed to a participating provider for covered health care. |  |
| Protection from Surprise Bills | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303-C.html)-C[Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303-E.html)-E[Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303-F.html)-FRule 365 | With respect to a “surprise bill” (defined below) or a bill for covered emergency services rendered by an out-of-network provider:1. A carrier shall require an enrollee to pay only the applicable coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed for health care services if the services were rendered by a network provider. The carrier shall calculate any coinsurance amount based on the median network rate for that service per paragraph B. 2. If a carrier has an inadequate network, as determined by the superintendent, the carrier shall ensure that the enrollee obtains the covered service at no greater cost to the enrollee than if the service were obtained from a network provider or shall make other arrangements acceptable to the superintendent.3unless the carrier and out-of-network provider agree otherwise, a carrier shall reimburse an out-of-network provider for ambulance services that are covered emergency services at the rate required by section 4303-F. |  |
| Referrals by Direct Primary Care Providers | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(22) [Bulletin 434](https://www.maine.gov/pfr/insurance/themes/insurance/pdf/434.pdf) | A plan requiring a referral from a participating primary care provider to receive a health care service covered under a health plan must provide that a referral made by a direct primary care provider (defined below) who has a direct primary care service agreement (defined below) with an enrollee will be honored on the same terms as a referral made by a participating primary care provider. A carrier may not deny payment for any covered health care service solely on the basis that the enrollee's referral was made by a direct primary care provider who is not a member of the carrier's provider network. |  |
| Timely Payment of Undisputed Insurance Claims | [Title 24-A § 2436](https://legislature.maine.gov/statutes/24-A/title24-Asec2436.html)[Title 24-A § 4207](https://legislature.maine.gov/statutes/24-A/title24-Asec4207.html)[Title 24-A § 4222-B](https://legislature.maine.gov/statutes/24-A/title24-Asec4222-B.html)(13)[Rule 191](https://www.maine.gov/sos/cec/rules/02/031/031c191.docx)(9)(C)(4) | An undisputed claim for payment of benefits under a policy or certificate of insurance delivered or issued for delivery in this State is payable within 30 days after proof of loss is received by the insurer An ”undisputed claim” means a manually or electronically submitted claim from a health care provider or health care facility that:A. Contains all the required data elements necessary for accurate adjudication without the need for additional information;B. Is not materially deficient or improper, including lacking substantiating documentation required by the carrier; andC. Has no particular or unusual circumstances requiring special treatment that prevent payment from being made by the carrier. |  |
| Enhance Access to a Second Opinion for Health Care Services or Treatment | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(25) | An enrollee in a health plan may not be required to obtain a 2nd opinion from a provider that practices in the same office location as the enrollee's provider, even if that office is the only in-network provider for the service. A carrier may not apply a greater deductible, coinsurance or copayment for the 2nd opinion than if they received the 2nd opinion in-network.  |  |
| Expedite the Health Insurance Referral Process for Specialists by Allowing Referrals During Urgent Care Visits | [Title 24-A § 4301](https://legislature.maine.gov/statutes/24-A/title24-Asec4301-A.html)-A(2-A)[Title 24-A § 4301](https://legislature.maine.gov/statutes/24-A/title24-Asec4301.html)-A(21)[Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(22-A) | A carrier may not deny payment for any covered behavioral health care service or physical therapy service solely on the basis that the referral was made during an urgent care visit. A carrier may not apply greater cost sharing for an urgent care referral than a primary care referral. |  |
| Prior Authorization Requirements for Physical and Occupational Therapy Services | [Title 24-A § 4304](https://legislature.maine.gov/statutes/24-A/title24-Asec4304.html)(1)[Title 24-A § 4304](https://legislature.maine.gov/statutes/24-A/title24-Asec4304.html)-A | A carrier may not require prior authorization for rehabilitative or habilitative services, including, but not limited to, physical therapy services, occupational therapy services or chiropractic services, for the first 12 visits of each new episode of care. This does not limit the right of a carrier to deny a claim when an appropriate review concludes that the services or treatment were not medically necessary. |  |
| **GRIEVANCES & APPEALS** |  |  |  |
| Grievance and Appeal Procedures | [Title 24-A § 2747](https://legislature.maine.gov/statutes/24-A/title24-Asec2747.html)[Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(4)[Title 24-A § 4312](https://legislature.maine.gov/statutes/24-A/title24-Asec4312.html)[Rule 850](https://www.maine.gov/sos/cec/rules/02/031/031c850.docx) § 8 [Rule 850](https://www.maine.gov/sos/cec/rules/02/031/031c850.docx) § 9 | All policies must specify all grievance and appeals procedures contained in [Rule 850](https://www.maine.gov/sos/cec/rules/02/031/031c850.docx), including 1) procedures for review decisions; 2) requests for reconsideration; 3) the first and second level appeals of adverse health care treatment decisions (including prior authorizations), including expedited first level appeals; 4) the first and second level appeals of adverse benefit determinations not involving heath care treatment decisions, 5) the right to external review (including prior authorizations), and 6) the right to file a grievance regarding policy provisions or denial of benefits. Enrollees are entitled to provider notice as required by statute when acting as enrollees' representative.PLEASE REFER TO [RULE 850](https://www.maine.gov/sos/cec/rules/02/031/031c850.docx) FOR FULL COMPLIANCE CRITERIA. |  |
| **PROVIDERS / NETWORKS** |  |  |  |
| Acupuncture Services | [Title 24-A § 2745](https://legislature.maine.gov/statutes/24-A/title24-Asec2745-B.html)-B | Policies that provide coverage for acupuncture must cover those services when performed by an acupuncturist licensed in Maine under the same conditions that apply to the services when performed by a licensed physician. |  |
| Certified nurse practitioners, certified midwives, and certified nurse (aka: Advanced midwives Practice Registered Nurse) | [Title 24-A § 2757](https://legislature.maine.gov/statutes/24-A/title24-Asec2757.html)[Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(5) | Coverage for services provided by nurse practitioners, certified midwives, and certified nurse midwives and allows nurse practitioners to serve as primary care providers. |  |
| Coverage for Services Provided by Certified Registered Nurse Anesthetists | [Title 24-A § 4320](https://legislature.maine.gov/legis/statutes/24-A/title24-Asec4320-Q.html)-Q | Coverage for services provided by certified registered nurse anesthetists (CRNA) is required. |  |
| Coverage for services provided by registered nurse first assistants | [Title 24-A § 2758](https://legislature.maine.gov/statutes/24-A/title24-Asec2758.html) | Benefits must be provided for coverage for surgical first assisting benefits or services shall provide coverage and payment under those contracts to a registered nurse first assistant who performs services that are within the scope of a registered nurse first assistant's qualifications. |  |
| Enrollee choice of PCP | [Title 24-A § 4306](https://legislature.maine.gov/statutes/24-A/title24-Asec4306.html) | A carrier offering or renewing a managed care plan shall allow enrollees to choose their own primary care providers, as allowed under the managed care plan's rules, from among the panel of participating providers made available to enrollees under the managed care plan's rules. A carrier shall allow physicians, including, but not limited to, pediatricians and physicians who specialize in obstetrics and gynecology, and certified nurse practitioners who have been approved by the State Board of Nursing to practice advanced practice registered nursing without the supervision of a physician pursuant to Title 32, section 2102, subsection 2-A to serve as primary care providers for managed care plans. |  |
| Inadequate Network | [Rule 850](https://www.maine.gov/sos/cec/rules/02/031/031c850.docx) § 7(B)(5) | If the carrier has an insufficient number or type of participating providers to provide a covered benefit, the carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers. |  |
| Independent Practice Dental Hygienists | [Title 24-A § 2765](https://legislature.maine.gov/statutes/24-A/title24-Asec2765.html)[Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-Q.html)-Q | Coverage must be provided for dental services performed by a licensed independent practice dental hygienist when those services are covered services under the contract and when they are within the lawful scope of practice of the independent practice dental hygienist. |  |
| Naturopathic doctor | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-K.html)-K | Must provide coverage for health care services performed by a naturopathic doctor licensed in this State when those services are covered services under the plan when performed by any other health care provider and those services are within the lawful scope of practice of the naturopathic doctor. Any deductible, copayment or coinsurance cannot exceed the deductible, copayment or coinsurance applicable to the same service provided by other health care providers. |  |
| Pharmacy Providers – “Any Willing Pharmacy” | [Title 24-A § 4317](https://legislature.maine.gov/statutes/24-A/title24-Asec4317.html) | A carrier that provides coverage for prescription drugs as part of a health plan may not refuse to contract with a pharmacy provider that is qualified and is willing to meet the terms and conditions of the carrier's criteria for pharmacy participation as stipulated in the carrier's contractual agreement with its pharmacy providers. |  |
| Provider directories | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303-D.html)-D | 1. Requirement. A carrier shall make available provider directories in accordance with this section. A. A carrier shall post electronically a current and accurate provider directory for each of its network plans with the information and search functions described in subsection 2. In making the directory available electronically, the carrier shall ensure that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number. B. A carrier shall update each provider directory at least monthly. The carrier shall periodically audit at least a reasonable sample size of its provider directories for accuracy and retain documentation of such an audit to be made available to the superintendent upon request. C. A carrier shall provide a print copy, or a print copy of the requested directory information, of a current provider directory with the information described in subsection 2 upon request of a covered person or a prospective covered person. D. For each network plan, a carrier shall include in plain language in both the electronic and print directories the following general information: (1) A description of the criteria the carrier has used to build its provider network; (2) If applicable, a description of the criteria the carrier has used to tier providers;(3) If applicable, how the carrier designates the different provider tiers or levels in the network and identifies for each specific provider, hospital or other type of facility in the network the tier in which each is placed, whether by name, symbols, grouping or another designation, so that a covered person or a prospective covered person is able to identify the provider tier; and (4) If applicable, that authorization or referral may be required to access some providers. E. A carrier shall make clear in both its electronic and print directories which provider directory applies to which network plan by including the specific name of the network plan as marketed and issued in this State. The carrier shall include in both its electronic and print directories a customer service e-mail address and telephone number or electronic link that covered persons or the general public may use to notify the carrier of inaccurate provider directory information. F. For the information required pursuant to subsections 2, 3 and 4 in a provider directory pertaining to a health care professional, a hospital or a facility other than a hospital, a carrier shall make available through the directory the source of the information and any limitations on the information, if applicable. G. A provider directory, whether in electronic or print format, must accommodate the communication needs of individuals with disabilities and include a link to or information regarding available assistance for persons with limited English proficiency. 2. Information in searchable format. A carrier shall make available through an electronic provider directory, for each network plan, the information under this subsection in a searchable format: A. For health care professionals: (1) The health care professional's name; (2) The health care professional's gender; (3) The participating office location or locations; (4) The health care professional's specialty, if applicable; (5) Medical group affiliations, if applicable; (6) Facility affiliations, if applicable; (7) Participating facility affiliations, if applicable; (8) Languages other than English spoken by the health care professional, if applicable; and (9) Whether the health care professional is accepting new patients; B. For hospitals: (1) The hospital's name; (2) The hospital's type;(3) Participating hospital location; and (4) The hospital's accreditation status. C. For facilities, other than hospitals, by type: (1) The facility's name; (2) The facility's type; (3) Types of services performed; and (4) Participating facility location or locations. 3. Additional information. In the electronic provider directories for each network plan, a carrier shall make available the following information in addition to all of the information available under subsection 2: A. For health care professionals: (1) Contact information;(2) Board certifications; and (3) Languages other than English spoken by clinical staff, if applicable;B. For hospitals, the telephone number; and C. For facilities other than hospitals, the telephone number. 4. Information available in printed form. A carrier shall make available in print, upon request, the following provider directory information for the applicable network plan: A. For health care professionals: (1) The health care professional's name; (2) The health care professional's contact information; (3) Participating office location or locations; (4) The health care professional's specialty, if applicable;(5) Languages other than English spoken by the health care professional, if applicable; and (6) Whether the health care professional is accepting new patients; B. For hospitals: (1) The hospital's name; (2) The hospital's type; and (3) Participating hospital location and telephone number; and C. For facilities, other than hospitals, by type: (1) The facility's name; (2) The facility's type; (3) Types of services performed; and (4) Participating facility location and telephone number. The carrier shall include a disclosure in the directory that the information included in the directory is accurate as of the date of printing and that covered persons or prospective covered persons should consult the carrier's electronic provider directory on its website to obtain current provider directory information. |  |
| **GENERAL HEALTH CARE TREATMENT / COVERAGE** |  |  |  |
| Abortion services | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-M-1.html)-M | A health plan that provides coverage for maternity services must provide coverage for abortion services in accordance with the following:no deductible, copayment, coinsurance or other cost-sharing requirement for the costs of abortion services allowed. However, the plan 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 law. Reasonable limitations include where an insured knowingly goes to an out-of-network provider when an in-network provider was available. |  |
| Anesthesia for Dentistry | [Title 24-A § 2760](https://legislature.maine.gov/statutes/24-A/title24-Asec2760.html) | Anesthesia & associated facility charges for dental procedures are mandated benefits for certain vulnerable persons. |  |
| Breast reduction and symptomatic varicose vein surgery | [Title 24-A § 2761](https://legislature.maine.gov/statutes/24-A/title24-Asec2761.html) | Coverage must be offered for breast reduction surgery and symptomatic varicose vein surgery determined to be medically necessary |  |
| Chiropractic Services/Manipulative Therapy | [Title 24-A § 2748](https://legislature.maine.gov/statutes/24-A/title24-Asec2748.html) | Must provide benefits for care by chiropractors at least equal to benefit paid to other providers treating similar neuro-musculoskeletal conditions. Therapeutic, adjustive and manipulative services must be covered if performed by an allopathic, osteopathic or chiropractic doctor. |  |
| Clinical Trials | [Title 24-A § 4310](https://legislature.maine.gov/statutes/24-A/title24-Asec4310.html)PHSA § 2709 | A carrier may not deny a qualified enrollee participation in an approved clinical trial or deny, limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial. A non-grandfathered health plan may not discriminate on the basis of participation in a clinical trial and must cover routine patient costs of individuals in clinical trials for treatment of cancer or other life-threatening conditions. |  |
| Colorectal Cancer Screening | [Title 24-A § 2763](https://legislature.maine.gov/statutes/24-A/title24-Asec2763.html) | Coverage must be provided for colorectal cancer screening for asymptomatic individuals who are: At average risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society; or At high risk for colorectal cancer. “Colorectal cancer screening” means all colorectal cancer examinations and laboratory tests recommended by a health care provider in accordance with the most recently published colorectal cancer screening guidelines of a national cancer society. If a colonoscopy is recommended by a health care provider as the colorectal cancer screening test in accordance with this section and a lesion is discovered and removed during that colonoscopy, the health care provider must bill the insurance company for a screening colonoscopy as the primary procedure. |  |
| Emergency Services, definitions of “Emergency Services” and “Emergency Medical Condition” – Must be Verbatim | [Title 24-A § 4301](https://legislature.maine.gov/statutes/24-A/title24-Asec4301-A.html)-A(4-A) & (4-B) [Title 24-A § 4304](https://legislature.maine.gov/statutes/24-A/title24-Asec4304.html)(5) [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-C.html)-C[Rule 850](https://www.maine.gov/sos/cec/rules/02/031/031c850.docx) Sec 5PHSA §2719A([75 Fed Reg 37188](https://www.federalregister.gov/documents/2010/06/28/2010-15278/patient-protection-and-affordable-care-act-preexisting-condition-exclusions-lifetime-and-annual),45 CFR §147.138)SSA §1395dd | The plan must cover emergency services without prior authorization.  Cost-sharing requirements, such as a deductible, copayment amount or coinsurance rate, for out-of-network services are the same as requirements that would apply if such services were provided in network , and any payment made by an enrollee pursuant to this section must be applied to the enrollee's in-network cost-sharing limit. The enrollee's responsibility for payment for covered out-of-network emergency services must be limited so that if the enrollee has paid the enrollee's share of the charge as specified in the plan for in-network services, the carrier shall hold the enrollee harmless from any additional amount owed to an out-of-network provider for covered emergency services and make payment to the out-of-network provider in accordance with [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)-C (as amended by PL 2019, Ch. 668) or, if there is a dispute, in accordance with [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)-E (as enacted by PL 2019, Ch. 668).“Emergency service” means a health care item or service furnished or required to evaluate and treat an emergency medical condition that is provided in an emergency facility or setting. “Emergency medical condition” means the sudden and, at the time, unexpected onset of a physical or mental health condition, including severe pain, manifesting itself by symptoms of sufficient severity, regardless of the final diagnosis that is given, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe: A. That the absence of immediate medical attention for an individual could reasonably be expected to result in:(1) Placing the physical or mental health of the individual or, with respect to a pregnant woman, the health of the pregnant woman or her unborn child in serious jeopardy;(2) Serious impairment of a bodily function; or(3) Serious dysfunction of any organ or body part; or B. With respect to a pregnant woman who is having contractions, that there is:(1) Inadequate time to effect a safe transfer of the woman to another hospital before delivery; or(2) A threat to the health or safety of the woman or unborn child if the woman were to be transferred to another hospital. Before a carrier denies benefits or reduces payment for an emergency service based on a determination of the absence of an emergency medical condition or a determination that a lower level of care was needed, the carrier shall conduct a utilization review done by a board certified emergency physician who is licensed in this State, including a review of the enrollee's medical record related to the emergency medical condition subject to dispute. If a carrier requests records related to a potential denial of or payment reduction for an enrollee's benefits when emergency services were furnished to an enrollee, a provider has an affirmative duty to respond to the carrier in a timely manner. This does not apply when a reduction in payment is made by a carrier based on a contractually agreed upon adjustment for healthcare service. |  |
| Health care services for COVID-19 | [Title 24-A § 4320](https://legislature.maine.gov/legis/statutes/24-A/title24-Asec4320-P-1.html)-P | Notwithstanding any requirements of this Title to the contrary, a carrier offering a health plan in this State shall provide, at a minimum, coverage as required by this section for screening, testing and immunization for COVID-19. 1. Definitions. For the purposes of this section, unless the context otherwise indicates, the following terms have the following meanings. A. "COVID-19" means the coronavirus disease 2019 resulting from SARS-CoV-2, severe acute respiratory syndrome coronavirus 2, and any virus mutating from that virus. B. "Surveillance testing program" means a structured program of asymptomatic testing at a community or population level to understand the incidence or prevalence of COVID-19 in a group. "Surveillance testing program" does not include a program of testing that occurs less often than once per month per individual. 2. Testing. A carrier shall provide coverage for screening and testing for COVID-19 as follows. A. A carrier shall provide coverage for screening and testing for COVID-19, except when such screening and testing is part of a surveillance testing program. B. A carrier may not impose any deductible, copayment, coinsurance or other cost sharing requirement for the costs of COVID-19 screening and testing, including all associated costs of administration. C. A carrier may not make coverage without cost sharing as required by paragraph B dependent on any prior authorization requirement. D. A carrier may not make coverage without cost sharing as required by paragraph B dependent on the use of a provider in a carrier's network unless an enrollee is offered screening and testing by a network provider without additional delay and the enrollee chooses instead to obtain screening from an out-of-network provider or to be tested by an out-of-network laboratory. E. For the purposes of this subsection, with respect to COVID-19 screening and testing rendered by an out-of-network provider, a carrier shall reimburse the out-of-network provider in accordance with section 4303-C, subsection 2, paragraph B. 3. Immunization; COVID-19 vaccines. A carrier shall provide coverage for COVID19 vaccines as follows. A. A carrier shall provide coverage for any COVID-19 vaccine licensed or authorized under an emergency use authorization by the United States Food and Drug Page 4 - 130LR0653(10) Administration that is recommended by the United States Centers for Disease Control and Prevention Advisory Committee on Immunization Practices, or successor organization, for administration to an enrollee. B. A carrier may not impose any deductible, copayment, coinsurance or other cost sharing requirement for the cost of COVID-19 vaccines, including all associated costs of administration. C. A carrier may not make coverage without cost sharing as required by paragraph B dependent on any prior authorization requirement. D. A carrier may not make coverage without cost sharing as required by paragraph B dependent on the use of a provider in a carrier's network unless an enrollee is offered immunization by a network provider without additional delay and the enrollee chooses instead to obtain immunization from an out-of-network provider. |  |
| Hearing aids | [Title 24-A § 2762](https://legislature.maine.gov/statutes/24-A/title24-Asec2762.html) | Coverage is required for the purchase of hearing aids for each hearing-impaired ear, in accordance with the following: The hearing loss must be documented by a physician or audiologist licensed in this State. The hearing aid must be purchased in accordance with federal and state laws, regulations and rules for the sale and dispensing of hearing aids. The policy or contract may limit coverage to $3,000 per hearing aid for each hearing-impaired ear every 36 months. |  |
| Home health care coverage | [Title 24-A § 2745](https://legislature.maine.gov/statutes/24-A/title24-Asec2745.html)[Title 24-A § 2837](https://legislature.maine.gov/statutes/24-A/title24-Asec2837.html)[Rule 191](https://www.maine.gov/sos/cec/rules/02/031/031c191.docx) § 9(M) | Policies that provide coverage on an expense incurred basis for inpatient hospital care shall make available coverage for home health care services by a home health care provider. The policy may contain a reasonable limitation on the number of home care visits and other services provided, but the number of such visits shall not be less than 90 in any continuous period of 12 months for each person covered under the policy. Each visit by an individual member of a home health care provider shall be considered as one home care visit.1. Definition of home health care services. "Home health care services" means those health care services rendered in his place of residence on a part time basis to a covered person only if: A. Hospitalization or confinement in a skilled nursing facility as would otherwise have been required if home health care was not provided; and B. The plan covering the home health services is established as prescribed in writing by a physician. There shall be no requirement that hospitalization be an antecedent to coverage under the policy.2. Home health care services shall include: A. Visits by a registered nurse or licensed practical nurse to carry out treatments prescribed, or supportive nursing care and observation as indicated; B. A physician's home or office visits or both; C. Visits by a registered physical, speech, occupational, inhalation or dietary therapist for services or for evaluation of, consultation with and instruction of nurses in carrying out such therapy prescribed by the attending physician, or both; D. Any prescribed laboratory tests and x-ray examination using hospital or community facilities, drugs, dressings, oxygen or medical appliances and equipment as prescribed by a physician, but only to the extent that such charges would have been covered under the contract if the covered person had remained in the hospital; and E. Visits by persons who have completed a home health aide training course under the supervision of a registered nurse for the purpose of giving personal care to the patient and performing light household tasks as required by the plan of care, but not including services.3. Home health care provider.  "Home health care provider" means a home health care agency which: A. Is primarily engaged in and licensed or certified to provide skilled nursing and other therapeutic services; B. Has standards, policies and rules established by a professional group, associated with the agency or organization, which professional group must include at least one physician and one registered nurse; C. Is available to provide the care needed in the home 7 days a week and has telephone answering service available 24 hours per day; D. Has the ability to and does provide, either directly or through contract, the services of a coordinator responsible for case discovery and planning and assuring that the covered person receives the services ordered by the physician; E. Has under contract the services of a physician-advisor licensed by the State or a physician; F. Conducts periodic case conferences for the purpose of individualized patient care planning and utilization review; and G. Maintains a complete medical record on each patient. MUST PROVIDE UNLIMITED VISITS PURSUANT TO THE BENCHMARK PLAN. |  |
| Hospice Care Services | [Title 24-A § 2759](https://legislature.maine.gov/statutes/24-A/title24-Asec2759.html) | Hospice care services must be provided to a person who is terminally ill (life expectancy of 12 months or less). Must be provided whether the services are provided in a home setting or an inpatient setting. See section for further requirements. |  |
| Leukocyte Antigen Testing To Establish Bone Marrow Donor | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-I.html)-I | Must provide coverage for laboratory fees up to $150 arising from human leukocyte antigen testing performed to establish bone marrow transplantation suitability in accordance with the following requirements: A. The enrollee must meet the criteria for testing established by the National Marrow Donor Program, or its successor organization;B. The testing must be performed in a facility that is accredited by a national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists and is certified under the federal Clinical Laboratories Improvement Act of 1967, 42 United States Code, Section 263a;C. At the time of the testing, the enrollee must complete and sign an informed consent form that authorizes the results of the test to be used for participation in the National Marrow Donor Program, or its successor organization, and acknowledges a willingness to be a bone marrow donor if a suitable match is found; andD. The carrier may limit each enrollee to one test per lifetime. Prohibition on cost-sharing. A carrier may not impose any deductible, copayment, coinsurance or other cost-sharing requirement on an enrollee for the coverage required under this section. |  |
| Preventive health services Preventive health services without cost-sharing requirements including deductibles, co-payments, and co-insurance. | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-A.html)-A[Rule 191](https://www.maine.gov/sos/cec/rules/02/031/031c191.docx) § 9(M)PHSA § 2713 ([75 Fed Reg 41726](https://www.federalregister.gov/documents/2010/07/19/2010-17242/interim-final-rules-for-group-health-plans-and-health-insurance-issuers-relating-to-coverage-of), [45 CFR § 147](https://www.ecfr.gov/cgi-bin/text-idx?SID=985c38eeddaa13128929637cc7ec919e&pitd=20180719&node=pt45.1.147&rgn=div5).130) | Must, at a minimum, provide coverage for, and may not impose cost-sharing requirements for, the following preventive services: The evidence-based items or services that have a rating of A or B in the recommendations of the USPSTF or equivalent rating from a successor organization; With respect to the individual insured, immunizations that have a recommendation from the federal DHHS, CDC, Advisory Committee on Immunization Practices; With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the most recent version of the comprehensive guidelines supported by the federal DHHS, HRSA; and With respect to women, such additional preventive care and screenings not described in paragraph A, provided for in the comprehensive guidelines supported by the federal DHHS, HRSA women's preventive services guidelines. If one of the recommendations referenced above is changed during a plan year, a carrier is not required to make changes to that health plan during the plan year. SEE SEPARATE CHECKLIST FOR SPECIFIC SERVICES. |  |
| Prostate cancer screening | [Title 24-A § 2745](https://legislature.maine.gov/statutes/24-A/title24-Asec2745-G.html)-G | Coverage required for prostate cancer screening: Digital rectal examinations and prostate-specific antigen tests covered if recommended by a physician, at least once a year for men 50 years of age or older until age 72. |  |
| Reconstructive surgery after mastectomy | [Title 24-A § 2745](https://legislature.maine.gov/statutes/24-A/title24-Asec2745-C.html)-CPHSA § 2727 | Coverage with for inpatient breast cancer treatment must be provided for the duration determined by the attending physician. If covers mastectomy, then must also cover reconstructive surgery in a manner determined in consultation with provider and patient. Coverage must include: Reconstruction of the breast on which the mastectomy was performed (all stages);Surgery and reconstruction of the other breast to produce symmetrical appearance; Prostheses; and Treatment of physical complications at all stages of mastectomy. Does not limit mastectomy to cancer diagnosis. |  |
| Telehealth Services | [Title 24-A § 4316](https://legislature.maine.gov/statutes/24-A/title24-Asec4316.html) | Carrier must provide coverage for telehealth services if the service would be covered if it were provided through in-person consultation and as long as the provider is acting within the scope of practice of the provider’s license with regard to telehealth services. Can’t put any restriction on the prescribing of medication through telehealth that could otherwise be prescribed in-person. The availability of health care services may not be considered for the purposes of demonstrating provider network adequacy. |  |
| **WOMEN & MATERNITY** |  |  |  |
| Mammogram screenings | [Title 24-A § 2745](https://legislature.maine.gov/statutes/24-A/title24-Asec2745-A.html)-A[Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320.html)-A | If radiological procedures are covered, benefits must be made available for screening mammography at least once a year for women 40 years of age and over. A screening mammogram also includes an additional radiologic procedure recommended by a provider when the results of an initial radiologic procedure are not definitive. |  |
| Maternity and routine newborn care | [Title 24-A § 2743](https://legislature.maine.gov/statutes/24-A/title24-Asec2743-A.html)-APHSA § 2725([45 CFR § 148.170](https://www.ecfr.gov/cgi-bin/text-idx?SID=985c38eeddaa13128929637cc7ec919e&pitd=20180719&node=pt45.1.148&rgn=div5#se45.1.148_1170)) | Benefits must be provided for maternity (length of stay)and routine newborn care, in accordance with "Guidelines for Perinatal Care" as determined by attending provider and mother. Benefits for routine newborn care required by this section are part of the mother's benefit. The mother and the newborn are treated as one person in calculating the deductible, coinsurance and copayments for coverage required by this section. Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section. An issuer is required to provide notice unless state law requires coverage for 48/96-hour hospital stay, requires coverage for maternity and pediatric care in accordance with an established professional medical association, or requires that decisions about the hospital length of stay are left to the attending provider and the mother. |  |
| Maternity benefits for unmarried women; dependent children | [Title 24-A § 2741](https://legislature.maine.gov/statutes/24-A/title24-Asec2741.html)[Title 24-A § 2742](https://legislature.maine.gov/statutes/24-A/title24-Asec2742.html) | Applicable only if maternity and dependent child coverage provided: must provide, at appropriate rates, the same maternity benefits for unmarried women policyholders and the minor dependents of policyholders with dependent or family coverage under the same terms and conditions as is provided to married policyholders or the wives of policyholders with maternity coverage. |  |
| Newborn coverage | [Title 24-A § 2743](https://legislature.maine.gov/statutes/24-A/title24-Asec2743.html) | Newborns must be automatically covered under the plan from the moment of birth for the first 31 days. An adopted child is deemed to be newly born to the adoptive parents from the date of the signed placement agreement. |  |
| **INFANTS & CHILDREN** |  |  |  |
| Coverage for Autism | [Title 24-A § 2768](https://legislature.maine.gov/statutes/24-A/title24-Asec2768.html) | Must provide coverage for autism spectrum disorders for an individual covered under a policy or contract who is 10 years of age or under in accordance with this section. |  |
| Early Childhood Intervention | [Title 24-A § 2767](https://legislature.maine.gov/statutes/24-A/title24-Asec2767.html) | Individual health insurance policies must provide coverage for children's early intervention services in accordance with the requirements of this section. "Children's early intervention services" is defined in this section. |  |
| Infant Formula | [Title 24-A § 2764](https://legislature.maine.gov/statutes/24-A/title24-Asec2764.html) | Coverage of amino acid-based elemental infant formula must be provided when a physician has diagnosed and documented one of the following: Symptomatic allergic colitis or proctitis; Laboratory- or biopsy-proven allergic or eosinophilic gastroenteritis; A history of anaphylaxis Gastroesophageal reflux disease that is nonresponsive to standard medical therapies Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider Cystic fibrosis; or Malabsorption of cow milk-based or soy milk-based formula Medical necessity is determined when a licensed physician has submitted documentation that the amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater and that other commercial infant formulas, including cow milk-based and soy milk-based formulas, have been tried and have failed or are contraindicated. Coverage for amino acid-based elemental infant formula under a policy, contract or certificate issued in connection with a health savings account may be subject to the same deductible and out-of-pocket limits that apply to overall benefits under the policy, contract or certificate. |  |
| Medical food coverage for inborn error of metabolism | [Title 24-A § 2745](https://legislature.maine.gov/statutes/24-A/title24-Asec2745-D.html)-D | Must provide coverage for metabolic formula and up to $3,000 per year for prescribed modified low-protein food products. |  |
| Require Private Insurance Coverage for Donor Breast Milk | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320.html)-V | Coverage for medically necessary pasteurized donor breast milk is required. |  |
| **MENTAL HEALTH & SUBSTANCE ABUSE SERVICES / COVERAGE** |  |  |  |
| Mental health coverage | [Title 24-A § 2749-C](https://legislature.maine.gov/statutes/24-A/title24-Asec2749-C.html)[Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-D.html)-D | The contract must provide coverage for treatment of certain mental illnesses (including substance use disorders), as diagnosed by specific providers, and the coverage must meet the following state parity requirements in addition to Federal parity requirements:•benefits for treatment and diagnosis of mental illnesses must be provided under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illness; and•providers may be required to furnish data substantiating that initial/continued treatment is medically necessary health care, and in determining medical necessity, the same criteria must be used for medical treatment for mental illness as for medical treatment for physical illness under the policy. |  |
| Mental health services provided by certain professionals | [Title 24-A § 2744](https://legislature.maine.gov/statutes/24-A/title24-Asec2744.html) | A covered person is entitled to reimbursement for services performed by one of the following professionals if the policy reimburses for those services and those services are within the professional’s lawful scope of practice:• Psychologist licensed to practice in Maine;• Certified social worker licensed for independent practice of social work in Maine;• Licensed clinical professional counselor licensed for independent practice of counseling in Maine;• Licensed nurse certified by the American Nurses’ Association as a clinical specialist in adult psychiatric and mental health nursing or as a clinical specialist in child and adolescent psychiatric and mental health nursing;• Marriage and family therapist licensed as such in Maine;• Licensed pastoral counselor licensed as such in Maine. |  |
| **PRESCRIPTION DRUGS** |  |  |  |
| Abuse-deterrent opioid analgesic drug products | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-J.html)-J | Must provide coverage for abuse-deterrent opioid analgesic drug products listed on any formulary, preferred drug list or other list of drugs used by the carrier on a basis not less favorable than that for opioid analgesic drug products that are not abuse-deterrent and are covered by the health plan. An increase in enrollee cost sharing to achieve compliance with this section may not be implemented. "Abuse-deterrent opioid analgesic drug product" means a brand or generic opioid analgesic drug product approved by the federal Food and Drug Administration with abuse-deterrent labeling claims that indicate the drug product is expected to result in a meaningful reduction in abuse. "Opioid analgesic drug product" means a drug product in the opioid analgesic drug class prescribed to treat moderate to severe pain or other conditions, whether in immediate release or extended release, long-acting form and whether or not combined with other drug substances to form a single drug product or dosage form. |  |
| Contraceptives | [Title 24-A § 2756](https://legislature.maine.gov/statutes/24-A/title24-Asec2756.html) | If the plan provides coverage for prescription drugs or outpatient medical services, it must cover all prescription contraceptives approved by the federal FDA or for outpatient contraceptive services, respectively, to the same extent coverage is provided for other prescription drugs or outpatient medical services. The coverage must include coverage for contraceptive supplies in accordance with the requirements set forth in this section. "Outpatient contraceptive services" and "contraceptive supplies" are defined in this section. |  |
| Coverage for HIV Prevention Drugs | [Title 24-A § 4317](https://legislature.maine.gov/statutes/24-A/title24-Asec4317-D.html)-D | A. If the FDA has approved one or more HIV prevention drugs that use the same method of administration, a carrier must cover at least one approved drug for each method of administration with no out-of-pocket cost. B. A carrier is not required to cover pre- or post-exposure prophylaxis drug dispensed or administered by an out-of-network pharmacy provider unless the enrollee's health plan provides an out-of-network pharmacy benefit. C. A carrier may not prohibit a pharmacy from dispensing or administering any HIV prevention drugs. |  |
| Diabetes supplies | [Title 24-A § 2754](https://legislature.maine.gov/statutes/24-A/title24-Asec2754.html) | Contracts must cover medically appropriate and necessary equipment, limited to insulin, oral hypoglycemic agents, monitors, test strips, syringes and lancets, and the out-patient self-management training and educational services used to treat diabetes, if a physician certifies that the equipment and services are necessary, and the diabetes out-patient self-management training and educational services are provided through ambulatory diabetes education facilities authorized by the State's Diabetes Control Project within the Bureau of Health. |  |
| Early refills of prescription eye drops  | [Title 24-A § 4314](https://legislature.maine.gov/statutes/24-A/title24-Asec4314-A.html)-A | If prescription eye drops are a covered benefit under the health plan, the coverage must include one early refill of a prescription for eye drops if the criteria set forth in Section 4314-A is met. |  |
| Electronic transmission of prior authorization requests for prescription drugs | [Title 24-A § 4304](https://legislature.maine.gov/statutes/24-A/title24-Asec4304.html)(2-B)[Title 24-A § 4304](https://legislature.maine.gov/statutes/24-A/title24-Asec4304.html)(2) | If a health plan provides coverage for prescription drugs, the carrier must accept and respond to prior authorization requests through a secure electronic transmission using standards recommended by a national institute for the development of fair standards and adopted by a national council for prescription drug programs for electronic prescribing transactions. Transmission of a facsimile through a proprietary payer portal or by use of an electronic form is not considered electronic transmission.A carrier's electronic transmission system for prior authorization requests for prescription drugs must comply with the requirements of the statute. (For 2023 and beyond, a carrier’s electronic benefit tool(s) must integrate with all of its providers’ systems.) Upon request, the superintendent may grant a waiver from the requirements on a demonstration of good cause. The prescription drug and prior authorization standards used must be clear and readily available to enrollees, participating providers, pharmacists and other providers. |  |
| No Prior Authorization or step therapy for mental illness drugs | [Title 24-A § 4304](https://legislature.maine.gov/statutes/24-A/title24-Asec4304.html)(2-C)[Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-N.html)-N | Carrier must approve all prior authorizations for drugs to treat serious mental illness. No step therapy for such drugs. Serious mental illness means mental illness must result in serious functional impairment that substantially interferes with or limits one or more major life activities. |  |
| Off-label use of prescription drugs for cancer and HIV or AIDS | [Title 24-A § 2745](https://legislature.maine.gov/statutes/24-A/title24-Asec2745-E.html)-E[Title 24-A § 2745](https://legislature.maine.gov/statutes/24-A/title24-Asec2745-F.html)-F | If providing coverage for prescription drugs, must provide coverage for off-label use of prescription drugs for treatment of cancer, HIV, or AIDS. |  |
| Orally Administered Cancer Therapy | [Title 24-A § 4317](https://legislature.maine.gov/statutes/24-A/title24-Asec4317-B.html)-B | If providing coverage for cancer chemotherapy treatment, must provide coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells that is equivalent to the coverage provided for intravenously administered or injected anticancer medications. An increase in patient cost sharing for anticancer medications may not be used to achieve compliance with this section. This section may not be construed to prohibit or limit a carrier's ability to establish a prescription drug formulary or to require a carrier to cover an orally administered anticancer medication on the sole basis that it is an alternative to an intravenously administered or injected anticancer medication. |  |
| Prescription drug access | [Title 24-A § 4311](https://legislature.maine.gov/statutes/24-A/title24-Asec4311.html) | Formulary: if the plan provides coverage for prescription drug and limits the coverage to drugs included in a formulary, the coverage must meet the requirements set forth in Section 4311(1).Access to clinically appropriate drug not otherwise covered by the plan: a carrier must allow enrollees to request and gain access to clinically appropriate drugs not otherwise covered by the plan in accordance with the criteria and timeframes set forth in Section 4311(1-A), including an expedited review process. If a request is approved, the drug must be treated as an essential health benefit, including counting any cost-sharing toward the plan’s annual cost-sharing limit and when calculating the plan’s actuarial value.Approved drugs and medical devices: if the plan provides coverage for prescription drugs and medical devices, coverage cannot be denied on the basis that the use of the drug or device is investigational if the intended use is included in the labeling authorized by the FDA or is recognized in one of the standard reference compendia or in peer-reviewed medical literature. |  |
| Prescription Drug Coverage During Emergency Declared by the Governor | [Title 24-A § 4311](https://legislature.maine.gov/statutes/24-A/title24-Asec4311.html) (2-A) | Except as provided in this subsection, a carrier shall provide coverage for the furnishing or dispensing of a prescription drug in accordance with a valid prescription issued by a provider in a quantity sufficient for an extended period of time, not to exceed a 180-day supply, during a statewide state of emergency declared by the Governor in accordance with Title 37-B, section 742. This subsection does not apply to coverage of prescribed contraceptive supplies furnished and dispensed pursuant to section 2756, 2847-G or 4247 or coverage of opioids prescribed in accordance with limits set forth in Title 32. |  |
| Prior authorization of medication-assisted treatment for opioid use disorder | [Title 24-A § 4304](https://legislature.maine.gov/statutes/24-A/title24-Asec4304.html)(2-A) | A carrier may not require prior authorization for medication-assisted treatment for opioid use disorder for the prescription of at least one drug for each therapeutic class of medication used in medication-assisted treatment, except that a carrier may not impose any prior authorization requirements on a pregnant woman for medication-assisted treatment for opioid use disorder. "Medication-assisted treatment" means an evidence-based practice that combines pharmacological interventions with substance use disorder counseling. |  |
| Step therapy requirements | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320.html)-N | Step therapy requirements when a carrier provides prescription drug coverage, and coverage of a prescription drug is restricted through the use of a step therapy protocol. |  |
| Access to lower-priced comparable health care services from out-of-network providers, online form for enrollees | [Title 24-A § 4318](https://legislature.maine.gov/statutes/24-A/title24-Asec4318-B.html)-B(1)[Title 24-A § 4318](https://legislature.maine.gov/statutes/24-A/title24-Asec4318-A.html)-A(1)(A) | If an enrollee covered under a health plan other than a health maintenance organization plan elects to obtain a covered comparable health care service as defined in section 4318-A, subsection 1, paragraph A (referenced below) from an out-of-network provider at a price that is the same or less than the statewide average for the same covered health care service based on data reported on the publicly accessible health care costs website of the Maine Health Data Organization, the carrier shall allow the enrollee to obtain the service from the out-of-network provider at the provider's charge and, upon request by the enrollee, shall apply the payments made by the enrollee for that comparable health care service toward the enrollee's deductible and out-of-pocket maximum as specified in the enrollee's health plan as if the health care services had been provided by an in-network provider. A carrier may use the average price paid to a network provider for the covered comparable health care service under the enrollee's health plan in lieu of the statewide average price on the Maine Health Data Organization's publicly accessible website as long as the carrier uses a reasonable method to calculate the average price paid and the information is available to enrollees through a website accessible to the enrollee and a toll-free telephone number that provide, at a minimum, information relating to comparable health care services. The enrollee is responsible for demonstrating to the carrier that payments made by the enrollee to the out-of-network provider should be applied toward the enrollee's deductible or out-of-pocket maximum pursuant to this section. The carrier shall provide a downloadable or interactive online form to the enrollee for the purpose of making such a demonstration and may require that copies of bills and proof of payment be submitted by the enrollee. For the purposes of this section, "out-of-network provider" means a provider located in Massachusetts, New Hampshire or this State that is enrolled in the MaineCare program and participates in Medicare. "Comparable health care service" means nonemergency, outpatient health care services in the following categories: (1) Physical and occupational therapy services;(2) Radiology and imaging services;(3) Laboratory services; and(4) Infusion therapy services. |  |
| Health care price transparency tools; website, toll-free telephone number, and cost estimates | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(21)[Title 24-A § 4318](https://legislature.maine.gov/statutes/24-A/title24-Asec4318.html)-A(1)(A) | A carrier shall develop and make available a website accessible to enrollees and a toll-free telephone number that enable enrollees to obtain information on the estimated costs for obtaining a comparable health care service, from network providers, as well as quality data for those providers, to the extent available. |  |
| Disclosure to Enrollees of Cash Price  | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(25) | A carrier may not prohibit a provider from providing an enrollee with the option of paying the provider's discounted cash price for health care services. |  |
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