

CHAPTER 33

HEALTH INSURANCE CONTRACTS

§2701. Scope of chapter

Nothing in this chapter shall apply to or affect: [PL 1969, c. 132, §1 (NEW).]

1. Any policy of liability or workers' compensation insurance with or without supplementary expense coverage therein;
[PL 1989, c. 502, Pt. A, §94 (AMD).]

2. Any group or blanket policy, except that:

A. Sections 2736, 2736-A and 2736-B apply to group Medicare supplement policies as defined in chapter 67, group nursing home care and long-term care insurance policies as defined in chapter 68 or 68-A; [PL 2003, c. 428, Pt. G, §3 (AMD).]

B. Section 2752 applies with respect to mandated benefits for group or blanket health policies; and [PL 1995, c. 332, Pt. J, §1 (AMD).]

C. Sections 2736, 2736-A, 2736-B and 2736-C apply to:

(1) Association groups as defined by section 2805-A, except as to any employer subgroups of the association group when the employer is a member of the group and provides coverage through the group as a bona fide employee benefit;

(1-A) Credit union groups as defined by section 2807-A; and

(2) Other groups as defined by section 2808, except:

(a) Employee leasing companies registered pursuant to Title 32, chapter 125; and

(b) As to any employer subgroups of the other group when the employer provides coverage to its employees through the group as a bona fide employee benefit. [PL 2009, c. 244, Pt. F, §1 (AMD).]

[PL 2009, c. 244, Pt. F, §1 (AMD).]

3. Life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to health insurance as:

A. Provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means, or as [PL 1969, c. 132, §1 (NEW).]

B. Operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract; [PL 1983, c. 801, §8 (AMD).]

[PL 1983, c. 801, §8 (AMD).]

4. Reinsurance; and

[PL 1983, c. 801, §8 (AMD).]

5. Legal services insurance.

[PL 1983, c. 801, §9 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1983, c. 801, §§8,9 (AMD). PL 1985, c. 648, §9 (AMD). PL 1989, c. 502, §A94 (AMD). PL 1989, c. 556, §A4 (AMD). PL 1991, c. 701, §5 (AMD). PL 1995,

c. 332, §J1 (AMD). PL 2001, c. 258, §E1 (AMD). PL 2003, c. 428, §G3 (AMD). PL 2005, c. 121, §B1 (AMD). PL 2009, c. 244, Pt. F, §1 (AMD).

§2702. Short title

This chapter may be cited as the "Uniform Health Policy Provision Law". [PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2703. Scope, format of policy

No policy of health insurance shall be delivered or issued for delivery to any person in this State unless it otherwise complies with this Title, and complies with the following: [PL 1969, c. 132, §1 (NEW).]

1. The entire money and other considerations therefore shall be expressed therein; [PL 1969, c. 132, §1 (NEW).]

2. The time when the insurance takes effect and terminates shall be expressed therein; [PL 1969, c. 132, §1 (NEW).]

3. It shall purport to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family, who shall be deemed the policyholder, any 2 or more eligible members of that family, including husband, wife, dependent children or any children under a specified age which shall not exceed 23 years and any other person dependent upon the policyholder; [PL 1969, c. 132, §1 (NEW).]

4. The style, arrangement and overall appearance of the policy shall give no undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers shall be plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lower case unspaced alphabet length not less than one hundred and twenty-point; the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions; [PL 1969, c. 132, §1 (NEW).]

5. The exceptions and reductions of indemnity shall be set forth in the policy and, other than those contained in sections 2705 to 2729, shall be printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "Exceptions", or "Exceptions and Reductions", except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies; [PL 1969, c. 132, §1 (NEW).]

6. Each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof; and [PL 1969, c. 132, §1 (NEW).]

7. The policy shall contain no provision purporting to make any portion of the charter, rules, constitution or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the superintendent. [PL 1973, c. 585, §12 (AMD).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1973, c. 585, §12 (AMD).

§2704. Required provisions; captions -- omissions -- substitutions

1. Except as provided in subsection 2, each such policy delivered or issued for delivery to any person in this State shall contain the provisions specified in sections 2705 to 2716, in the words in which the same appear; except that the insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the superintendent which are in each instance not less favorable in any respect to the insured or the beneficiary. Each such provision shall be preceded individually by the applicable caption shown, or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the superintendent may approve.

[PL 1973, c. 585, §12 (AMD).]

2. If any such provision is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the superintendent, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of a provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

[PL 1973, c. 585, §12 (AMD).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1973, c. 585, §12 (AMD).

§2705. Entire contract -- changes

There shall be a provision as follows: [PL 1969, c. 132, §1 (NEW).]

Entire contract; changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions. [PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2706. Time limit on certain defenses

There shall be a provision as follows: [PL 1969, c. 132, §1 (NEW).]

Time limit on certain defenses: (a) After 3 years from the date of issue of this 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, as defined in the policy, commencing after the expiration of such 3-year period. [PL 1969, c. 132, §1 (NEW).]

1. The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial 3-year period, nor to limit the application of sections 2717 through 2723 in the event of misstatement with respect to age or occupation or other insurance.

[PL 1969, c. 132, §1 (NEW).]

2. A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium 1 until at least age 50 or, 2 in the case of a policy issued after age 44, for at least 5 years from its date of issue, may contain in lieu of the foregoing the following provision, from which the clause in parentheses may be omitted at the insurer's option, under the caption "Incontestable:"

[PL 1969, c. 132, §1 (NEW).]

After this policy has been in force for a period of 3 years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. [PL 1969, c. 132, §1 (NEW).]

(b) No claim for loss incurred or disability, as defined in the policy, commencing after 3 years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy. [PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2707. Grace period

There shall be a provision as follows: [PL 1969, c. 132, §1 (NEW).]

A grace period of , insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies, days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force. [PL 1969, c. 132, §1 (NEW).]

A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision: [PL 1969, c. 132, §1 (NEW).]

Unless not less than 30 days prior to the premium due date the insurer has delivered to the insured or has mailed to the insured's last address as shown by the records of the company written notice of its intention not to renew this policy beyond the period for which the premium has been accepted. [RR 2021, c. 1, Pt. B, §237 (COR).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). RR 2021, c. 1, Pt. B, §237 (COR).

§2707-A. Notification prior to cancellation; restrictions on lapse or termination due to cognitive impairment or functional incapacity

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. [PL 2011, c. 123, §2 (AMD); PL 2011, c. 123, §5 (AFF).]

Within 90 days after cancellation due to nonpayment of premium, a policyholder, a person authorized to act on behalf of the policyholder or a dependent of the policyholder covered under a health insurance policy or certificate may request reinstatement on the basis that the loss of coverage was the result of the policyholder's cognitive impairment or functional incapacity. An insurer may require a medical demonstration that the policyholder suffered from cognitive impairment or functional incapacity at the time of cancellation. If the medical demonstration is waived or substantiates the existence of a cognitive impairment or functional incapacity at the time of policy cancellation to the satisfaction of the insurer, the policy must be reinstated. The medical demonstration may be at the expense of the policyholder. [PL 2011, c. 123, §2 (NEW); PL 2011, c. 123, §5 (AFF).]

A policy reinstated pursuant to this section must cover any loss or claim occurring from the date of the cancellation. Within 15 days after request from an insurer, a policyholder of a policy reinstated pursuant to this section shall pay any unpaid premium from the date of the last premium payment at the rate that would have been in effect had the policy remained in force. If the premium is not paid as required, the policy may not be reinstated and the insurer is not responsible for claims incurred after the initial date of cancellation. If an insurer denies a request for reinstatement, the insurer shall notify the policyholder that the policyholder may request a hearing before the superintendent. [PL 2011, c. 123, §2 (NEW); PL 2011, c. 123, §5 (AFF).]

The superintendent may adopt rules to implement the requirements of this section. The rules may include, but are not limited to, definitions, minimum disclosure requirements, notice provisions and the

right of reinstatement. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [PL 2011, c. 123, §2 (AMD); PL 2011, c. 123, §5 (AFF).]

SECTION HISTORY

PL 1989, c. 835, §2 (NEW). PL 2011, c. 123, §2 (AMD). PL 2011, c. 123, §5 (AFF).

§2708. Reinstatement

1. There shall be a provision as follows:

Reinstatement: 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; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed herein or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

[PL 1969, c. 132, §1 (NEW).]

2. The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums

A. Until at least age 50, or [PL 1969, c. 132, §1 (NEW).]

B. In the case of a policy issued after age 44, for at least 5 years from its date of issue. [PL 1969, c. 132, §1 (NEW).]

[PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2709. Notice of claim

1. There shall be a provision as follows:

Notice of claim: 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.

[PL 1969, c. 132, §1 (NEW).]

2. In a policy providing a loss-of-time benefit that may be payable for at least 2 years, an insurer may at its option insert the following between the first and 2nd sentence of the above provision:

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least 2 years, the insured shall, at least once in every 6 months after having given notice of the claim, give to the insurer notice of continuance of such disability, except in the event of legal incapacity. The period of 6 months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole

or in part by the insurer must be excluded in applying this provision. Delay in the giving of such notice does not impair the insured's right to any indemnity that would otherwise have accrued during the period of 6 months preceding the date on which such notice is actually given.

[RR 2021, c. 1, Pt. B, §238 (COR).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). RR 2021, c. 1, Pt. B, §238 (COR).

§2710. Claim forms

There shall be a provision as follows:

Claim forms: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. 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 as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. [PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2711. Proofs of loss

There shall be a provision as follows:

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. [PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2712. Time of payment of claims

There shall be a provision as follows:

Time of payment of claims: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof. [PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2713. Payment of claims

1. There shall be a provision as follows:

Payment of claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be

payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the company, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

[PL 1969, c. 132, §1 (NEW).]

2. The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:

A. "If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding \$ (insert an amount which shall not exceed \$1,000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment. [PL 1969, c. 132, §1 (NEW).]

B. Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person. Nothing in this provision prohibits an insurer from providing an incentive for insureds to use the services of a particular provider. [PL 1985, c. 704, §5 (AMD).]

[PL 1985, c. 704, §5 (AMD).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1985, c. 704, §5 (AMD).

§2713-A. Explanation and notice to parent

If the insured is covered as a dependent child, and if the insurer is so requested by a parent of the insured, the insurer shall provide that parent with: [PL 2009, c. 244, Pt. B, §1 (AMD).]

1. Payment or denial of claim. An explanation of the payment or denial of any claim filed on behalf of the insured, except to the extent that the insured has the right to withhold consent and does not affirmatively consent to notifying the parent;

[PL 2009, c. 244, Pt. B, §1 (AMD).]

2. Change in terms and conditions. An explanation of any proposed change in the terms and conditions of the policy; or

[PL 1989, c. 556, Pt. D, §2 (NEW).]

3. Notice of lapse. Reasonable notice that the policy may lapse, but only if the parent has provided the insurer with the address at which the parent may be notified.

[PL 1989, c. 556, Pt. D, §2 (NEW).]

In addition, any parent who is able to provide the information necessary for the insurer to process a claim must be permitted to authorize the filing of any claims under the policy. [PL 2009, c. 244, Pt. B, §1 (AMD).]

SECTION HISTORY

PL 1989, c. 556, §D2 (NEW). PL 2009, c. 244, Pt. B, §1 (AMD).

§2714. Physical examination, autopsy

There shall be a provision as follows:

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. [PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2715. Legal actions

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. [PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2716. Change of beneficiary

1. There shall be a provision as follows:

Change of beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change the beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

[PL 1969, c. 132, §1 (NEW).]

2. The first clause of the above provision relating to the irrevocable designation of beneficiary may be omitted at the insurer's option.

[PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2717. Right to examine and return policy

1. Except as to nonrenewable accident policies and individual credit health insurance policies, every individual health insurance policy shall contain a provision therein or in a separate rider attached thereto when delivered, stating in substance that the person to whom the policy is issued shall be permitted to return the policy within 10 days of its delivery to such person and to have a refund of the premium paid if after examination of the policy the purchaser is not satisfied with it for any reason. The provision shall be set forth in the policy under an appropriate caption, and if not so printed on the face page of the policy adequate notice of the provision shall be printed or stamped conspicuously on the face page.

[PL 1969, c. 132, §1 (NEW).]

2. The policy may be so returned to the insurer at its home or branch office to the agent through whom it was applied for, and thereupon shall be void as from the beginning and as if the policy had not been issued.

[PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2717-A. Disability benefit offsets

1. Disclosure to applicants. At or before the time of application for any policy subject to this chapter that provides disability income benefits, the insurer shall provide the applicant with a clear and conspicuous written notice, on the application form or in a separate document, that accurately explains to the applicant all types of other sources of income that may result in a reduction of the benefits payable under the policy.

[PL 2005, c. 42, §1 (NEW).]

2. Recovery of disability benefit overpayments. For claims filed after January 1, 2006, an insurer that is entitled to reduce disability income benefit payments when the insured receives income from other sources and that is entitled to recover overpayments through offsets against current payments to the insured may not recover such overpayments at a rate greater than 20% of the net benefit per benefit payment period unless:

A. For policies applied for after September 13, 2003, the insurer has complied with the requirements of subsection 1; [PL 2005, c. 42, §1 (NEW).]

B. The insurer effects the offset of benefits within 60 days of notice to the insurer, or such later date as the insurer begins paying benefits to the insured, that the insured is receiving or is entitled to receive income that may result in a reduction of benefits payable under the policy; [PL 2005, c. 42, §1 (NEW).]

C. The overpayment did not result from the insurer's miscalculation of benefit reductions or the insurer's miscalculation of benefits payable under the policy; and [PL 2005, c. 42, §1 (NEW).]

D. The insurer provided the insured with clear and conspicuous written notice that accurately explains to the insured all types of other sources of income that may result in a reduction of the benefits payable under the policy within 30 days of the date a claim for disability benefits was filed. [PL 2005, c. 42, §1 (NEW).]

[PL 2005, c. 42, §1 (NEW).]

SECTION HISTORY

PL 2003, c. 321, §1 (NEW). PL 2005, c. 42, §1 (RPR).

§2718. Optional policy provisions

Except as provided in section 2704, subsection 2, no such policy delivered or issued for delivery to any person in this State shall contain provisions respecting the matters set forth in sections 2719 to 2728, unless such provisions are in the words in which the same appear in the applicable section, except that the insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the superintendent which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the superintendent may approve. [PL 1973, c. 585, §12 (AMD).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1969, c. 177, §46 (AMD). PL 1973, c. 585, §12 (AMD).

§2719. Change of occupation

There may be a provision as follows:

Change of occupation: If the insured be injured or contract sickness after having changed the insured's occupation to one classified by the company as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes the insured's occupation to one classified by the insurer as less hazardous than that stated in

this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates must be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates must be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation. [RR 2021, c. 1, Pt. B, §239 (COR).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). RR 2021, c. 1, Pt. B, §239 (COR).

§2720. Misstatement of age

There may be a provision as follows:

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. [PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2721. Overinsurance -- same insurer

(REPEALED)

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1973, c. 247 (RP).

§2721-A. Overinsurance in accident policies; same insurer

Whenever accident policies are effective immediately upon purchase, including but not limited to those policies purchased through coin-operated machines, there may be a provision included in the policy as follows:

"If an accident policy or policies previously issued by the insurer to the insured be in force concurrently herewith making the aggregate indemnity for (insert type of coverage or coverages) in excess of \$ (insert maximum limit of indemnity or indemnities) the excess is void and all premiums for such excess must be returned to the insured or to the insured's estate." [RR 2021, c. 1, Pt. B, §240 (COR).]

SECTION HISTORY

PL 1975, c. 121 (NEW). RR 2021, c. 1, Pt. B, §240 (COR).

§2721-B. Flight insurance limitation

(REPEALED)

SECTION HISTORY

PL 1975, c. 121 (NEW). PL 1999, c. 256, §K1 (RP).

§2722. Insurance with other insurers, provision of service or expense incurred basis

1. There may be a provision as follows:

Insurance with other insurers: If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this

insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

[PL 1969, c. 132, §1 (NEW).]

2. If the foregoing policy provision is included in a policy which also contains the policy provision set out in section 2723 there shall be added to the caption of the foregoing provision the phrase "--expense incurred benefits." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the superintendent, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the superintendent. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organization or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage."

[PL 1989, c. 502, Pt. A, §95 (AMD).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1973, c. 585, §12 (AMD). PL 1989, c. 502, §A95 (AMD).

§2723. Insurance with other insurers -- other benefits

1. There may be a provision as follows:

Insurance with other insurers: If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice, including the indemnities under this policy, bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined.

[PL 1969, c. 132, §1 (NEW).]

2. If the foregoing policy provision is included in a policy which also contains the policy provision set out in section 2722, there shall be added to the caption of the foregoing provision the phrase "other benefits." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the superintendent, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the superintendent. In the absence of such definition such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect

to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage."

[PL 1989, c. 502, Pt. A, §96 (AMD).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1973, c. 585, §12 (AMD). PL 1989, c. 502, §A96 (AMD).

§2723-A. Coordination of benefits

1. Authorization. There may be a provision for coordination of benefits payable under the policy and under other plans of insurance or health care coverage, in conformance with rules adopted by the superintendent to establish uniformity in the permissive use of coordination of benefits provisions in order to avoid claim delays and misunderstandings that otherwise result from the use of inconsistent or incompatible provisions among the several insurers and nonprofit hospital or medical service organization plans and nonprofit health care organization plans. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

[PL 1999, c. 256, Pt. N, §1 (NEW).]

2. Coordination with Medicare. Coordination of benefits with Medicare is governed by the following provisions.

A. The policy may not coordinate benefits with Medicare Part A unless:

- (1) The insured is enrolled in Medicare Part A;
- (2) The insured was previously enrolled in Medicare Part A and voluntarily disenrolled;
- (3) The insured stated on an application or other document that the insured was enrolled in Medicare Part A; or
- (4) The insured is eligible for Medicare Part A without paying a premium and the policy states that it will not pay benefits that would be payable under Medicare even if the insured fails to exercise the insured's right to premium-free Medicare Part A coverage. [PL 1999, c. 256, Pt. N, §1 (NEW).]

B. The policy may not coordinate benefits with Medicare Part B unless:

- (1) The insured is enrolled in Medicare Part B;
- (2) The insured was previously enrolled in Medicare Part B and voluntarily disenrolled;
- (3) The insured stated on an application or other document that the insured was enrolled in Medicare Part B; or
- (4) The insured is eligible for Medicare Part A without paying a premium and the insurer provided prominent notification to the insured both when the policy was issued and, if applicable, when the insured becomes eligible for Medicare due to age. The notification must state that the policy will not pay benefits that would be payable under Medicare even if the insured fails to enroll in Medicare Part B. [PL 1999, c. 790, Pt. D, §7 (AMD).]

C. Coordination is not permitted with Medicare coverage for which the insured is eligible but not enrolled except as provided in paragraphs A and B. [PL 1999, c. 256, Pt. N, §1 (NEW).]

[PL 1999, c. 790, Pt. D, §7 (AMD).]

3. Credit toward deductible. 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.

[PL 2005, c. 121, Pt. D, §2 (NEW).]

SECTION HISTORY

PL 1999, c. 256, §N1 (NEW). PL 1999, c. 790, §D7 (AMD). PL 2005, c. 121, §D2 (AMD).

§2724. Relation of earnings to insurance

There may be a provision as follows:

If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or the average monthly earnings for the period of 2 years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such 2 years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of \$200 or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time. The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (A.) until at least age 50 or, (B.) in the case of a policy issued after age 44, for at least 5 years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage", approved as to form by the superintendent, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the superintendent or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, or benefits provided by union welfare plans or by employer or employee benefit organizations. [PL 1989, c. 502, Pt. A, §97 (AMD).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1973, c. 585, §12 (AMD). PL 1989, c. 502, §A97 (AMD).

§2725. Unpaid premiums

There may be a provision as follows:

Unpaid premium: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom. [PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2726. Conformity with state statutes

There may be a provision as follows:

Conformity with state statutes: Any provision of this policy which, on its effective date is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes. [PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2727. Illegal occupation

There may be a provision as follows:

Illegal occupation: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation [PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2728. Intoxicants and narcotics

1. Intoxicants; narcotics. A policy under this chapter may not include the following provision:

"Intoxicants 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."

[PL 2007, c. 216, §1 (NEW).]

2. Exemption. This section does not apply to the following types of insurance or any combination of the following types of insurance: accidental injury, specified disease, hospital indemnity, dental, vision, disability income, long-term care, Medicare supplement or other limited benefit health insurance.

[PL 2007, c. 216, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 2007, c. 216, §1 (RPR).

§2729. Renewability

Health insurance policies, other than accident insurance only policies, in which the insurer reserves the right to refuse renewal on an individual basis, shall provide in substance in a provision thereof or in an endorsement thereon or rider attached thereto that subject to the right to terminate the policy upon nonpayment of premium when due, such right to refuse renewal may not be exercised so as to take effect before the renewal date occurring on, or after and nearest, each policy anniversary (or in the case of lapse and reinstatement, at the renewal date occurring on, or after and nearest, each anniversary of the last reinstatement), and that any refusal of renewal shall be without prejudice to any claim originating while the policy is in force. The parenthetical reference to lapse and reinstatement may be omitted at the insurer's option. [PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2729-A. Limits on priority liens

No policy for health insurance shall provide for priority over the insured 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 is entitled to receive payment reimbursement from any other person as a result of legal action or claim, except as provided herein. [PL 1975, c. 471, §1 (NEW).]

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. Such factors shall include, but are not limited to: [PL 1975, c. 471, §1 (NEW).]

1. Legal defenses. Questions of liability and comparative negligence or other legal defenses; [PL 1975, c. 471, §1 (NEW).]

2. Exigencies of trial. Exigencies of trial that reduce a settlement or award in order to resolve the claim; and [PL 1975, c. 471, §1 (NEW).]

3. Limits of coverage. Limits on the amount of applicable insurance coverage that reduce the claim to an amount recoverable by the insured. [PL 1975, c. 471, §1 (NEW).]

In the event of a dispute as to the application of any such provision or the amount available for payment to those claiming payment for services or reimbursement, the dispute shall be determined if the action is pending, before the court in which it is pending; or if no action is pending, by filing an action in any court for determination of the dispute. [PL 1975, c. 471, §1 (NEW).]

SECTION HISTORY

PL 1975, c. 471, §1 (NEW).

§2730. Order of certain provisions

The provisions which are the subject of sections 2704 to 2716, and 2718 to 2728, or any corresponding provisions which are used in lieu thereof in accordance with such sections shall be printed in the consecutive order of the provisions in such sections or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided that the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse or likely to mislead a person to whom the policy is offered, delivered or issued. [PL 1969, c. 177, §47 (AMD).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1969, c. 177, §47 (AMD).

§2731. Third party ownership

The word "insured", as used in this chapter, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits and rights provided therein. [PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2731-A. "Medically necessary mastectomy surgery" defined (REPEALED)

SECTION HISTORY

PL 1991, c. 333, §1 (NEW). PL 1995, c. 295, §2 (RP).

§2732. Requirements of other jurisdictions

1. Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this State, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of this chapter and which is prescribed or required by the law of the state or country under which the insurer is organized.

[PL 1969, c. 132, §1 (NEW).]

2. Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

[PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2733. Policies issued for delivery in another state

If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance superintendent or corresponding public official of such other state has informed the superintendent that any such policy is not subject to approval or disapproval by such official, the superintendent may by ruling require that the policy meet the standards set forth in sections 2703 to 2732. [PL 1973, c. 585, §12 (AMD).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1973, c. 585, §12 (AMD).

§2734. Conforming to statute

1. No policy provision which is not subject to this chapter shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to this chapter.

[PL 1969, c. 132, §1 (NEW).]

2. A policy delivered or issued for delivery to any person in this State in violation of this chapter shall be held valid but shall be construed as provided in this chapter. When any provision in a policy subject to this chapter is in conflict with any provision of this chapter, the rights, duties, and obligations of the insurer, the insured and the beneficiary shall be governed by the provisions of this chapter.

[PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2735. Age limit

If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force, subject to any right of termination, until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy. [PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2735-A. Notice of rate filing and rate increase

1. **Notice of rate filing or rate increase on existing policies.** An insurer offering individual health plans as defined in section 2736-C must provide written notice by first class mail of a rate filing to all affected policyholders at least 60 days before the effective date of any proposed increase in premium rates or any proposed rating formula, classification of risks or modification of any formula or classification of risks. Except as otherwise provided in section 2736-C, subsection 2-B, the notice must also inform policyholders of their right to request a hearing pursuant to section 229. The notice must

show the proposed rate and, unless otherwise provided in section 2736-C, subsection 2-B, state that the rate is subject to regulatory approval. Except as otherwise provided in section 2736-C, subsection 2-B, the superintendent may not take final action on a rate filing until 40 days after the date notice is mailed by an insurer. An increase in premium rates may not be implemented until 60 days after the notice is provided or until the effective date under section 2736, whichever is later.

[PL 2011, c. 364, §1 (AMD).]

1-A. Notice of rate filings or rate increase on existing policies renewed in calendar year 2006.
[PL 2005, c. 400, Pt. A, §1 (NEW); MRSA T. 24-A §2735-A, sub-§1-A (RP).]

2. Notice of rate increase on new business. When an insurer offering individual health plans as defined in section 2736-C quotes a rate for new business, it must disclose any rate increase that the insurer anticipates implementing within the following 90 days. If the quote is in writing, the disclosure must also be in writing. If the increase is pending approval at the time of notice, the disclosure must include the proposed rate and state that it is subject to regulatory approval. If disclosure required by this subsection is not provided, an increase may not be implemented until at least 90 days after the date the quote is provided or the effective date under section 2736, whichever is later.

[PL 2001, c. 432, §4 (NEW).]

3. Notice of rate increase on new business for calendar year 2006.
[PL 2005, c. 400, Pt. A, §1 (NEW); MRSA T. 24-A §2735-A, sub-§3 (RP).]

SECTION HISTORY

PL 2001, c. 432, §4 (NEW). PL 2005, c. 400, §A1 (AMD). PL 2009, c. 244, Pt. C, §4 (AMD).
PL 2011, c. 364, §1 (AMD).

§2736. Rate filings on individual health insurance policies

1. Filing of rate information. Every insurer shall file for approval by the superintendent every rate, rating formula, classification of risks and every modification of any formula or classification that it proposes to use in connection with individual health insurance policies and certain group policies specified in section 2701. If the filing applies to individual health plans as defined in section 2736-C, the insurer shall simultaneously file a copy with the Attorney General. Every such filing must state the effective date of the filing. Every such filing must be made not less than 60 days in advance of the stated effective date, unless the 60-day requirement is waived by the superintendent, and the effective date may be suspended by the superintendent for a period of time not to exceed 30 days. A filing required under this section must be made electronically in a format required by the superintendent unless exempted by rule adopted by the superintendent. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[PL 2009, c. 439, Pt. C, §1 (RPR).]

2. Filing; information. When a filing is not accompanied by the information upon which the insurer supports such filing, or the superintendent does not have sufficient information to determine whether such filing meets the requirements that rates not be excessive, inadequate or unfairly discriminatory, the superintendent shall require the insurer to furnish the information upon which it supports the filing. A filing and all supporting information, except for protected health information required to be kept confidential by state or federal statute and descriptions of the amount and terms or conditions or reimbursement in a contract between an insurer and a 3rd party, are public records notwithstanding Title 1, section 402, subsection 3, paragraph B and become part of the official record of any hearing held pursuant to section 2736-A.

[PL 2009, c. 439, Pt. C, §2 (AMD).]

3. Criteria for special rate hearings.

[PL 2009, c. 244, Pt. C, §5 (RP).]

4. Special rate hearing.

[PL 2009, c. 244, Pt. C, §6 (RP).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1973, c. 585, §12 (AMD). PL 1977, c. 493, §3 (RPR). PL 1979, c. 558, §§6,7 (AMD). PL 1985, c. 648, §10 (AMD). PL 1997, c. 344, §8 (AMD). PL 2001, c. 432, §§5,6 (AMD). PL 2003, c. 428, §F2 (AMD). PL 2003, c. 469, §§E9,10 (AMD). PL 2007, c. 629, Pt. M, §§1, 2 (AMD). PL 2009, c. 14, §4 (AMD). PL 2009, c. 244, Pt. C, §§5, 6 (AMD). PL 2009, c. 244, Pt. G, §1 (AMD). PL 2009, c. 439, Pt. C, §§1, 2 (AMD).

§2736-A. Hearing

If at any time the superintendent has reason to believe that a filing does not meet the requirements that rates not be excessive, inadequate or unfairly discriminatory or that the filing violates any of the provisions of chapter 23, the superintendent shall cause a hearing to be held. If a filing proposes an increase in rates in an individual health plan as defined in section 2736-C, the superintendent shall cause a hearing to be held at the request of the Attorney General. In any hearing conducted under this section, the insurer has the burden of proving rates are not excessive, inadequate or unfairly discriminatory. [PL 2011, c. 364, §2 (AMD).]

Hearings held under this section must conform to the procedural requirements set forth in the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter 4. [PL 2003, c. 469, Pt. E, §11 (AMD).]

SECTION HISTORY

PL 1977, c. 493, §4 (NEW). PL 1977, c. 694, §422 (AMD). PL 1979, c. 330, §2 (AMD). PL 1979, c. 558, §8 (RPR). PL 2003, c. 469, §E11 (AMD). PL 2007, c. 629, Pt. M, §3 (AMD). PL 2009, c. 439, Pt. C, §3 (AMD). PL 2011, c. 364, §2 (AMD).

§2736-B. Order

The superintendent shall issue an order or decision within 30 days after the close of the hearing, or of any rehearing or reargument or within such other period as the superintendent for good cause may require, but not to exceed an additional 30 days. In the order or decision, the superintendent shall either approve or disapprove the rate filing. If the superintendent disapproves the rate filing, the superintendent shall establish the date on which the filing is no longer effective, specify the filing the superintendent would approve and authorize the insurer to submit a new filing in accordance with the terms of the order or decision. [PL 1989, c. 269, §14 (AMD).]

SECTION HISTORY

PL 1979, c. 558, §9 (NEW). PL 1989, c. 269, §14 (AMD).

§2736-C. Individual health plans

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Carrier" means any insurance company, nonprofit hospital and medical service organization or health maintenance organization authorized to issue individual health plans in this State. For the purposes of this section, carriers that are affiliated companies or that are eligible to file consolidated tax returns are treated as one carrier and any restrictions or limitations imposed by this section apply as if all individual health plans delivered or issued for delivery in this State by affiliated carriers were issued by one carrier. For purposes of this section, health maintenance organizations are treated as separate organizations from affiliated insurance companies and nonprofit hospital and medical service organizations. [PL 1993, c. 477, Pt. C, §1 (NEW); PL 1993, c. 477, Pt. F, §1 (AFF).]

B. "Community rate" means the rate charged to all eligible individuals for individual health plans prior to any adjustments pursuant to subsection 2, paragraphs C and D. [PL 1993, c. 477, Pt. C, §1 (NEW); PL 1993, c. 477, Pt. F, §1 (AFF).]

C. "Individual health plan" means any hospital and medical expense-incurred policy or health, hospital or medical service corporation plan contract. It includes both individual contracts and certificates issued under group contracts specified in section 2701, subsection 2, paragraph C. "Individual health plan" does not include the following types of insurance:

- (1) Accident;
- (2) Credit;
- (3) Disability;
- (4) Long-term care or nursing home care;
- (5) Medicare supplement;
- (6) Specified disease;
- (7) Dental or vision;
- (8) Coverage issued as a supplement to liability insurance;
- (9) Workers' compensation;
- (10) Automobile medical payment;
- (11) Insurance under which benefits are payable with or without regard to fault and that is required statutorily to be contained in any liability insurance policy or equivalent self-insurance; or
- (12) Short-term, limited-duration policies, as described in section 2849-B, subsection 1. [PL 2019, c. 330, §1 (AMD).]

C-1. "Legally domiciled" means a person who lives in this State and who satisfies the criteria contained in 2 of the following subparagraphs.

- (1) The person has a motor vehicle operator's license or nondriver identification card from this State.
- (2) The person has a valid passport or visa and is lawfully admitted to the United States.
- (3) The person is registered to vote in this State.
- (4) The person has a permanent dwelling place in this State.
- (5) The person submits a written sworn affidavit declaring that person's intent to reside in this State.
- (6) The person files an income tax return for this State that declares the person is a Maine resident.

A person may establish that that person is legally domiciled in this State by providing evidence of other relevant criteria associated with residency. A child is legally domiciled in this State if at least one of the child's parents or the child's legal guardian is legally domiciled in this State. A person with a developmental or other disability that prevents that person from obtaining a motor vehicle operator's license, registering to vote or filing an income tax return is legally domiciled in this State by living in this State. [PL 2005, c. 493, §1 (RPR).]

C-2. "Resident" means a person who is legally domiciled in this State and has been for at least the last 60 days. [PL 1997, c. 445, §8 (NEW); PL 1997, c. 445, §32 (AFF).]

D. "Premium rate" means the rate charged to an individual for an individual health plan. [PL 1993, c. 477, Pt. C, §1 (NEW); PL 1993, c. 477, Pt. F, §1 (AFF).]

E. "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as amended. [PL 1997, c. 370, Pt. E, §2 (NEW).]
[PL 2019, c. 330, §1 (AMD).]

2. Rating practices. The following requirements apply to the rating practices of carriers providing individual health plans.

A. A carrier issuing an individual health plan after December 1, 1993 must file the carrier's community rate and any formulas and factors used to adjust that rate with the superintendent prior to issuance of any individual health plan. [PL 1993, c. 547, §3 (AMD).]

B. A carrier may not vary the premium rate due to the gender, health status, occupation or industry, claims experience or policy duration of the individual or any other rating factor not specified in this subsection. [PL 2019, c. 5, Pt. A, §1 (AMD).]

C. A carrier may vary the premium rate due to family membership. The premium rate for a family must equal the sum of the premiums for each individual in the family, except that it may not be based on more than 3 dependent children who are less than 21 years of age. [PL 2019, c. 5, Pt. A, §2 (AMD).]

C-1. A carrier may vary the premium rate due to geographic area in accordance with the limitation set out in this paragraph. For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 2012, the rating factor used by a carrier for geographic area may not exceed 1.5. [PL 2011, c. 90, Pt. A, §2 (NEW).]

D. A carrier may vary the premium rate due to age and tobacco use in accordance with the limitations set out in this paragraph. A carrier that varies the premium rate due to age must vary the premium rate according to a uniform age curve. The superintendent shall adopt rules establishing a uniform age curve that is substantially similar to the age curve in effect on January 1, 2019 under the federal Affordable Care Act. Rules adopted under this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between December 1, 1993 and July 14, 1994, the premium rate may not deviate above or below the community rate filed by the carrier by more than 50%.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1994 and July 14, 1995, the premium rate may not deviate above or below the community rate filed by the carrier by more than 33%.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1995 and June 30, 2012, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.

(5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 1, 2012 and December 31, 2013, the maximum rate differential due to age filed by the carrier as determined by ratio is 3 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(6) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2014 and December 31, 2014, the maximum rate differential due to age filed by the carrier as determined by ratio is 4 to 1 to the extent permitted by the federal Affordable Care Act. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(7) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2015, except as provided in subparagraph (9), the maximum rate differential due to age filed by the carrier as determined by ratio is 5 to 1 to the extent permitted by the federal Affordable Care Act. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(8) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 1, 2012 and December 31, 2022, the maximum rate differential due to tobacco use filed by the carrier as determined by ratio is 1.5 to 1, except that the carrier may not apply a rate differential pursuant to this subparagraph when the covered individual is participating in an evidence-based tobacco cessation strategy approved by the United States Department of Health and Human Services, Food and Drug Administration. For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2023 and December 31, 2023, the maximum rate differential due to tobacco use filed by the carrier as determined by ratio is 1.25 to 1, except that the carrier may not apply a rate differential pursuant to this subparagraph when the covered individual is participating in an evidence-based tobacco cessation strategy approved by the United States Department of Health and Human Services, Food and Drug Administration. For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2024, a carrier may not vary the premium rate due to tobacco use.

(9) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after the effective date of this subparagraph, the maximum rate differential due to age filed by the carrier as determined by ratio is 3 to 1 for individuals 21 years of age and older on the first day of coverage under the policy, contract or certificate. The variation in rate due to age must be actuarially justified for individuals under 21 years of age consistent with the uniform age rating curve adopted under this paragraph. [PL 2021, c. 344, §1 (AMD).]

E. A separate community rate may be established for individuals eligible for Medicare Part A without paying a premium; however, this rate may not be applied if both the Medicare eligibility date and the issue date are prior to July 1, 2000. [PL 1999, c. 44, §1 (AMD); PL 1999, c. 44, §2 (AFF).]

F. [PL 2019, c. 5, Pt. A, §4 (RP).]

G. [PL 2011, c. 90, Pt. B, §4 (RP); PL 2011, c. 90, Pt. B, §10 (AFF).]

H. [PL 2011, c. 90, Pt. A, §4 (RP).]

I. [PL 2019, c. 5, Pt. A, §5 (RP).]

J. Except for enrollees in grandfathered health plans under the federal Affordable Care Act, beginning January 1, 2014, a carrier shall consider all enrollees in all individual health plans offered by the carrier to be members of a single risk pool to the extent required by the federal Affordable Care Act. [PL 2011, c. 364, §6 (NEW).]

[PL 2021, c. 344, §1 (AMD).]

2-A. Reinsurance requirement.

[PL 2011, c. 90, Pt. B, §5 (RP); PL 2011, c. 90, Pt. B, §10 (AFF).]

2-B. Optional guaranteed loss ratio. Notwithstanding section 2736, subsection 1 and section 2736-A, at the carrier's option, rate filings for a carrier's credible block of individual health plans may be filed in accordance with this subsection. Rates filed in accordance with this subsection are filed for informational purposes unless rate review is required pursuant to the federal Affordable Care Act.

A. A carrier's individual health plans are considered credible if the anticipated average number of members during the period for which the rates will be in effect meets standards for full or partial credibility pursuant to the federal Affordable Care Act. The rate filing must state the anticipated average number of members during the period for which the rates will be in effect and the basis for the estimate. If the superintendent determines that the number of members is likely to be less than needed to meet the credibility standard, the filing is subject to section 2736, subsection 1 and section 2736-A. [PL 2011, c. 364, §7 (AMD).]

B. On an annual schedule as determined by the superintendent, the carrier shall file a report with the superintendent showing the calculation of rebates as required pursuant to the federal Affordable Care Act, except that the calculation must be based on a minimum medical loss ratio of 80% if the applicable federal minimum for the individual market in this State is lower. If the calculation indicates that rebates must be paid, the carrier must pay the rebates in the same manner as is required for rebates pursuant to the federal Affordable Care Act. [PL 2011, c. 364, §7 (AMD).]
[PL 2011, c. 364, §7 (AMD).]

3. Guaranteed issuance and guaranteed renewal. Carriers providing individual health plans must meet the following requirements on issuance and renewal.

A. Coverage must be guaranteed to all residents of this State other than those eligible without paying a premium for Medicare Part A. Coverage must be guaranteed to all legally domiciled federally eligible individuals, as defined in section 2848, regardless of the length of time they have been legally domiciled in this State. Except for federally eligible individuals, coverage need not be issued to an individual whose coverage was terminated for nonpayment of premiums during the previous 91 days or for fraud or intentional misrepresentation of material fact during the previous 12 months. When a managed care plan, as defined by section 4301-A, provides coverage a carrier may:

- (1) Deny coverage to individuals who neither live nor reside within the approved service area of the plan for at least 6 months of each year; and
- (2) Deny coverage to individuals if the carrier has demonstrated to the superintendent's satisfaction that:
 - (a) The carrier does not have the capacity to deliver services adequately to additional enrollees within all or a designated part of its service area because of its obligations to existing enrollees; and
 - (b) The carrier is applying this provision uniformly to individuals and groups without regard to any health-related factor.

A carrier that denies coverage in accordance with this subparagraph may not enroll individuals residing within the area subject to denial of coverage or groups or subgroups within that area for a period of 180 days after the date of the first denial of coverage. [PL 2011, c. 621, §1 (AMD).]

B. Renewal is guaranteed, pursuant to section 2850-B. [PL 1997, c. 445, §10 (RPR); PL 1997, c. 445, §32 (AFF).]

C. A carrier is exempt from the guaranteed issuance requirements of paragraph A provided that the following requirements are met.

- (1) The carrier does not issue or deliver any new individual health plans on or after the effective date of this section;
- (2) If any individual health plans that were not issued on a guaranteed renewable basis are renewed on or after December 1, 1993, all such policies must be renewed by the carrier and renewal must be guaranteed after the first such renewal date; and

(3) The carrier complies with the rating practices requirements of subsection 2. [PL 1993, c. 477, Pt. C, §1 (NEW); PL 1993, c. 477, Pt. F, §1 (AFF).]

D. Notwithstanding paragraph A, carriers offering supplemental coverage for the Civilian Health and Medical Program for the Uniformed Services, CHAMPUS, are not required to issue this coverage if the applicant for insurance does not have CHAMPUS coverage. [PL 1999, c. 256, Pt. D, §1 (NEW).]

E. As part of the application process for individual health coverage, a carrier shall require an individual to complete the health statement developed by the Board of Directors of the Maine Guaranteed Access Reinsurance Association pursuant to section 3955, subsection 1, paragraph E. A carrier may not deny coverage or refuse to renew or cancel an individual health plan on the basis of an individual's complete or incomplete health statement, claims history or risk scores or on the basis of any omission of material information from a health statement or misrepresentation of an individual's health status. The rejection of an application for individual health coverage by a carrier because an individual has not submitted a completed health statement is not a denial of coverage for the purposes of this paragraph. [PL 2011, c. 621, §1 (AMD).]

[PL 2011, c. 621, §1 (AMD).]

4. Cessation of business. Carriers that provide individual health plans after the effective date of this section that plan to cease doing business in the individual health plan market must comply with the following requirements.

A. Notice of the decision to cease doing business in the individual health plan market must be provided to the bureau 3 months prior to the cessation unless a shorter notice period is approved by the superintendent. If existing contracts are nonrenewed, notice must be provided to the policyholder or contract holder 6 months prior to nonrenewal. [PL 2001, c. 258, Pt. B, §1 (AMD).]

B. Carriers that cease to write new business in the individual health plan market continue to be governed by this section. [PL 1993, c. 477, Pt. C, §1 (NEW); PL 1993, c. 477, Pt. F, §1 (AFF).]

C. Carriers that cease to write new business in the individual health plan market are prohibited from writing new business in that market for a period of 5 years from the date of notice to the superintendent unless the superintendent waives this requirement for good cause shown. [PL 2001, c. 258, Pt. B, §2 (AMD).]

[PL 2001, c. 258, Pt. B, §§1, 2 (AMD).]

5. Loss ratios. Except as provided in subsection 2-B, for all policies and certificates issued on or after the effective date of this section, the superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for an individual health policy unless it is anticipated that the medical loss ratio calculated under section 4319 will be at least 80%.

[PL 2019, c. 5, Pt. A, §6 (AMD).]

6. Fair marketing standards. Carriers providing individual health plans must meet the following standards of fair marketing.

A. Each carrier must actively market individual health plan coverage, including any standardized plans defined pursuant to subsection 8, to individuals in this State. [PL 1995, c. 332, Pt. K, §1 (AMD).]

B. A carrier or representative of the carrier may not directly or indirectly engage in the following activities:

(1) Encouraging or directing individuals to refrain from filing an application for coverage with the carrier because of any of the rating factors listed in subsection 2; or

- (2) Encouraging or directing individuals to seek coverage from another carrier because of any of the rating factors listed in subsection 2. [PL 1993, c. 477, Pt. C, §1 (NEW); PL 1993, c. 477, Pt. F, §1 (AFF).]
- C. A carrier may not directly or indirectly enter into any contract, agreement or arrangement with a representative of the carrier that provides for or results in the compensation paid to the representative for the sale of an individual health plan to be varied because of the rating factors listed in subsection 2. A carrier may enter into a compensation arrangement that provides compensation to a representative of the carrier on the basis of percentage of premium, provided that the percentage does not vary because of the rating factors listed in subsection 2. [PL 1993, c. 477, Pt. C, §1 (NEW); PL 1993, c. 477, Pt. F, §1 (AFF).]
- D. A carrier may not terminate, fail to renew or limit its contract or agreement of representation with a representative for any reason related to the rating factors listed in subsection 2. [PL 1993, c. 477, Pt. C, §1 (NEW); PL 1993, c. 477, Pt. F, §1 (AFF).]
- E. Denial by a carrier of an application for coverage from an individual must be in writing and must state the reason or reasons for the denial. [PL 1993, c. 477, Pt. C, §1 (NEW); PL 1993, c. 477, Pt. F, §1 (AFF).]
- F. The superintendent may establish rules setting forth additional standards to provide for the fair marketing and broad availability of individual health plans in this State. [PL 1993, c. 477, Pt. C, §1 (NEW); PL 1993, c. 477, Pt. F, §1 (AFF).]
- G. A violation of this section by a carrier or a representative of the carrier is an unfair trade practice under chapter 23. If a carrier enters into a contract, agreement or other arrangement with a 3rd-party administrator to provide administrative, marketing or other services related to the offering of individual health plans in this State, the 3rd-party administrator is subject to this section as if it were a carrier. [PL 1993, c. 477, Pt. C, §1 (NEW); PL 1993, c. 477, Pt. F, §1 (AFF).]
[PL 1995, c. 332, Pt. K, §1 (AMD).]

7. Applicability. This section applies to all policies, plans, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after December 1, 1993 with the exception of short-term contracts, as defined in section 2849-B. For purposes of this section, all contracts are deemed renewed no later than the next yearly anniversary of the contract date. [PL 1997, c. 445, §11 (AMD); PL 1997, c. 445, §32 (AFF).]

8. Authority of the superintendent.
[PL 2011, c. 90, Pt. F, §1 (RP).]

9. Exemption for certain associations. The superintendent may exempt a group health insurance policy or group nonprofit hospital or medical service corporation contract issued to an association group, organized pursuant to section 2805-A, from the requirements of subsection 3, paragraph A; subsection 6, paragraph A; and subsection 8 if:

- A. Issuance and renewal of coverage under the policy or contract is guaranteed to all members of the association who are residents of this State and to their dependents; [PL 1995, c. 570, §7 (NEW).]
- B. Rates for the association comply with the premium rate requirements of subsection 2 or are established on a nationwide basis and substantially comply with the purposes of this section, except that exempted associations may be rated separately from the carrier's other individual health plans, if any; [PL 1995, c. 570, §7 (NEW).]
- C. The group's anticipated loss ratio, as defined in subsection 5, is at least 75%; [PL 1995, c. 570, §7 (NEW).]

D. The association's membership criteria do not include age, health status, medical utilization history or any other factor with a similar purpose or effect; [PL 1995, c. 570, §7 (NEW).]

E. The association's group health plan is not marketed to the general public; [PL 1995, c. 570, §7 (NEW).]

F. The association does not allow insurance agents or brokers to market association memberships, accept applications for memberships or enroll members, except when the association is an association of insurance agents or brokers organized under section 2805-A; [PL 1995, c. 570, §7 (NEW).]

G. Insurance is provided as an incidental benefit of association membership and the primary purposes of the association do not include group buying or mass marketing of insurance or other goods and services; and [PL 1995, c. 570, §7 (NEW).]

H. Granting an exemption to the association does not conflict with the purposes of this section. [PL 1995, c. 570, §7 (NEW).]

Except for individuals with grandfathered health plans under the federal Affordable Care Act, this subsection does not apply to policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2014. [PL 2011, c. 364, §8 (AMD).]

10. Pilot projects; persons under 30 years of age. The superintendent shall authorize pilot projects in accordance with this subsection that allow a health insurance carrier that offers individual insurance, is marketing an individual insurance policy in this State and has a medical-loss ratio of at least 70% in the individual market to offer individual medical insurance products to persons under 30 years of age beginning July 1, 2009.

A. The superintendent shall review pilot project proposals submitted in accordance with rules adopted pursuant to paragraph E. The superintendent shall approve a pilot project proposal if it meets the minimum benefit requirements set forth in rules adopted pursuant to paragraph E and may not approve a proposal that does not provide such minimum benefit requirements. [PL 2007, c. 629, Pt. I, §1 (NEW).]

B. Notwithstanding any requirements in this Title for specific health services, specific diseases and certain providers of health care services, the superintendent may adopt minimum benefit requirements that exclude certain benefits if determined by the superintendent to provide affordable and attractive individual health plans for persons under 30 years of age. [PL 2007, c. 629, Pt. I, §1 (NEW).]

C. A pilot project approved by the superintendent pursuant to this subsection qualifies as creditable coverage under this Title. Notwithstanding section 2849-B, subsection 4, a policy that replaces coverage issued under a pilot project approved under this subsection is not subject to any preexisting conditions exclusion provisions. Each carrier that offers an individual product pursuant to a pilot project approved under this subsection must combine the experience for that product with other individual products offered by that carrier as filed with the bureau when determining premium rates. The experience of a carrier's closed pool may not be taken into account in determining pilot project premium rates. [PL 2007, c. 629, Pt. I, §1 (NEW).]

D. Beginning in 2010, the superintendent shall report by March 1st annually to the joint standing committee of the Legislature having jurisdiction over insurance matters on the status of any pilot project approved by the superintendent pursuant to this subsection. The report must include an analysis of the effectiveness of the pilot project in encouraging persons under 30 years of age to purchase insurance and an analysis of the impact of the pilot project on the broader insurance market, including any impact on premiums and availability of coverage. [PL 2007, c. 629, Pt. I, §1 (NEW).]

E. The superintendent shall establish by rule procedures and policies that facilitate the implementation of a pilot project pursuant to this subsection, including, but not limited to, a process for submitting a pilot project proposal, minimum requirements for approval of a pilot project and any requirements for minimum benefits. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A and must be adopted no later than 90 days after the effective date of this subsection. [PL 2007, c. 629, Pt. I, §1 (NEW).]

[PL 2007, c. 629, Pt. I, §1 (NEW).]

11. Open enrollment; rules. Notwithstanding subsection 3, on or after January 1, 2014, a carrier may restrict enrollment in individual health plans to open enrollment periods and special enrollment periods to the extent not inconsistent with applicable federal law. The superintendent may adopt rules establishing minimum open enrollment dates and minimum criteria for special enrollment periods for all individual health plans offered in this State. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[PL 2019, c. 5, Pt. A, §7 (AMD).]

SECTION HISTORY

PL 1993, c. 477, Pt. C, §1 (NEW). PL 1993, c. 477, Pt. F, §1 (AFF). PL 1993, c. 546, §1 (AMD). PL 1993, c. 547, §3 (AMD). PL 1993, c. 645, §§A3, B2 (AMD). PL 1995, c. 177, §1 (AMD). PL 1995, c. 332, §§J2, K1 (AMD). PL 1995, c. 342, §§4, 5 (AMD). PL 1995, c. 570, §7 (AMD). PL 1997, c. 370, Pt. E, §§2-4 (AMD). PL 1997, c. 445, §§8-11 (AMD). PL 1997, c. 445, §32 (AFF). PL 1999, c. 44, §1 (AMD). PL 1999, c. 44, §2 (AFF). PL 1999, c. 256, §§C1, D1, 2 (AMD). RR 2001, c. 1, §30 (COR). PL 2001, c. 258, §§B1, 2, E2 (AMD). PL 2001, c. 410, Pt. A, §§1, 2 (AMD). PL 2001, c. 410, Pt. A, §10 (AFF). PL 2003, c. 428, Pt. H, §3 (AMD). PL 2003, c. 469, Pt. E, §§12, 13 (AMD). PL 2005, c. 493, §1 (AMD). PL 2007, c. 629, Pt. A, §§3-7 (AMD). PL 2007, c. 629, Pt. I, §1 (AMD). PL 2007, c. 629, Pt. M, §§4, 5 (AMD). PL 2011, c. 90, Pt. A, §§1-5 (AMD). PL 2011, c. 90, Pt. B, §§4-6 (AMD). PL 2011, c. 90, Pt. B, §10 (AFF). PL 2011, c. 90, Pt. D, §§2, 3 (AMD). PL 2011, c. 90, Pt. F, §1 (AMD). PL 2011, c. 238, Pt. D, §1 (AMD). PL 2011, c. 364, §§3-8 (AMD). PL 2011, c. 621, §1 (AMD). PL 2013, c. 271, §1 (AMD). PL 2019, c. 5, Pt. A, §§1-7 (AMD). PL 2019, c. 330, §1 (AMD). PL 2021, c. 344, §1 (AMD).

§2737. Noncancellable disability insurance defined

"Noncancellable disability insurance" means insurance against disability resulting from sickness, ailment or bodily injury, but not including insurance solely against accidental injury, under any contract which does not give the insurer the option to cancel or otherwise terminate the contract at or after one year from its effective date or renewal date. [PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW).

§2738. Notice as to renewability

The superintendent shall have the right to make the following requirements: [PL 1973, c. 585, §12 (AMD).]

1. When a policy has neither a brief description nor a separate statement printed on the first page and on the filing back, referring to the renewal conditions of the policy, a separately captioned provision, setting forth the conditions under which the policy may be renewed, must appear on the first page of the policy. The caption shall be clear and definite and shall be approved by the superintendent; but any one of the following captions is acceptable:

"RENEWAL SUBJECT TO CONSENT OF COMPANY.

RENEWAL SUBJECT TO COMPANY CONSENT.

RENEWABLE AT OPTION OF COMPANY."

[PL 1973, c. 585, §12 (AMD).]

2. If the policy is not renewable, a separate, appropriately captioned provision on the first page of the policy shall so state.

[PL 1969, c. 132, §1 (NEW).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1973, c. 585, §12 (AMD).

§2739. Lapse of policy, advance notice; limitation of action

An individual policy of health insurance issued or delivered in this State, except a policy which by its terms is renewable or continuable with the insurer's consent, or except a policy the premiums for which are payable monthly or at shorter intervals, may not terminate or lapse for nonpayment of any premium until the expiration of 3 months from the due date of such premium, unless the insurer, within not less than 10 nor more than 45 days prior to such due date, has mailed, postage prepaid, duly addressed to the insured at the insured's last address shown by the insurer's records, a notice showing the amount of such premium and its due date. If such a notice is not so sent, the insured may pay the premium in default at any time within such period of 3 months. The affidavit of any officer, clerk or agent of the insurer, or of any other person authorized to mail such notice, that the notice required by this section has been duly mailed by the insurer in the manner required is prima facie evidence that such notice was duly given. An action may not be maintained on any policy to which this section applies and that has lapsed for nonpayment of any premium unless such action is commenced within 2 years from the due date of such premium. [RR 2021, c. 1, Pt. B, §241 (COR).]

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). RR 2021, c. 1, Pt. B, §241 (COR).

§2740. Franchise health insurance law

(REPEALED)

SECTION HISTORY

PL 1969, c. 132, §1 (NEW). PL 1973, c. 205 (AMD). PL 1995, c. 332, §C1 (RP).

§2741. Maternity benefits for unmarried women policyholders and the minor dependents of policyholders with dependent or family coverage required

All health insurance policies and plans shall 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 such maternity coverage is provided to married policyholders or the wives of policyholders with maternity coverage. This requirement shall apply to all insurance policies and plans issued or renewed after the effective date of this Act. [PL 1975, c. 276, §2 (NEW).]

SECTION HISTORY

PL 1975, c. 276, §2 (NEW). PL 1975, c. 428, §2 (NEW). PL 1975, c. 561 (NEW). PL 1975, c. 770, §§102,103 (RP).

§2741-A. Mandated offer of domestic partner benefits

1. Definition. As used in this section, unless the context otherwise indicates, "domestic partner" means the partner of a policyholder who:

A. Is a mentally competent adult as is the policyholder; [PL 2001, c. 347, §2 (NEW); PL 2001, c. 347, §5 (AFF).]

B. Has been legally domiciled with the policyholder for at least 12 months; [PL 2001, c. 347, §2 (NEW); PL 2001, c. 347, §5 (AFF).]

C. Is not legally married to or legally separated from another individual; [PL 2001, c. 347, §2 (NEW); PL 2001, c. 347, §5 (AFF).]

D. Is the sole partner of the policyholder and expects to remain so; and [PL 2001, c. 347, §2 (NEW); PL 2001, c. 347, §5 (AFF).]

E. Is jointly responsible with the policyholder for each other's common welfare as evidenced by joint living arrangements, joint financial arrangements or joint ownership of real or personal property. [PL 2001, c. 347, §2 (NEW); PL 2001, c. 347, §5 (AFF).]
[PL 2001, c. 347, §2 (NEW); PL 2001, c. 347, §5 (AFF).]

2. Mandated offer of domestic partner benefits. All individual health insurance policies or contracts issued by any insurer operating pursuant to this chapter 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 those benefits or options for benefits are provided to spouses of married policyholders.

[PL 2001, c. 347, §2 (NEW); PL 2001, c. 347, §5 (AFF).]

3. Financial dependency. Financial dependency of a domestic partner on the policyholder may not be required as a condition for eligibility for coverage.

[PL 2001, c. 347, §2 (NEW); PL 2001, c. 347, §5 (AFF).]

4. Evidence of domestic partnership. As a condition of eligibility for coverage, an insurer may require a policyholder and the policyholder's domestic partner to sign an affidavit attesting that the policyholder and the policyholder's domestic partner meet the definition in subsection 1 and to show documentation of joint ownership or occupancy of real property, such as a joint deed, joint mortgage or a joint lease, or the existence of a joint credit card, joint bank account or powers of attorney in which each domestic partner is authorized to act for the other.

[PL 2001, c. 347, §2 (NEW); PL 2001, c. 347, §5 (AFF).]

5. Preexisting conditions. A domestic partner is subject to the same provisions on coverage of preexisting conditions as any spouse or dependent of a policyholder.

[PL 2001, c. 347, §2 (NEW); PL 2001, c. 347, §5 (AFF).]

6. Termination of domestic partner benefits. An insurer may terminate coverage in accordance with other applicable provisions of this Title for the domestic partner of a policyholder upon notification by the policyholder that the domestic partner relationship has terminated. A policyholder may not enroll another individual as a domestic partner under an individual contract until 12 months after the termination of coverage for a prior domestic partner.

[PL 2001, c. 347, §2 (NEW); PL 2001, c. 347, §5 (AFF).]

7. Construction. This section does not prohibit an insurer from negotiating a policy providing domestic partner benefits to a policyholder that does not comply with the requirements of this section.

[PL 2001, c. 347, §2 (NEW); PL 2001, c. 347, §5 (AFF).]

8. Exemption. This section does not apply to accidental injury, specified disease, hospital indemnity, Medicare supplement, disability income, long-term care and other limited benefit health insurance policies.

[PL 2001, c. 347, §2 (NEW); PL 2001, c. 347, §5 (AFF).]

SECTION HISTORY

PL 2001, c. 347, §2 (NEW). PL 2001, c. 347, §5 (AFF).

§2742. Child coverage

1. Definitions. For the purposes of this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Dependent children" means children who are under 19 years of age and are children, stepchildren or adopted children of, or children placed for adoption with the policyholder, member or spouse of the policyholder or member. [PL 1993, c. 666, Pt. A, §3 (NEW).]

B. "Placed for adoption" means the assumption and retention of a legal obligation by a person for the total or partial support of a child in anticipation of adoption of the child. If the legal obligation ceases to exist, the child is no longer considered placed for adoption. [PL 1993, c. 666, Pt. A, §3 (NEW).]

[PL 1993, c. 666, Pt. A, §3 (RPR).]

2. Coverage. All insurance policies or plans issued in accordance with the requirements of section 2741 must provide unmarried women policyholders with the coverage or option of coverage for dependent children, under the same terms and conditions and at appropriate rates as are extended to married policyholders with dependents.

[PL 1991, c. 200, Pt. B, §3 (NEW).]

3. Financial dependency. Financial dependency of dependent children on the policyholder or the spouse of the policyholder may not be required as a condition for eligibility coverage.

[PL 1991, c. 200, Pt. B, §3 (NEW).]

4. Adopted children. All individual policies issued in accordance with the requirements of this section must provide the same benefits to dependent children placed for adoption with the policyholder or spouse of the policyholder under the same terms and conditions as apply to natural dependent children or stepchildren of the policyholder or spouse of the policyholder, irrespective of whether the adoption has become final.

[PL 1993, c. 666, Pt. A, §4 (NEW).]

5. Compliance. An insurer issuing policies under this chapter must comply with 42 United States Code, Section 1396g-1. If a parent is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family health coverage through an insurer, the insurer shall permit either of the child's parents or the Department of Health and Human Services to enroll the child under the family coverage without regard to any enrollment season restrictions if the child is otherwise eligible for the coverage. An insurer must provide policy information to the custodial parent of any dependent child so that the custodial parent can obtain benefits for the child directly from the insurer. An insurer must permit the custodial parent of any dependent child to submit claims for covered services without the approval of the noncustodial parent. If the custodial parent approves, an insurer must permit the provider to submit claims for covered services without the approval of the noncustodial parent. An insurer shall make payment on claims submitted under this section directly to the custodial parent or, if the custodial parent approves, to the provider.

[PL 1997, c. 795, §8 (AMD); PL 2003, c. 689, Pt. B, §6 (REV).]

6. Nondiscrimination. An insurer may not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance and who is covered for health benefits from the insurer that are different from requirements applicable to an agent or assignee of any other individual so covered. If a child is otherwise eligible for health coverage, an insurer may not refuse to provide the coverage for the child because the child is eligible for medical assistance under Title 22.

[PL 1997, c. 795, §9 (NEW).]

SECTION HISTORY

PL 1975, c. 276, §2 (NEW). PL 1991, c. 200, §B3 (RPR). PL 1993, c. 666, §§A3,4 (AMD). PL 1995, c. 418, §C2 (AMD). PL 1997, c. 795, §§8,9 (AMD). PL 2003, c. 689, §B6 (REV).

§2742-A. Extension of coverage for dependent children

Notwithstanding section 2703, subsection 3, an individual health insurance policy that provides coverage for a dependent child at certain ages only if the child is a student must continue that coverage if the child is unable to remain enrolled in school on a full-time basis due to a mental or physical illness or an accidental injury. This coverage may be terminated at the age at which coverage for students terminates under the terms of the policy. An insurer may require, as a condition of eligibility for continued coverage in accordance with this section, that the student provide written documentation from a health care provider and the student's school that the student is no longer enrolled in school on a full-time basis due to a mental or physical illness or accidental injury. [PL 2005, c. 532, §1 (NEW).]

SECTION HISTORY

PL 2005, c. 532, §1 (NEW).

§2742-B. Mandatory offer to extend coverage for dependent children up to 26 years of age

1. Dependent child; definition. As used in this section, "dependent child" means the child of a person covered under an individual health insurance policy.

A. [PL 2019, c. 5, Pt. A, §8 (RP).]

B. [PL 2019, c. 5, Pt. A, §8 (RP).]

C. [PL 2019, c. 5, Pt. A, §8 (RP).]

D. [PL 2007, c. 514, §3 (RP).]

[PL 2019, c. 5, Pt. A, §8 (AMD).]

2. Offer of coverage. Notwithstanding section 2703, subsection 3, an individual health insurance policy that offers coverage for a dependent child must offer such coverage, at the option of the policyholder, until the dependent child attains 26 years of age.

[PL 2019, c. 5, Pt. A, §8 (AMD).]

3. Notice.

[PL 2007, c. 514, §5 (NEW); MRSA T. 24-A §2742-B, sub-§3 (RP).]

SECTION HISTORY

PL 2007, c. 115, §1 (NEW). PL 2007, c. 115, §5 (AFF). PL 2007, c. 514, §§1-5 (AMD). PL 2019, c. 5, Pt. A, §8 (AMD).

§2743. Newborn children coverage

All individual health insurance policies providing coverage on an expense-incurred basis must provide that health insurance benefits are payable with respect to a newly born child of the insured or subscriber from the moment of birth. [PL 1997, c. 604, Pt. C, §2 (AMD).]

The coverage for newly born children must consist of coverage of injury, sickness or other benefits provided by the policy, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. [PL 1997, c. 604, Pt. C, §2 (AMD).]

If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within 31 days after the date of birth in order to have the coverage continue beyond that 31-day period. The payment may be required to be retroactive to the date of birth. Benefits required by section 2743-A must be paid regardless of whether coverage under this section is elected. [PL 1997, c. 604, Pt. C, §2 (AMD).]

The requirements of this section apply to all policies delivered or issued for delivery in this State more than 120 days after the effective date of this Act. [PL 1997, c. 604, Pt. C, §2 (AMD).]

SECTION HISTORY

PL 1975, c. 770, §104 (NEW). PL 1995, c. 332, §N2 (AMD). PL 1997, c. 604, §C2 (AMD).

§2743-A. Maternity and routine newborn care

An insurer that issues individual contracts providing maternity benefits, including benefits for childbirth, shall provide coverage for services related to maternity and routine newborn care, including coverage for hospital stay, in accordance with the attending physician's or attending certified nurse midwife's determination in conjunction with the mother that the mother and newborn meet the criteria outlined in the "Guidelines for Perinatal Care," published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology. For the purposes of this section, "routine newborn care" does not include any services provided after the mother has been discharged from the hospital. For the purposes of this section, "attending physician" includes the obstetrician, pediatrician or other physician attending the mother and newborn. 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. [PL 2001, c. 258, Pt. A, §2 (AMD).]

SECTION HISTORY

PL 1995, c. 615, §2 (NEW). PL 2001, c. 258, §A2 (AMD).

§2744. Mental health services

1. Notwithstanding any provision of a health insurance policy subject to this chapter, whenever the policy provides for payment or reimbursement for services that are within the lawful scope of practice of a professional listed in subsection 2-A, any person covered by the policy is entitled to reimbursement for these services if the services are performed by a physician or a professional listed in subsection 2-A. Payment or reimbursement for services rendered by a professional listed in subsection 2-A, paragraph B, C, D, E or F may not be conditioned upon prior diagnosis or referral by a physician or other health care professional, except when diagnosis of the condition for which the services are rendered is beyond the scope of their licensure.

[PL 2005, c. 683, Pt. A, §39 (RPR).]

2. Nothing in subsection 1 may be construed to require a health insurance policy subject to this chapter to provide for reimbursement of services that are within the lawful scope of practice of a professional listed in subsection 2-A.

[PL 2005, c. 683, Pt. A, §39 (RPR).]

2-A. Subsections 1 and 2 apply with respect to the following types of professionals:

A. A psychologist licensed to practice in this State; [PL 2005, c. 683, Pt. A, §39 (RPR).]

B. A certified social worker licensed for the independent practice of social work in this State; [PL 2005, c. 683, Pt. A, §39 (RPR).]

C. A licensed clinical professional counselor licensed for the independent practice of counseling in this State; [PL 2005, c. 683, Pt. A, §39 (RPR).]

D. A licensed nurse who is 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; [PL 2005, c. 683, Pt. A, §39 (RPR).]

E. A marriage and family therapist licensed as a marriage and family therapist in this State; and [PL 2005, c. 683, Pt. A, §39 (NEW).]

F. A licensed pastoral counselor licensed as a pastoral counselor in this State. [PL 2005, c. 683, Pt. A, §39 (NEW).]

[PL 2005, c. 683, Pt. A, §39 (RPR).]

3. Mental health services provided by counseling professionals. Except as provided in subsection 1 with regard to reimbursement of clinical professional counselors, pastoral counselors and marriage and family therapists licensed in this State, an insurer that issues individual health care contracts providing coverage for mental health services shall offer coverage for those services when performed by a counseling professional who is licensed by the State pursuant to Title 32, chapter 119 to assess and treat interpersonal and intrapersonal problems, has at least a master's degree in counseling or a related field from an accredited educational institution and has been employed as a counselor for at least 2 years. Any contract providing coverage for the services of counseling professionals pursuant to this section may be subject to any reasonable limitations, maximum benefits, coinsurance, deductibles or exclusion provisions applicable to overall benefits under the contract. This subsection applies to all contracts executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1997. For purposes of this subsection, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

[PL 2005, c. 683, Pt. A, §39 (RPR).]

SECTION HISTORY

PL 1975, c. 770, §104 (NEW). PL 1983, c. 546, §2 (AMD). PL 1983, c. 805, §2 (AMD). PL 1987, c. 80, §2 (AMD). PL 1995, c. 561, §2 (AMD). PL 2003, c. 65, §1 (AMD). PL 2003, c. 65, §5 (AFF). PL 2005, c. 121, §§1,2 (AMD). PL 2005, c. 213, §1 (AMD). PL 2005, c. 213, §3 (AFF). PL 2005, c. 214, §1 (AMD). PL 2005, c. 214, §3 (AFF). PL 2005, c. 683, §A39 (RPR).

§2745. Home health care coverage

Every insurer which issues or issues for delivery in this State individual health policies, which provide coverage on an expense incurred basis for inpatient hospital care, shall make available such coverage for home health care services by a home health care provider. [PL 1977, c. 470, §2 (NEW).]

The policy providing coverage for home health care services may contain 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. [PL 1977, c. 470, §2 (NEW).]

1. Definition of home health care services. "Home health care services" means those health care services rendered in a covered person's place of residence on a part-time basis to a covered person only if:

- A. Hospitalization or confinement in a skilled nursing facility as defined in Title XVIII of the Social Security Act, 42 U.S.C. § 1395, et seq., would otherwise have been required if home health care was not provided; and [PL 1977, c. 470, §2 (NEW).]
- B. The plan covering the home health services is established as prescribed in writing by a physician. [PL 1977, c. 470, §2 (NEW).]

There may not be a requirement that hospitalization be an antecedent to coverage under the policy. [RR 2021, c. 1, Pt. B, §242 (COR).]

2. Home health care services included. 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; [PL 1977, c. 470, §2 (NEW).]
- B. A physician's home or office visits or both; [PL 1977, c. 470, §2 (NEW).]
- 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; [PL 1977, c. 470, §2 (NEW).]

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 [PL 1977, c. 470, §2 (NEW).]

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. [PL 1977, c. 470, §2 (NEW).]

[PL 1977, c. 470, §2 (NEW).]

3. Home health care provider. "Home health care provider" means a home health care agency which is certified under Title XVIII of the Social Security Act of 1965, as amended, which:

A. Is primarily engaged in and licensed or certified to provide skilled nursing and other therapeutic services; [PL 1977, c. 470, §2 (NEW).]

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; [PL 1977, c. 470, §2 (NEW).]

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; [PL 1977, c. 470, §2 (NEW).]

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; [PL 1977, c. 470, §2 (NEW).]

E. Has under contract the services of a physician-advisor licensed by the State or a physician; [PL 1977, c. 470, §2 (NEW).]

F. Conducts periodic case conferences for the purpose of individualized patient care planning and utilization review; and [PL 1977, c. 470, §2 (NEW).]

G. Maintains a complete medical record on each patient. [PL 1977, c. 470, §2 (NEW).]

[PL 1977, c. 470, §2 (NEW).]

4. Exclusions.

A. No policy shall require home health care coverage to persons eligible for medicare; and [PL 1977, c. 470, §2 (NEW).]

B. No payment shall be made for services provided by a person who resides in the covered person's residence or who is a member of the covered person's family. [PL 1977, c. 470, §2 (NEW).]

[PL 1977, c. 470, §2 (NEW).]

SECTION HISTORY

PL 1977, c. 470, §2 (NEW). RR 2021, c. 1, Pt. B, §242 (COR).

§2745-A. Screening mammograms

1. Definition. For purposes of this section, "screening mammogram" means a radiologic procedure that is provided to an asymptomatic woman for the purpose of early detection of breast cancer and that consists of 2 radiographic views per breast. A screening mammogram also includes an additional radiologic procedure recommended by a provider when the results of an initial radiologic procedure are not definitive.

[PL 2007, c. 153, §1 (AMD); PL 2007, c. 153, §5 (AFF).]

2. Required coverage. All individual insurance policies that cover radiologic procedures, except those designed to cover only specific diseases, accidental injury or dental procedures, must provide

coverage for screening mammograms performed by providers that meet the standards established by the Department of Health and Human Services rules relating to radiation protection. The policies must reimburse for screening mammograms performed at least once a year for women 40 years of age and over.

A. [PL 1997, c. 408, §3 (RP); PL 1997, c. 408, §8 (AFF).]

B. [PL 1997, c. 408, §3 (RP); PL 1997, c. 408, §8 (AFF).]
[PL 1997, c. 408, §3 (RPR); PL 1997, c. 408, §8 (AFF); PL 2003, c. 689, Pt. B, §6 (REV).]

3. Application. This section applies to all policies, contracts and certificates that cover radiologic procedures, except those policies that cover only dental procedures, accidental injury or specific diseases, executed, delivered, issued for delivery, continued or renewed in this State on or after March 1, 1991. For purposes of this section, all policies and contracts are deemed to be renewed no later than the next yearly anniversary of the policy or contract date.

[PL 1991, c. 156, §1 (AMD).]

4. Reports. Each insurer that issues policies subject to this section shall report to the superintendent its experience for each calendar year beginning with 1991 not later than April 30th of the following calendar year. The report must include the information required and be presented in the form prescribed by the superintendent. The report must include the amount of claims paid in this State for services required by this section. The superintendent shall compile this data in an annual report and submit the report to the joint standing committee of the Legislature having jurisdiction over banking and insurance matters.

[PL 1991, c. 701, §6 (AMD).]

SECTION HISTORY

PL 1989, c. 875, §13 (NEW). PL 1991, c. 156, §1 (AMD). PL 1991, c. 701, §6 (AMD). PL 1997, c. 408, §3 (AMD). PL 1997, c. 408, §8 (AFF). PL 2003, c. 689, §B6 (REV). PL 2007, c. 153, §1 (AMD). PL 2007, c. 153, §5 (AFF).

§2745-B. Acupuncture services

All individual insurance policies providing coverage for acupuncture must provide coverage for those services when performed by an acupuncturist licensed pursuant to Title 32, chapter 113-B, subchapter II, under the same conditions that apply to the services of a licensed physician. [PL 1995, c. 671, §9 (AMD).]

SECTION HISTORY

PL 1991, c. 647, §2 (NEW). PL 1995, c. 671, §9 (AMD).

§2745-C. Coverage for breast cancer treatment

1. Inpatient care. All individual health policies providing coverage for medical and surgical benefits, except accidental injury, specified disease, hospital indemnity, Medicare supplement, long-term care and other limited benefit health insurance policies and contracts, must ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time determined by the attending physician, after providing notice to the patient regarding the coverage required by this subsection and in consultation with the patient, to be medically appropriate following a mastectomy, a lumpectomy or a lymph node dissection for the treatment of breast cancer.

Nothing in this subsection may be construed to require the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is appropriate.

In implementing the requirements of this subsection, an individual health policy may not modify the terms and conditions of coverage based on the determination by any enrollee to request less than the minimum coverage required under this subsection.

All individual health policies must provide written notice to each enrollee under the contract regarding the coverage required by this subsection. The notice must be prominently positioned in any literature or correspondence made available or distributed by the plan and must be transmitted in the next mailing made by the plan to the enrollee or as part of any yearly information packet sent to the enrollee, whichever is earlier. The notice must also be made available to any physician participating in the insurer's provider network.

[PL 2015, c. 227, §2 (AMD); PL 2015, c. 227, §5 (AFF).]

2. Reconstruction. All individual health policies providing coverage for mastectomy surgery must provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.

[PL 1997, c. 408, §4 (NEW); PL 1997, c. 408, §8 (AFF).]

SECTION HISTORY

RR 1995, c. 1, §15 (COR). PL 1995, c. 295, §3 (NEW). PL 1995, c. 369, §2 (NEW). PL 1997, c. 408, §4 (RPR). PL 1997, c. 408, §8 (AFF). PL 2015, c. 227, §2 (AMD). PL 2015, c. 227, §5 (AFF).

§2745-D. Medical food coverage for inborn error of metabolism

1. Inborn error of metabolism; special modified low-protein food product. As used in this section, "inborn error of metabolism" means a genetically determined biochemical disorder in which a specific enzyme defect produces a metabolic block that may have pathogenic consequences at birth or later in life. As used in this section, "special modified low-protein food product" means food formulated to reduce the protein content to less than one gram of protein per serving and does not include foods naturally low in protein.

[PL 1995, c. 369, §2 (NEW).]

2. Required coverage. All individual insurance policies and contracts, except accidental injury, specified disease, hospital indemnity, Medicare supplement, long-term care and other limited benefit health insurance policies and contracts, must provide coverage for metabolic formula and special modified low-protein food products that have been prescribed by a licensed physician for a person with an inborn error of metabolism. The policies and contracts must reimburse:

A. For metabolic formula; and [PL 1995, c. 369, §2 (NEW).]

B. Up to \$3,000 per year for special modified low-protein food products. [PL 1995, c. 369, §2 (NEW).]

[PL 1995, c. 369, §2 (NEW).]

3. Application. The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1996. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[PL 1995, c. 369, §2 (NEW).]

SECTION HISTORY

RR 1995, c. 1, §15 (RNU). PL 1995, c. 369, §2 (NEW).

§2745-E. Off-label use of prescription drugs for cancer

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Medically accepted indication" includes any use of a drug that has been approved by the federal Food and Drug Administration and includes another use of the drug if that use is supported by one

or more citations in the standard reference compendia or if the insurer involved, based upon guidance provided by the federal Department of Health and Human Services Medicare program pursuant to 42 United States Code, Section 1395x(t), determines that that use is medically accepted based on supportive clinical evidence in peer-reviewed medical literature. [PL 1997, c. 701, §2 (NEW).]

B. "Off-label use" means the prescription and use of drugs for medically accepted indications other than those stated in the labeling approved by the federal Food and Drug Administration. [PL 1997, c. 701, §2 (NEW).]

C. "Peer-reviewed medical literature" means scientific studies published in at least 2 articles from major peer-reviewed medical journals that present data that supports the proposed off-label use as generally safe and effective. [PL 1997, c. 701, §2 (NEW).]

D. "Standard reference compendia" means:

(1) The United States Pharmacopeia Drug Information or information published by its successor organization; or

(2) The American Hospital Formulary Service Drug Information or information published by its successor organization. [PL 1997, c. 701, §2 (NEW).]

[PL 1997, c. 701, §2 (NEW).]

2. Required coverage for off-label use. All individual insurance policies and contracts that provide coverage for prescription drugs must provide coverage for off-label use in accordance with the following.

A. Individual insurance policies and contracts that provide coverage for prescription drugs may not exclude coverage for any such drug used for the treatment of cancer for a medically accepted indication on the grounds that the drug has not been approved by the federal Food and Drug Administration for that indication, as long as use of that drug is a medically accepted indication for the treatment of cancer. [PL 1997, c. 701, §2 (NEW).]

B. Coverage of a drug required by this subsection also includes medically necessary services associated with the administration of the drug. [PL 1997, c. 701, §2 (NEW).]

C. This subsection may not be construed to require coverage for a drug when the federal Food and Drug Administration has determined its use to be contraindicated for treatment of the current indication. [PL 1997, c. 701, §2 (NEW).]

D. A drug use that is covered pursuant to paragraph A may not be denied coverage based on a "medical necessity" requirement except for a reason that is unrelated to the legal status of the drug use. [PL 1997, c. 701, §2 (NEW).]

E. A contract that provides coverage of a drug as required by this subsection may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the same extent that these provisions are applicable to coverage of all prescription drugs and are not inconsistent with the requirements of this subsection. [PL 1997, c. 701, §2 (NEW).]

[PL 1997, c. 701, §2 (NEW).]

3. Application. The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1999. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[PL 1997, c. 701, §2 (NEW).]

REVISOR'S NOTE: : §2745-E. Coverage for prostate cancer screening (As enacted by PL 1997, c. 754, §2 is REALLOCATED TO TITLE 24-A, SECTION 2745-G)

SECTION HISTORY

RR 1997, c. 2, §51 (RAL). PL 1997, c. 701, §2 (NEW). PL 1997, c. 754, §2 (NEW).

§2745-F. Off-label use of prescription drugs for HIV or AIDS

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Off-label use" means the prescription and use of drugs for indications other than those stated in the labeling approved by the federal Food and Drug Administration. [PL 1997, c. 701, §2 (NEW).]

B. "Peer-reviewed medical literature" means scientific studies published in at least 2 articles from major peer-reviewed medical journals that present data that supports the proposed off-label use as generally safe and effective. [PL 1997, c. 701, §2 (NEW).]

C. "Standard reference compendia" means:

(1) The United States Pharmacopeia Drug Information or information published by its successor organization; or

(2) The American Hospital Formulary Service Drug Information or information published by its successor organization. [PL 1997, c. 701, §2 (NEW).]

[PL 1997, c. 701, §2 (NEW).]

2. Required coverage for off-label use. All individual insurance policies and contracts that provide coverage for prescription drugs must provide coverage for off-label use in accordance with the following.

A. Individual insurance policies and contracts that provide coverage for prescription drugs may not exclude coverage for any such drug used for the treatment of HIV or AIDS on the grounds that the drug has not been approved by the federal Food and Drug Administration for that indication, as long as that drug is recognized for the treatment of that indication in one of the standard reference compendia or in peer-reviewed medical literature. [PL 1997, c. 701, §2 (NEW).]

B. Coverage of a drug required by this subsection also includes medically necessary services associated with the administration of the drug. [PL 1997, c. 701, §2 (NEW).]

C. This subsection may not be construed to require coverage for a drug when the federal Food and Drug Administration has determined its use to be contraindicated for treatment of the current indication. [PL 1997, c. 701, §2 (NEW).]

D. A drug use that is covered pursuant to paragraph A may not be denied coverage based on a "medical necessity" requirement except for a reason that is unrelated to the legal status of the drug use. [PL 1997, c. 701, §2 (NEW).]

E. A contract that provides coverage of a drug as required by this subsection may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the same extent that these provisions are applicable to coverage of all prescription drugs and are not inconsistent with the requirements of this subsection. [PL 1997, c. 701, §2 (NEW).]

[PL 1997, c. 701, §2 (NEW).]

3. Application. The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1999. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[PL 1997, c. 701, §2 (NEW).]

SECTION HISTORY

PL 1997, c. 701, §2 (NEW).

§2745-G. Coverage for prostate cancer screening

(REALLOCATED FROM TITLE 24-A, SECTION 2745-E)

1. Definition. As used in this section, "services for the early detection of prostate cancer" means the following procedures provided to a man for the purpose of early detection of prostate cancer:

A. A digital rectal examination; and [RR 1997, c. 2, §51 (RAL).]

B. A prostate-specific antigen test. [RR 1997, c. 2, §51 (RAL).]
[RR 1997, c. 2, §51 (RAL).]

2. Required coverage for prostate cancer screening. All individual insurance policies and contracts except accidental injury, specified disease, hospital indemnity, Medicare supplement, long-term care and other limited benefit health insurance policies and contracts must provide coverage for services for the early detection of prostate cancer. The contracts must reimburse for services for the early detection of prostate cancer, if recommended by a physician, at least once a year for men 50 years of age or older until a man reaches the age of 72.

[RR 1997, c. 2, §51 (RAL).]

3. Application. The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after September 1, 1998. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[RR 1997, c. 2, §51 (RAL).]

SECTION HISTORY

RR 1997, c. 2, §51 (RAL).

§2746. Optional coverage for chiropractic services

(REALLOCATED TO TITLE 24-A, SECTION 2840)

SECTION HISTORY

PL 1979, c. 335, §2 (NEW). PL 1979, c. 663, §145 (RAL).

§2747. Review and arbitration

1. Any insurer denying medical expense reimbursement benefits on any of the grounds specified in subsection 2 for a claim filed pursuant to a policy issued under this chapter, other than a policy that is subject to section 4312, shall provide the policy or certificate holder with an opportunity to have the denial reviewed by the insurer and to arbitrate the denial if not satisfied after review. The right to review and arbitrate must be prominently set forth in any written notice sent to the policy or certificate holder denying the claim. The arbitration is nonbinding and must be carried out in accordance with procedures established by the insurer.

[PL 2003, c. 428, Pt. H, §4 (AMD).]

2. The procedure specified in subsection 1 shall apply to the denial of any medical expense reimbursement benefits based upon:

A. A health condition existing prior to the effective coverage of the policy or certificate; or [PL 1981, c. 205, §2 (NEW).]

B. The lack of medical necessity. [PL 1981, c. 205, §2 (NEW).]
[PL 1981, c. 205, §2 (NEW).]

SECTION HISTORY

PL 1981, c. 205, §2 (NEW). PL 2003, c. 428, §H4 (AMD).

§2748. Coverage for chiropractic services

1. Therapeutic, adjustive and manipulative services. Notwithstanding any other provisions of this chapter, every insurer which issues health care contracts providing coverage for the services of a "physician" or "doctor" to residents of this State shall provide coverage to any subscriber or other person covered under those contracts for those services when performed by a chiropractor, to the extent that the services are within the lawful scope of practice of a chiropractor licensed to practice in this State. Therapeutic, adjustive and manipulative services shall be covered whether performed by an allopathic, osteopathic or chiropractic doctor.

[PL 1985, c. 516, §3 (NEW).]

2. Limits; coinsurance; deductibles. Any contract which provides coverage for the services required by this section 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 section or the limitations, coinsurance, deductibles or exclusions imposed on other providers.

[PL 1985, c. 516, §3 (NEW).]

3. Reports to the Superintendent of Insurance. Every insurer subject to this section shall report its experience for each calendar year to the Superintendent of Insurance not later than April 30th of the following year. The report must be in a form prescribed by the superintendent and include the amount of claims paid in this State for the services required by this section and the total amount of claims paid in this State for health care contracts. The report must include complaints concerning access to services under this section and the results of those complaints. The superintendent shall compile this data for all insurers in an annual report.

[PL 1993, c. 669, §2 (AMD).]

4. Application; expiration.

[PL 1989, c. 141, §4 (RP).]

5. Reimbursement; discrimination. An insurer subject to this section may not refuse to reimburse a chiropractic provider who participates in the insurer's provider network for providing a health care service or procedure covered by the insurer as long as the chiropractic provider is acting within the lawful scope of that provider's license in the delivery of the covered service or procedure. Consistent with reasonable medical management techniques specified under the insurer's contract with respect to the method, treatment or setting for a covered service or procedure, the insurer may not discriminate based on the chiropractic provider's license. This subsection does not require an insurer to accept all chiropractic providers into a network or govern the amount of the reimbursement paid to a chiropractic provider.

[PL 2015, c. 111, §1 (NEW); PL 2015, c. 111, §4 (AFF).]

SECTION HISTORY

PL 1985, c. 516, §3 (NEW). PL 1989, c. 141, §§3,4 (AMD). PL 1993, c. 669, §2 (AMD). PL 2015, c. 111, §1 (AMD). PL 2015, c. 111, §4 (AFF).

§2749. Utilization review data

1. Report required. On or before April 1st of each year, any insurer which issues a program or contract in this State providing coverage for hospital care that contains a provision whereby in nonemergency cases the insured is required to be prospectively evaluated through a prehospital admission certification, preinpatient service eligibility program or any similar preutilization review or screening procedure prior to the delivery of contemplated hospitalization, inpatient or outpatient health care or medical services which are prescribed or ordered by a duly licensed physician shall file a report

on the results of that evaluation for the preceding year with the superintendent which shall contain the following:

A. The number and type of evaluations performed.

(1) For the purposes of this section, the term "type of evaluations" means the following preutilization review categories: Presurgical inpatient days; setting of medical service, such as inpatient or outpatient services; and the number of days of service; [PL 1987, c. 168, §4 (NEW).]

B. The result of the evaluation, such as whether the medical necessity of the level of service contemplated by the patient's physician was agreed to or whether benefits paid for the service were reduced by the insurer; [PL 1987, c. 168, §4 (NEW).]

C. The number and result of any appeals by patients or their physicians as a result of initial review decisions to reduce benefits for services as determined through prospective evaluations; and [PL 1987, c. 168, §4 (NEW).]

D. Any complaints filed in a court of competent jurisdiction and served upon an insurer filing under this section stating a cause of action against that insurer on the basis of damages to patients alleged to have been proximately caused by a delay, reduction or denial of medical benefits by the insurer, as determined through prospective evaluations, and the determination of liability or other disposition of the complaint. [PL 1987, c. 168, §4 (NEW).]

[PL 1987, c. 168, §4 (NEW).]

2. Maine residents. This section is applicable to evaluations, appeals and complaints relating to Maine residents only.

[PL 1987, c. 168, §4 (NEW).]

3. Confidentiality. Any information provided pursuant to this section shall not identify the names of patients.

[PL 1987, c. 168, §4 (NEW).]

SECTION HISTORY

PL 1987, c. 168, §4 (NEW).

§2749-A. Penalty for failure to notify of hospitalization

An insurance 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, section 1829. [PL 1989, c. 767, §3 (NEW).]

This section applies to policies and certificates executed, delivered, issued for delivery, continued or renewed in this State after the effective date of this section. For purposes of this section, all policies are deemed to be renewed no later than the next yearly anniversary of the contract date. [PL 1989, c. 767, §3 (NEW).]

SECTION HISTORY

PL 1989, c. 767, §3 (NEW).

§2749-B. Penalty for noncompliance with utilization review programs

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. [PL 1995, c. 332, Pt. M, §4 (AMD).]

SECTION HISTORY

PL 1993, c. 645, §B3 (NEW). PL 1995, c. 332, §M4 (AMD).

§2749-C. Mandated offer of coverage for certain mental illnesses

1. Coverage for treatment for certain mental illnesses. Coverage for medical treatment for mental illnesses listed in paragraph A-1 by all individual policies is subject to this section.

A. [PL 2019, c. 5, Pt. D, §1 (RP).]

A-1. All individual contracts must provide, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following categories of mental illness as defined in the Diagnostic and Statistical Manual as defined in section 2843, subsection 3, paragraph A-1, except for those that are designated as "V" codes by the Diagnostic and Statistical Manual:

- (1) Psychotic disorders, including schizophrenia;
- (2) Dissociative disorders;
- (3) Mood disorders;
- (4) Anxiety disorders;
- (5) Personality disorders;
- (6) Paraphilias;
- (7) Attention deficit and disruptive behavior disorders;
- (8) Pervasive developmental disorders;
- (9) Tic disorders;
- (10) Eating disorders, including bulimia and anorexia; and
- (11) Substance use disorders.

For the purposes of this paragraph, the mental illness must be diagnosed by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness. [PL 2019, c. 5, Pt. D, §1 (NEW).]

B. All individual policies and contracts executed, delivered, issued for delivery, continued or renewed in this State must provide coverage providing benefits that meet the requirements of this paragraph.

(1) The coverage must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a reimbursing insurer, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary health care. When making the determination of whether treatment is medically necessary health care, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the individual policy. [PL 2019, c. 5, Pt. D, §1 (AMD).]

[PL 2019, c. 5, Pt. D, §1 (AMD).]

2. Contracts; providers. An insurer incorporated under this chapter shall offer contracts to providers authorizing the provision of mental health services within the scope of the provider's licensure.

[PL 2003, c. 20, Pt. VV, §9 (AMD); PL 2003, c. 20, Pt. VV, §25 (AFF).]

3. Limits; coinsurance; deductibles. A policy or contract that provides coverage for the services required by this section 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 section.

[PL 1995, c. 407, §5 (NEW).]

4. Reports to the superintendent. Every insurer subject to this section shall report its experience for each calendar year to the superintendent no later than April 30th of the following year. The report must be in a form prescribed by the superintendent and include the amount of claims paid in this State for the services required by this section and the total amount of claims paid in this State for individual health care policies, both separated according to those paid for inpatient, day treatment and outpatient services. The superintendent shall compile this data for all insurers in an annual report.

[PL 1995, c. 407, §5 (NEW).]

5. Application. Except as otherwise provided, the requirements of this section apply to all policies and contracts executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 1996. For purposes of this section, all policies are deemed renewed no later than the next yearly anniversary of the contract date. Nothing in this section applies to accidental injury, specified disease, hospital indemnity, Medicare supplement, long-term care or other limited benefit health insurance policies.

[PL 1995, c. 407, §5 (NEW).]

SECTION HISTORY

PL 1995, c. 407, §5 (NEW). PL 1995, c. 637, §3 (AMD). PL 2003, c. 20, §§VV8,9 (AMD). PL 2003, c. 20, §VV25 (AFF). PL 2019, c. 5, Pt. D, §1 (AMD).

§2750. Acquired Immune Deficiency Syndrome

No individual or family health insurance policy delivered or issued for delivery in this State may provide more restrictive benefits for sickness or disablement or the related expenses resulting from Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or HIV related diseases than for any other sickness or disabling condition or exclude benefits for AIDS, ARC or HIV related diseases except through an exclusion under which all sickness and diseases are treated the same. This section shall not apply to a policy providing benefits for specific diseases or accidental injury only.

[PL 1989, c. 176, §5 (NEW).]

SECTION HISTORY

PL 1989, c. 176, §5 (NEW).

§2751. Assessment of mandated benefits proposals; studies of mandated benefits issues

(REPEALED)

SECTION HISTORY

PL 1989, c. 556, §A5 (NEW). PL 1989, c. 875, §§I4,5 (AMD). PL 1991, c. 333, §2 (AMD). PL 1991, c. 701, §7 (RP).

§2752. Mandated health legislation procedures

1. Mandated health benefits proposals. For purposes of this section, a mandated health benefit proposal is one that mandates health insurance coverage for specific health services, specific diseases

or certain providers of health care services as part of individual or group health insurance policies. A mandated option is not a mandated benefit for purposes of this section.

[PL 1991, c. 701, §8 (NEW).]

2. Procedures before legislative committees. Whenever a legislative measure containing a mandated health benefit is proposed, the joint standing committee of the Legislature having jurisdiction over the proposal shall hold a public hearing and determine the level of support for the proposal among the members of the committee. If there is support for the proposed mandate among a majority of the members of the committee, the committee may refer the proposal to the Bureau of Insurance for review and evaluation pursuant to subsection 3. Once a review and evaluation has been completed, the committee shall review the findings of the bureau. A proposed mandate may not be enacted into law unless review and evaluation pursuant to subsection 3 has been completed.

[PL 1997, c. 616, §4 (AMD).]

3. Review and evaluation. Upon referral of a mandated health benefit proposal from the joint standing committee of the Legislature having jurisdiction over the proposal, the Bureau of Insurance shall conduct a review and evaluation of the mandated health benefit proposal and shall report to the committee in a timely manner. The report must include, at the minimum and to the extent that information is available, the following:

A. The social impact of mandating the benefit, including:

- (1) The extent to which the treatment or service is utilized by a significant portion of the population;
- (2) The extent to which the treatment or service is available to the population;
- (3) The extent to which insurance coverage for this treatment or service is already available;
- (4) If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment;
- (5) If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment;
- (6) The level of public demand and the level of demand from providers for the treatment or service;
- (7) The level of public demand and the level of demand from the providers for individual or group insurance coverage of the treatment or service;
- (8) The level of interest in and the extent to which collective bargaining organizations are negotiating privately for inclusion of this coverage in group contracts;
- (9) The likelihood of achieving the objectives of meeting a consumer need as evidenced by the experience of other states;
- (10) The relevant findings of the appropriate health system agency relating to the social impact of the mandated benefit;
- (11) The alternatives to meeting the identified need;
- (12) Whether the benefit is a medical or a broader social need and whether it is consistent with the role of health insurance and the concept of managed care;
- (13) The impact of any social stigma attached to the benefit upon the market;
- (14) The impact of this benefit on the availability of other benefits currently being offered;
- (15) The impact of the benefit as it relates to employers shifting to self-insured plans and the extent to which the benefit is currently being offered by employers with self-insured plans; and

- (16) The impact of making the benefit applicable to the state employee health insurance program; [PL 2011, c. 90, Pt. J, §21 (AMD).]
- B. The financial impact of mandating the benefit, including:
- (1) The extent to which the proposed insurance coverage would increase or decrease the cost of the treatment or service over the next 5 years;
 - (2) The extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next 5 years;
 - (3) The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service;
 - (4) The methods that will be instituted to manage the utilization and costs of the proposed mandate;
 - (5) The extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next 5 years;
 - (6) The extent to which insurance coverage of the health care service or provider may be reasonably expected to increase or decrease the insurance premium and administrative expenses of policyholders;
 - (7) The impact of indirect costs, which are costs other than premiums and administrative costs, on the question of the costs and benefits of coverage;
 - (8) The impact of this coverage on the total cost of health care, including potential benefits and savings to insurers and employers because the proposed mandated treatment or service prevents disease or illness or leads to the early detection and treatment of disease or illness that is less costly than treatment or service for later stages of a disease or illness;
 - (9) The effects of mandating the benefit on the cost of health care, particularly the premium and administrative expenses and indirect costs, to employers and employees, including the financial impact on small employers, medium-sized employers and large employers; and
 - (10) The effect of the proposed mandate on cost-shifting between private and public payors of health care coverage and on the overall cost of the health care delivery system in this State.

In order to enable the committee to assess the financial impact of the benefit, the report must include a comparison of the rate of increase in the Consumer Price Index for medical care services to the rate of increase in the Consumer Price Index for the previous year and the current year as reported by the United States Department of Labor, Bureau of Labor Statistics; [PL 2005, c. 125, §1 (AMD).]

- C. The medical efficacy of mandating the benefit, including:
- (1) The contribution of the benefit to the quality of patient care and the health status of the population, including the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service; and
 - (2) If the legislation seeks to mandate coverage of an additional class of practitioners:
 - (a) The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered; and
 - (b) The methods of the appropriate professional organization that assure clinical proficiency; and [PL 1991, c. 701, §8 (NEW).]
- D. The effects of balancing the social, economic and medical efficacy considerations, including:

- (1) The extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders;
- (2) The extent to which the problem of coverage may be solved by mandating the availability of the coverage as an option for policyholders; and
- (3) The cumulative impact of mandating this benefit in combination with existing mandates on the costs and availability of coverage. [PL 1997, c. 616, §5 (AMD).]

[PL 2011, c. 90, Pt. J, §21 (AMD).]

SECTION HISTORY

PL 1991, c. 701, §8 (NEW). PL 1997, c. 616, §§4,5 (AMD). PL 2001, c. 258, §11 (AMD). PL 2005, c. 125, §1 (AMD). PL 2011, c. 90, Pt. J, §21 (AMD).

§2753. Standardized claim forms

All insurers providing individual medical expense insurance on an expense-incurred basis providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a health care practitioner must accept the current standardized claim form for professional services approved by the Federal Government and submitted electronically. All insurers providing individual medical expense insurance on an expense-incurred basis providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form for professional or facility services, as applicable, approved by the Federal Government and submitted electronically. An insurer may not be required to accept a claim submitted on a form other than the applicable form specified in this section and may not be required to accept a claim that is not submitted electronically, except from a health care practitioner who is exempt pursuant to Title 24, section 2985. All services provided by a health care practitioner in an office setting must be submitted on the standardized federal form used by noninstitutional providers and suppliers. Services in a nonoffice setting may be billed as negotiated between the insurer and health care practitioner. For purposes of this section, "office setting" means a location where the health care practitioner routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis whether or not the office is physically located within a facility. [PL 2005, c. 97, §2 (AMD).]

SECTION HISTORY

PL 1993, c. 477, §D10 (NEW). PL 1993, c. 477, §F1 (AFF). PL 2003, c. 218, §6 (AMD). PL 2003, c. 469, §D6 (AMD). PL 2003, c. 469, §D9 (AFF). PL 2005, c. 97, §2 (AMD).

§2754. Coverage for diabetes supplies

All individual health policies and contracts, except accidental injury, specified disease, hospital indemnity, Medicare supplement, long-term care and other limited benefit health insurance policies and contracts, must provide coverage for the 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: [PL 1995, c. 592, §2 (NEW).]

1. Certification of medical necessity. The insured's treating physician or a physician who specializes in the treatment of diabetes certifies that the equipment and services are necessary; and [PL 1995, c. 592, §2 (NEW).]

2. Provision of medical services. 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.

[PL 1995, c. 592, §2 (NEW).]

SECTION HISTORY

PL 1995, c. 592, §2 (NEW).

§2755. Assignment of benefits

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. [PL 1999, c. 21, §2 (AMD).]

SECTION HISTORY

PL 1997, c. 604, §E2 (NEW). PL 1999, c. 21, §2 (AMD).

§2756. Coverage for contraceptives

1. Coverage requirements. All individual health policies and contracts, except accidental injury, specified disease, hospital indemnity, Medicare supplement, disability income, long-term care and other limited benefit health insurance policies and contracts, that provide coverage for prescription drugs or outpatient medical services must provide coverage for all prescription contraceptives approved by the federal Food and Drug Administration or for outpatient contraceptive services, respectively, to the same extent that coverage is provided for other prescription drugs or outpatient medical services. For purposes of this section, the term "outpatient contraceptive services" means consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of contraceptive methods to prevent an unintended pregnancy. This section may not be construed to apply to prescription drugs or devices that are designed to terminate a pregnancy. [PL 1999, c. 341, §2 (NEW); PL 1999, c. 341, §5 (AFF).]

2. Exclusion for religious employer. A religious employer may request and an insurer shall grant an exclusion under the policy or contract for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains an exclusion under this subsection shall provide prospective insureds and those individuals insured under its policy written notice of the exclusion. This section may not be construed as authorizing an insurer to exclude coverage for prescription drugs prescribed for reasons other than contraceptive purposes or for prescription contraception that is necessary to preserve the life or health of a covered person. For the purposes of this section, "religious employer" means an employer that is a church, convention or association of churches or an elementary or secondary school that is controlled, operated or principally supported by a church or by a convention or association of churches as defined in 26 United States Code, Section 3121 (w) (3) (A) and that qualifies as a tax-exempt organization under 26 United States Code, Section 501(c) (3). [PL 1999, c. 341, §2 (NEW); PL 1999, c. 341, §5 (AFF).]

3. Coverage of contraceptive supplies. Coverage required under this section must include coverage for contraceptive supplies in accordance with the following requirements. For purposes of this section, "contraceptive supplies" means all contraceptive drugs, devices and products approved by the federal Food and Drug Administration to prevent an unwanted pregnancy.

A. Coverage must be provided without any deductible, coinsurance, copayment or other cost-sharing requirement for at least one contraceptive supply within each method of contraception that is identified by the federal Food and Drug Administration to prevent an unwanted pregnancy and prescribed by a health care provider. [PL 2017, c. 190, §1 (NEW).]

B. If there is a therapeutic equivalent of a contraceptive supply within a contraceptive method approved by the federal Food and Drug Administration, an insurer may provide coverage for more than one contraceptive supply and may impose cost-sharing requirements as long as at least one contraceptive supply within that method is available without cost sharing. [PL 2017, c. 190, §1 (NEW).]

C. If an individual's health care provider recommends a particular contraceptive supply approved by the federal Food and Drug Administration for the individual based on a determination of medical necessity, the insurer shall defer to the provider's determination and judgment and shall provide coverage without cost sharing for the prescribed contraceptive supply. [PL 2017, c. 190, §1 (NEW).]

D. Coverage must be provided for the furnishing or dispensing of prescribed contraceptive supplies intended to last for a 12-month period, which may be furnished or dispensed all at once or over the course of the 12 months at the discretion of the health care provider. [PL 2017, c. 190, §1 (NEW).]

[PL 2017, c. 190, §1 (NEW).]

REVISOR'S NOTE: §2756. Coverage for services of certified nurse practitioners; certified nurse midwives (As enacted by PL 1999, c. 396, §2 and affected by §7 is REALLOCATED TO TITLE 24-A, SECTION 2757)

REVISOR'S NOTE: §2756. Coverage for services provided by registered nurse first assistants (As enacted by PL 1999, c. 412, §2 is REALLOCATED TO TITLE 24-A, SECTION 2758)

SECTION HISTORY

PL 1999, c. 341, §2 (NEW). PL 1999, c. 341, §5 (AFF). PL 1999, c. 396, §2 (NEW). PL 1999, c. 396, §7 (AFF). PL 1999, c. 412, §2 (NEW). RR 1999, c. 1, §§32,33 (RAL). PL 2017, c. 190, §1 (AMD).

§2757. Coverage for services of certified nurse practitioners; certified midwives; certified nurse midwives

(REALLOCATED FROM TITLE 24-A, SECTION 2756)

1. Required coverage for services upon referral of primary care provider. An insurer that issues individual health insurance policies and contracts shall provide coverage under those contracts for services performed by a certified nurse practitioner, certified midwife or certified nurse midwife to a patient who is referred to the certified nurse practitioner, certified midwife or certified nurse midwife by a primary care provider when those services are within the lawful scope of practice of the certified nurse practitioner, certified midwife or certified nurse midwife.

[PL 2021, c. 79, §2 (AMD).]

2. Required coverage for self-referred services. With respect to individual health insurance policies and contracts that do not require the selection of a primary care provider, an insurer shall provide coverage under those contracts for services performed by a certified nurse practitioner, certified midwife or certified nurse midwife when those services are covered services and when they are within the lawful scope of practice of the certified nurse practitioner, certified midwife or certified nurse midwife.

[PL 2021, c. 79, §2 (AMD).]

3. Limits; coinsurance; deductibles. Any contract that provides coverage for services under this section 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 section.

[RR 1999, c. 1, §32 (RAL).]

SECTION HISTORY

RR 1999, c. 1, §32 (RAL). PL 2021, c. 79, §2 (AMD).

§2758. Coverage for services provided by registered nurse first assistants

(REALLOCATED FROM TITLE 24-A, SECTION 2756)

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Perioperative nursing" means a practice of nursing in which the nurse provides preoperative, intraoperative and postoperative nursing care to surgical patients. [RR 1999, c. 1, §33 (RAL).]

B. "Recognized program" means a program that addresses all content of the core curriculum for registered nurse first assistants as established by the Association of Operating Room Nurses or its successor organization. [RR 1999, c. 1, §33 (RAL).]

C. "Registered nurse first assistant," or "RNFA," means a person who:

(1) Is licensed as a registered nurse under Title 32, chapter 31;

(2) Is experienced in perioperative nursing; and

(3) Has successfully completed a recognized program. [RR 1999, c. 1, §33 (RAL).]

[RR 1999, c. 1, §33 (RAL).]

2. Institutional powers. Each health care institution, as defined in Title 22, chapter 405, may establish specific procedures for the appointment and reappointment of registered nurse first assistants and for granting, renewing and revising their clinical privileges.

[RR 1999, c. 1, §33 (RAL).]

3. Required coverage for services. Notwithstanding any other provisions of this chapter, an insurer that issues individual health insurance policies and contracts that provide 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. The provisions of this subsection apply only if reimbursement for an assisting physician would be covered and a registered nurse first assistant who performed those services is used as a substitute. This section does not apply to policies or contracts that cover only specified diseases.

[RR 1999, c. 1, §33 (RAL).]

4. Limits; coinsurance; deductibles. Any contract that provides coverage for the services required by this section 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 section.

[RR 1999, c. 1, §33 (RAL).]

SECTION HISTORY

RR 1999, c. 1, §33 (RAL).

§2759. Coverage for hospice care services

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Hospice care services" means services provided on a 24-hours-a-day, 7-days-a-week basis to a person who is terminally ill and that person's family. "Hospice care services" includes, but is not limited to, physician services; nursing care; respite care; medical and social work services; counseling services; nutritional counseling; pain and symptom management; medical supplies and durable medical equipment; occupational, physical or speech therapies; volunteer services; home health care services; and bereavement services. [PL 2001, c. 358, Pt. LL, §2 (NEW); PL 2001, c. 358, Pt. LL, §5 (AFF).]

B. "Person who is terminally ill" means a person that has a medical prognosis that the person's life expectancy is 12 months or less if the illness runs its normal course. [PL 2001, c. 358, Pt. LL, §2 (NEW); PL 2001, c. 358, Pt. LL, §5 (AFF).]

[PL 2001, c. 358, Pt. LL, §2 (NEW); PL 2001, c. 358, Pt. LL, §5 (AFF).]

2. Coverage for hospice care services. All individual health policies must provide coverage for hospice care services to a person who is terminally ill. Hospice care services must be provided according to a written care delivery plan developed by a hospice care provider and the recipient of hospice care services. Coverage for hospice care services must be provided whether the services are provided in a home setting or an inpatient setting.

[PL 2001, c. 358, Pt. LL, §2 (NEW); PL 2001, c. 358, Pt. LL, §5 (AFF).]

REVISOR'S NOTE: §2759. Coverage for general anesthesia for dentistry (As enacted by PL 2001, c. 423, §2 and affected by § 5 is REALLOCATED TO TITLE 24-A, SECTION 2760)

SECTION HISTORY

RR 2001, c. 1, §31 (RAL). PL 2001, c. 358, §LL2 (NEW). PL 2001, c. 358, §LL5 (AFF). PL 2001, c. 423, §2 (NEW). PL 2001, c. 423, §5 (AFF).

§2760. Coverage for general anesthesia for dentistry

(REALLOCATED FROM TITLE 24-A, SECTION 2759)

1. Enrollee defined. For the purposes of this section, unless the context otherwise indicates, "enrollee" means a person who is covered under an individual health insurance contract provided by an insurer.

[RR 2001, c. 1, §31 (RAL).]

2. General anesthesia and associated facility charges. An insurer that issues individual health insurance contracts shall provide coverage for general anesthesia and associated facility charges for dental procedures rendered in a hospital when the clinical status or underlying medical condition of an enrollee requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital. The insurer may require prior authorization of general anesthesia and associated charges required for dental care procedures in the same manner that prior authorization is required for other covered diseases or conditions.

[RR 2001, c. 1, §31 (RAL).]

3. Limitations on coverage. This section applies only to general anesthesia and associated facility charges for only the following enrollees if the enrollees meet the criteria in subsection 2:

A. Enrollees, including infants, exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, can not be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result; [RR 2001, c. 1, §31 (RAL).]

B. Enrollees demonstrating dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy; [RR 2001, c. 1, §31 (RAL).]

C. Extremely uncooperative, fearful, anxious or uncommunicative children or adolescents with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity; and [RR 2001, c. 1, §31 (RAL).]

D. Enrollees who have sustained extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised. [RR 2001, c. 1, §31 (RAL).]

[RR 2001, c. 1, §31 (RAL).]

4. Dental procedures and dentist's fee not covered. This section does not require an insurer that issues individual contracts to cover any charges for the dental procedure itself, including, but not limited to, the professional fee of the dentist. Coverage for anesthesia and associated facility charges pursuant to this section is subject to all other terms and conditions of the individual contract that apply generally to other benefits.

[RR 2001, c. 1, §31 (RAL).]

5. Coordination of benefits with dental insurance. If an enrollee eligible for coverage under this section is also eligible for coverage for general anesthesia and associated facility charges under a dental insurance policy or contract, the nonprofit health care service organization or insurer providing dental insurance is the primary payer responsible for those charges and the insurer providing individual health insurance is the secondary payer.

[RR 2001, c. 1, §31 (RAL).]

SECTION HISTORY

RR 2001, c. 1, §31 (RAL).

§2761. Offer of coverage for breast reduction surgery and symptomatic varicose vein surgery

All individual health insurance policies, contracts and certificates must make available coverage for breast reduction surgery and symptomatic varicose vein surgery determined to be medically necessary health care as defined in section 4301-A, subsection 10-A. [PL 2005, c. 128, §2 (NEW); PL 2005, c. 128, §5 (AFF).]

SECTION HISTORY

PL 2005, c. 128, §2 (NEW). PL 2005, c. 128, §5 (AFF).

§2762. Coverage for hearing aids

1. Hearing aid; definition. For purposes of this section, "hearing aid" means a nonexperimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, excluding batteries and cords and other assistive listening devices, including, but not limited to, frequency modulation systems.

[PL 2007, c. 452, §2 (NEW).]

2. Required coverage. All individual health policies and contracts must provide coverage for the purchase of a hearing aid for each hearing-impaired ear for an individual covered under the policy or contract in accordance with the following requirements.

A. The hearing loss must be documented by a physician or audiologist licensed pursuant to Title 32, chapter 137. [PL 2015, c. 494, Pt. A, §28 (AMD).]

B. The hearing aid must be purchased in accordance with federal and state laws, regulations and rules for the sale and dispensing of hearing aids. [PL 2019, c. 418, §1 (AMD).]

C. The policy or contract may limit coverage to \$3,000 per hearing aid for each hearing-impaired ear every 36 months. [PL 2019, c. 418, §1 (AMD).]

[PL 2019, c. 418, §1 (AMD).]

3. Application of coverage.

[PL 2019, c. 418, §2 (RP).]

4. Limits; coinsurance; deductibles. Except as otherwise provided in this section, any policy or contract that provides coverage for services under this section 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 section.

[PL 2007, c. 452, §2 (NEW).]

SECTION HISTORY

PL 2007, c. 452, §2 (NEW). PL 2015, c. 494, Pt. A, §28 (AMD). PL 2019, c. 418, §§1, 2 (AMD).

§2763. Coverage for colorectal cancer screening

1. Colorectal cancer screening. For the purposes of this section, "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.

[PL 2019, c. 86, §1 (AMD).]

2. Required coverage. All individual health insurance policies and contracts must provide coverage for colorectal cancer screening for asymptomatic individuals who are:

A. At average risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society; or [PL 2019, c. 86, §2 (AMD).]

B. At high risk for colorectal cancer. [PL 2019, c. 86, §3 (AMD).]
[PL 2019, c. 86, §§2, 3 (AMD).]

3. Billing. 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.

[PL 2007, c. 516, §2 (NEW); PL 2007, c. 516, §5 (AFF).]

REVISOR'S NOTE: §2763. Coverage for medically necessary infant formula (As enacted by PL 2007, c. 595, §2 is REALLOCATED TO TITLE 24-A, SECTION 2764)

SECTION HISTORY

RR 2007, c. 2, §11 (RAL). PL 2007, c. 516, §2 (NEW). PL 2007, c. 516, §5 (AFF). PL 2007, c. 595, §2 (NEW). PL 2007, c. 595, §5 (AFF). PL 2019, c. 86, §§1-3 (AMD).

§2764. Coverage for medically necessary infant formula

(REALLOCATED FROM TITLE 24-A, SECTION 2763)

All individual health insurance policies, contracts and certificates must provide coverage for amino acid-based elemental infant formula for children 2 years of age and under in accordance with this section. [RR 2007, c. 2, §11 (RAL).]

1. Determination of medical necessity. Coverage for amino acid-based elemental infant formula must be provided when a licensed physician has submitted documentation that the amino acid-based elemental infant formula is medically necessary health care as defined in section 4301-A, subsection 10-A, 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. A licensed physician may be required to confirm and document ongoing medical necessity at least annually.

[RR 2007, c. 2, §11 (RAL).]

2. Method of delivery. Coverage for amino acid-based elemental infant formula must be provided without regard to the method of delivery of the formula.

[RR 2007, c. 2, §11 (RAL).]

3. Required diagnosis. Coverage for amino acid-based elemental infant formula must be provided when a licensed physician has diagnosed and through medical evaluation has documented one of the following conditions:

A. Symptomatic allergic colitis or proctitis; [RR 2007, c. 2, §11 (RAL).]

B. Laboratory- or biopsy-proven allergic or eosinophilic gastroenteritis; [RR 2007, c. 2, §11 (RAL).]

C. A history of anaphylaxis; [RR 2007, c. 2, §11 (RAL).]

D. Gastroesophageal reflux disease that is nonresponsive to standard medical therapies; [RR 2007, c. 2, §11 (RAL).]

E. Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider; [RR 2007, c. 2, §11 (RAL).]

F. Cystic fibrosis; or [RR 2007, c. 2, §11 (RAL).]

G. Malabsorption of cow milk-based or soy milk-based infant formula. [RR 2007, c. 2, §11 (RAL).]

[RR 2007, c. 2, §11 (RAL).]

4. Health savings accounts. Coverage for amino acid-based elemental infant formula under a health insurance policy, contract or certificate issued in connection with a health savings account as authorized under Title XII of the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 may be subject to the same deductible and out-of-pocket limits that apply to overall benefits under the policy, contract or certificate.

[RR 2007, c. 2, §11 (RAL).]

SECTION HISTORY

RR 2007, c. 2, §11 (RAL).

§2765. Coverage for services provided by independent practice dental hygienist

1. Services provided by independent practice dental hygienist. An insurer that issues individual dental insurance or health insurance that includes coverage for dental services shall provide coverage for dental services performed by an independent practice dental hygienist licensed under Title 32, chapter 143 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.

[PL 2015, c. 429, §11 (AMD).]

2. Limits; coinsurance; deductibles. A contract that provides coverage for the services required by this section 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 section.

[PL 2009, c. 307, §2 (NEW); PL 2009, c. 307, §6 (AFF).]

3. Coordination of benefits with dental insurance. If an enrollee eligible for coverage under this section is eligible for coverage under a dental insurance policy or contract and a health insurance policy or contract, the insurer providing dental insurance is the primary payer responsible for charges under subsection 1 and the insurer providing individual health insurance is the secondary payer.

[PL 2009, c. 307, §2 (NEW); PL 2009, c. 307, §6 (AFF).]

4. Application. The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[PL 2009, c. 307, §2 (NEW); PL 2009, c. 307, §6 (AFF).]

SECTION HISTORY

PL 2009, c. 307, §2 (NEW). PL 2009, c. 307, §6 (AFF). PL 2015, c. 429, §11 (AMD).

§2765-A. Coverage for services provided by dental therapist

1. Services provided by dental therapist. An insurer that issues individual dental insurance or health insurance that includes coverage for dental services shall provide coverage for dental services performed by a dental therapist licensed under Title 32, chapter 143 when those services are covered services under the contract and when they are within the lawful scope of practice of the dental therapist.

[PL 2019, c. 388, §3 (AMD).]

2. Limits; coinsurance; deductibles. A contract that provides coverage for the services required by this section 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 section.

[PL 2013, c. 575, §5 (NEW); PL 2013, c. 575, §10 (AFF).]

3. Coordination of benefits with dental insurance. If an enrollee eligible for coverage under this section is eligible for coverage under a dental insurance policy or contract and a health insurance policy or contract, the insurer providing dental insurance is the primary payer responsible for charges under subsection 1 and the insurer providing individual health insurance is the secondary payer.

[PL 2013, c. 575, §5 (NEW); PL 2013, c. 575, §10 (AFF).]

4. Application. The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[PL 2013, c. 575, §5 (NEW); PL 2013, c. 575, §10 (AFF).]

SECTION HISTORY

PL 2013, c. 575, §5 (NEW). PL 2013, c. 575, §10 (AFF). PL 2015, c. 429, §12 (AMD). PL 2019, c. 388, §3 (AMD).

§2766. Enrollment of dependent children in dental coverage

1. Offer of dependent coverage; enrollment period. 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 at appropriate rates during the following periods:

A. From birth to 30 days of age; and [PL 2009, c. 578, §2 (NEW); PL 2009, c. 578, §4 (AFF).]

B. Any open or annual enrollment period. [PL 2009, c. 578, §2 (NEW); PL 2009, c. 578, §4 (AFF).]

REVISOR'S NOTE: §2766. Coverage for children's early intervention services (As enacted by PL 2009, c. 634, §2; §5 is REALLOCATED TO TITLE 24-A, SECTION 2767)

REVISOR'S NOTE: §2766. Coverage for the diagnosis and treatment of autism spectrum disorders (As enacted by PL 2009, c. 635, §2; §6 is REALLOCATED TO TITLE 24-A, SECTION 2768)

[PL 2009, c. 578, §2 (NEW); PL 2009, c. 578, §4 (AFF).]

SECTION HISTORY

PL 2009, c. 578, §2 (NEW). PL 2009, c. 578, §4 (AFF). PL 2009, c. 634, §2 (NEW). PL 2009, c. 634, §5 (AFF). PL 2009, c. 635, §2 (NEW). PL 2009, c. 635, §6 (AFF). PL 2011, c. 420, Pt. A, §23 (RAL). PL 2011, c. 420, Pt. A, §24 (RAL).

§2766-A. Dental benefit waiting period

1. Enrollee defined. For the purposes of this section, unless the context otherwise indicates, "enrollee" means a person who is covered under an individual policy or contract provided by an insurer. [PL 2019, c. 605, §5 (NEW).]

2. No waiting period for enrollee under 19 years of age. An insurer that issues individual dental insurance or health insurance that includes coverage for dental services may not impose a waiting period, as defined in section 2848, subsection 5, for any dental or oral health service or treatment, except for orthodontic treatment, for an enrollee if the enrollee is under 19 years of age.

[PL 2019, c. 605, §5 (NEW).]

SECTION HISTORY

PL 2019, c. 605, §5 (NEW).

§2767. Coverage for children's early intervention services

(REALLOCATED FROM TITLE 24-A, SECTION 2766)

1. Definition. For purposes of this section, "children's early intervention services" means services provided by licensed occupational therapists, physical therapists, speech-language pathologists or clinical social workers working with children from birth to 36 months of age with an identified developmental disability or delay as described in the federal Individuals with Disabilities Education Act, Part C, 20 United States Code, Section 1411, et seq.

[PL 2011, c. 420, Pt. A, §23 (RAL).]

2. Required coverage. All individual health insurance policies, contracts and certificates must provide coverage for children's early intervention services in accordance with this subsection.

A. A referral from the child's primary care provider is required. [PL 2011, c. 420, Pt. A, §23 (RAL).]

B. The policy, contract or certificate may limit coverage to \$3,200 per year for each child not to exceed \$9,600 by the child's 3rd birthday. [PL 2011, c. 420, Pt. A, §23 (RAL).]

C. The policy, contract or certificate 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 section. [PL 2011, c. 420, Pt. A, §23 (RAL).]

[PL 2011, c. 420, Pt. A, §23 (RAL).]

SECTION HISTORY

PL 2011, c. 420, Pt. A, §23 (RAL).

§2768. Coverage for the diagnosis and treatment of autism spectrum disorders

(REALLOCATED FROM TITLE 24-A, SECTION 2766)

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior. [PL 2011, c. 420, Pt. A, §24 (RAL).]

B. "Autism spectrum disorders" means any of the pervasive developmental disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified. [PL 2011, c. 420, Pt. A, §24 (RAL).]

C. "Treatment of autism spectrum disorders" includes the following types of care prescribed, provided or ordered for an individual diagnosed with an autism spectrum disorder:

- (1) Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain and restore the functioning of an individual to the extent possible. To be eligible for coverage, applied behavior analysis must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts;

(2) Counseling services provided by a licensed psychiatrist, psychologist, clinical professional counselor or clinical social worker; and

(3) Therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist. [PL 2011, c. 420, Pt. A, §24 (RAL).]

[PL 2011, c. 420, Pt. A, §24 (RAL).]

2. Required coverage. All individual health insurance policies and contracts 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 the following.

A. The policy or contract must provide coverage for any assessments, evaluations or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an autism spectrum disorder. [PL 2011, c. 420, Pt. A, §24 (RAL).]

B. The policy or contract must provide coverage for the treatment of autism spectrum disorders when it is determined by a licensed physician or licensed psychologist that the treatment is medically necessary health care as defined in section 4301-A, subsection 10-A. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity for coverage provided under this section at least annually. [PL 2011, c. 420, Pt. A, §24 (RAL).]

C. The policy or contract may not include any limits on the number of visits. [PL 2011, c. 420, Pt. A, §24 (RAL).]

D. The policy or contract may limit coverage for applied behavior analysis to \$36,000 per year. An insurer may not apply payments for coverage unrelated to autism spectrum disorders to any maximum benefit established under this paragraph. [PL 2011, c. 420, Pt. A, §24 (RAL).]

E. This subsection may not be construed to require coverage for prescription drugs if prescription drug coverage is not provided by the policy or contract. Coverage for prescription drugs for the treatment of autism spectrum disorders must be determined in the same manner as coverage for prescription drugs for the treatment of any other illness or condition is determined under the policy or contract. [PL 2011, c. 420, Pt. A, §24 (RAL).]

[PL 2013, c. 597, §1 (AMD); PL 2013, c. 597, §4 (AFF).]

3. Limits; coinsurance; deductibles. Except as otherwise provided in this section, any policy or contract that provides coverage for services under this section 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 section.

[PL 2011, c. 420, Pt. A, §24 (RAL).]

4. Individualized education plan. This section may not be construed to affect any obligation to provide services to an individual with an autism spectrum disorder under an individualized education plan or an individualized family service plan.

[PL 2011, c. 420, Pt. A, §24 (RAL).]

SECTION HISTORY

PL 2011, c. 420, Pt. A, §24 (RAL). PL 2013, c. 597, §1 (AMD). PL 2013, c. 597, §4 (AFF).

§2769. Prescription synchronization

1. Synchronization. If a health plan provides coverage for prescription drugs, a carrier:

A. Shall permit and apply a prorated daily cost-sharing rate to a prescription that is dispensed by a pharmacist in the carrier's network for less than a 30-day supply if the prescriber or pharmacist determines that filling or refilling the prescription for less than a 30-day supply is in the best interest of the patient and the patient requests or agrees to less than a 30-day supply in order to synchronize

the refilling of that prescription with the patient's other prescriptions; [PL 2015, c. 93, §1 (NEW); PL 2015, c. 93, §2 (AFF).]

B. May not deny coverage for the dispensing of a medication prescribed for the treatment of a chronic illness that is made in accordance with a plan developed by the carrier, the insured, the prescriber and a pharmacist to synchronize the filling or refilling of multiple prescriptions for the insured. The carrier shall allow a pharmacy to override any denial codes indicating that a prescription is being refilled too soon in order to synchronize the patient's prescriptions; and [PL 2015, c. 93, §1 (NEW); PL 2015, c. 93, §2 (AFF).]

C. May not use payment structures incorporating prorated dispensing fees. Dispensing fees for partially filled or refilled prescriptions must be paid in full for each prescription dispensed, regardless of any prorated copay for the insured or fee paid for alignment services. [PL 2015, c. 93, §1 (NEW); PL 2015, c. 93, §2 (AFF).]

[PL 2015, c. 93, §1 (NEW); PL 2015, c. 93, §2 (AFF).]

2. Application; exclusion. The requirements of this section do not apply to a prescription for:

A. Solid oral doses of antibiotics; or [PL 2015, c. 93, §1 (NEW); PL 2015, c. 93, §2 (AFF).]

B. Solid oral doses that are dispensed in their original container as indicated in the federal Food and Drug Administration Prescribing Information or are customarily dispensed in their original packaging to assist a patient with compliance. [PL 2015, c. 93, §1 (NEW); PL 2015, c. 93, §2 (AFF).]

[PL 2015, c. 93, §1 (NEW); PL 2015, c. 93, §2 (AFF).]

SECTION HISTORY

PL 2015, c. 93, §1 (NEW). PL 2015, c. 93, §2 (AFF).

§2770. Absolute discretion clauses

An individual health insurance policy, contract or certificate, including, but not limited to, a disability income insurance policy, contract or certificate, may not contain a provision purporting to reserve sole or absolute discretion to the insurer to interpret the terms of the contract, to provide standards of interpretation or review, to determine eligibility for benefits, to determine the amount of benefits or to resolve factual disputes. An insurer may not enforce a provision in a policy, contract or certificate that was offered, executed, delivered or issued for delivery in this State and has been continued or renewed by an individual policy holder in this State that purports to reserve sole or absolute discretion to the insurer to interpret the terms of the contract, to provide standards of interpretation or review, to determine eligibility for benefits, to determine the amount of benefits or to resolve factual disputes. [PL 2019, c. 179, §1 (NEW).]

SECTION HISTORY

PL 2019, c. 179, §1 (NEW).

The State of Maine claims a copyright in its codified statutes. If you intend to republish this material, we require that you include the following disclaimer in your publication:

All copyrights and other rights to statutory text are reserved by the State of Maine. The text included in this publication reflects changes made through the First Special Session of the 130th Maine Legislature and is current through October 31, 2021. The text is subject to change without notice. It is a version that has not been officially certified by the Secretary of State. Refer to the Maine Revised Statutes Annotated and supplements for certified text.

The Office of the Revisor of Statutes also requests that you send us one copy of any statutory publication you may produce. Our goal is not to restrict publishing activity, but to keep track of who is publishing what, to identify any needless duplication and to preserve the State's copyright rights.

PLEASE NOTE: The Revisor's Office cannot perform research for or provide legal advice or interpretation of Maine law to the public. If you need legal assistance, please contact a qualified attorney.