AFFORDABLE CARE ACT INDIVIDUAL AND SMALL GROUP MAJOR MEDICAL CHECKLIST
PLAN YEAR 2023

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

- H16I.005 Individual Health – Major Medical
- H16G.003 Group Health – Major Medical – Small Group

This checklist must be submitted with all Individual and Small Group Major Medical filings (excluding short-term, limited duration insurance), including those submitted for certification as qualified health plans (QHPs), subject to the Affordable Care Act (ACA) and applicable federal regulation, as well as Nebraska laws and regulations. This checklist is also to be used for "off-exchange" plans.

These standards are summaries only. Review of the entire statute or rule may be necessary. Complete each item by marking the check box to verify a "yes" response **and indicate the page on which it can be found**. **Not submitting a completed checklist for each product may cause your filing to be incomplete and returned without review.** These standards are subject to change.

Additional Guidance:

- Company Bulletin 130 provides detailed instructions for filers.
- Issuers should submit plan binders by June 1, 2022.

Notes for PY 2023:

- The federal tobacco age is 21. Increased tobacco rates cannot be charged for ages 20 and younger for QHPs.
- As has been the practice for the last few years, for individual plans, Nebraska will use county-based rating instead of zip-code-based rating. Small group remains zip-code-based.
- The Nebraska Children of Nebraska Hearing Aid Act, §§ 44-5001 to 44-5005, (effective September 1, 2019) requires coverage above the EHB benchmark plan for children up to and including age 18. The 2021 NBPP finalized annual state reporting of state-required benefits that are in addition to EHB, for which states are required to defray the costs. Insurers should be carefully tracking these costs.
- No Surprises Act – language explaining when the insured is protected from balance bills must be clear and describe when the NSA applies.
- Some federal requirements have been changed. Pay close attention to the QHP issuer instruction guide at https://www.qhpcertification.cms.gov/s/Application%20Instructions.
- SBC instructions are different.
- MHPAEA documentation for FR/QTLs and NQTLs is required. Templates to demonstrate analysis are provided in the SERFF binder and in SERFF general instructions.
- Access plan must be provided. Template for access plan is provided in the SERFF binder and in SERFF general instructions.
- The descriptive plan name in the PBT will be closely examined for accuracy and compared to SBCs.
- Rate filings only need to be filed in SERFF – they do not need to be submitted in HIOS. See CB-130 and federal instructions for details on rate filings.
- Rate filings must include commission schedules. Commissions cannot vary by type of enrollment period (open enrollment vs. special enrollment period).

	FILER: PLEASE TYPE INFORMATION IN THE AREA DIRECTLY BELOW.			
	Company name: Product name: Plan names and HIOS Plan IDs: SERFF filing number: Form numbers:			[TOI here]
	SERFF filing number for corresponding rate filing:			
(DOI reviewer) Check as complete d	**Review Requirements**	**Reference (§ 44 refers to Neb. Rev. Stat. Chapter 44, Nebraska's Insurance Code)**	**Description**	**Filer: Provide page number, form name & number if separate document, or N/A**
	SCHEDULE OF BENEFITS AND COVERAGE			
☐	Complete Schedule of Benefits and Coverage (SBC) page	45 CFR 147.200 and ACA Implementation FAQs, Sets 8 and 9	Issuers may combine information for different cost-sharing selections in one SBC for the product. If brackets are used, then a SOV must be filed listing each plan name with HIOS ID, then listing the dollar amounts or other information specific to that plan and HIOS ID. Separate SBCs for each plan can also be filed. When in doubt, defer to the federal sample completed SBC.	
☐	Non-English language	45 CFR 156.250 , 45 CFR Part 92, and technical guidance	Notice indicating how to access language services	

☐	Federal SBC requirements	CCIIO Resources page provides samples and instructions. Also see FAQs.	Issuers are required to use the 2021 Summary of Benefits and Coverage (SBC), the 2021 SBC Calculator Guide and Narratives.	
	COVER PAGE			
☐	Full Company name and address	§ 44-350	Advisable to include contact phone and email for questions.	
☐	"Free Look" period	§ 44-710.18	Policy can be returned within 10 days for full refund and is voided.	
☐	Descriptive title	§ 44-710.01(4)	A brief description of the type of coverage.	
☐	One officers' signature required on face 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.	
☐	Guaranteed Renewable	45 CFR § 148.122	Cover page must have renewability provision.	
	APPLICATION			
☐	Electronic application and delivery of documents or notices	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.	

☐	Prohibition on genetic information as condition of eligibility or premium rates	42 USC § 300gg-53	Requests for genetic information or genetic testing are not allowed.	
☐	No ambiguous questions	§ 44-710	Questions must be clear and specific. Ambiguous or open-ended questions not allowed.	
	NEBRASKA STANDARD MANDATORY PROVISIONS			
☐	Policy and Statutory definitions if any		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. ACA requires coverage to age 26 regardless of student or marital status or financial dependence.	
☐	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	§ 44-710.19	Covered from moment of birth. Automatic coverage first 31 days. Insurers cannot charge for the mandated 31 days of coverage as a condition of continuing the child on the plan.	
☐	Adopted Child	§ 44-799	Covered from date of placement	
☐	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.	
☐	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. Language must match statutory provision or be substantially similar.	
	NEBRASKA STANDARD PERMISSIVE PROVISIONS			

☐	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.	
☐	Exclusion for incarceration	Nebraska Filing Requirement	DOI allows exclusion for incarceration.	
☐	Court Ordered	Nebraska 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.	
	AFFORDABLE CARE ACT AND STATE MANDATED BENEFITS			
☐	Metal Levels	42 USC § 18022(d)	Metal levels include: Bronze at 60% AV, Silver at 70% AV, Gold at 80% AV and Platinum at 90% AV. Bronze and Platinum are optional. URRT must be submitted in SERFF rate filing. Rate filing must include Actuarial Memo, URRT and Rate Data template.	(URRT is not filed until later)

☐	Statewide Gold and Silver Plans	45 CFR § 156.200(c)(1)	Please provide the Plan names and Plan IDs for the plans that constitute statewide coverage.	[list plans here]
☐	Catastrophic Plan	42 USC § 18022(e)	Optional plan for under age 30 or with hardship exemption. Contains high deductible.	
☐	No annual dollar limits on EHBs.	45 CFR § 147.126(2)		
☐	No lifetime dollar limits on EHBs.	45 CFR § 147.126(1)		
☐	Maximum Out-of-Pocket (MOOP)	https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/	Maximum annual limit on In-Network cost sharing (all copays, deductible and coinsurance for EHBs). Does not include premiums, non-covered services, balance billing or Out-of-Network cost sharing).	

☐	Guaranteed issue, guaranteed renewable, no health questions or medical underwriting	45 CFR § 147.102	Must be guaranteed issue and guaranteed renewable. May not establish rules for eligibility based on evidence of insurability, medical history, genetic information, claims experience, health status, disability, receipt of health care, or medical condition. Cannot discriminate based on life expectancy or disability. Rates may not vary by more than 3:1 based on age and not more than 1.5:1 based on tobacco use.	
☐	No Preexisting Condition Limitations.	45 CFR § 147.108		

☐	Special Enrollment Periods	45 CFR § 155.420	Triggering events and becoming newly eligible for cost-sharing reductions, if enrolled between the first and the fifteenth of the month, coverage the first day of the next month, and if between the sixteenth and the last day of the month, coverage the first day of the second following month.	
☐	Preventive Care	42 USC § 300gg-13	Cover specific preventive services and screenings In-Network with no cost sharing. Current lists for adults, women, and children at healthcare.gov	
☐	No Rescission	45 CFR 147.128	Except for fraud and intentional misrepresentation of material fact.	
☐	Termination of Coverage	45 CFR § 155.430	Enrollee-initiated termination permitted, including "free look" under Nebraska law. Termination for failure to pay premiums is on the last day of the first month of the 3-month grace period.	

☐	Grace Periods	45 CFR § 155.430 and 45 CFR § 156.270	3-month grace period for enrollees who when first failing to timely pay premiums are receiving APTC. Issuer pays the first month's claims and may pend claims for the second and third months. Issuer must provide enrollee with notice of payment delinquency.	
☐	Notice of right to designate primary care provider	29 CFR § 2590.715-2719A(a)	Any participating primary care provider who is available to accept the participant can be designated; for children, a pediatrician can be the primary care provider; no authorization or referral required to see ob/gyn.	

☐	Providers operating within scope of practice	42 USC § 300gg-5 and § 44-513	If provider is operating within scope of license, issuer cannot discriminate with respect to participation in the plan or coverage. Reimbursement may still vary based on quality or performance issues. Covered services may be provided by the providers listed at § 44-513 if within scope of practice, but negotiation of preferred provider networks is still allowed under §§ 44-4101 to 44-4113.	

	Internal claims procedures	45 CFR § 147.136	Must comply with 29 CFR § 2560.503-1(b). Describe all claims procedures, including procedures for obtaining prior authorization and utilization review and applicable time frames. Must allow authorized representative to act on behalf of claimant. Must allow claimant to review claim file and present evidence and testimony. Must provide reason for adverse benefit determination including denial code and its corresponding meaning, plus issuer's standard, if any, used to deny the claim. Must provide appeal information.	
☐	Claims Settlement Practices	Title 210 Chapter 61	Chapter 61 is applicable to Major Medical.	

☐	Internal complaint other than adverse benefit determination	§ 44-7308(2) and (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).	

☐	Internal appeal procedures	45 CFR § 147.136	Must define "adverse benefit determination." Must allow claimant to review claim file and present evidence and testimony. Must provide claimant with rationale for final internal adverse benefit determination if based on a new or additional rationale. Must provide reason for adverse benefit determination including denial code and its corresponding meaning, plus issuer's standard, if any, used to deny the claim, and a discussion of the decision. Must provide external appeal information. Individual coverage can only include one level of internal appeal.	
☐	Corresponding state internal appeal procedures for adverse determinations	§ 44-7308(1)	Standard internal review of adverse determination with written decision within 15 working days. Requirements for written decision at § 44-7308(3).	

☐	Expedited procedures for internal appeals and external review	45 CFR § 147.136; § 44-7311	Expedited review within 72 hours.	
☐	External Review	§ 44-1308 § 44-1309 Title 210 Chapter 87	Complete internal review first. Request for external review made to DOI within 4 months after internal appeal decision. IRO assigned. Written decision within 45 days.	
☐	External review for denials based on experimental or investigational	§ 44-1308 § 44-1309 § 44-1310 Title 210 Chapter 87	See standards and deadlines for clinical reviewers' opinions and IRO decisions at § 44-1310.	
☐	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.	

☐	Hold harmless	General Fairness Requirement. § 44-511	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.	

☐	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.	
☐	Overpayment of claim, offset against another claim	Title 210 Chapter 61 009.	Overpayment of an earlier claim can only be recouped by withholding part of payment for a second claim if the requirements at 009 are met.	

☐	Essential Health Benefits (EHB)	42 USC § 18022(b) and Nebraska benchmark plan	Requires coverage of: Ambulatory patient services, Emergency services, Hospitalization, Maternity and newborn care, Mental Health and Substance Abuse, Behavioral Health, Prescription drugs, Rehabilitative and habilitative services, Laboratory, Preventive care, Wellness, Chronic disease management, Pediatric services, including oral and vision care.	

☐	Nebraska Mandated Benefits	§ 44-785 § 44-797 § 44-786 § 44-788 § 44-790 § 44-797 § 44-7,102 § 44-784 § 44-789 § 44-788 § 44-798 § 44-5004	Mammography Breast reconstruction OB/GYN Drug coverage cancer/AIDS Diabetes Reconstructive breast surgery Colorectal cancer screening Childhood immunizations TMJ Off-label drugs for cancer and HIV/AIDS Dental care requiring hospitalization and general anesthesia Hearing aids for under age 19 (does not apply to small group per 44-5003(1))	
☐	Clinical trials	42 USC § 300gg-8	Cover routine patient costs for phase I, II, III or IV approved clinical trials for cancer or life threatening disease.	
☐	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) and 2021 NBPP fact sheet	"To the extent consistent with State law, issuers will be permitted, but not required, to count toward the annual limitation on cost sharing amounts paid toward reducing out-of-pocket costs using any form of direct support offered by drug manufacturers to enrollees for specific prescription drugs." Please clearly state in the policy how drug coupons will, or will not, be counted toward deductible and MOOP.	

☐	Maternity Stay	45 CFR § 148.170	May not restrict hospital stay to less than 48 hours for normal delivery or 96 hours for C-section.	
☐	Mental Health Parity and Addiction Equity Act	MHPAEA resources available online, may complete self-compliance tool to demonstrate plan compliance	Mental health benefits same as physical sickness. Benefits for mental health/substance use disorder same cost sharing and limits as medical/surgical. Excel templates for FR/QTLs and for NQTLs are available in SERFF. **New this year, issuers must demonstrate MHPAEA analysis for filings in both FR/QTLs and NQTLs.**	

☐	Network Adequacy	§ 44-7105 and 45 CFR § 156.230	Health carriers must have an access plan containing the requirements at 44-7105(2). 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." **New this year, a template Access Plan is available in SERFF.**	

☐	Posted Network	45 CFR § 156.230(b)	QHP issuers must make provider directories available to the Exchange; Up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, must be published on the issuer's public web site, distinguishing provider networks if multiple networks are maintained.	
☐	Out-of-Network (OON) Emergency Coverage	45 CFR § 156.130(g)	**Non-emergency OON** – must define what benefits are based on and how calculated. **Emergency OON** – now covered by No Surprises Act.	

☐	No Surprises Act (NSA)	cms.gov/nosurprises for federal resources	Applies to emergency services (some past-stabilization emergency services are covered), non-emergency services by OON providers at in-network facilities, and air ambulance (but not ground ambulance). *Policy must describe the types of services that are protected from balance billing. A list of CPT codes is not required. *Policy must explain that when a claim is made, the insurer will send an Explanation of Benefits that includes contact information for the insurer in the event an insured receives a surprise balance bill.	

	Clarification of interaction between NSA and Nebraska surprise balance billing statutes (not required in policy language, just for filers' information)		All services covered by the Nebraska surprise billing law are covered by the No Surprises Act, so a description of the protection from balance billing in the NSA is sufficient to give the insured notice of all instances where there is protection from balance bills.	
	PRODUCT VARIATIONS **These requirements only apply to certain products – see the left column for product types.**			
☐	HMO and EPO, disclosure of network limitation on coverage	§ 44-710	To avoid misleading consumers, clear explanation on network limitations for payment is required, including procedure for consumers to follow when a closed plan/HMO does not include the necessary provider.	
☐	HMO, in-network coverage for basic health care services	§ 44-3294	Basic health care services must be included in the network with no exposure to balance billing.	
☐	HMO, certificate of authority	§ 44-32,115, § 44-32,151 and § 44-3295	Certificate of Authority required as *either* an HMO or an insurer.	

☐	EPO, in-network coverage	§ 44-7105	Because EPOs provide closed networks like an HMO, Nebraska requires that in-network providers be available for all covered benefits, subject to the Managed Care Plan Network Adequacy Act standards.	
	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.**			
☐	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
☐				
☐				
☐				
☐				
	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.	
☐	NE Filing Form List	NE Filing Requirement	Use page 2 for additional forms.	
	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.

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Name of Company

______________________________ ____________________________________
Typed Name of Authorized Filer (Electronic Signature) Date