INDIVIDUAL SHORT TERM MAJOR MEDICAL CHECKLIST

This Checklist Applies to the Following Types of Insurance (TOI):

- H16I.004 Individual Health - Major Medical, Sub-TOI for H16G.004 Short Term

Please refer to September 14, 2018 from Director Bruce R. Ramge
https://doi.nebraska.gov/sites/default/files/doc/Short-TermDurationMedicalPlanFilingReqs.pdf

FILER: PLEASE TYPE IN THE SERFF FILING NUMBER AND EACH FORM NUMBER SUBMITTED FOR DOI APPROVAL IN THIS FILING, AND LIST THE TOI THAT APPLIES				
	[SERFF filing number and form numbers here]			[TOI here]
(DOI reviewer) Check as completed	**Review Requirements**	**Reference**	**Description**	**Page number, form name & number if separate document, or N/A**
	COVER PAGE			
☐	Full Company name and address	§ 44-350	Advisable to include contact phone and email for questions.	
☐	Descriptive title	§ 44-710.01(4)	A brief description of the type of coverage.	
☐	One officers' signature required on face page (or last page)	§ 44-710.03(1)	Can be bracketed as variable for future replacement of officers.	
☐	Application and Premium	§ 44-710.01(1)	Entire money and other considerations expressed therein.	
☐	Effective Date	§ 44-710.01(2)	The time insurance takes effect and terminates. Include renewability information.	
☐	Form number	§ 44-710.01(6)	Must be on all pages including cover, in the lower left corner to identify and distinguish form from all others used by company. Must match form number on SERFF Form Schedule tab and NE Filing Form List.	

	COVER PAGE DISCLOSURES			
☐	Federal Government Notice	45 CFR Parts 144, 146, and 148 Displays prominently on the first page (in either paper or electronic form, including on a website) of the policy, certificate, or contract of insurance, and in any marketing, application, and enrollment materials (including reenrollment materials) provided to individuals at or before the time an individual has the opportunity to enroll (or reenroll) in the coverage, in at least 14-point font, the language in the following notice:	**IMPORTANT: This is a short-term, limited-duration policy, NOT comprehensive health coverage** ***See Appendix A**	
☐	10-day Free Look	Director Ramge Notice 9/14/18 § 44-710.18		
	SCHEDULE PAGE **[may be submitted as a septate insert page]**			
☐	Complete Schedule of Benefits page with hypothetical variable data	Industry norm	Include Covered Services, deductibles, co-pays, coinsurance, OOPM, limits, tiers, In-Network benefits, Out-of-Network benefits.	
☐	Policy fees	§ 44-354	Disclose any fees in the policy schedule.	
	DEFINITIONS			
☐	Policy and Statutory definitions, if any	Industry norm	Include definitions for terms used in contract.	
☐	Eligibility, Dependents	§ 44-710.01 (3) § 44-7,103	May insure one adult as policyholder and one or more eligible members of family, including spouse, dep. children, or any children under a certain age not to exceed age 30.	
☐	Disabled Child	§ 44-710.01 (3)	Reaching age limit shall not terminate child's coverage if incapable of self-support due to	

			intellectual or physical disability. Furnish proof within 31 days of limiting age.	
☐	Newborn Baby	§ 44-710.19	Covered from moment of birth. Automatic coverage first 31 days.	
☐	Adopted Child	§ 44-799	Covered from date of placement and shall be the same as for other dependents.	
	STANDARD MANDATORY PROVISIONS			
☐	Length of the contract and Renewability	Director Ramge Notice 9/14/18 § 144.103	Has an expiration date specified in the policy, certificate, or contract of insurance that is no more than 3 months after the original effective date of the policy, certificate, or contract of insurance, and taking into account any renewals or extensions, has a duration no longer than 4 months in total. A renewal or extension includes the term of a new short-term, limited-duration insurance policy, certificate, or contract of insurance issued by the same issuer, or if the issuer is a member of a controlled group, any other issuer that is a member of such controlled group, to the same policyholder within the 12- month period beginning on the original effective date of the initial policy, certificate, or contract of insurance.	
☐	Pre-Existing Conditions	Director Ramge Notice 9/14/18	The carrier shall clearly define within the policy what constitutes a pre-existing condition. If the policy offers a waiver of pre-existing conditions, the policy must also contain a statement as to how the conditions are waived, length of the waiver and additional premium costs, if any, of the waiver.	
☐	ACA Comparison chart	Director Ramge Notice 9/14/18	The carrier shall provide a comparison between the benefits offered in the plan	

			compared to the benefits required under an Affordable Care Act (ACA) individual market plan. If the plan provides benefits that are mandated under the ACA, but at a coverage level lower than the ACA coverage standard, the policy shall disclose an explanation of the limited level of benefit coverage in order to prevent consumer confusion.	
☐	Provider Networks	Director Ramge Notice 9/14/18	The carrier must provide a disclosure of the plan's provider network. The website and toll-free number shall be displayed prominently in the policy and in advertisements.	
☐	Internal complaint other than adverse benefit determination	§ 44-7308(2)(3)	Health carrier shall issue written decision within 15 working days, may extend another 15 working days if prevented from making a timely decision due to circumstances beyond the carrier's control and if notice is provided to the covered person of the extension and reason for delay. Covered person does not have the right to attend or have a representative in attendance, but can submit written material. Carrier shall make these rights known to insured and provide the name, address, and telephone number of the person designated to coordinate the grievance within 3 working days after receiving a grievance. Requirements for written decision at § 44-7308(3).	
☐	Appeal procedure	§ 44-7310 § 44-7311	Standard internal review of adverse determination with written decision within 15 working days. Expedited review within 72 hours.	
☐	External Review	Director Ramge Notice 9/14/18	Complete internal review first. Request for external review made to DOI within 4 months	

	Expedited External Review/ External Review for denials based on experimental or investigational claims	§ 44-1308 § 44-1309 § 44-1310 Title 210 Chapter 87	after internal appeal decision. IRO assigned. Written decision within 45 days. See standards and deadlines for clinical reviewers' opinions and IRO decisions at § 44-1310.	
☐	Electronic External Review	Director Ramge Notice 12/8/2020	Please provide assurance incorporation of our notice of the external review portal is available and language adverse determination form is disclosed to the consumer.	
☐	Coordination of Benefits	Title 210 Chapter 39 003.11(C)(i)	Individual and group plans are able to coordinate benefits – if no COB language in policy, plan will be primary. COB language in regulation.	
☐	Death of Insured – refund unearned premium	§ 44-310	In the event of the death of the insured, the insurer shall refund the unearned premium prorated to the month of the insured's death if the request has been made within one year after the insured's death. The refund of the premium and termination of the coverage shall be without prejudice to any claim originating prior to the date of the insured's death.	
☐	Nebraska Mandated Benefits	§ 44-785 § 44-786 § 44-788 § 44-790 § 44-796 § 44-797 § 44-7,102	☐Mammography ☐OB/GYN ☐Drug coverage cancer/AIDS ☐Diabetes ☐Newborn hearing screening ☐Reconstructive breast surgery ☐*Colorectal cancer screening (*plans 6 months or longer)	
☐	Hearing Aid Mandate	§ 44-5004	Plans must cover children (ages 0-18), for each ear affected by hearing impairment, including:	

			(a) A hearing aid purchased from a licensed audiologist with the medical clearance from an otolaryngologist and costs related to dispensing such hearing aid; (b) Evaluation for a hearing aid; (c) Fitting of a hearing aid; (d) Programming of a hearing aid; (e) Probe microphone measurements for verification that hearing aid gain and output meet the prescribed targets; (f) Hearing aid repairs; (g) Follow-up adjustments, servicing, and maintenance of a hearing aid; (h) Ear mold impressions; (i) Ear molds; and (j) Auditory rehabilitation and training. These items must be "covered on a continual basis to the extent that benefits paid for such items and services during the immediately preceding forty-eight-month period have not exceeded three thousand dollars." Replacement hearing aids and associated services should be covered within three months of the dispensing date if the hearing aid fails to meet prescribed targets or the hearing aid is unable to be repaired or adjusted. If an insured child uses a hearing aid on the effective date of this law and the hearing aid has been deemed unrepairable or obsolete by the manufacturer of the device, the insured child is eligible to use the benefits required by this law towards the acquisition of a new hearing aid, parts, and associated services.	

			Coverage under this law must be subject to the same deductible, copayment, and coinsurance as similar covered items and services under the health plan.	
☐	Mental health coverage parity	§ 44-793	Note that if coverage is provided, parity is required.	
☐	Autism Spectrum	§ 44-7,106	Screening, diagnosis, and treatment of autism spectrum disorder in individuals under age 21.	
☐	Oral anticancer meds	§ 44-7,104	Cover oral anticancer meds no less favorable than intravenous or injected anticancer meds.	
☐	Mail order drugs	§ 44-513.02	Mail order pharmacy cannot be mandatory. Same copay for prescriptions less than 180 days whether they are obtained through pharmacy or mail. N/A to long term maintenance drugs or HMO.	
☐	Synchronizing prescriptions	§ 44-7,108	Not required to be stated in policy, but policy cannot conflict.	
☐	Prescription Drug Manufacturer Coupons	§ 156.130(h) (pages 114-115 of 115) does not apply to short-term medical.	Insurers can exclude drug coupons from deductible and any maximum out-of-pocket limitation.	
☐	Information regarding cost, price, or copayment of a prescription drug; pharmacist or contracted pharmacy	§ 71-2484	SBP and any description of pharmacy copays should include a statement where the pharmacy's price is lower than the stated copayment; the insured is only required to pay the pharmacy price.	
☐	Maternity Stay	PHSA 2725 (45 CFR 148.170) (applies to short-term medical)	May not restrict hospital stay to less than 48 hours for normal delivery or 96 hours for C-section.	
☐	Network Adequacy	§ 44-7105	For plans with a network: Reasonable access standards, travel time, number of specialists, current complete provider directory online and paper on request. If the carrier's in-network hospital does not have an in-	

			network ancillary provider, then the carrier has to reimburse the nonparticipating provider at UCR. This requires a definition of UCR with a method to calculate UCR, not just "in an amount determined by the insurer.	
☐	Entire contract	§ 44-710.03 (1)	The policy and any attached papers (endorsements, riders, amendments and application) constitute the entire contract. No policy change valid unless approved & signed by executive officer.	
☐	Time Limit on Certain Defenses and incontestability	§ 44-710.03 (2)	After two years from date of policy issue, no misstatements, except fraudulent misstatements, made in application may be used to void policy or deny claim.	
☐	Grace Period	§ 44-710.03 (3)	Policy continues in force during Grace Period. Usually 31 days.	
☐	Reinstatement	§ 44-710.03 (4)	If money accepted with no reinstatement application, it is reinstated. If application is required and a conditional receipt is given, the policy is reinstated upon approval or 45 days following date of conditional receipt unless insurer provides disapproval in writing. • Reinstated policy covers loss from accidental injury after reinstatement date. • Reinstated policy covers loss due to sickness more than 10 days after reinstatement date. • Premium applied to period not more than 60 days prior to date of reinstatement.	
☐	Notice of Claim	§ 44-710.03 (5)	20 days after loss or as soon as reasonably possible	
☐	Claim Form	§ 44-710.03 (6)	If claim forms not furnished by insurer within 15 days, file proof of loss.	

☐	Proof of Loss	§ 44-710.03 (7)	90 days after loss or as soon as possible but no later than one year unless legally incapacitated.	
☐	Time of Payment of Claim	§ 44-710.03 (8)	Immediately upon receipt of proof of loss. (Will accept within 30 days.)	
☐	Payment of Claim	§ 44-710.03 (9)	Minor or incompetent to give valid release – can pay to relative up to $5000	
☐	Physical Exam and Autopsy	§ 44-710.03 (10)	At insurer's expense as often as reasonably required during pendency of claim	
☐	Legal Actions	§ 44-710.03 (11)	60 days, 3 years	
☐	Change of Beneficiary	§ 44-710.03 (12)	Right to change beneficiary unless irrevocable.	
☐	Conformity with State and Federal Law	§ 44-710.03 (13)	Based on where insured resides on effective date of policy.	
	PERMISSIVE PROVISIONS			
☐	Misstatement of Age	§ 44-710.04 (2)	If age of insured has been misstated, the amount payable under the policy shall be such as the premium paid would purchase at the correct age. Misstatement of "Facts" is too broad.	
☐	Felony exclusion	§ 44-710.04 (10)	Commission of or attempt to commit a felony or being engaged in an illegal occupation.	
☐	Intoxicants and Narcotics exclusion	§ 44-710.04 (11)	Insured being intoxicated or under influence of narcotics unless administered on advice of physician.	
☐	Court Ordered	NE Filing Requirement	Exclusion for court ordered services allowed but must include exception for medically necessary services.	
☐	Unpaid premium	§ 44-710.04 (7)	Can deduct from claim.	
	OTHER			
☐	Surprise balance bills	Consolidated Appropriations Act, 2021; Neb. Rev. Stat. §§ 44-6834 to 44-6850	Applies to emergency services, includes air ambulances but not ground ambulances, and applies to ancillary nonemergency services provided at an in-network facility by an out-of-	

			network provider (for example, a radiologist, anesthesiologist, or pathologist). For purposes of plan review for large group, small group, and individual policies, a list of the services for which an insured will not be exposed to balance billing is sufficient, along with a statement that for these services, in-network cost sharing applies. **NDOI also requires that insurers include instructions to insureds that if they receive a bill for the listed services from any provider, they should immediately provide that bill to the insurer, with an email address and mailing address to submit those bills.**	
☐	Hold harmless	General Fairness Requirement.	Remove any "hold harmless" language from the application or policy when: Form language states that the company or producers are held harmless for any losses or liabilities. We will object to hold harmless language if the insured person could be harmed in any way. The company is responsible for its officers, employees and agents and cannot waive its liability. There must be a means of recourse to provide a safety net for the consumer.	
☐	No arbitration	§ 25-2602.01	Nebraska does not allow arbitration in any insurance contracts.	
☐	Subrogation	BCBS, Inc. v. Dailey, 733,687 N.W.2nd 689 (2004)	The insured must be fully compensated before the insurer may subrogate against its insured.	
☐	Artificial Intelligence in Utilization Review	§ 44-5443 (1) & (2)	Confirm compliance that an artificial intelligence-based algorithm shall not be the sole basis of a utilization review and the utilization review agent shall disclose to the department, to each health care provider in its	

			network, to each enrollee, and on its public website if AI based algorithms are used or will be used in the utilization review process.	
☐	Death of Insured – refund unearned premium (n/a group)	§ 44-310	In the event of the death of the insured, the insurer shall refund the unearned premium prorated to the month of the insured's death if the request has been made within one year after the insured's death. The refund of the premium and termination of the coverage shall be without prejudice to any claim originating prior to the date of the insured's death.	
☐	Telehealth	§ 44-312, § 44-7,107	Any insurer offering (a) any individual or group sickness and accident insurance policy, certificate, or subscriber contract delivered, issued for delivery, or renewed in this state, (b) any hospital, medical, or surgical expense-incurred policy, except for policies that provide coverage for a specified disease or other limited-benefit coverage, or (c) any self-funded employee benefit plan to the extent not preempted by federal law, shall provide upon request to a policyholder, certificate holder, or health care provider a description of the telehealth and telemonitoring services covered under the relevant policy, certificate, contract, or plan.	
	APPLICATION			
☐	Application	§ 44-761 (1) NE Filing Requirement	Part of entire contract. If previously approved, provide form number and SERFF tracking #.	
☐	GINA-Prohibition on	Federal Genetic Information Non-	Requests for genetic information, family health	

	genetic information as condition of eligibility or premium rates	discrimination Act, 30 U.S.C. 801.	history questions or genetic testing are not allowed.	
☐	Electronic application and delivery of documents or notices	§ 44-315 Federal ESIGN law, 15 U.S.C. 7001. (UETA), §§ 668.50(5) and (8), F.S.	Consumer must affirmatively consent to electronic delivery and be given notice of option to withdraw consent. Describe safeguards used to protect private and confidential information. Must be in accord with Uniform Electronic Transaction Act. Recorded telephone conversations do not count as electronic signatures.	
☐	Authorization to Release Information	§ 44-916 § 44-917(1)(e) § 44-917 (2)	Signature valid for up to 24 months and must include the right to revoke.	
☐	Ambiguous questions	§ 44-710	Questions must be clear and specific. Ambiguous or open ended questions are not allowed.	
	ENDORSEMENTS, RIDERS, OR AMENDMENTS **For additional forms submitted for approval, please list each here by form number. Each of these must comply with the requirements for officer signature, form number in the lower left corner of every page, descriptive title, company name, premium payment or fees (if applicable), and effective date (if not stated on schedule). Please complete the fields below as indicated.**			
☐	Signature requirement	§ 44-710.17	If restricting coverage, and if endorsement/rider will apply to already inforce policies, **signature of insured is required.** Provide assurance that endorsement/rider will only apply to newly issued policies or provide form to be used to collect insured's signature.	
☐	Title of document	Form number	Reference to SERFF filing for previous approval, if applicable	N/A if any of the listed requirements do not apply
☐				
☐				
☐				
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	SUPPORTING DOCUMENTS REQUIRED Reference name of separate document in right column.			
☐	Actuarial memorandum	NE Filing Requirement	Must be dated and signed by Actuary. Rates are required to be filed as a separate SERFF filing.	
☐	Flesch /readability certification	§ 44-3405 NE Filing Requirement	Minimum score of 40.	
☐	Redlined version	NE Filing Requirement	If replacing existing previous version.	
☐	Statement of variables (SOV)	NE Filing Requirement	Describe variables, ranges of numbers, minimums and maximums of bracketed material.	
	EXPLANATION FOR ANY ITEMS MARKED NOT APPLICABLE			
☐	Please use this space provide an explanation for any checklist requirement marked "N/A" to avoid receiving an objection in SERFF.			

CERTIFICATION OF COMPLIANCE

I, the undersigned authorized filer, hereby certify that this filing complies with applicable Nebraska statutes, regulations, Bulletins and guidelines, to the best of my knowledge. This filing contains no unusual or controversial content according to insurance industry norms. The forms included in this filing contain no unfair, unjust, inequitable, misleading or deceptive provisions or language. I am authorized to sign on behalf of the Company identified below.

_____
Name of Company

_____ _____
Typed Name of Authorized Filer (Electronic Signature) Date

Appendix A

IMPORTANT: This is a short-term, limited-duration policy, NOT comprehensive health coverage

This is a temporary limited policy that has fewer benefits and Federal protections than other types of health insurance options, like those on HealthCare.gov.

This policy	Insurance on HealthCare.gov
Might not cover you due to preexisting health conditions like diabetes, cancer, stroke, arthritis, heart disease, mental health & substance use disorders	Can't deny you coverage due to preexisting health conditions
Might not cover things like prescription drugs, preventive screenings, maternity care, emergency services, hospitalization, pediatric care, physical therapy & more	Covers all essential health benefits
Might have **no limit on what you pay** out-of-pocket for care	Protects you with limits on what you pay each year out-of-pocket for essential health benefits
You **won't qualify** for Federal financial help to pay premiums & out-of-pocket costs	Many people qualify for Federal financial help
Doesn't have to meet Federal standards for comprehensive health coverage	All plans must meet Federal standards

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."