

Maine Bureau of Insurance
Form Filing Review Requirements Checklist
H10I – Individual Dental Plans
(Amended 11/05/2012)

BENEFIT/PROVISION REQUIREMENT	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENT	IDENTIFY LOCATION OF STANDARD IN FILING <i>OR EXPLAIN IF REQUIREMENT IS INAPPLICABLE</i>
Assignment of Benefits	24-A M.R.S.A. §2755	Permits insureds to assign benefits directly to their provider of care. Applies to medical and dental expense incurred plans. Does not include indemnity plans.	
Calculation of health benefits based on actual cost	24-A M.R.S.A. §2185	Policies must comply with the requirements of 24-A §2185 which requires calculation of health benefits based on actual cost. All health insurance policies, health maintenance organization plans and subscriber contracts or certificates of nonprofit hospital or medical service organizations with respect to which the insurer or organization has negotiated discounts with providers must provide for the calculation of all covered health benefits, including without limitation all coinsurance, deductibles and lifetime maximum benefits, on the basis of the net negotiated cost and must fully reflect any discounts or differentials from charges otherwise applicable to the services provided. With respect to policies or plans involving risk-sharing compensation arrangements, net negotiated costs may be calculated at the time services are rendered on the basis of reasonably anticipated compensation levels and are not subject to retrospective adjustment at the time a cost settlement between a provider and the insurer or	

		organization is finalized.	
Claim forms	24-A M.R.S.A. §2710	The insurer will furnish claim forms to the claimant. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy for filing of claim forms.	
Coordination of Benefits and Evidence of Coverage	24-A M.R.S.A. §2723-A Rule 790	Lists items that are required to be placed in an Evidence of Coverage. Also §9 states: Evidences of coverage may contain a provision for coordination of benefits, provided that such provision shall not relieve an HMO of its duty to provide or arrange for a covered health care service to an enrollee solely because the enrollee is entitled to coverage under any other contract, policy or plan, including coverage provided under government programs. Medicaid is always secondary.	
Dependent Children - Offer	24-A M.R.S.A. §2766	All individual dental insurance policies and contracts that offer dependent coverage must offer the opportunity to enroll a dependent child in the dental insurance coverage during the following periods: A. From birth to 30 days of age; and B. Any open or annual enrollment period.	
Dependent Children Up to Age 25	24-A M.R.S.A. §2742-B	An individual or group health maintenance organization contract that offers coverage for dependent children must offer such coverage until the dependent child is 25 years of age.	
Dependent children with mental or physical illness	§2742-A	Requires health insurance policies to continue coverage for dependent children up to 24 years of age who are unable to maintain enrollment in college due to mental or physical illness if they would otherwise terminate coverage due to a	

		requirement that dependent children of a specified age be enrolled in college to maintain eligibility.	
Dependent, Definition of	24-A M.R.S.A. §2742	Children (including stepchildren, adopted children or children placed for adoption) under the age of 19. Cannot use financial dependency as a requirement for eligibility. Adopted, or placed for adoption children are to be provided the same benefits as natural dependent children and stepchildren.	
Emergency services	24-A M.R.S.A. §2749-A	No prior authorization can be required for emergency services.	
Explanations for any Exclusion of Coverage for work related sicknesses or injuries	24-A M.R.S.A. §2413	If the policy excludes coverage for work related sicknesses or injuries, clearly explain whether the coverage is excluded if the enrollee is exempt from requirements from state workers compensation requirements or has filed an exemption from the workers compensation laws.	
Explanations Regarding Deductibles	24-A M.R.S.A. §2413	All policies must include clear explanations of all of the following regarding deductibles: <ol style="list-style-type: none"> 1. Whether it is a calendar or policy year deductible. 2. Clearly advise whether non-covered expenses apply to the deductible. 3. Clearly advise whether it is a per person or family deductible or both. 	
Free look period	24-A M.R.S.A. §2717	10 day free look.	
Grace Period	24-A M.R.S.A. §2707 Bulletin 288	30 or 31 days.	
Independent Practice Dental Hygienists	24-A M.R.S.A. §2765	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.	
Legal actions	24-A M.R.S.A. §2715	No action can be brought to recover on the policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of the policy. No such action shall be brought after the expiration of 3 years (for individual plans) (2 years for group plans) after the time written proof of loss is required to be furnished.	
Limits on priority liens/subrogation	24-A M.R.S.A. §2729-A	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.	
Misstatement of age	24-A M.R.S.A. §2720	Misstatement of age: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age	
Network approval	24-A M.R.S.A. §2673-A, Rule 360 Rule 850	All managed care arrangements except MEWAs must be filed for adequacy & compliance with Rule 850 & Rule 360 access standards.	
Notice of claim	24-A M.R.S.A. §2709	There shall be a provision that written notice of sickness or of injury must be given to the insurer within 20 days (30 days for group) after the date when such sickness or injury occurred. Failure to give notice within such time shall not invalidate	

		nor reduce any claim, if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.	
Outline of Coverage - Dental Requirements	Rule 755, Sec. 7(N)	This subsection describes the required provisions and disclosures for the Outline of Coverage for Dental Coverage.	
Outline of Coverage - General Requirements	Rule 755, Sec. 7(B)	This subsection contains general requirements and disclosures for Outlines of Coverage.	
PPO Benefit level differential	24-A M.R.S.A. §2677-A	There cannot be more than a 20% differential in benefits between preferred and non-preferred providers. Superintendent can grant waiver for the 20%, in particular for designated providers for cost or quality.	
Renewal provision	24-A M.R.S.A. §2738	Policy must contain the terms under which the policy can or cannot be renewed.	
Required disclosure statements on policies/certificates	Rule 755, Sec. 7(A)(22)	All dental plan policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following: “Notice to Buyer: This [policy] [certificate] provides dental benefits only.”	
Limits on priority liens/Subrogation	§2729-A	Does this policy have subrogation provisions? If yes see provision below: Subrogation requires prior written approval of the insured and allows such payments only on a just and equitable basis and not on the basis of a priority lien. Applies to point of service contracts in the HMO but doesn't apply to closed network arrangements.	Yes <input type="checkbox"/> Please provide citation for section in policy <hr/> No <input type="checkbox"/>

Third Party Notice, Cancellation and Reinstatement	24-A M.R.S.A. §2707-A Rule 580	Third party notice of cancellation and reinstatement for cognitive impairment or functional incapacity.	
Time limit on defenses	24-A M.R.S.A. §2706	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.	