## General Requirements --- Individual Health Insurance Forms

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<td>Discretionary Language</td>
<td>AS 21.36.&lt;br&gt;AS 21.42.130</td>
<td>A contract may not assert exclusive or discretionary authority to interpret contractual provisions.</td>
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<tr>
<td>Domestic Partnership Benefits</td>
<td>AS 21.36.090(b),&lt;br&gt;AS 21.42.130</td>
<td>Domestic partnership benefits, if offered, must be available to both same and opposite sex partners.</td>
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<tr>
<td>Topic</td>
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<td>Arbitration</td>
<td>AS 21.42.130, AS 21.42.392(e)</td>
<td>Venue must be in place of insured's residence and method of arbitration and source of information on the arbitration process must be provided to the insured.</td>
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<td>Terrorism Exclusions</td>
<td>AS 21.36, AS 21.45.250(2)</td>
<td>Terrorism and terrorism-related exclusions are prohibited.</td>
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<td>Applications</td>
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<td>Applications must state that information provided by the applicant are representations and not warranties.</td>
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<td>AS 21.51.260</td>
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<td>45-day Notice</td>
<td>AS 21.36.225</td>
<td>45-days notice prior to cancellation or changes to premiums or benefits. For products subject to the ACA, a 60 day notice is required before the effective date of any material modification including changes in preventive benefits.</td>
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<tr>
<td>REVIEW REQUIREMENTS</td>
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</table>
| Coverage of Dependents and Children            | AS 21.42.345  
                AS 21.36.485                  | Children must be covered if dependent coverage is available. Newly born children of dependent children must be made an offer of coverage. |
| Coverage of Dependent Students on leave of absence | AS 21.42.410  
                          42 USC 300gg-54                  | Consistent with Federal requirements.                                     |
| Acupuncture*                                   | AS 21.42.353                  |                                                                          |
| Services Provided by Nurse Midwives            | AS 21.42.355                  |                                                                          |
| Diabetes                                       | AS 21.42.390                  | When pharmacy services are covered, diabetes treatment must also be covered, including outpatient self-management training or education. |
| Reconstructive Surgery Following Mastectomy    | AS 21.42.400  
                          42 USC 300gg-6  
                          42 USC 300gg-52                  | Consistent with Federal requirements                                       |
| Costs of Birth                                 | AS 21.42.347                  | Time frames consistent with Federal requirements. Requirement does not affect a payment arrangement between the provider/hospital and the insurer See “Maternity Coverage” below for ACA requirements. |
| Infant and Newborn hearing screening           | AS 21.42.349                  |                                                                          |
| Well-baby Exams                                | AS 21.42.351                  |                                                                          |
| Mammograms*                                    | AS 21.42.375                  |                                                                          |
| Colorectal Cancer Screening                    | AS 21.42.377                  | American Cancer Society recommendations                                  |
| Phenylketonuria*                               | AS 21.42.380                  |                                                                          |
## Autism Spectrum Disorders

Under AS 21.42.397(b)(3) minimum autism coverage is subject to “copayment, deductible, and coinsurance provisions, and other general exclusions or limitations included in a health insurance policy to the same extent as other health care services covered by the policy”. This means that a policy may apply the same cost-sharing requirements to autism coverage as are applied to other coverage. Note that beginning on 1/1/2014 treatment for mental health and behavioral health conditions are mandated benefits under the ACA and therefore insurers will not be able to exclude coverage for autism, despite the “general exclusions or limitations” provision of this mandate.

## Dental, Vision, and Hearing*

Minimum coverage must be offered as rider or separate policy, unless insurer has written less than $300,000 premiums in previous calendar year.

## Clinical Trials related to Cancer

Includes palliative care, complications and transportation

See “Approved Clinical Trials” below for ACA requirements.

## Coverage for prescription drugs; specialty drug tiers

90 day notice

## Coverage for telehealth and mental health benefits

If a plan has mental health benefits, coverage for telehealth must also be provided. A prior in-person contact requirement between the health care provider and the patient is not permitted.

## Coverage for topical eye medication

Allows for the early refill of topical eye medication for treatment of a chronic condition.

## Coverage for anti-cancer medication

No higher cost sharing for oral/self-administered anti-cancer medication as for injected, intravenously health care provider administered anti-cancer medication.

### ACA Requirements -- Grandfathered and Non-Grandfathered Health Care Insurance Plans

#### Rescissions

No rescissions except in cases of fraud or intentional misrepresentation of material fact.

Coverage may not be cancelled except with 30 days prior notice to each enrolled person who would be affected.

#### Annual or lifetime limits

For non-grandfathered plans:
- No annual or lifetime limits are allowed on the dollar value of Essential Health Benefits (EHB)
- Issuers are not prohibited from using lifetime limits for specific covered
<table>
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<tr>
<th>Coverage for dependents to age 26</th>
<th>PHSA §2714 (75 Fed Reg 27122, 45 CFR §147.120)</th>
<th>Available if dependent coverage offered.</th>
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<td>Use of Uniform Summary of Benefits and Coverage with Examples and Uniform Definitions</td>
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**ACA Requirements-Non-Grandfathered Health Care Insurance Plans (Issued on or after 1/1/2014)**

**Note:** In addition to the listed items, health care plans must also include EHB benefits consistent with the Alaska Benchmark plan

| No pre-existing condition exclusions | PHSA §2704  
PHSA §1255 (75 Fed Reg 37188, 45 CFR §147.108) | No pre-existing condition exclusions for individuals 19 and under.  
For plan years beginning on or after 01/01/2014, no pre-existing condition exclusions for all individuals |
|-------------------------------------|-----------------------------------------------|------------------------------------------|
| Provide Essential Health Benefits  
- Ambulatory patient services  
- Emergency services  
- Hospitalization  
- Maternity and newborn care  
- Mental health and substance use disorder services, including behavioral health treatment  
- Prescription drugs  
- Rehabilitative and habilitative services and devices  
- Laboratory services  
- Preventive and wellness services and chronic disease management  
- Pediatric services, including oral and vision care | PHSA §2707 | Mental health and substance use disorder services must comply with federal parity law and final rules for plans renewing on or after 1/1/2015. |
<p>| Preventive Services | PHSA §2713 (75 Fed Reg 41726, 45 CFR §147.130) | Covers preventive services without cost-sharing requirements including deductibles, co-payments, and co-insurance. |
| 60 day advance notice to enrollees | PHSA 2715 (75 Fed Reg 41760) | Notice before the effective date of any material modification including changes in preventive benefits. |
| Coverage for emergency | PHSA §2719A | Must be covered at in-network cost-sharing |</p>
<table>
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<tr>
<th>services</th>
<th>(75 Fed Reg 37188, 45 CFR §147.138) SSA §1395dd</th>
<th>level (patient is not penalized for emergency care at out-of-network provider)</th>
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<tr>
<td>Designated primary care provider</td>
<td>PHSA §2719A (75 Fed Reg 37188, 45 CFR §147.138)</td>
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| Maternity coverage, hospital stays related to childbirth | PHSA §2725 (45 CFR §148.170) | Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section.  
No prior authorization required for 48/96 hour hospital stay.  
Length of stay begins at the time of delivery if in hospital, admission to hospital if delivery occurred outside the hospital.  
Insurer may not require the mother to give birth in a hospital. May not provide inducements to provider or mother to accept less than the minimum requirements. |
| Mental Health and Substance Use Disorder Benefits Parity | PHSA §2726 | Mental Health and Substance Use must be on par with other benefits. As an EHB, these services must not have a lifetime or annual limit. |
| Coverage for reconstructive surgery after mastectomy | PHSA §2727 | If plan covers mastectomy, then must cover reconstructive surgery for mastectomy. Coverage includes, breast on which mastectomy performed, other breast to produce symmetrical appearance, prostheses; and treatment of complications. Notice of benefit given at issue and annually. |
| Dependent student on medically necessary leave of absence | PHSA §2728 (45 CFR §147.145) | If plan covers dependent students beyond age 26 |
| Coverage is guaranteed renewable | PHSA §2702 (45 CFR §148.122) | May only non-renew or cancel coverage for nonpayment of premiums, fraud, market exit, movement outside of service area, or cessation of bona-fide association membership. |
| Coverage not based on genetic information (GINA) | PHSA §2753 (74 Fed Reg 51664, 45 CFR §148.180) | The incidental collection of genetic information is permitted, as long as it is not used for underwriting purposes. |
| Non-discrimination of providers | PHSA§2706 | Issuers may not discriminate against any provider operating within their scope of license. |
| **Approved Clinical Trials** | PHSA §2709 | Approved clinical trial means phase I, II, III, or IV clinical trial, conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. Federal requirements would allow requiring services to be provided by a network provider. Alaska law prohibits a requirement for a covered person to receive services from a particular provider. |
| **Claims procedures** | 45 CFR §147.136, 29 CFR §2560.503-1 | Required to include a description of: o claims procedures; o procedures for obtaining prior approval; o preauthorization procedures; o utilization review procedures; and o applicable time frames. Under Alaska law, urgent utilization review determination must be made within 24 hours. For all other utilization review decisions must be made within 72 hours. |
| **Internal appeals of adverse benefit determinations - processes, rights and required notices** | PHSA §2719 (75 Fed Reg 43330, 76 Fed Reg 37208, 45 CFR §147.136) | Alaska law requires allowance for situations in which a covered person cannot meet an appeal deadline. Appeal determinations must be made within 18 working days, for utilization review appeals. Appeal must be reviewed by one holding the same professional license as the treating provider. |
| **External review processes rights** | PHSA §2719 (75 Fed Reg 43330, 76 Fed Reg 37208, 45 CFR §147.136) | Exhaustion of internal appeal not required if insurer did not meet internal appeal process timelines or for urgent care. Cost must be borne by the insurer. $25 filing fee permitted. Minimum dollar amount to qualify for external appeal not allowed. Appeal must be filed within 4 months, decision must be made within 45 days, 72 hours for urgent appeals. The decision of the IRO is binding. HHS Administered external review process offers two options: • HHS administered • Insurer contract with multiple IROs |
| **Meets Annual limits on Deductibles/cost sharing** | | |
| **Open Enrollment** | | A Catastrophic plan may have a lower AV, certification of AV level must be included in |
### Checklists/Filings/Individual Health Page 8 of 10 (Rev. 3/24/2017)

#### Notice of premium non-payment and notice of pending claims
- **45 CFR 156.270**

#### Health management
- Alaska benchmark plan
  - Including but not limited to: health education, nicotine dependency programs.

#### Neurodevelopmental therapy
- Alaska benchmark plan
  - Up to age 7

#### Nutritional therapy
- Alaska benchmark plan

#### Electronic Visits
- Alaska benchmark plan

#### Sales tax for medical equipment and supplies
- Alaska benchmark plan

### Additional Requirements for Health Care Insurance Plans Offered on the FFM

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<td>Provides access to directory of providers</td>
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<td>Grace Period</td>
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<td>Three month grace period for enrollees receiving tax credits</td>
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### Claim Provisions

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### INDIVIDUAL HEALTH POLICY FORM CHECKLIST

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<th>Claim Payments–UCR</th>
<th>3 AAC 26.110(a)</th>
<th>Must reimburse at 80th percentile or higher. Must provide explanation of the basis of payments in the policy, including any payments for which a covered individual may be responsible and must be included on any schedule or summary of benefits page accompanying the policy.</th>
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<tr>
<td>Prompt Payment of Claims</td>
<td>AS 21.36.495 3 AAC 26.110(k)</td>
<td>Clean claims must be paid within 30 calendar days after receipt by insurer or TPA. Claims other than clean claims must be paid within 15 days of receipt of needed information. Delaying payment to negotiate discounts with provider not valid reason for considering the claim not to be clean.</td>
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<tr>
<td>Recovery of Overpayments</td>
<td>AS 21.36.125(a)(3) 3 AAC 26.110(d)</td>
<td>Recovering or correcting payments after the time period allowed for an insured to appeal or submit a claim is a violation of AS 21.36.</td>
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<td>Reducing Payment due to overpayment on previous claim</td>
<td>AS 21.36.125(a)(6) AS 21.36.495 Bulletin B07-06</td>
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### Provider, External Appeal, Utilization Review Provisions

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<tr>
<td>Choice of Provider</td>
<td>AS 21.07.030</td>
<td>Network only (closed network) plans are not allowed in Alaska</td>
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<tr>
<td>Non-Contracted Providers within a Contracted Facility</td>
<td>AS 21.42.130 Bulletin B07-06 3 AAC 26.110(f)</td>
<td>Alaska requires insurers to disclose the responsibility of a covered person to pay for charges greater than UCR if the covered person is admitted to a contracted hospital and receives services from a non-contracted provider. Payment must be at in-network rates when non-contracted provider provides services in a contracted facility and the individual does not have a choice as to who performs the services.</td>
</tr>
<tr>
<td>Reasonable Access to Providers</td>
<td>3 AAC 26.110(f) AS 21.36.125 AS 21.42.130</td>
<td>If there is not reasonable access to a network provider as defined in the policy (e.g. 50 miles from individual's residence), coverage for a non-network provider must be at the same benefit level (i.e. deductibles, coinsurance and other cost sharing requirements) as a network provider for all covered services.</td>
</tr>
<tr>
<td>Direct Payment of Claims</td>
<td>AS 21.51.120</td>
<td>Payment of claim to provider upon written request of covered person</td>
</tr>
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### External Appeals

| AS 21.07.005 | AS 21.07.050-.070 | For plans subject to ACA, these external appeal provisions have been preempted by ACA. Insurers are required to comply with the ACA external appeal requirements until regulations under AS 21.07.005 are finalized and effective. |

### Dental Care Coverage

| AS 21.42.392 | A covered person may bring a civil action against a health care insurer to enforce the person's rights under this section if the covered person has exhausted the administrative appeal process. |

*Not applicable to Fraternal Benefit Societies*

### REQUIREMENTS FOR HOSPITAL OR MEDICAL SERVICE CORPORATIONS

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<th>Form Filings</th>
<th>AS 21.87.180</th>
<th>Forms and agreements must be filed for approval.</th>
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<td>Service Agreements</td>
<td>AS 21.87.140</td>
<td>Medical and hospital service agreements must be filed for approval.</td>
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<td>AS 21.87.150</td>
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<tr>
<td>Allowable Medical Services and Benefits</td>
<td>AS 21.87.120</td>
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<tr>
<td>Allowable Hospital Services and Benefits</td>
<td>AS 21.87.130</td>
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### REQUIREMENTS FOR FRATERNAL BENEFIT SOCIETIES

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<td>AS 21.84.230</td>
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<tr>
<td>Benefit Contract</td>
<td>AS 21.84.255</td>
<td>Contract must be filed for approval, 60-day review period.</td>
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