

Title 24-A: MAINE INSURANCE CODE
Chapter 35: GROUP AND BLANKET HEALTH INSURANCE

Table of Contents

Section 2801. SCOPE OF CHAPTER -- SHORT TITLE.....	5
Section 2802. GROUP INSURANCE DEFINED.....	5
Section 2803. REQUIREMENTS.....	6
Section 2803-A. LOSS INFORMATION.....	6
Section 2804. EMPLOYEE GROUPS.....	7
Section 2804-A. PRIVATE PURCHASING ALLIANCES.....	7
Section 2804-B. GROUP DISABILITY INCOME PROTECTION PLAN.....	8
Section 2805. LABOR UNION GROUPS.....	8
Section 2805-A. ASSOCIATION GROUPS.....	9
Section 2806. TRUSTEE GROUPS.....	9
Section 2807. DEBTOR GROUPS.....	10
Section 2807-A. CREDIT UNION GROUPS.....	10
Section 2808. OTHER GROUPS.....	11
Section 2808-A. RATING PRACTICES IN GROUP HEALTH INSURANCE (REPEALED).....	12
Section 2808-B. SMALL GROUP HEALTH PLANS.....	12
Section 2809. COVERAGE OF FAMILY, DEPENDENTS; CONTINUATION OF COVERAGE.....	21
Section 2809-A. CONVERSION ON TERMINATION OF POLICY OR ELIGIBILITY.....	22
Section 2810. GROUP HEALTH INSURANCE PAYMENTS; BENEFICIARIES.....	26
Section 2811. PAYMENT OF EXPENSES.....	27
Section 2812. READJUSTMENT OF PREMIUM RATE (REPEALED).....	27
Section 2812-A. DIVIDENDS AND EXPERIENCE REFUNDS.....	27
Section 2813. "BLANKET HEALTH INSURANCE" DEFINED.....	28
Section 2814. BLANKET HEALTH INSURANCE -- PAYMENTS; BENEFICIARIES.....	29
Section 2815. LEGAL LIABILITY OF POLICYHOLDERS.....	29
Section 2816. REQUIREMENTS.....	29
Section 2817. APPLICANT'S STATEMENTS; WAIVERS, AMENDMENTS.....	29
Section 2818. STATEMENTS IN APPLICATION.....	30
Section 2819. NEW EMPLOYEES, MEMBERS.....	30
Section 2820. RENEWAL OF POLICY.....	30
Section 2821. INDIVIDUAL CERTIFICATES.....	30
Section 2822. AGE LIMITS.....	30
Section 2823. NOTICE OF CLAIM.....	31
Section 2823-A. EXPLANATION AND NOTICE TO PARENT.....	31

Section 2823-B. STANDARDIZED CLAIM FORMS.....	31
Section 2824. PROOF OF LOSS.....	32
Section 2825. FORMS FOR PROOF OF LOSS.....	32
Section 2826. EXAMINATION, AUTOPSY.....	32
Section 2827. TIME FOR PAYMENT OF BENEFITS.....	32
Section 2827-A. ASSIGNMENT OF BENEFITS.....	33
Section 2828. TIME FOR SUITS.....	33
Section 2829. EXCEPTIONS.....	33
Section 2829-A. DISABILITY BENEFIT OFFSETS.....	34
Section 2830. OMISSIONS, MODIFICATIONS: SUPERINTENDENT MAY APPROVE.....	34
Section 2831. HOSPITAL, MEDICAL BENEFITS -- DIRECT PAYMENT.....	34
Section 2832. MATERNITY BENEFITS FOR UNMARRIED WOMEN CERTIFICATE HOLDERS AND THE MINOR DEPENDENTS OF CERTIFICATE HOLDERS WITH DEPENDENT OR FAMILY COVERAGE REQUIRED.....	35
Section 2832-A. MANDATED OFFER OF DOMESTIC PARTNER BENEFITS.....	35
Section 2833. CHILD COVERAGE.....	36
Section 2833-A. EXTENSION OF COVERAGE FOR DEPENDENT CHILDREN.....	37
Section 2833-B. MANDATORY OFFER TO EXTEND COVERAGE FOR DEPENDENT CHILDREN UP TO 25 YEARS OF AGE.....	37
Section 2834. NEWBORN CHILDREN COVERAGE.....	38
Section 2834-A. MATERNITY AND ROUTINE NEWBORN CARE.....	38
Section 2834-B. DEPENDENT SPECIAL ENROLLMENT PERIOD.....	39
Section 2834-C. COMPLIANCE WITH FEDERAL LAW.....	40
Section 2835. MENTAL HEALTH SERVICES.....	40
Section 2836. LIMITS ON PRIORITY LIENS.....	41
Section 2837. HOME HEALTH CARE COVERAGE.....	42
Section 2837-A. SCREENING MAMMOGRAMS.....	43
Section 2837-B. ACUPUNCTURE SERVICES.....	44
Section 2837-C. COVERAGE FOR BREAST CANCER TREATMENT.....	44
Section 2837-D. MEDICAL FOOD COVERAGE FOR INBORN ERROR OF METABOLISM.....	45
Section 2837-E. COVERAGE FOR PAP TESTS.....	46
Section 2837-F. OFF-LABEL USE OF PRESCRIPTION DRUGS FOR CANCER.....	46
Section 2837-G. OFF-LABEL USE OF PRESCRIPTION DRUGS FOR HIV OR AIDS.....	47
Section 2837-H. COVERAGE FOR PROSTATE CANCER SCREENING (REALLOCATED FROM TITLE 24-A, SECTION 2837-F).....	48
Section 2838. COMMUNITY HEALTH SERVICE COVERAGE (REPEALED).....	49
Section 2839. RATES FILED.....	49
Section 2839-A. NOTICE OF RATE INCREASE.....	49
Section 2839-B. LARGE GROUP RATES.....	50

Section 2840. OPTIONAL COVERAGE FOR CHIROPRACTIC SERVICES (REALLOCATED FROM TITLE 24-A, SECTION 2746) (REPEALED)..... 50

Section 2840-A. COVERAGE FOR CHIROPRACTIC SERVICES..... 51

Section 2841. OPTIONAL COVERAGE FOR OPTOMETRIC SERVICES..... 52

Section 2842. EQUITABLE HEALTH CARE FOR SUBSTANCE USE DISORDER TREATMENT..... 52

Section 2843. MENTAL HEALTH SERVICES COVERAGE..... 54

Section 2844. COORDINATION OF BENEFITS..... 59

Section 2845. CARDIAC REHABILITATION COVERAGE..... 60

Section 2846. ACQUIRED IMMUNE DEFICIENCY SYNDROME..... 61

Section 2847. UTILIZATION REVIEW DATA..... 61

Section 2847-A. PENALTY FOR FAILURE TO NOTIFY OF HOSPITALIZATION..... 62

Section 2847-B. JURY SERVICE..... 62

Section 2847-C. NOTIFICATION PRIOR TO CANCELLATION; RESTRICTIONS ON CANCELLATION, TERMINATION OR LAPSE DUE TO COGNITIVE IMPAIRMENT OR FUNCTIONAL INCAPACITY..... 62

Section 2847-D. PENALTY FOR NONCOMPLIANCE WITH UTILIZATION REVIEW PROGRAMS..... 63

Section 2847-E. COVERAGE FOR DIABETES SUPPLIES..... 63

Section 2847-F. GYNECOLOGICAL AND OBSTETRICAL SERVICES (REALLOCATED FROM TITLE 24-A, SECTION 2850-A)..... 64

Section 2847-G. COVERAGE FOR CONTRACEPTIVES..... 65

Section 2847-H. COVERAGE FOR SERVICES OF CERTIFIED NURSE PRACTITIONERS; CERTIFIED NURSE MIDWIVES (REALLOCATED FROM TITLE 24-A, SECTION 2847-G)..... 66

Section 2847-I. COVERAGE FOR SERVICES PROVIDED BY REGISTERED NURSE FIRST ASSISTANTS (REALLOCATED FROM TITLE 24-A, SECTION 2847-G)..... 67

Section 2847-J. COVERAGE FOR HOSPICE CARE SERVICES..... 68

Section 2847-K. COVERAGE FOR GENERAL ANESTHESIA FOR DENTISTRY (REALLOCATED FROM TITLE 24-A, SECTION 2847-J)..... 68

Section 2847-L. OFFER OF COVERAGE FOR BREAST REDUCTION SURGERY AND SYMPTOMATIC VARICOSE VEIN SURGERY..... 70

Section 2847-M. ENROLLMENT FOR INDIVIDUALS OR FAMILIES ESTABLISHING ELIGIBILITY FOR MAINECARE..... 70

Section 2847-N. COVERAGE FOR COLORECTAL CANCER SCREENING..... 70

Section 2847-O. COVERAGE FOR HEARING AIDS (REALLOCATED FROM TITLE 24-A, SECTION 2847-M)..... 71

Section 2847-P. COVERAGE FOR MEDICALLY NECESSARY INFANT FORMULA (REALLOCATED FROM TITLE 24-A, SECTION 2847-N)..... 72

Section 2847-Q. COVERAGE FOR SERVICES PROVIDED BY INDEPENDENT PRACTICE DENTAL HYGIENIST..... 73

Section 2847-R. ENROLLMENT OF DEPENDENT CHILDREN IN DENTAL COVERAGE..... 73

**Section 2847-S. COVERAGE FOR CHILDREN'S EARLY INTERVENTION SERVICES
(REALLOCATED FROM TITLE 24-A, SECTION 2847-R)..... 74**

**Section 2847-T. COVERAGE FOR THE DIAGNOSIS AND TREATMENT OF AUTISM
SPECTRUM DISORDERS (REALLOCATED FROM TITLE 24-A, SECTION 2847-
R)..... 74**

**Section 2847-U. COVERAGE FOR SERVICES PROVIDED BY DENTAL HYGIENE
THERAPIST..... 76**

Maine Revised Statutes
Title 24-A: MAINE INSURANCE CODE
Chapter 35: GROUP AND BLANKET HEALTH INSURANCE

§2801. SCOPE OF CHAPTER -- SHORT TITLE

1. This chapter applies only to group health insurance contracts and to blanket health insurance contracts as herein provided. Nothing in this chapter pertains to legal services insurance as described in chapter 38, except to the extent expressly permitted in that chapter.

[1983, c. 801, §10 (AMD) .]

2. This chapter may be cited as the "Group or Blanket Health Insurance Law."

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY

1969, c. 132, §1 (NEW). 1983, c. 801, §10 (AMD).

§2802. GROUP INSURANCE DEFINED

1. Any policy or contract of insurance against death or injury resulting from accident or from accidental means which covers more than one person, except blanket accident policies as defined in section 2813 and family accident and sickness policies conforming to section 2703, shall be deemed a group accident insurance policy.

[1969, c. 177, §48 (AMD) .]

2. Any policy or contract which insures against disablement, disease or sickness of the insured, excluding disablement which results from accident or from accidental means, and which covers more than one person, except blanket sickness insurance policies as defined in section 2813 and family accident and sickness policies conforming to section 2703, shall be deemed a group sickness insurance policy or contract.

[1969, c. 132, §1 (NEW) .]

3. Any policy or contract of insurance which combines the coverage of group accident insurance and of group sickness insurance shall be deemed a group accident and sickness insurance policy.

[1969, c. 132, §1 (NEW) .]

4. Any reference hereinafter to group health insurance shall mean group accident, group sickness and group accident and sickness insurance as herein defined.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY

1969, c. 132, §1 (NEW). 1969, c. 177, §48 (AMD).

§2803. REQUIREMENTS

A policy of group health insurance may not be delivered in this State, nor may any certificate of group health insurance that derives from a policy issued in another state be delivered in this State unless the group policyholder conforms to one of the descriptions set forth in sections 2804 to 2808. [2011, c. 238, Pt. G, §1 (AMD).]

SECTION HISTORY

1969, c. 132, §1 (NEW). 1981, c. 147, §1 (RPR). 1993, c. 171, §C2 (AMD). 2011, c. 238, Pt. G, §1 (AMD).

§2803-A. LOSS INFORMATION

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

A. "Insurance policy" means the insurance policy relating to the loss information requested pursuant to this section. [1995, c. 71, §2 (NEW).]

B. "Loss information" means the aggregate claims experience of the group insurance policy or contract. "Loss information" includes the amount of premium received, the amount of claims paid and the loss ratio. "Loss information" does not include any information or data pertaining to the medical diagnosis, treatment or health status that identifies an individual covered under the group contract or policy. [1995, c. 71, §2 (NEW).]

C. "Loss ratio" means the ratio between the amount of premium received and the amount of claims paid by the insurer under the group insurance contract or policy. [1995, c. 71, §2 (NEW).]

[1995, c. 71, §2 (NEW) .]

2. Disclosure of basic loss information. Upon written request, every insurer shall provide loss information concerning a group policy or contract to its policyholder, to a former policyholder or to a school administrative unit pursuant to Title 20-A, section 1001, subsection 14, paragraph E within 21 business days of the date of the request. This subsection does not apply to a former policyholder whose coverage terminated more than 18 months prior to the date of a request. For the purposes of this subsection, "school administrative unit" has the same meaning as in Title 20-A, section 1, subsection 26.

[2015, c. 420, §2 (AMD) .]

3. Transmittal of request. An insurance producer or other authorized representative who receives a request for loss information in accordance with this section shall transmit the request for loss information to the insurer within 4 business days.

[2001, c. 410, Pt. B, §1 (AMD) .]

4. Exception. An insurer is not required to provide the loss information described in this section for a group that is eligible for small group coverage pursuant to section 2808-B.

[2001, c. 410, Pt. B, §2 (AMD) .]

SECTION HISTORY

1995, c. 71, §2 (NEW). 1997, c. 370, §E5 (AMD). 2001, c. 410, §§B1,2 (AMD). 2003, c. 428, §D1 (AMD). RR 2011, c. 1, §39 (COR). 2011, c. 395, §4 (AMD). 2015, c. 420, §2 (AMD).

§2804. EMPLOYEE GROUPS

A group of individuals may be insured under a policy issued to an employer or to the trustees of a fund established by an employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements. [1981, c. 147, §2 (RPR).]

1. The employees eligible for insurance under the policy must be all of the employees of the employer, or all of any class or classes thereof. The policy may provide that the term "employees" includes the employees of one or more subsidiary corporations and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of the affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term "employees" includes the individual proprietor or partners if the employer is an individual proprietorship or partnership. The policy may provide that the term "employees" includes retired employees and directors of a corporate employer. A policy issued to insure the employees of a public body may provide that the term "employees" includes elected or appointed officials. If authorized by the school boards of the alternative organizational structure's member school administrative units pursuant to Title 20-A, section 1001, an alternative organizational structure established pursuant to Title 20-A, section 1461-B may contract for group health insurance that is offered to all eligible employees and retirees of the alternative organizational structure and its member school administrative units and their dependents in one or more employment classifications.

[2015, c. 420, §3 (AMD) .]

2. The premium for the policy shall be paid either from the employer's funds or from funds contributed by the insured employees, or from both. Except as provided in subsection 3, a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject such coverage in writing.

[1981, c. 147, §2 (RPR) .]

3. Except as provided in section 2736-C, section 2808-B and chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

[1999, c. 256, Pt. G, §1 (AMD) .]

4.

[1981, c. 147, §2 (RP) .]

SECTION HISTORY

1969, c. 132, §1 (NEW). 1969, c. 177, §49 (AMD). 1981, c. 147, §2 (RPR). 1989, c. 867, §§2,10 (AMD). 1999, c. 256, §G1 (AMD). 2015, c. 420, §3 (AMD).

§2804-A. PRIVATE PURCHASING ALLIANCES

A group of individuals may be insured under a policy issued to a private purchasing alliance meeting the requirements of chapter 18-A. [1995, c. 673, Pt. A, §4 (NEW).]

SECTION HISTORY

1995, c. 673, §A4 (NEW).

§2804-B. GROUP DISABILITY INCOME PROTECTION PLAN

An employer may offer its employees an employer-sponsored group disability income protection plan in accordance with the requirements of section 2804. As used in this section, "disability income protection plan" means a group short-term disability policy or a group long-term disability policy instituted by an employer that provides income benefits to an employee who is unable to work for an extended period of time because of sickness or an accident. For the purpose of Title 26, section 629, subsection 1, the premium paid by an employee for an employer-sponsored group disability income protection plan issued pursuant to this section is considered a premium that the employee has agreed to pay if the group disability income protection plan provides for appropriate disclosure regarding the plan chosen by the employer, a method of enrollment that allows employees to opt out of coverage and an appropriate time period for employees to voluntarily terminate coverage. An employee must be provided information regarding the employer-sponsored group disability income protection plan at least 30 days prior and a 2nd time at least 10 days prior to the initial payroll deduction of that employee's premiums. The information provided must include a statement of the employee's right to opt out of coverage, the process by which the employee may exercise the right to opt out of coverage and any deadline to opt out of coverage. [2015, c. 490, §1 (NEW).]

SECTION HISTORY

2015, c. 490, §1 (NEW).

§2805. LABOR UNION GROUPS

A group of individuals may be insured under a policy issued to a labor union or similar employee organization, which shall be deemed to be the policyholder, to insure members of that union or organization for the benefit of persons other than the union or organization or any of its officials, representatives or agents, subject to the following requirements. [1981, c. 147, §3 (RPR).]

1. The members eligible for insurance under the policy shall be all of the members of the union or organization or all of any class or classes thereof.

[1981, c. 147, §3 (RPR) .]

2. The premium for the policy shall be paid either from funds of the union or organization, or from funds contributed by the insured members specifically for their insurance, or from both. Except as provided in subsection 3, a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject such coverage in writing.

[1981, c. 147, §3 (RPR) .]

3. Except as provided in section 2736-C, section 2808-B and chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

[1999, c. 256, Pt. G, §2 (AMD) .]

4.

[1981, c. 147, §3 (RP) .]

SECTION HISTORY

1969, c. 132, §1 (NEW). 1981, c. 147, §3 (RPR). 1989, c. 867, §§3,10 (AMD). 1999, c. 256, §G2 (AMD).

§2805-A. ASSOCIATION GROUPS

A group of individuals may be insured under a policy issued to an association or to a trust or to the trustees of a fund established, created or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of 50 persons; shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least 2 years; and shall have a constitution and bylaws which provides that: The association or associations hold regular meetings not less than annually to further purposes of the members; except for credit unions, the association or associations collect dues or solicit contributions from members; and the members have voting privileges and representation on the governing board and committees. The policy is subject to the following requirements. [1981, c. 147, §4 (NEW).]

1. The policy may insure members of the association or associations, employees thereof or employees of members or one or more of the preceding or all of any class or classes thereof for the benefit of persons other than the employees' employer.

[1981, c. 147, §4 (NEW) .]

2. The premium for the policy shall be paid from funds contributed by the association or associations or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations or employer members.

[1981, c. 147, §4 (NEW) .]

3. Except as provided in subsection 4, a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their insurance must insure all eligible persons, except those who reject that coverage in writing.

[1981, c. 147, §4 (NEW) .]

4. Except as provided in section 2736-C, section 2808-B and chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

[1999, c. 256, Pt. G, §3 (AMD) .]

SECTION HISTORY

1981, c. 147, §4 (NEW). 1989, c. 867, §§4,10 (AMD). 1999, c. 256, §G3 (AMD).

§2806. TRUSTEE GROUPS

A group of individuals may be insured under a policy issued to a trust or to the trustee or trustees of a fund established by 2 or more employers, or by one or more labor unions or similar employee organizations, or by one or more employers and one or more labor unions or similar employee organizations, which trust or trustee or trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements. [1981, c. 147, §5 (RPR).]

1. The persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes thereof. The policy may provide that the term "employees" includes retired employees, the individual proprietor or partners if an employer is an

individual proprietorship or a partnership and directors of a corporate employer. The policy may provide that the term "employees" includes the trustees or their employees, or both, if their duties are principally connected with that trusteeship.

[1981, c. 147, §5 (RPR) .]

2. The premium for the policy shall be paid from funds contributed by the employer or employers of the insured persons or by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and the employer or union or similar employee organization. Except as provided in subsection 3, a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, except those who reject such coverage in writing.

[1981, c. 147, §5 (RPR) .]

3. Except as provided in section 2736-C, section 2808-B and chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

[1999, c. 256, Pt. G, §4 (AMD) .]

4.

[1981, c. 147, §5 (RP) .]

SECTION HISTORY

1969, c. 132, §1 (NEW). 1969, c. 177, §§50,51 (AMD). 1977, c. 655, §2 (AMD). 1981, c. 147, §5 (RPR). 1989, c. 867, §§5,10 (AMD). 1999, c. 256, §4 (AMD).

§2807. DEBTOR GROUPS

A group of individuals may be insured under a policy issued to a creditor, or its parent holding company or to a trustee or trustees or agent designated by 2 or more creditors, which creditor, holding company, affiliate, trustee, trustees or agent shall be deemed the policyholder, to insure debtors of the creditor or creditors, as the case may be, all as defined and set forth under section 2604-A, provided that the amount of indemnity payable with respect to any person insured thereunder shall not at any time exceed the aggregate of the periodic scheduled unpaid installments, including, with respect to mortgage indebtedness, such real estate taxes and insurance costs incident to the mortgaged property as may become due during the scheduled period and provided that nothing in this paragraph may be construed or deemed to apply to or affect disability benefit provisions in group credit life insurance policies as authorized under section 2604-A. [1981, c. 698, §109 (AMD).]

SECTION HISTORY

1969, c. 132, §1 (NEW). 1979, c. 127, §§156-A (AMD). 1981, c. 147, §6 (AMD). 1981, c. 698, §109 (AMD).

§2807-A. CREDIT UNION GROUPS

A group of individuals may be insured under a policy issued to a credit union or to a trustee or trustees or agent designated by 2 or more credit unions, which credit union, trustee, trustees or agent is considered the policyholder, to insure members of the credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee or trustees or agent or any of their officials, subject to the following requirements. [1981, c. 147, §7 (NEW).]

1. The members eligible for insurance are all of the members of the credit union or credit unions or all of any class or classes thereof.

[1981, c. 147, §7 (NEW) .]

2. The premium for the policy shall be paid either from funds of the credit union or from funds contributed by the insured members specifically for their insurance, or from both. Except as provided in subsection 3, a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject the coverage in writing.

[1981, c. 147, §7 (NEW) .]

3. Except as provided in section 2736-C, section 2808-B and chapter 36, an insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer.

[1999, c. 256, Pt. G, §5 (AMD) .]

SECTION HISTORY

1981, c. 147, §7 (NEW). 1989, c. 867, §§6,10 (AMD). 1999, c. 256, §5 (AMD).

§2808. OTHER GROUPS

Group health insurance offered to a resident of this State under a group health insurance policy issued to a group other than one described in sections 2804 to 2807-A is subject to the following requirements.

[1981, c. 147, §8 (RPR).]

1. No group health insurance policy may be delivered in this State, pursuant to this section, unless the superintendent finds that:

A. The policyholder is a bona fide group formed for purposes other than procurement of insurance;

[1987, c. 476, §4 (AMD).]

B. The issuance of the group policy would be actuarially sound; [1981, c. 147, §8 (NEW).]

C. The issuance of the group policy would result in economies of acquisition or administration; and

[1987, c. 476, §4 (AMD).]

D. The benefits are reasonable in relation to the premiums charged. [1981, c. 147, §8 (NEW).]

[1987, c. 476, §4 (AMD) .]

2. No group health insurance coverage may be offered in this State, pursuant to this section, by an insurer under a policy issued in another state, unless the superintendent has made a determination that the requirements of subsection 1, paragraphs A, B, C and D have been met.

[1987, c. 476, §5 (RPR) .]

2-A. Notwithstanding subsections 1 and 2, an employee leasing company registered pursuant to Title 32, chapter 125 qualifies as an eligible group for purposes of the purchase of group health insurance as provided in this section.

[1997, c. 393, Pt. A, §26 (AMD) .]

3. The premium for the policy shall be paid either from the policyholder's funds or from funds contributed by the covered persons, or from both.

[1981, c. 147, §8 (NEW) .]

4. Except as provided in section 2736-C, section 2808-B and chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

[1999, c. 256, Pt. G, §6 (AMD) .]

SECTION HISTORY

1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1981, c. 147, §8 (RPR). 1987, c. 476, §§4,5 (AMD). 1989, c. 867, §§7,10 (AMD). 1995, c. 618, §3 (AMD). 1997, c. 393, §A26 (AMD). 1999, c. 256, §G6 (AMD).

§2808-A. RATING PRACTICES IN GROUP HEALTH INSURANCE

(REPEALED)

SECTION HISTORY

1989, c. 422, §2 (NEW). 1991, c. 353, (AMD). 1991, c. 696, (AMD). 1991, c. 828, §24 (AMD). 1995, c. 332, §B1 (RP).

§2808-B. SMALL GROUP 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 small group 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 small group 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. [1991, c. 861, §2 (NEW).]

B. "Community rate" means the rate to be charged to all eligible groups for small group health plans prior to any adjustments pursuant to subsection 2, paragraphs C and D. [1991, c. 861, §2 (NEW) .]

C. "Eligible employee" means an employee who works on a full-time basis, with a normal work week of 30 hours or more. "Eligible employee" includes a sole proprietor, a partner of a partnership or an independent contractor, but does not include employees who work on a temporary or substitute basis. An employer may elect to treat as eligible employees part-time employees who work a normal work week of 10 hours or more as long as at least one employee works a normal work week of 30 hours or more. An employer may elect to treat as eligible employees employees who retire from the employer's employment. [1999, c. 256, Pt. P, §1 (AMD).]

D. "Eligible group" means any person, firm, corporation, partnership, association or subgroup engaged actively in a business that employed an average of 50 or fewer eligible employees during the preceding calendar year.

(1) If an employer was not in existence throughout the preceding calendar year, the determination must be based on the average number of employees that the employer is reasonably expected to employ on business days in the current calendar year.

(2) In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one employer.

(3) A group is not an eligible group if there is any one other state where there are more eligible employees than are employed within this State and the group had coverage in that state or is eligible for guaranteed issuance of coverage in that state.

(4) An employer qualifies as an eligible group for 2-person coverage if the employer provides a carrier with the following information demonstrating that the employer's business and employees meet the minimum qualifications for group coverage in paragraph C:

(a) A copy of the most recent quarterly combined filing for income tax withholding and unemployment contributions, Form 941/C1-ME;

(b) For an employee claimed to be an employee eligible for group coverage whose name is not listed on Form 941/C1-ME, a copy of the employer's payroll records for the most recent 3 months showing tax withholding or a wage report from a payroll company showing wages paid to that employee for the most recent quarter with tax withholding;

(c) If an employer is exempt from filing Form 941/C1-ME for group coverage, documentation of that exemption and a copy of the employer's payroll records for the most recent 3 months showing tax withholding or a wage report from a payroll company showing wages paid to that employee for the most recent quarter with tax withholding; or

(d) If the name of the business owner or employee does not appear on Form 941/C1-ME, a copy of one of the following:

(i) Federal income tax Form Schedule C or Schedule F;

(ii) Federal income tax Form 1120S, Schedule K-1;

(iii) Federal income tax Form 1065, Schedule K-1;

(iv) A workers' compensation insurance audit or evidence of a waiver of benefits under Title 39-A;

(v) A description of operations in a commercial general liability insurance policy or equivalent insurance policy providing coverage for the business; or

(vi) A signature card from a financial institution or credit union authorizing the employee to sign checks on a business checking or share draft account that is at least 6 months old; a notarized affidavit from the employer describing the duties of the employee and the average number of hours worked by the employee and attesting that the employer is not defrauding the carrier and is aware of the consequences of committing fraud or making a material misrepresentation to the carrier, including a loss of coverage and benefits; and, if the group coverage is purchased through a producer, a notarized affidavit from the producer affirming the producer's belief that the employer qualifies as an eligible group for coverage.

In determining if a new business or a business that adds an owner or a new employee to payroll during the course of a year qualifies as an eligible group for 2-person coverage under this subparagraph, the employer must submit an affidavit stating that all employees meet the criteria in this subparagraph and that the documentation and forms required under this subparagraph will be provided to the carrier when payroll records become available, when ownership distribution forms become available or the first renewal date of the coverage, whichever date is earlier. A false affidavit or misrepresentation on an affidavit submitted by an employer may result in the loss of group coverage and repayment of claims paid. This subparagraph may not be construed to prohibit a carrier from recognizing an employer as an eligible group if the employer has not produced the documentation required in this subparagraph.

This subparagraph applies only to an employer applying for group health insurance coverage as a 2-person group from October 1, 2001 to December 31, 2013. [2011, c. 364, §9 (AMD).]

E. "Late enrollee" means an eligible employee or dependent who requests enrollment in a small group health plan following the initial minimum 30-day enrollment period provided under the terms of the plan, except that, an eligible employee or dependent is not considered a late enrollee if the eligible employee or dependent meets the requirements of section 2849-B, subsection 3, paragraph A, B, C-1 or D. [1997, c. 777, Pt. B, §2 (AMD).]

F. "Premium rate" means the rate charged to an eligible group or eligible individual for a small group health plan. [1991, c. 861, §2 (NEW).]

G. "Small group health plan" means any hospital and medical expense-incurred policy; health, hospital or medical service corporation plan contract; or health maintenance organization subscriber contract covering an eligible group. "Small group 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; or
- (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. [1991, c. 861, §2 (NEW).]

H. "Subgroup" means an employer with 50 or fewer employees within an association, a multiple employer trust, a private purchasing alliance or any similar subdivision of a larger group covered by a single group health policy or contract. For group policies issued to an employee leasing company as defined in Title 32, chapter 125, each client having 50 or fewer employees is considered a separate subgroup. [2009, c. 244, Pt. F, §2 (AMD).]

[2011, c. 364, §9 (AMD) .]

2. Rating practices. The following requirements apply to the rating practices of carriers providing small group health plans. This subsection does not apply to policies issued before January 1, 1998 to eligible groups that employed, on average, 25 to 50 eligible employees until their first renewal date on or after January 1, 1998.

A. [2003, c. 469, Pt. E, §14 (RP).]

B. A carrier may not vary the premium rate due to the gender, health status, claims experience or policy duration of the eligible group or members of the group. [1993, c. 477, Pt. B, §1 (AMD); 1993, c. 477, Pt. F, §1 (AFF).]

C. A carrier may vary the premium rate due to occupation and industry, family membership and participation in wellness programs to the extent permitted by the federal Affordable Care Act. The superintendent may adopt rules setting forth appropriate methodologies regarding rate discounts for participation in wellness programs and rating for occupation and industry pursuant to this paragraph. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [2011, c. 638, §1 (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 October 1, 2011, the rating factor used by a carrier for geographic area may not exceed 1.5. [2011, c. 90, Pt. A, §7 (NEW).]

D. A carrier may vary the premium rate due to age, group size and tobacco use only under the following schedule and within the listed percentage bands.

- (1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 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 September 30, 2011, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.
- (4) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between October 1, 2011 and September 30, 2012, the maximum rate differential due to age filed by the carrier as determined by ratio is 2 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.
- (5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between October 1, 2012 and December 31, 2013, the maximum rate differential due to age and group size filed by the carrier as determined by ratio is 2.5 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 and group size filed by the carrier as determined by ratio is 3 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 between January 1, 2015 and December 31, 2015, the maximum rate differential due to age and group size 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.
- (8) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2016, the maximum rate differential due to age and group size 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.
- (9) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after October 1, 2011, the maximum rate differential due to tobacco use filed by the carrier as determined by ratio is 1.5 to 1. [2011, c. 638, §2 (AMD).]

D-1. [2011, c. 90, Pt. A, §9 (RP).]

D-2. Notwithstanding the requirements of paragraph D, rates with respect to employees whose work site is not in this State may be based on area adjustment factors appropriate to that location. [1997, c. 1, §22 (RAL).]

E. The superintendent may authorize a carrier to establish a separate community rate for an association group organized pursuant to section 2805-A or a trustee group organized pursuant to section 2806, as long as association group membership or eligibility for participation in the trustee group is not conditional on health status, claims experience or other risk selection criteria and all small group health plans offered by the carrier through that association or trustee group:

- (1) Are otherwise in compliance with the premium rate requirements of this subsection; and
- (2) Are offered on a guaranteed issue basis to all eligible employers that are members of the association or are eligible to participate in the trustee group except that a professional association may require that a minimum percentage of the eligible professionals employed by a subgroup be members of the association in order for the subgroup to be eligible for issuance or renewal of coverage through the association. The minimum percentage must not exceed 90%. For purposes of this subparagraph, "professional association" means an association that:
 - (a) Serves a single profession that requires a significant amount of education, training or experience or a license or certificate from a state authority to practice that profession;
 - (b) Has been actively in existence for 5 years;
 - (c) Has a constitution and bylaws or other analogous governing documents;
 - (d) Has been formed and maintained in good faith for purposes other than obtaining insurance;
 - (e) Is not owned or controlled by a carrier or affiliated with a carrier;
 - (g) Has at least 1,000 members if it is a national association; 200 members if it is a state or local association;
 - (h) All members and dependents of members are eligible for coverage regardless of health status or claims experience; and
 - (i) Is governed by a board of directors and sponsors annual meetings of its members.

Producers may only market association memberships, accept applications for membership or sign up members in the professional association where the individuals are actively engaged in or directly related to the profession represented by the professional association.

Except for employers with plans that have grandfathered status under the federal Affordable Care Act, this paragraph 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. [2011, c. 1, §40 (COR) .]

F. Premium rates charged to a private purchasing alliance, as defined by chapter 18-A, may be reduced in accordance with rules adopted pursuant to that chapter. [1995, c. 673, Pt. A, §6 (NEW) .]

G. [2003, c. 469, Pt. E, §15 (RP) .]

H. A carrier that offered small group health plans prior to October 1, 2011 may close its small group book of business sold prior to October 1, 2011 and may establish a separate community rate for eligible groups applying for coverage under a small group health plan on or after October 1, 2011. If a carrier closes its small group book of business as permitted under this paragraph, the carrier may vary the premium rate for that closed book of business only as permitted in this paragraph and paragraphs C and C-1.

- (1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between October 1, 2011 and September 30, 2012, the maximum rate differential due to age filed by the carrier as determined by ratio is 2 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.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between October 1, 2012 and December 31, 2013, the maximum rate differential due to age and group size filed by the carrier as determined by ratio is 2.5 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.

(3) 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 and group size filed by the carrier as determined by ratio is 3 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.

(4) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2015 and December 31, 2015, the maximum rate differential due to age and group size 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.

(5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2016, the maximum rate differential due to age and group size 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.

(6) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after October 1, 2011, the maximum rate differential due to tobacco use filed by the carrier as determined by ratio is 1.5 to 1. [2011, c. 638, §3 (AMD) .]

I. Except for plans that have grandfathered status under the federal Affordable Care Act, beginning January 1, 2014, a carrier shall consider all enrollees in all small group health plans offered by the carrier to be members of a single risk pool to the extent required by the federal Affordable Care Act. [2011, c. 364, §14 (NEW) .]

[2011, c. 90, Pt. A, §10 (AMD); 2011, c. 90, Pt. A, §6 (AMD); 2011, c. 90, Pt. A, §8 (AMD); 2011, c. 638, §§1-3 (AMD) .]

2-A. Rate filings. A carrier offering small group health plans shall file with the superintendent the community rates for each plan and every rate, rating formula and classification of risks and every modification of any formula or classification that it proposes to use.

A. Every filing must state the effective date of the filing. Every 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. The effective date may be suspended by the superintendent for a period of time not to exceed 30 days. [2009, c. 244, Pt. C, §7 (AMD) .]

B. A filing and all supporting information, except for protected health information required to be kept confidential by state or federal statute and except for 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 subsection 2-B, paragraph B or F. [2009, c. 439, Pt. D, §1 (AMD) .]

C. Rates for small group health plans must be filed in accordance with this section and subsections 2-B and 2-C for premium rates effective on or after July 1, 2004, except that the filing of rates for small group health plans are not required to account for any payment or any recovery of that payment pursuant to subsection 2-B, paragraph D and former section 6913 for rates effective before July 1, 2005. [2007, c. 629, Pt. M, §6 (AMD) .]

[2009, c. 244, Pt. C, §7 (AMD); 2009, c. 439, Pt. D, §1 (AMD) .]

2-B. Rate review and hearings. Except as provided in subsection 2-C, rate filings are subject to this subsection.

A. Rates subject to this subsection must be filed for approval by the superintendent. The superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for a small group health plan unless it is anticipated that the aggregate benefits estimated to be paid under all the small group health plans maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least 75% of the aggregate premiums collected for those policies, as determined in accordance with accepted actuarial principles and practices and on the basis of incurred claims experience and earned premiums. For the purposes of this calculation, any payments paid pursuant to former section 6913 must be treated as incurred claims. [2009, c. 244, Pt. G, §2 (AMD).]

B. 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. Hearings held under this subsection must conform to the procedural requirements set forth in Title 5, chapter 375, subchapter 4. 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. [2003, c. 469, Pt. E, §16 (NEW).]

C. When a filing is not accompanied by the information upon which the carrier supports the filing or the superintendent does not have sufficient information to determine whether the filing meets the requirements that rates not be excessive, inadequate or unfairly discriminatory, the superintendent shall require the carrier to furnish the information upon which it supports the filing. [2011, c. 364, §15 (AMD).]

D. A carrier that adjusts its rate shall account for the savings offset payment or any recovery of that savings offset payment in its experience consistent with this section and former section 6913. [2007, c. 629, Pt. M, §8 (AMD).]

E. [2009, c. 244, Pt. C, §8 (RP).]

F. [2009, c. 244, Pt. C, §9 (RP).]

[2007, c. 629, Pt. M, §§7-9 (AMD); 2011, c. 364, §15 (AMD).]

2-C. Guaranteed loss ratio. Notwithstanding subsection 2-B, rate filings for a credible block of small group health plans may be filed in accordance with this subsection instead of subsection 2-B. Rates filed in accordance with this subsection are filed for informational purposes.

A. A block of small group health plans is 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 subsection 2-B. [2011, c. 364, §16 (AMD).]

A-1. [2011, c. 364, §16 (RP).]

B. [2011, c. 364, §16 (RP).]

C. [2011, c. 364, §16 (RP).]

D. [2011, c. 364, §16 (RP).]

E. [2011, c. 364, §16 (RP).]

[2007, c. 629, Pt. M, §10 (AMD); 2011, c. 90, Pt. D, §4 (AMD); 2011, c. 364, §16 (AMD) .]

3. Coverage for late enrollees. In providing coverage to late enrollees, small group health plan carriers are allowed to exclude or limit coverage for a late enrollee subject to the limitations set forth in section 2849-B, subsection 3.

[1999, c. 256, Pt. L, §1 (AMD) .]

4. Guaranteed issuance and guaranteed renewal. Carriers providing small group health plans must meet the following requirements on issuance and renewal.

A. Any small group health plan offered to any eligible group or subgroup must be offered to all eligible groups that meet the carrier's minimum participation requirements, which may not exceed 75%, to all eligible employees and their dependents in those groups. In determining compliance with minimum participation requirements, eligible employees and their dependents who have existing health care coverage may not be considered in the calculation. If an employee declines coverage because the employee has other coverage, any dependents of that employee who are not eligible under the employee's other coverage are eligible for coverage under the small group health plan. A carrier may deny coverage under a managed care plan, as defined by section 4301-A:

- (1) To employers who have no employees who live, reside or work within the approved service area of the plan; and
- (2) To employers 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. [2001, c. 1, §32 (COR) .]

B. Renewal is guaranteed under section 2850-B. [1997, c. 445, §32 (AFF); 1997, c. 445, §17 (RPR) .]

[2001, c. 1, §32 (COR) .]

5. Cessation of business.

[1997, c. 445, §32 (AFF); 1997, c. 445, §18 (RP) .]

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

A. Each carrier must actively market small group health plan coverage, including any standardized plans required to be offered pursuant to subsection 8-A, to eligible groups in this State. [2009, c. 439, Pt. D, §2 (AMD) .]

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

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

(2) Encouraging or directing eligible groups to seek coverage from another carrier because of any of the rating factors listed in subsection 2. [1991, c. 861, §2 (NEW).]

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 a small group 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. [1991, c. 861, §2 (NEW).]

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. [1991, c. 861, §2 (NEW).]

E. A carrier or representative of the carrier may not induce or otherwise encourage an eligible group to separate or otherwise exclude an employee from small group health plan coverage or benefits. [1991, c. 861, §2 (NEW).]

F. Denial by a carrier of an application for coverage from an eligible group must be in writing and must state the reason or reasons for the denial. [1991, c. 861, §2 (NEW).]

G. The superintendent may establish rules setting forth additional standards to provide for the fair marketing and broad availability of small group health plans in this State. [1991, c. 861, §2 (NEW).]

H. 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 small group health plans in this State, the 3rd-party administrator is subject to this section as if it were a carrier. [1991, c. 861, §2 (NEW).]

I. Notwithstanding any other provision of this section, prior to January 1, 2014, a carrier may choose whether it will offer to groups having only one member coverage under the carrier's individual health policies offered to other individuals in this State in accordance with section 2736-C or coverage under a small group health plan in accordance with this section, or both, but the carrier need not offer to groups of one both small group and individual health coverage. [2011, c. 364, §17 (AMD).]

[2011, c. 364, §17 (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 July 15, 1993. For purposes of this section, all contracts are deemed renewed no later than the next yearly anniversary date of the policy, plan, contract or certificate.

[1995, c. 332, Pt. D, §4 (AMD) .]

8. Standardized plans.

[2001, c. 410, Pt. A, §7 (RP) .]

8-A. Authority of the superintendent. The superintendent may by rule define one or more standardized small group health plans that must be offered by all carriers offering small group health plans in the State. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2009, c. 439, Pt. D, §3 (NEW) .]

9. Reinsurance mechanism. Small group carriers, except nonprofit hospital and medical service organizations, may form a reinsurance pool for the purpose of reinsuring small group risks. This pool may not become operative until the superintendent has approved a plan of operation. The superintendent may approve a plan only after the superintendent determines that the plan is in the public interest and is consistent with this section. The participants in the plan of operation of the pool shall guarantee, without limitation, the solvency of the pool. That guarantee constitutes a permanent financial obligation of each participant on a pro rata basis.

[1993, c. 325, §1 (NEW) .]

SECTION HISTORY

1991, c. 861, §2 (NEW). 1993, c. 325, §1 (AMD). 1993, c. 477, §§B1-3 (AMD). 1993, c. 477, §F1 (AFF). 1993, c. 546, §2 (AMD). 1993, c. 588, §§1,2 (AMD). 1993, c. 645, §A4 (AMD). 1995, c. 177, §2 (AMD). 1995, c. 332, §§D1-4,K2 (AMD). 1995, c. 673, §§A5,6 (AMD). RR 1997, c. 1, §22 (COR). 1997, c. 370, §E6 (AMD). 1997, c. 445, §§12-18 (AMD). 1997, c. 445, §32 (AFF). 1997, c. 777, §B2 (AMD). 1999, c. 256, §§E1,2,L1,P1 (AMD). RR 2001, c. 1, §32 (COR). 2001, c. 258, §§D1,E3,4 (AMD). 2001, c. 400, §1 (AMD). 2001, c. 400, §2 (AFF). 2001, c. 410, §§A3-7 (AMD). 2001, c. 410, §A10 (AFF). 2003, c. 313, §§1,2 (AMD). 2003, c. 428, §H5 (AMD). 2003, c. 469, §§E14-16 (AMD). 2005, c. 121, §§E1,2 (AMD). 2007, c. 629, Pt. M, §§6-10 (AMD). 2009, c. 244, Pt. C, §§7-9 (AMD). 2009, c. 244, Pt. F, §2 (AMD). 2009, c. 244, Pt. G, §2 (AMD). 2009, c. 439, Pt. D, §§1-3 (AMD). RR 2011, c. 1, §40 (COR). 2011, c. 90, Pt. A, §§6-10 (AMD). 2011, c. 90, Pt. D, §4 (AMD). 2011, c. 364, §§9-17 (AMD). 2011, c. 638, §§1-3 (AMD).

§2809. COVERAGE OF FAMILY, DEPENDENTS; CONTINUATION OF COVERAGE

1. Any policy of group health insurance issued pursuant to sections 2804 (employee groups), 2805 (labor union groups), 2805-A (association groups), 2806 (trustee groups), 2807-A (credit union groups) or 2808 (other groups) may include coverage for members of the family or dependents of individuals otherwise insured in such groups.

[1981, c. 147, §9 (AMD) .]

1-A. Any such policy of group health insurance that provides coverage for family members or dependents of individuals in the insured group may not define the terms "family" or "dependent" to exclude from coverage those minor children of any covered individual who do not reside with that individual. Insurers must comply with 42 United States Code, Section 1396g-1.

[1995, c. 418, Pt. C, §3 (AMD) .]

2. Any group health insurance policy which contains provisions for the payment by the insurer of benefits for expenses incurred on account of hospital, nursing, medical or surgical services for members of the family or dependents of an individual in the insured group may provide for the continuation of such benefit provisions, or any part or parts thereof, after the death of such individual.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY

1969, c. 132, §1 (NEW). 1981, c. 147, §9 (AMD). 1985, c. 652, §51 (AMD). 1995, c. 418, §C3 (AMD).

§2809-A. CONVERSION ON TERMINATION OF POLICY OR ELIGIBILITY

1. A group policy issued prior to January 1, 1996, that provides hospital, surgical or major medical expense insurance or any combination thereof, other than a policy that provides benefits for specific diseases or accidental injuries only, must contain a provision that if the insurance on an employee or member ceases because of termination of employment or termination of the policy or any portion of a policy, and the person has been continuously insured for a period of at least 3 months under the group policy or under the group policy and any prior group policy or contract providing similar benefits that it replaces, that person is entitled to have issued to that person by the insurer, without evidence of insurability, an individual policy or, at the insurer's option, a group certificate of health insurance, provided that application is made and the first premium paid to the insurer within 90 days after that termination. At the option of the employee or member, the converted policy may cover the employee or member, the employee or member and the employee or member's dependents or the dependents of the employee or member if, in the latter 2 cases, the dependents have been covered for a period of at least 3 months under the group policy, unless the dependent persons were not eligible for coverage until after the beginning of the 3-month period. The insurer has the option to provide the required coverage upon conversion through either a group or individual policy, and may issue a separate converted policy to cover any dependent. An insurer is not required to provide a conversion privilege if termination of insurance under the group policy occurred because the employee or member failed to pay any required contribution or if any discontinued group coverage is replaced by continuous and substantially similar group coverage within 31 days.

[1995, c. 332, Pt. A, §8 (AMD) .]

1-A. Notification of cancellation. An insurer may not cancel or refuse to renew any policy for hospital, surgical, dental or major medical expense insurance until the insurer has provided by first class mail at least 10 days' prior notification according to this section. The notice must include the date of cancellation of coverage and, if applicable, the time period for exercising policy conversion rights. The notice also must include an explanation of any applicable grace period. Notification is not required when the insurer has received written notice from the group policyholder that replacement coverage has been obtained.

A. Notice must be mailed to the group policyholder or subgroup sponsor. [1995, c. 625, Pt. A, §25 (RPR) .]

B. [2003, c. 156, §2 (RP) .]

B-1. At the time of notification under paragraph A, notice must be mailed to the certificate holder at the last address provided to the insurer by the subgroup sponsor, the group policyholder or the certificate holder. If the insurer does not have an address on file for the certificate holder, the notice must be mailed to the office of the subgroup sponsor, if any, or the group policy holder. The notice must also include information to the certificate holder about the availability of individual coverage as described in subsection 1-B. [2003, c. 428, Pt. B, §2 (AMD) .]

B-2. All notices of cancellation sent to certificate holders pursuant to paragraph B-1 must include a toll-free telephone number that certificate holders can call to determine if the policy has been cancelled for nonpayment of premium or if the policy has been reinstated because the premium has been paid. [2009, c. 439, Pt. A, §1 (NEW) .]

C. [2003, c. 428, Pt. B, §2 (RP) .]

[2009, c. 439, Pt. A, §1 (AMD) .]

1-B. Notification of availability of individual coverage. An insurer shall provide forms to group policyholders, and certificate holders when required by subsection 1-A, for the purpose of informing terminating group members of their right to purchase any individual health plan available in this State. An adequate supply of forms must be provided to each group policyholder when the policy is issued and at least annually after the policy is issued. The superintendent may prescribe the content of the form by routine technical rule pursuant to Title 5, chapter 375, subchapter 2-A. The form must include at least the following:

- A. A statement that all state residents not eligible for Medicare have a right to purchase any individual health plan available in this State; [1997, c. 604, Pt. B, §3 (NEW).]
- B. A statement that in order to avoid a gap in coverage, the individual should apply for individual coverage prior to termination of group coverage; [1997, c. 604, Pt. B, §3 (NEW).]
- C. A statement that if more than 90 days pass between the time the group coverage ends and the time individual coverage begins, the individual coverage may exclude preexisting conditions for one year; and [1997, c. 604, Pt. B, §3 (NEW).]
- D. A statement that information concerning individual coverage is available from the Bureau of Insurance. The bureau's toll-free telephone number must also be provided. [1997, c. 604, Pt. B, §3 (NEW).]

[2007, c. 199, Pt. F, §1 (AMD) .]

2. If a conversion privilege is applicable pursuant to subsection 1, it must also be available:

- A. Upon the death of an employee or member, to the surviving spouse with respect to the spouse and the children whose coverage terminates by reason of that death, or if there is no surviving spouse to each surviving child whose coverage so terminates. If the group policy provides for continuation of dependents' coverage upon the death of the employee or member, the conversion privilege must be made available at the end of that continuation; [1995, c. 332, Pt. A, §10 (AMD).]
- B. To the spouse of a member or employee upon termination of coverage by reason of ceasing to be a qualified family member under the group policy whether by divorce or otherwise, whether or not the employee or member remains insured, with respect to the spouse and the children whose coverage terminates at the same time; [1981, c. 606, §2 (NEW).]
- C. To a child upon termination of coverage by reason of ceasing to be a qualified family member under the group policy if a conversion privilege is not otherwise provided with respect to that child in this subsection; or [1995, c. 332, Pt. A, §10 (AMD).]
- D. To an employee or member whose coverage would otherwise continue under the group policy upon retirement prior to eligibility for coverage under Medicare, "United States Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, Public Law 89-97, as amended, at the option of that employee or member in lieu of continued coverage under the group policy. [1981, c. 606, §2 (NEW).]

[1995, c. 332, Pt. A, §10 (AMD) .]

3. The insurer shall not be required to issue a converted policy covering an otherwise eligible person:

A. If:

- (1) That person is eligible for Medicare; or
- (2) That person:
 - (a) Is covered for similar benefits by any other plan or program;
 - (b) Is eligible for similar benefits under any group coverage arrangement whether on an insured or uninsured basis; or
 - (c) Has similar benefits provided for or available to him pursuant to requirements of any state or federal law; and [1981, c. 606, §2 (NEW).]

B. The benefits as described in paragraph A, subparagraph 2, division (a) (b) or (c) provided for or available to the person together with the benefits provided by the converted policy would result in overinsurance according to standards which have been filed by the insurer prior to denial of coverage and approved by the superintendent. [1981, c. 606, §2 (NEW).]

[1981, c. 606, §2 (NEW) .]

3-A. Policies issued or renewed on or after January 1, 1996. An insurer that offers individual health plans pursuant to section 2736-C is permitted, but not required, to include a conversion privilege in group policies issued or renewed on or after January 1, 1996. If the insurer does include a conversion privilege in those policies, individuals exercising these rights must be offered a choice of any individual health plan offered by the insurer. An insurer that does not offer individual health plans pursuant to section 2736-C may not include a conversion privilege in group policies issued or renewed on or after January 1, 1996.

[1995, c. 332, Pt. A, §11 (NEW) .]

4. The premium on the converted policy must be determined in accordance with premium rates applicable to individually underwritten standard risks for the age and class of risk of each person to be covered and the type and amount of insurance provided. Experience under converted policies is not an acceptable basis for establishing rates for converted policies, except to the extent permitted by rules adopted by the superintendent.

The superintendent may establish maximum rates by rule for standard benefit options.

Maximum rates do not apply if all of the following conditions are met:

A. Conversion is provided through a form that is also issued to members of the general public applying for an individual health plan pursuant to section 2736-C; [1995, c. 332, Pt. A, §12 (AMD) .]

B. The rates for that form comply with section 2736-C; and [1995, c. 332, Pt. A, §12 (AMD) .]

C. The rates have been filed pursuant to section 2736. [1991, c. 668, §2 (NEW) .]

[1995, c. 332, Pt. A, §12 (AMD) .]

5. The effective date of the converted policy shall be the date of termination of the individual's insurance under the group policy.

[1981, c. 606, §2 (NEW) .]

6. A converted policy issued under this section must conform to rules adopted by the superintendent. These rules must ensure that continuity of coverage with similar benefits as determined by the superintendent is offered. The rules must also specify plans with more limited benefits that must be offered, but may not require an insurer to provide benefits in excess of those provided under the group policy from which conversion is made.

[1991, c. 668, §2 (AMD) .]

7. Notice. Notice of the conversion privilege, if one is applicable, must be included in each certificate of coverage.

[1995, c. 332, Pt. A, §13 (AMD) .]

8. A converted policy issued pursuant to this section which is delivered outside this State may be on such form as the insurer may then be offering for that conversion in the jurisdiction where the delivery is to be made.

[1981, c. 606, §2 (NEW) .]

9. Refusal to renew. A policy issued pursuant to the conversion privilege provided by this section may provide that the insurer may refuse to renew the policy or coverage of any person insured only as permitted by section 2736-C.

A. [1995, c. 332, Pt. A, §13 (RP).]

B. [1995, c. 332, Pt. A, §13 (RP).]

[1995, c. 332, Pt. A, §13 (AMD) .]

10. Additional conversion period for injured workers.

[1995, c. 332, Pt. A, §14 (RP) .]

11. Continued group coverage; certain circumstances. Notwithstanding this section, if the termination of an individual's group insurance coverage is for one of the reasons listed in paragraph A-1, the insurer shall allow the member or employee to elect, within the time period prescribed by paragraph B, to continue coverage under the group policy at no higher level than the level of benefits or coverage received by the employee immediately before termination and at the member's or employee's expense or, at the member's or employee's option, to convert to a policy of individual coverage without evidence of insurability in accordance with this section.

A. For the purposes of this subsection, the term "member or employee" includes only those persons who have been a member or employee for at least 6 months. [1985, c. 684, §2 (NEW).]

A-1. A member or employee is eligible for continued coverage under this section only if the member or employee's group insurance coverage terminated for one of the following reasons:

- (1) The member or employee was temporarily laid off;
- (2) The member or employee was permanently laid off on or after the effective date of this paragraph and is eligible for premium assistance pursuant to federal law providing premium assistance for laid-off employees who continue coverage under their former employer's group health plan as determined by the superintendent; or
- (3) The member or employee lost employment because of an injury or disease that the employee claims to be compensable under former Title 39 or Title 39-A. [2009, c. 574, §1 (NEW) .]

B. [1989, c. 447, §2 (RP).]

B-1. The member or employee has 31 days from the termination of coverage in which to elect and make the initial payment under this subsection. [1991, c. 885, Pt. E, §30 (AMD); 1991, c. 885, Pt. E, §47 (AFF).]

C. An insurer is not required to continue coverage under a group policy if the member or employee meets the conditions set out in subsection 3, paragraph A. [1985, c. 684, §2 (NEW).]

D. The payment amount for continued group coverage under this subsection may not exceed 102% of the group rate in effect for a group member, including an employer's contribution, if any. [1987, c. 25, §3 (AMD) .]

E. At the option of the member or employee, the continued group coverage may cover the member or employee, the member or employee and any dependents or only the dependents of the member or employee; provided that, in the latter 2 cases, the dependents have been covered for a period of at least 3 months under the group policy, unless the dependents were not eligible for coverage until after the beginning of the 3-month period. [1989, c. 447, §2 (AMD).]

F. Except as provided in paragraph G, coverage provided under this section continues and may not be terminated until one year from the last day of work. [1991, c. 885, Pt. E, §30 (AMD); 1991, c. 885, Pt. E, §47 (AFF).]

G. Coverage provided under this section may be terminated sooner than provided under paragraph F if:

- (1) The member or employee fails to make timely payment of a required premium amount;
- (2) The member or employee becomes eligible for coverage under another group policy; or
- (3) The Workers' Compensation Board determines that the injury or disease that entitles the employee to continue coverage under this section is not compensable under Title 39-A. [1991, c. 885, Pt. E, §30 (AMD); 1991, c. 885, Pt. E, §47 (AFF).]

H. At the expiration of any continued group coverage obtained under this subsection, the member or employee has the same conversion privileges as otherwise granted under this section. [1985, c. 684, §2 (NEW).]

I. This subsection may not be construed to:

- (1) Prevent members or employees from negotiating for or receiving greater continued coverage of group insurance than is provided in this subsection;
- (2) Require coverage beyond the time limit set in paragraph F; or
- (3) Permit an employee to increase the level of benefits or coverage that the employee received immediately before the termination of the employee's coverage. [1991, c. 885, Pt. E, §30 (AMD); 1991, c. 885, Pt. E, §47 (AFF).]

J. This subsection does not apply to any group policy subject to the United States Consolidated Omnibus Budget Reconciliation Act, Public Law 99-272, Title X, Private Health Insurance Coverage, Sections 10001 to 10003. [1987, c. 25, §4 (NEW).]

[2009, c. 574, §1 (AMD) .]

12. This section applies to all policies issued in other states to the extent they cover employees whose primary workplace is in this State.

[1991, c. 668, §3 (NEW) .]

SECTION HISTORY

1981, c. 606, §2 (NEW). 1983, c. 91, §2 (AMD). 1985, c. 684, §2 (AMD). 1987, c. 25, §§3,4 (AMD). 1989, c. 447, §2 (AMD). 1991, c. 668, §§2,3 (AMD). 1991, c. 822, §§3,4 (AMD). 1991, c. 822, §6 (AFF). 1991, c. 885, §§E29,30 (AMD). 1991, c. 885, §E47 (AFF). 1995, c. 189, §2 (AMD). 1995, c. 189, §4 (AFF). 1995, c. 332, §§A8-14 (AMD). 1995, c. 625, §A25 (AMD). 1997, c. 604, §B3 (AMD). 2003, c. 156, §§2-4 (AMD). 2003, c. 428, §B2 (AMD). 2007, c. 199, Pt. F, §1 (AMD). 2009, c. 439, Pt. A, §1 (AMD). 2009, c. 574, §1 (AMD).

§2810. GROUP HEALTH INSURANCE PAYMENTS; BENEFICIARIES

The benefits payable under any policy or contract of group health insurance shall be payable to the employee or other insured member of the group or to some beneficiary or beneficiaries designated by him, other than the employer or the association or any officer thereof as such; but if there is no designated

beneficiary as to all or any part of the insurance at the death of the employee or member, then the amount of insurance payable for which there is no designated beneficiary shall be payable to the estate of the employee or member, except that the insurer may in such case, at its option, pay such insurance to any one or more of the following surviving relatives of the employee or member: Wife, husband, mother, father, child or children, brothers or sisters; and except that payment of benefits for expenses incurred on account of hospitalization or medical or surgical aid, as provided in section 2811, may be made by the insurer to the hospital or other person or persons furnishing such aid. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid. [1969, c. 132, §1 (NEW).]

SECTION HISTORY

1969, c. 132, §1 (NEW).

§2811. PAYMENT OF EXPENSES

Any policy or contract of group health insurance may include provisions for the payment by the insurer of benefits for expenses incurred, by the employee or other member of the insured group, on account of hospitalization or medical or surgical aid for himself, his spouse, his child or children, or other persons chiefly dependent upon him for support and maintenance. [1969, c. 132, §1 (NEW).]

SECTION HISTORY

1969, c. 132, §1 (NEW).

§2812. READJUSTMENT OF PREMIUM RATE

(REPEALED)

SECTION HISTORY

1969, c. 132, §1 (NEW). 1969, c. 177, §52 (AMD). 1991, c. 200, §D3 (RP).

§2812-A. DIVIDENDS AND EXPERIENCE REFUNDS

The following requirements apply to all group health insurance with the exception of insurance in which the policyholder is subject to the fiduciary standards of the federal Employee Retirement Income Security Act of 1974, ERISA, 29 United States Code, Section 1001-1381 (1975). [1991, c. 200, Pt. D, §4 (NEW).]

1. Refunds. The amount by which any dividend, experience refund or rate reduction exceeds the amount of premium contributed by the group policyholder for the same period must be refunded to the employees, members or debtors in proportion to their premium contributions for that period, except as provided in subsection 2.

[1991, c. 200, Pt. D, §4 (NEW) .]

2. Refund amounts less than \$25 per employee, member or debtor. If the refunds required by subsection 1 would average less than \$25 per employee, member or debtor, then the group policyholder may request approval from the superintendent to apply those amounts in a different manner. The superintendent shall approve the request if, in the superintendent's opinion, the manner of application proposed would be for the sole benefit of insured employees, members or debtors.

[1991, c. 200, Pt. D, §4 (NEW) .]

SECTION HISTORY

1991, c. 200, §D4 (NEW).

§2813. "BLANKET HEALTH INSURANCE" DEFINED

Blanket health insurance is hereby declared to be that form of health insurance covering groups of persons as enumerated in one of the following paragraphs: [1969, c. 132, §1 (NEW) .]

1. Under a policy or contract issued to any common carrier or to any operator, owner or lessee of a means of transportation, who or which shall be deemed the policyholder, covering a group of persons who may become passengers defined by reference to their travel status on such common carrier or such means of transportation.

[1969, c. 132, §1 (NEW) .]

2. Under a policy or contract issued to an employer, who shall be deemed the policyholder, covering any group of employees, dependents or guests, defined by reference to specified hazards incident to an activity or activities or operations of the policyholder.

[1969, c. 132, §1 (NEW) .]

3. Under a policy or contract issued to a college, school or other institution of learning, a school district or districts, or school jurisdictional unit, or to the head, principal or governing board of any such educational unit, who or which shall be deemed the policyholder, covering students, teachers, or employees.

[1969, c. 132, §1 (NEW) .]

4. Under a policy or contract issued to any religious, charitable, recreational, educational, or civic organization, or branch thereof, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder.

[1969, c. 132, §1 (NEW) .]

5. Under a policy or contract issued to a sports team, camp or sponsor thereof, which shall be deemed the policyholder, covering members, campers, employees, officials or supervisors.

[1969, c. 132, §1 (NEW) .]

6. Under a policy or contract issued to any volunteer fire department or first aid, emergency management or other such volunteer organization, which is deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by the policyholder.

[2013, c. 462, §3 (AMD) .]

7. Under a policy or contract issued to a newspaper or other publisher, which shall be deemed the policyholder, covering its carriers.

[1969, c. 132, §1 (NEW) .]

8. Under a policy or contract issued to an association, including a labor union, which has a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder.

[1969, c. 132, §1 (NEW) .]

9. Under a policy or contract issued to cover any other risk or class of risks which, in the discretion of the superintendent, may be properly eligible for blanket health insurance. The discretion of the superintendent may be exercised on an individual risk basis or class of risks, or both.

[1973, c. 585, §12 (AMD) .]

Policies that otherwise meet the description of group policies pursuant to section 2804, 2805, 2805-A, 2806, 2807, 2807-A or 2808-B are not blanket policies. [2011, c. 238, Pt. B, §1 (NEW).]

SECTION HISTORY

1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 2011, c. 238, Pt. B, §1 (AMD). 2013, c. 462, §3 (AMD).

§2814. BLANKET HEALTH INSURANCE -- PAYMENTS; BENEFICIARIES

All benefits under any blanket health insurance policy shall be payable to the person insured, or to his designated beneficiary or beneficiaries, or to his estate, as shall be specified in the policy, except that if the person insured be a minor, such benefits may be made payable to his parent, guardian or other person actually supporting him, or to a person or persons chiefly dependent upon him for support and maintenance. [1969, c. 132, §1 (NEW).]

SECTION HISTORY

1969, c. 132, §1 (NEW).

§2815. LEGAL LIABILITY OF POLICYHOLDERS

Nothing contained in this chapter shall be deemed to affect the legal liability of policyholders for the death of or injury to any member of any such group. [1969, c. 132, §1 (NEW).]

SECTION HISTORY

1969, c. 132, §1 (NEW).

§2816. REQUIREMENTS

No policy of group or blanket health insurance shall, except as provided in section 2829, be delivered or issued for delivery in this State, unless the policy contains in substance each and all of the provisions set forth in sections 2817 to 2828, or provisions which in the opinion of the superintendent are more favorable to the holders of such certificates or not less favorable to the holders of such certificates and more favorable to policyholders. Insurers offering policies under this chapter shall offer to certificate holders the right of review and arbitration set forth in section 2747, subsection 1, with respect to denials of medical expense reimbursement benefits based upon the grounds set forth in section 2747, subsection 2, except that the requirement of section 2747, subsection 1 shall not apply to certificate holders in groups subject to the United States Employee Retirement Income Security Act of 1974, Public Law 93-406, as amended, or to any policy or certificate holder to whom the insurer voluntarily extends a review similar to that which it provides to persons insured under group policies subject to that Act. [1981, c. 698, §110 (AMD).]

SECTION HISTORY

1969, c. 132, §1 (NEW). 1969, c. 177, §53 (AMD). 1981, c. 205, §3 (AMD). 1981, c. 698, §110 (AMD).

§2817. APPLICANT'S STATEMENTS; WAIVERS, AMENDMENTS

There shall be a provision that no statement made by the applicant for insurance shall avoid the insurance or reduce benefits thereunder unless contained in the written application signed by the applicant; and a provision that no agent has authority to change the policy or to waive any of its provisions; and that no change

in the policy shall be valid unless approved by an officer of the insurer and evidenced by indorsement on the policy, or by amendment to the policy signed by the policyholder and the insurer. [1969, c. 132, §1 (NEW).]

SECTION HISTORY

1969, c. 132, §1 (NEW).

§2818. STATEMENTS IN APPLICATION

There shall be a provision that all statements contained in any such application for insurance shall be deemed representations and not warranties. [1969, c. 132, §1 (NEW).]

SECTION HISTORY

1969, c. 132, §1 (NEW).

§2819. NEW EMPLOYEES, MEMBERS

There shall be a provision that all new employees or new members, as the case may be, in the groups or classes eligible for such insurance must be added to such groups or classes for which they are respectively eligible. [1969, c. 132, §1 (NEW).]

SECTION HISTORY

1969, c. 132, §1 (NEW).

§2820. RENEWAL OF POLICY

There shall be a provision stating the conditions under which the insurer may decline to renew the policy. [1969, c. 132, §1 (NEW).]

SECTION HISTORY

1969, c. 132, §1 (NEW).

§2821. INDIVIDUAL CERTIFICATES

Except in the case of blanket health insurance, a provision that the insurer shall issue to the policyholder, for delivery to each member of the insured group, an individual certificate or printed information setting forth in summary form a statement of the essential features of the insurance coverage of such employee or such member and in substance the provisions of sections 2821 to 2828. The insurer shall also provide for distribution by the policyholder to each member of the insured group a statement, where applicable, setting forth to whom the benefits under such policy are payable. If dependents are included in the coverage, only one certificate or printed summary need be issued for each family unit. [1975, c. 183, §2 (AMD).]

SECTION HISTORY

1969, c. 132, §1 (NEW). 1969, c. 177, §54 (AMD). 1975, c. 183, §2 (AMD).

§2822. AGE LIMITS

There shall be a provision specifying the ages, if any there be, to which the insurance provided therein shall be limited; and the ages, if any there be, for which additional restrictions are placed on benefits and the additional restrictions placed on the benefits at such ages. [1969, c. 132, §1 (NEW).]

SECTION HISTORY

1969, c. 132, §1 (NEW).

§2823. NOTICE OF CLAIM

There shall be a provision that written notice of sickness or of injury must be given to the insurer within 30 days after the date when such sickness or injury occurred. Failure to give notice within such time shall not invalidate nor reduce any claim, if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. [1969, c. 132, §1 (NEW).]

SECTION HISTORY

1969, c. 132, §1 (NEW).

§2823-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: [2009, c. 244, Pt. B, §2 (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;

[2009, c. 244, Pt. B, §2 (AMD) .]

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

[1989, c. 556, Pt. D, §3 (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.

[1989, c. 556, Pt. D, §3 (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. [2009, c. 244, Pt. B, §2 (AMD) .]

SECTION HISTORY

1989, c. 556, §D3 (NEW). 2009, c. 244, Pt. B, §2 (AMD).

§2823-B. STANDARDIZED CLAIM FORMS

All insurers providing group 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 health care practitioner must accept the current standardized claim form for professional services approved by the Federal Government and submitted electronically. All insurers providing group 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. [2005, c. 97, §3 (AMD).]

SECTION HISTORY

1993, c. 477, §D11 (NEW). 1993, c. 477, §F1 (AFF). 2003, c. 218, §7 (AMD). 2003, c. 469, §D7 (AMD). 2003, c. 469, §D9 (AFF). 2005, c. 97, §3 (AMD).

§2824. PROOF OF LOSS

There shall be a provision that in the case of claim for loss of time for disability, written proof of such loss must be furnished to the insurer within 30 days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss, written proof of such loss must be furnished to the insurer within 90 days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim, if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible. [1969, c. 132, §1 (NEW).]

SECTION HISTORY

1969, c. 132, §1 (NEW).

§2825. FORMS FOR PROOF OF LOSS

There shall be a provision that the insurer will furnish to the policyholder such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of 15 days after the insurer received notice of any claim under the policy, the person making such claim shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made. [1969, c. 132, §1 (NEW).]

SECTION HISTORY

1969, c. 132, §1 (NEW).

§2826. EXAMINATION, AUTOPSY

There shall be a provision that the insurer shall have the right and opportunity to examine the person of the insured when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy in case of death where it is not prohibited by law. [1969, c. 132, §1 (NEW).]

SECTION HISTORY

1969, c. 132, §1 (NEW).

§2827. TIME FOR PAYMENT OF BENEFITS

There shall be a provision that all benefits payable under the policy, other than benefits for loss of time, will be payable not more than 60 days after receipt of proof, and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time will be paid not later than at the expiration of each period of 30 days during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof. [1969, c. 132, §1 (NEW).]

SECTION HISTORY

1969, c. 132, §1 (NEW).

§2827-A. ASSIGNMENT OF BENEFITS

All policies and certificates 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 or certificate. [1999, c. 21, §3 (AMD).]

SECTION HISTORY

1997, c. 604, §E3 (NEW). 1999, c. 21, §3 (AMD).

§2828. TIME FOR SUITS

There shall be a provision that no action at law or in equity shall be brought to recover on the policy prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of the policy and that no such action shall be brought at all, unless brought within 2 years from the expiration of the time within which proof of loss is required by the policy. [1969, c. 132, §1 (NEW).]

SECTION HISTORY

1969, c. 132, §1 (NEW).

§2829. EXCEPTIONS

1. Any portion of any such policy, delivered or issued for delivery in this State, which purports, by reason of the circumstances under which a loss is incurred, to reduce any benefits promised thereunder to an amount less than that provided for the same loss occurring under ordinary circumstances, shall be printed in such policy and in each certificate issued thereunder, in bold face type and with greater prominence than any other portion of the rest of such policy or certificate, respectively; and all other exceptions of the policy shall be printed in the policy and certificate with the same prominence as the benefits to which they apply.

[1969, c. 132, §1 (NEW) .]

2. If any such policy contains any provision which affects the liability of the insurer because of any violation of law by the insured during the term of the policy, it shall be in the following form: The insurer shall not be liable for death, injury incurred or disease contracted, to which a contributing cause was the insured's commission of or attempt to commit a felony, or which occurs while the insured is engaged in an illegal occupation.

[1969, c. 132, §1 (NEW) .]

3. If any such policy contains any provision which affects the liability of the insurer because of the insured's use of intoxicating liquor or narcotics or hallucinogenic drugs during the term of the policy, it shall be in the following form: The insurer shall not be liable for death, injury incurred or disease contracted while the insured is intoxicated or under the influence of narcotics or hallucinogenic drugs unless administered on the advice of a physician.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY

1969, c. 132, §1 (NEW).

§2829-A. DISABILITY BENEFIT OFFSETS

1. Disclosure to persons eligible for coverage. For any policy or contract subject to this chapter that provides disability income benefits, if the benefits under that policy or contract are subject to reduction due to other sources of income, then the insurer shall include in any written enrollment material and certificate of coverage developed by the insurer that is intended to be distributed to persons eligible for coverage under the policy or contract a clear and conspicuous notice that accurately explains all types of other sources of income that may result in a reduction of the benefits payable under the policy or contract. The notice requirement under this section does not apply to an advertisement intended for the general public.

[2005, c. 42, §2 (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; [2005, c. 42, §2 (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; [2005, c. 42, §2 (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 [2005, c. 42, §2 (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. [2005, c. 42, §2 (NEW) .]

[2005, c. 42, §2 (NEW) .]

SECTION HISTORY

2003, c. 321, §2 (NEW). 2005, c. 42, §2 (RPR).

§2830. OMISSIONS, MODIFICATIONS: SUPERINTENDENT MAY APPROVE

The superintendent may approve any form of group or blanket health insurance policy, or any form of certificate or printed information to be issued under such policy, which omits or modifies any of the provisions hereinbefore required, if he deems such omission or modification suitable for the character of such insurance and not unjust to the persons insured thereunder. [1973, c. 585, §12 (AMD) .]

SECTION HISTORY

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

§2831. HOSPITAL, MEDICAL BENEFITS -- DIRECT PAYMENT

Any such group or blanket policy may include benefits payable on account of hospital or medical or surgical aid for an employee or other member of the group insured by such policy, his or her spouse, child or children or other dependents, and may provide that, at the insured's option, any such benefits be paid by the insurer directly to the hospital, physician, surgeon doctor, nurse or other person furnishing services covered by such provisions of the policy. [1987, c. 219, (AMD) .]

SECTION HISTORY

1969, c. 132, §1 (NEW). 1987, c. 219, (AMD).

§2832. MATERNITY BENEFITS FOR UNMARRIED WOMEN CERTIFICATE HOLDERS AND THE MINOR DEPENDENTS OF CERTIFICATE HOLDERS WITH DEPENDENT OR FAMILY COVERAGE REQUIRED

All group or blanket health insurance policies, contracts and certificates shall provide the same maternity benefits for unmarried women certificate holders, and the minor dependents of certificate holders with dependent or family coverage, as is provided married certificate holders with maternity coverage and the wives of certificate holders with maternity coverage. This requirement applies to all group or blanket insurance written or renewed after the effective date of this Act, and includes, but is not limited to, all types and forms of group insurance issued by individual companies or corporations. [2003, c. 517, Pt. B, §11 (AMD).]

SECTION HISTORY

1975, c. 276, §3 (NEW). 1975, c. 428, §3 (NEW). 1975, c. 471, §2 (NEW). 1975, c. 562, (NEW). 1975, c. 770, §§105-107 (RP). 1979, c. 663, §146 (AMD). 2003, c. 517, §B11 (AMD).

§2832-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 certificate holder who:

A. Is a mentally competent adult as is the certificate holder; [2001, c. 347, §3 (NEW); 2001, c. 347, §5 (AFF).]

B. Has been legally domiciled with the certificate holder for at least 12 months; [2001, c. 347, §3 (NEW); 2001, c. 347, §5 (AFF).]

C. Is not legally married to or legally separated from another individual; [2001, c. 347, §3 (NEW); 2001, c. 347, §5 (AFF).]

D. Is the sole partner of the certificate holder and expects to remain so; and [2001, c. 347, §3 (NEW); 2001, c. 347, §5 (AFF).]

E. Is jointly responsible with the certificate holder for each other's common welfare as evidenced by joint living arrangements, joint financial arrangements or joint ownership of real or personal property. [2001, c. 347, §3 (NEW); 2001, c. 347, §5 (AFF).]

[2001, c. 347, §3 (NEW); 2001, c. 347, §5 (AFF) .]

2. Mandated offer of domestic partner benefits. All group or blanket health insurance policies or contracts issued by any insurer operating pursuant to this chapter must make available to group policyholders the option for additional benefits for the domestic partner of a certificate holder, at appropriate rates and under the same terms and conditions as those benefits or options for benefits are provided to spouses of married certificate holders covered under a group policy.

[2001, c. 347, §3 (NEW); 2001, c. 347, §5 (AFF) .]

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

[2001, c. 347, §3 (NEW); 2001, c. 347, §5 (AFF) .]

4. Evidence of domestic partnership. As a condition of eligibility for coverage, an insurer or group policyholder may require a certificate holder and the certificate holder's domestic partner to sign an affidavit attesting that the certificate holder and the certificate holder'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.

[2001, c. 347, §3 (NEW); 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 certificate holder.

[2001, c. 347, §3 (NEW); 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 certificate holder upon notification by the certificate holder that the domestic partner relationship has terminated. A certificate holder may not enroll another individual as a domestic partner under a group contract until 12 months after the termination of coverage for a prior domestic partner.

[2001, c. 347, §3 (NEW); 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.

[2001, c. 347, §3 (NEW); 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.

[2001, c. 347, §3 (NEW); 2001, c. 347, §5 (AFF) .]

SECTION HISTORY

2001, c. 347, §3 (NEW). 2001, c. 347, §5 (AFF).

§2833. 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 certificate holder, member or spouse of the certificate holder or member. [1993, c. 666, Pt. A, §5 (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. [1993, c. 666, Pt. A, §5 (NEW).]

[1993, c. 666, Pt. A, §5 (RPR) .]

2. Coverage. All group or blanket health insurance plans issued in accordance with the requirements of section 2832 must provide unmarried women certificate holders with the option of coverage of their children from the date of birth. A certificate holder who, pursuant to the laws of this State or any other state, has been adjudicated or has acknowledged himself to be the father of an illegitimate child must be given the

option of coverage for that child from the date of his adjudication or acknowledgement of paternity. This optional coverage must be the same as that provided the children of a married certificate holder with family or dependent coverage.

[1991, c. 200, Pt. B, §4 (NEW) .]

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

[1991, c. 200, Pt. B, §4 (NEW) .]

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

[1993, c. 666, Pt. A, §6 (NEW) .]

SECTION HISTORY

1975, c. 276, §3 (NEW). 1979, c. 663, §147 (AMD). 1985, c. 652, §52 (AMD). 1991, c. 200, §B4 (RPR). 1993, c. 666, §§A5,6 (AMD).

§2833-A. EXTENSION OF COVERAGE FOR DEPENDENT CHILDREN

Notwithstanding section 2822, a group 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. [2005, c. 532, §2 (NEW).]

SECTION HISTORY

2005, c. 532, §2 (NEW).

§2833-B. MANDATORY OFFER TO EXTEND COVERAGE FOR DEPENDENT CHILDREN UP TO 25 YEARS OF AGE

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

A. Is unmarried; [2007, c. 115, §2 (NEW); 2007, c. 115, §5 (AFF).]

B. Has no dependent of the child's own; and [2007, c. 514, §6 (AMD).]

C. Is a resident of this State or is enrolled as a full-time student at an accredited public or private institution of higher education. [2007, c. 514, §7 (AMD).]

D. [2007, c. 514, §8 (RP).]

[2007, c. 514, §§6-8 (AMD) .]

2. Offer of coverage. Notwithstanding section 2822, a group health insurance policy that offers coverage for a dependent child must offer such coverage, at the option of the policyholder, until the dependent child is 25 years of age. An insurer may require, as a condition of eligibility for coverage in accordance with this section, that a person seeking coverage for a dependent child provide written documentation on an annual basis that the dependent child meets the requirements in subsection 1.

[2007, c. 514, §9 (AMD) .]

3. Notice.

[2007, c. 514, §10 (NEW); T. 24-A, §2833-B, sub-§3 (RP) .]

SECTION HISTORY

2007, c. 115, §2 (NEW). 2007, c. 115, §5 (AFF). 2007, c. 514, §§6-10 (AMD).

§2834. NEWBORN CHILDREN COVERAGE

All group and blanket health insurance policies and certificates providing coverage on an expense-incurred basis must provide that health insurance benefits are payable for a newly born child of the insured or subscriber from the moment of birth. An adopted child is deemed to be newly born to the adoptive parents from the date of the signed placement agreement. Preexisting conditions of an adopted child may not be excluded from coverage. [2003, c. 517, Pt. A, §5 (AMD); 2003, c. 517, Pt. A, §13 (AFF).]

The coverage for newly born children must consist of coverage of injury or sickness or other benefits provided by the policy, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. [1997, c. 604, Pt. C, §3 (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 2834-A must be paid regardless of whether coverage under this section is elected. [1997, c. 604, Pt. C, §3 (AMD).]

The requirements of this section apply to all policies and certificates delivered or issued for delivery in this State. [2003, c. 517, Pt. A, §6 (AMD); 2003, c. 517, Pt. A, §13 (AFF).]

SECTION HISTORY

1975, c. 770, §108 (NEW). 1993, c. 686, §12 (AMD). 1993, c. 686, §13 (AFF). 1995, c. 332, §N3 (AMD). 1997, c. 604, §C3 (AMD). 2003, c. 517, §§A5,6 (AMD). 2003, c. 517, §A13 (AFF).

§2834-A. MATERNITY AND ROUTINE NEWBORN CARE

An insurer that issues group contracts and certificates 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. [2003, c. 517, Pt. B, §12 (AMD).]

SECTION HISTORY

1995, c. 615, §3 (NEW). 2001, c. 258, §A3 (AMD). 2003, c. 517, §B12 (AMD).

§2834-B. DEPENDENT SPECIAL ENROLLMENT PERIOD

1. Application. This section applies to all group and blanket medical insurance policies issued by nonprofit hospital or medical service organizations, insurers or health maintenance organizations except hospital indemnity, specified accident, specified disease and long-term care policies.

[1997, c. 445, §19 (NEW); 1997, c. 445, §32 (AFF) .]

2. Definition. For purposes of this section, an "eligible individual" is a person who is a certificate holder under the policy or who has met any waiting period applicable to becoming a certificate holder and is eligible to be enrolled under the policy but for a failure to enroll during a previous enrollment period.

[1997, c. 445, §19 (NEW); 1997, c. 445, §32 (AFF) .]

3. Requirement. If a policy makes coverage available with respect to dependents of certificate holders, the policy must provide for a dependent special enrollment period when a person becomes a dependent of an eligible individual through marriage, birth or adoption or placement for adoption, if a court order is issued changing custody of a child or if a dependent who has other coverage loses eligibility under that coverage. During this period, the dependent may be enrolled under the plan as a dependent of the eligible individual and, in the case of the birth or adoption of a child, the spouse of the eligible individual may be enrolled as a dependent if otherwise eligible for coverage. If the eligible individual is not already enrolled or is enrolled in a different benefit package, the individual may enroll during this period.

[2007, c. 199, Pt. A, §1 (AMD) .]

4. Length of period. A dependent special enrollment period under this section must be a period of not less than 30 days and must begin on the latest of:

A. The date dependent coverage is made available; [2007, c. 199, Pt. A, §2 (AMD).]

B. The date of the marriage, birth or adoption or placement for adoption or the date of the court order; and [2007, c. 199, Pt. A, §2 (AMD).]

C. The date a dependent loses other coverage. [2007, c. 199, Pt. A, §2 (NEW).]

[2007, c. 199, Pt. A, §2 (AMD) .]

5. No waiting period. If an individual seeks to enroll a dependent during the first 30 days of a dependent special enrollment period, the coverage of the dependent becomes effective:

A. In the case of marriage, no later than the first day of the first month beginning after the date the completed request for enrollment is received; [1997, c. 445, §19 (NEW); 1997, c. 445, §32 (AFF).]

B. In the case of a dependent's birth, as of the date of the birth; [1999, c. 256, Pt. B, §3 (AMD) .]

C. In the case of a dependent's adoption or placement for adoption, as of the date of the adoption or placement for adoption; [2007, c. 199, Pt. A, §3 (AMD).]

D. In the case of a court order changing custody of a child, as of the date of the order; or [2007, c. 199, Pt. A, §3 (AMD).]

E. In the case of a dependent who loses other coverage, as of the date of application for enrollment. [2007, c. 199, Pt. A, §3 (NEW).]

[2007, c. 199, Pt. A, §3 (AMD) .]

SECTION HISTORY

1997, c. 445, §19 (NEW). 1997, c. 445, §32 (AFF). 1999, c. 256, §§B1-4 (AMD). 2007, c. 199, Pt. A, §§1-3 (AMD).

§2834-C. COMPLIANCE WITH FEDERAL LAW

1. Application. This section applies to all group and blanket medical insurance policies issued by nonprofit hospital or medical service organizations, insurers or health maintenance organizations except hospital indemnity, accidental injury, specified disease and long-term care policies.

[2009, c. 244, Pt. E, §1 (NEW) .]

2. Requirement. Policies subject to this section must comply with the federal Children's Health Insurance Program Reauthorization Act of 2009, Section 311 concerning special enrollment periods in case of termination of coverage under a Medicaid plan or a state child health plan or eligibility for assistance in the purchase of employment-based coverage.

[2009, c. 244, Pt. E, §1 (NEW) .]

SECTION HISTORY

2009, c. 244, Pt. E, §1 (NEW).

§2835. MENTAL HEALTH SERVICES

1. Notwithstanding any provision of a health insurance policy or certificate issued under a group 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.

[2005, c. 683, Pt. A, §40 (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.

[2005, c. 683, Pt. A, §40 (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; [2005, c. 683, Pt. A, §40 (RPR).]

B. A certified social worker licensed for the independent practice of social work in this State; [2005, c. 683, Pt. A, §40 (RPR).]

C. A licensed clinical professional counselor licensed for the independent practice of counseling in this State; [2005, c. 683, Pt. A, §40 (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; [2005, c. 683, Pt. A, §40 (RPR).]

E. A marriage and family therapist licensed as a marriage and family therapist in this State; and [2005, c. 683, Pt. A, §40 (NEW).]

F. A licensed pastoral counselor licensed as a pastoral counselor in this State. [2005, c. 683, Pt. A, §40 (NEW).]

[2005, c. 683, Pt. A, §40 (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 group health care contracts providing coverage for mental health services shall make available 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 policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this subsection, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

[2005, c. 683, Pt. A, §40 (RPR) .]

SECTION HISTORY

1975, c. 770, §108 (NEW). 1979, c. 541, §A165 (AMD). 1983, c. 546, §3 (AMD). 1983, c. 805, §3 (AMD). 1987, c. 80, §3 (AMD). 1995, c. 561, §3 (AMD). 2003, c. 65, §2 (AMD). 2003, c. 65, §5 (AFF). 2003, c. 517, §B13 (AMD). 2005, c. 121, §§I3-5 (AMD). 2005, c. 213, §2 (AMD). 2005, c. 213, §3 (AFF). 2005, c. 214, §2 (AMD). 2005, c. 214, §3 (AFF). 2005, c. 683, §A40 (RPR).

§2836. LIMITS ON PRIORITY LIENS

No group or blanket policy shall provide for priority over the insured member 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 member is entitled to receive payment reimbursement from any other person as a result of legal action or claim, except as provided in this section. [1975, c. 770, §108 (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 member 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 member'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: [1975, c. 770, §108 (NEW).]

1. Legal defenses. Questions of liability and comparative negligence or other legal defenses;

[1975, c. 770, §108 (NEW) .]

2. Exigencies of trial. Exigencies of trial that reduce a settlement or award in order to resolve the claim; and

[1975, c. 770, §108 (NEW) .]

3. Limits of coverage. Limits on the amount of applicable insurance coverage that reduce the claim to an amount recoverable by the insured member.

[1975, c. 770, §108 (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. [1975, c. 770, §108 (NEW) .]

SECTION HISTORY

1975, c. 770, §108 (NEW) .

§2837. HOME HEALTH CARE COVERAGE

Every insurer which issues or issues for delivery in this State group or blanket health insurance policies or plans, which provide coverage on an expense incurred basis for inpatient hospital care, shall make available that coverage for home health care services by a home health care provider. [1977, c. 696, §202 (RPR) .]

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. [1977, c. 470, §3 (NEW) .]

1. Home health care services. "Home health care services" means those health care services rendered in his 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 [1977, c. 470, §3 (NEW) .]

B. The plan covering the home health services is established as prescribed in writing by a physician. [1977, c. 470, §3 (NEW) .]

There shall be no requirement that hospitalization be an antecedent to coverage under the policy.

[1977, c. 470, §3 (NEW) .]

2. Home health care 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; [1977, c. 470, §3 (NEW) .]

B. A physician's home or office visits or both; [1977, c. 470, §3 (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; [1977, c. 470, §3 (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 [1977, c. 470, §3 (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. [1977, c. 470, §3 (NEW).]

[1977, c. 470, §3 (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; [1977, c. 470, §3 (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; [1977, c. 470, §3 (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; [1977, c. 470, §3 (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; [1977, c. 470, §3 (NEW).]

E. Has under contract the services of a physician-advisor licensed by the State or a physician; [1977, c. 470, §3 (NEW).]

F. Conducts periodic case conferences for the purpose of individualized patient care planning and utilization review; and [1977, c. 470, §3 (NEW).]

G. Maintains a complete medical record on each patient. [1977, c. 470, §3 (NEW).]

[1977, c. 470, §3 (NEW) .]

4. Exclusions.

A. No policy shall require home health care coverage to persons eligible for medicare; and [1977, c. 470, §3 (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. [1977, c. 470, §3 (NEW).]

[1977, c. 470, §3 (NEW) .]

SECTION HISTORY

1977, c. 470, §3 (NEW). 1977, c. 696, §202 (AMD).

§2837-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.

[2007, c. 153, §2 (AMD); 2007, c. 153, §5 (AFF) .]

2. Required coverage. All group insurance policies that cover radiologic procedures, except those policies that cover only dental procedures, accidental injury or specific diseases, 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. [1997, c. 408, §8 (AFF); 1997, c. 408, §5 (RP).]

B. [1997, c. 408, §8 (AFF); 1997, c. 408, §5 (RP).]

[1997, c. 408, §8 (AFF); 1997, c. 408, §5 (RPR); 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.

[1991, c. 156, §2 (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.

[1991, c. 701, §9 (AMD) .]

SECTION HISTORY

1989, c. 875, §I6 (NEW). 1991, c. 156, §2 (AMD). 1991, c. 701, §9 (AMD). 1997, c. 408, §5 (AMD). 1997, c. 408, §8 (AFF). 2003, c. 689, §B6 (REV). 2007, c. 153, §2 (AMD). 2007, c. 153, §5 (AFF).

§2837-B. ACUPUNCTURE SERVICES

All group insurance policies and certificates providing coverage for acupuncture must provide coverage for those services when performed by an acupuncturist licensed pursuant to Title 32, chapter 113-B, subchapter 2, under the same conditions that apply to the services of a licensed physician. [2003, c. 517, Pt. B, §14 (AMD).]

SECTION HISTORY

1991, c. 647, §3 (NEW). 1995, c. 671, §10 (AMD). 2003, c. 517, §B14 (AMD).

§2837-C. COVERAGE FOR BREAST CANCER TREATMENT

1. Inpatient care. All group 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, a group 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 group 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.

[2015, c. 227, §3 (AMD); 2015, c. 227, §5 (AFF) .]

2. Reconstruction. All group 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.

[1997, c. 408, §6 (NEW); 1997, c. 408, §8 (AFF) .]

3. Application. The requirements of this section apply to all group 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.

[2003, c. 517, Pt. B, §15 (NEW) .]

SECTION HISTORY

RR 1995, c. 1, §17 (COR). 1995, c. 295, §4 (NEW). 1995, c. 369, §3 (NEW). 1997, c. 408, §8 (AFF). 1997, c. 408, §6 (RPR). 2003, c. 517, §B15 (AMD). 2015, c. 227, §3 (AMD). 2015, c. 227, §5 (AFF).

§2837-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.

[1995, c. 369, §3 (NEW) .]

2. Required coverage. All group 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 [1995, c. 369, §3 (NEW) .]

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

[1995, c. 369, §3 (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.

[1995, c. 369, §3 (NEW) .]

SECTION HISTORY

RR 1995, c. 1, §17 (RNU). 1995, c. 369, §3 (NEW).

§2837-E. COVERAGE FOR PAP TESTS

All group health insurance policies, contracts and certificates must provide coverage for screening Pap tests recommended by a physician. [2003, c. 517, Pt. A, §7 (AMD); 2003, c. 517, Pt. A, §13 (AFF).]

SECTION HISTORY

1995, c. 617, §3 (NEW). 1995, c. 617, §6 (AFF). 2003, c. 517, §A7 (AMD). 2003, c. 517, §A13 (AFF).

§2837-F. 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. [1997, c. 701, §3 (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. [1997, c. 701, §3 (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. [1997, c. 701, §3 (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. [1997, c. 701, §3 (NEW).]

[1997, c. 701, §3 (NEW) .]

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

A. Group insurance policies and contracts that provide coverage for prescription drugs may not exclude coverage of 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 that use of that drug is a medically accepted indication for the treatment of cancer. [1997, c. 701, §3 (NEW).]

B. Coverage of a drug required by this subsection also includes medically necessary services associated with the administration of the drug. [1997, c. 701, §3 (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. [1997, c. 701, §3 (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. [1997, c. 701, §3 (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. [1997, c. 701, §3 (NEW).]

[1997, c. 701, §3 (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.

§2837-F. Coverage for prostate cancer screening

(As enacted by PL 1997, c. 754, §3 is REALLOCATED TO TITLE 24-A, SECTION 2837-H)

[1997, c. 701, §3 (NEW) .]

SECTION HISTORY

RR 1997, c. 2, §52 (RAL). 1997, c. 701, §3 (NEW). 1997, c. 754, §3 (NEW).

§2837-G. 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. [1997, c. 701, §3 (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. [1997, c. 701, §3 (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. [1997, c. 701, §3 (NEW).]

[1997, c. 701, §3 (NEW) .]

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

A. Group insurance policies and contracts that provide coverage for prescription drugs may not exclude coverage of 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. [1997, c. 701, §3 (NEW).]

B. Coverage of a drug required by this subsection also includes medically necessary services associated with the administration of the drug. [1997, c. 701, §3 (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. [1997, c. 701, §3 (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. [1997, c. 701, §3 (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. [1997, c. 701, §3 (NEW).]

[1997, c. 701, §3 (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.

[1997, c. 701, §3 (NEW) .]

SECTION HISTORY

1997, c. 701, §3 (NEW).

§2837-H. COVERAGE FOR PROSTATE CANCER SCREENING

(REALLOCATED FROM TITLE 24-A, SECTION 2837-F)

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 [1997, c. 2, §52 (RAL).]

B. A prostate-specific antigen test. [1997, c. 2, §52 (RAL).]

[1997, c. 2, §52 (RAL) .]

2. Required coverage for prostate cancer screening. All group 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.

[1997, c. 2, §52 (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.

[1997, c. 2, §52 (RAL) .]

SECTION HISTORY

RR 1997, c. 2, §52 (RAL).

§2838. COMMUNITY HEALTH SERVICE COVERAGE

(REPEALED)

SECTION HISTORY

1979, c. 419, §2 (NEW). 1979, c. 558, §10 (NEW). 1979, c. 663, §148 (AMD). 1979, c. 663, §149 (RAL). 1983, c. 515, §5 (RP).

§2839. RATES FILED

A policy of group or blanket health insurance may not be delivered in this State until a copy of the rates to be used in calculating the premium for these policies has been filed for informational purposes with the superintendent. The filing must include the base rates and a description of any procedures to be used to adjust the base rates to reflect factors including but not limited to age, gender, health status, claims experience, group size and coverage of dependents. Notwithstanding this section, rates for group Medicare supplement, nursing home care or long-term care insurance contracts and for certain association groups and other groups specified in section 2701, subsection 2, paragraph C must be filed in accordance with section 2736. Rates for small group health insurance subject to section 2808-B are subject to the additional filing requirements specified in that section. 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 section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [2011, c. 238, Pt. C, §1 (AMD).]

SECTION HISTORY

1979, c. 558, §10 (NEW). 1979, c. 663, §149 (RAL). 1985, c. 648, §11 (AMD). 2003, c. 428, §E2 (AMD). 2009, c. 14, §5 (AMD). 2011, c. 238, Pt. C, §1 (AMD).

§2839-A. NOTICE OF RATE INCREASE

1. Notice of rate increase on existing policies. An insurer offering group health insurance, except for accidental injury, specified disease, hospital indemnity, disability income, Medicare supplement, long-term care or other limited benefit group health insurance, must provide written notice by mail or electronically of a rate increase to all affected policyholders or others who are directly billed for group coverage at least 60 days before the effective date of any increase in premium rates. An increase in premium rates may not be implemented until 60 days after the notice is provided. For small group health plan rates subject to section 2808-B, subsection 2-B, if the increase is pending approval at the time of notice, the disclosure must state that the increase is subject to regulatory approval.

[2011, c. 90, Pt. F, §2 (AMD) .]

1-A. Notice of rate increase on existing policies renewed in calendar year 2006.

[2005, c. 400, Pt. A, §2 (NEW); T. 24-A, §2839-A, sub-§1-A (RP) .]

2. Notice of rate increase on new business. When an insurer offering group health insurance, except for accidental injury, specified disease, hospital indemnity, disability income, Medicare supplement, long-term care or other limited benefit group health insurance, 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 such disclosure is not provided, an increase may not be implemented until at least 90 days after the date the quote is provided. For small group health plan rates subject to section 2808-B, subsection 2-B, if the increase is pending approval at the time of notice, the disclosure must state that the increase is subject to regulatory approval.

[2005, c. 121, Pt. F, §1 (AMD) .]

3. Notice of rate increase on new business for calendar year 2006.

[2005, c. 400, Pt. A, §2 (NEW); T. 24-A, §2839-A, sub-§3 (RP) .]

SECTION HISTORY

2001, c. 432, §7 (NEW). 2005, c. 121, §F1 (AMD). 2005, c. 400, §A2 (AMD). 2011, c. 90, Pt. F, §2 (AMD).

§2839-B. LARGE GROUP RATES

1. Application. This section applies to group health insurance offered in the large group market as defined in section 2850-B, except insurance covering only accidental injury, specified disease, hospital indemnity, dental, vision, disability income, long-term care, Medicare supplement or other limited benefit health insurance.

[2003, c. 469, Pt. E, §17 (NEW) .]

2. Annual filing. Every carrier offering group health insurance specified in subsection 1 shall annually file with the superintendent on or before April 30th a certification signed by a member in good standing of the American Academy of Actuaries or a successor organization that the carrier's rating methods and practices are in accordance with generally accepted actuarial principles and with the applicable actuarial standards of practice as promulgated by an actuarial standards board. The filing must also certify that the carrier has included in its experience any savings offset payments or recovery of those savings offset payments consistent with former section 6913. The filing also must state the number of policyholders, certificate holders and dependents, as of the close of the preceding calendar year, enrolled in large group health insurance plans offered by the carrier. A filing and supporting information are public records except as provided by Title 1, section 402, subsection 3.

[2007, c. 629, Pt. M, §11 (AMD) .]

3. Documentation. Every carrier shall maintain at its principal place of business a complete and detailed description of its rating practices, including information and documentation that demonstrates that its rating methods and practices are in accordance with generally accepted actuarial principles and with the applicable actuarial standards of practice as promulgated by an actuarial standards board.

[2003, c. 469, Pt. E, §17 (NEW) .]

SECTION HISTORY

2003, c. 469, §E17 (NEW). 2007, c. 629, Pt. M, §11 (AMD).

§2840. OPTIONAL COVERAGE FOR CHIROPRACTIC SERVICES

(REALLOCATED FROM TITLE 24-A, SECTION 2746)

(REPEALED)

SECTION HISTORY

1979, c. 663, §145 (RAL). 1981, c. 282, §2 (AMD). 1985, c. 516, §4 (RP).

§2840-A. COVERAGE FOR CHIROPRACTIC SERVICES

1. Therapeutic, adjustive and manipulative services. Notwithstanding any other provisions of this chapter, every insurer which issues group or blanket 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.

[1985, c. 516, §5 (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.

[1985, c. 516, §5 (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.

[1993, c. 669, §3 (AMD) .]

4. Application; expiration.

[1989, c. 141, §6 (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.

[2015, c. 111, §2 (NEW); 2015, c. 111, §4 (AFF) .]

SECTION HISTORY

1985, c. 516, §5 (NEW). 1989, c. 141, §§5,6 (AMD). 1993, c. 669, §3 (AMD). 2015, c. 111, §2 (AMD). 2015, c. 111, §4 (AFF).

§2841. OPTIONAL COVERAGE FOR OPTOMETRIC SERVICES

1. Coverage required to be made available. Every insurer which issues for delivery in this State group health policies which provide coverage on an expense-incurred basis for the services of a "physician" or "doctor" to residents of this State shall make available to all groups coverage for such services when performed by an optometrist, to the extent the services are within the scope of the practice of an optometrist licensed to practice in this State.

[1981, c. 254, §2 (NEW) .]

2. Policy. The group or blanket policy making available coverage for the services referred to in this section shall contain provisions for maximum benefits and coinsurance, and reasonable limitations, deductibles and exclusions.

[1981, c. 254, §2 (NEW) .]

SECTION HISTORY

1981, c. 254, §§2,3 (NEW) .

§2842. EQUITABLE HEALTH CARE FOR SUBSTANCE USE DISORDER TREATMENT

1. Purpose. The Legislature recognizes that substance use disorder constitutes a major health problem in the State and in the Nation. The Legislature further recognizes that substance use disorder is a disease that can be effectively treated. As such, substance use disorder warrants the same attention from the health care industry as other serious diseases and illnesses. The Legislature further recognizes that health insurance contracts, at times, fail to provide adequate benefits for the treatment of substance use disorder, which results in more costly health care for treatment of complications caused by the lack of early intervention and other treatment services for persons suffering from substance use disorder. This situation causes a higher health care, social, law enforcement and economic cost to the citizens of this State than is necessary, including the need for the State to provide treatment to some insureds at public expense. To assist the many citizens of this State who suffer from this illness in a more cost-effective way, the Legislature declares that certain health insurance coverage providing benefits for the treatment of the illness of substance use disorder must be included in all group health insurance contracts.

[2017, c. 407, Pt. A, §95 (AMD) .]

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

A. "Outpatient care" means care rendered by a state-licensed, approved or certified detoxification, residential treatment or outpatient program, or partial hospitalization program on a periodic basis, including, but not limited to, patient diagnosis, assessment and treatment, individual, family and group counseling and educational and support services. [1983, c. 527, §2 (NEW) .]

B. "Residential treatment" means services at a facility that provides care 24 hours daily to one or more patients, including, but not limited to, the following services: room and board; medical, nursing and dietary services; patient diagnosis, assessment and treatment; individual, family and group counseling; and educational and support services, including a designated unit of a licensed health care facility providing any and all other services specified in this paragraph to patients with substance use disorder. [2017, c. 407, Pt. A, §95 (AMD) .]

C. "Treatment plan" means a written plan initiated at the time of admission, approved by a Doctor of Medicine, a Doctor of Osteopathy or a Registered Substance Abuse Counselor employed by a certified or licensed substance use disorder program, including, but not limited to, the patient's medical and

substance use disorder history; record of physical examination; diagnosis; assessment of physical capabilities; mental capacity; orders for medication, diet and special needs for the patient's health or safety and treatment, including medical, psychiatric, psychological, social services, individual, family and group counseling; and educational, support and referral services. [2017, c. 2, §9 (COR).]

[2017, c. 2, §9 (COR) .]

3. Requirement. Every insurer that issues group health care contracts providing coverage for hospital care to residents of this State shall provide benefits as required in this section to any subscriber or other person covered under those contracts for the treatment of substance use disorder pursuant to a treatment plan.

[2017, c. 407, Pt. A, §95 (AMD) .]

4. Services; providers. Each group contract must provide, at a minimum, for the following coverage, pursuant to a treatment plan:

A. Residential treatment at a hospital or free-standing residential treatment center that is licensed, certified or approved by the State; and [2017, c. 407, Pt. A, §95 (AMD).]

B. Outpatient care rendered by state licensed, certified or approved providers. [1983, c. 527, §2 (NEW) .]

Treatment or confinement at any facility may not preclude further or additional treatment at any other eligible facility, provided that the benefit days used do not exceed the total number of benefit days provided for under the contract.

[2017, c. 407, Pt. A, §95 (AMD) .]

5. Exceptions. This section does not apply to employee group insurance policies issued to employers with 20 or fewer employees insured under the group policy or to group policies designed primarily to supplement the Civilian Health and Medical Program of the Uniformed Services, as described in the United States Code, Title 10, Section 1072, subsection 4.

[2017, c. 407, Pt. A, §95 (AMD) .]

6. Limits; coinsurance; deductibles. Any 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.

[2017, c. 407, Pt. A, §95 (AMD) .]

7. Notice. At the time of delivery or renewal, the group health insurer shall provide written notification to all individuals eligible for benefits under group policies or contracts of substance use disorder benefits.

[2017, c. 407, Pt. A, §95 (AMD) .]

8. Confidentiality. Substance use disorder treatment patient records are confidential.

[2017, c. 407, Pt. A, §95 (AMD) .]

9. Reports to the Superintendent of Insurance. Every insurer subject to this section shall report its experience for each calendar year beginning with 1984 to the superintendent not later than April 30th of the following year. The report must be in a form prescribed by the superintendent and must 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 group health care contracts, both separated between those paid for inpatient and outpatient services. The superintendent shall compile this data for all insurers in an annual report.

[2017, c. 407, Pt. A, §95 (AMD) .]

10. Application; expiration. The requirements of this section apply to all policies and any certificates or contracts executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1984. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2017, c. 407, Pt. A, §95 (AMD) .]

SECTION HISTORY

1981, c. 319, §§2,3 (NEW). 1983, c. 527, §2 (RPR). 1987, c. 480, §5 (AMD). 1989, c. 490, §3 (AMD). 2011, c. 320, Pt. A, §10 (AMD). RR 2015, c. 2, §14 (COR). RR 2017, c. 2, §9 (COR). 2017, c. 407, Pt. A, §95 (AMD).

§2843. MENTAL HEALTH SERVICES COVERAGE

1. Findings. The Legislature finds that:

A. Mental illness affects nearly 170,000 Maine people each year, resulting in anguish, grief, desperation, fear, isolation and a sense of hopelessness of significant levels among victims and families; [1983, c. 515, §6 (NEW).]

B. Consequences of mental illness include the expenditure of millions of dollars of public funds for treatment and losses of millions of dollars by Maine businesses in accidents, absenteeism, nonproductivity and turnover. Excessive stress and anxiety and other forms of mental illness clearly contribute to general health problems and costs; [1983, c. 515, §6 (NEW).]

C. Typical health coverage in this State discriminates against mental illness, the victims and affected families with nonexistent or limited benefits compared to provisions for other illnesses; and [1983, c. 515, §6 (NEW).]

D. Experience in this State and several other states demonstrates that the risk of mental illness can be insured at reasonable cost and with adequate controls on quality and utilization of treatment. [1983, c. 515, §6 (NEW).]

[1983, c. 515, §6 (NEW) .]

2. Policy and purpose. The Legislature declares that it is the policy of this State to:

A. Promote equitable and nondiscriminatory health coverage benefits for all forms of illness, including mental and emotional disorders, which are of significant consequence to the health of Maine people and which can be treated in a cost effective manner; [1983, c. 515, §6 (NEW).]

B. Assure that victims of mental and other illnesses have access to and choice of appropriate treatment at the earliest point of illness in least restrictive settings; [1983, c. 515, §6 (NEW).]

C. Assure that costs of treatment of mental illness are supported through an equitable combination of public and private responsibilities; and [1983, c. 515, §6 (NEW).]

D. Assure that the Legislature reasonably exercises its legal responsibility for insurance policy in this State by prescribing types of illnesses and treatment for which benefits shall be provided. [1983, c. 515, §6 (NEW).]

[1983, c. 515, §6 (NEW) .]

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

A. "Day treatment services" includes psychoeducational, physiological, psychological and psychosocial concepts, techniques and processes to maintain or develop functional skills of clients, provided to individuals and groups for periods of more than 2 hours but less than 24 hours per day. [1983, c. 515, §6 (NEW).]

A-1. "Diagnostic and statistical manual" means the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association. [2003, c. 20, Pt. VV, §10 (NEW); 2003, c. 20, Pt. VV, §25 (AFF).]

A-2. "Home health care services" means those services rendered by a licensed provider of mental health services to provide medically necessary health care to a person suffering from a mental illness in the person's place of residence if:

- (1) Hospitalization or confinement in a residential treatment facility would otherwise have been required if home health care services were not provided;
- (2) Hospitalization or confinement in a residential treatment facility is not required as an antecedent to the provision of home health care services; and
- (3) The services are prescribed in writing 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. [2003, c. 20, Pt. VV, §10 (NEW); 2003, c. 20, Pt. VV, §25 (AFF).]

B. "Inpatient services" includes a range of physiological, psychological and other intervention concepts, techniques and processes in a community mental health psychiatric inpatient unit, general hospital psychiatric unit or psychiatric hospital licensed by the Department of Health and Human Services or accredited public hospital to restore psychosocial functioning sufficient to allow maintenance and support of the client in a less restrictive setting. [1983, c. 515, §6 (NEW); 2003, c. 689, Pt. B, §6 (REV).]

B-1. "Medically necessary health care" has the same meaning as in section 4301-A, subsection 10-A. [2003, c. 20, Pt. VV, §11 (NEW); 2003, c. 20, Pt. VV, §25 (AFF).]

C. "Outpatient services" includes screening, evaluation, consultations, diagnosis and treatment involving use of psychoeducational, physiological, psychological and psychosocial evaluative and interventive concepts, techniques and processes provided to individuals and groups. [1983, c. 515, §6 (NEW).]

D. "Person suffering from a mental illness" means a person whose psychobiological processes are impaired severely enough to manifest problems in the areas of social, psychological or biological functioning. Such a person has a disorder of thought, mood, perception, orientation or memory that impairs judgment, behavior, capacity to recognize or ability to cope with the ordinary demands of life. The person manifests an impaired capacity to maintain acceptable levels of functioning in the areas of intellect, emotion or physical well-being. [2003, c. 20, Pt. VV, §12 (AMD); 2003, c. 20, Pt. VV, §25 (AFF).]

E. "Provider" means individuals included in section 2835, and a licensed physician with 3 years approved residency in psychiatry, an accredited public hospital or psychiatric hospital or a community agency licensed at the comprehensive service level by the Department of Health and Human Services. All agency or institutional providers named in this paragraph shall assure that services are supervised by a psychiatrist or licensed psychologist. [1995, c. 560, Pt. K, §82 (AMD); 1995, c. 560, Pt. K, §83 (AFF); 2001, c. 354, §3 (AMD); 2003, c. 689, Pt. B, §6 (REV).]

[2003, c. 20, Pt. VV, §§10-12 (AMD); 2003, c. 20, Pt. VV, §25 (AFF); 2003, c. 689, Pt. B, §6 (REV) .]

4. Requirement. Every insurer that issues group health care contracts providing coverage to residents of this State shall provide benefits as required in this section to any subscriber or other person covered under those contracts for conditions arising from mental illness.

[2003, c. 20, Pt. VV, §13 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

5. Services. Each group contract must provide for medically necessary health care for a person suffering from mental illness. Medically necessary health care includes, but is not limited to, the following services for a person suffering from a mental illness:

A. Inpatient care; [1983, c. 515, §6 (NEW) .]

B. Day treatment services; [2003, c. 20, Pt. VV, §13 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

C. Outpatient services; and [2003, c. 20, Pt. VV, §13 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

D. Home health care services. [2003, c. 20, Pt. VV, §13 (NEW); 2003, c. 20, Pt. VV, §25 (AFF) .]

[2003, c. 20, Pt. VV, §13 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

5-A. Exceptions. This section shall not apply to employee group insurance policies issued to employers with 20 or fewer employees insured under the group policy or to group policies designed primarily to supplement the Civilian Health and Medical Program of the Uniformed Services, as described in the United States Code, Title 10, Section 1072, subsection 4.

[1989, c. 490, §4 (AMD) .]

5-B. Coverage for certain mental illness treatment.

[1991, c. 881, §3 (NEW); 1991, c. 881, §7 (AFF); 1991, c. 881, §8 (RP) .]

5-C. Coverage for treatment for certain mental illness. Coverage for medical treatment for mental illnesses listed in paragraph A-1 is subject to this subsection.

A. [2003, c. 20, Pt. VV, §25 (AFF); 2003, c. 20, Pt. VV, §14 (RP) .]

A-1. All group 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, 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. [2017, c. 407, Pt. A, §96 (AMD).]

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

(1) The contracts 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 group contract.

(3) If benefits and coverage provided for treatment of physical illness are provided on an expense-incurred basis, the benefits and coverage required under this subsection may be delivered separately under a managed care system.

(4) A policy or contract may not have separate maximums for physical illness and mental illness, separate deductibles and coinsurance amounts for physical illness and mental illness, separate out-of-pocket limits in a benefit period of not more than 12 months for physical illness and mental illness or separate office visit limits for physical illness and mental illness.

(5) A health benefit plan may not impose a limitation on coverage or benefits for mental illness unless that same limitation is also imposed on the coverage and benefits for physical illness covered under the policy or contract.

(6) Copayments required under a policy or contract for benefits and coverage for mental illness must be actuarially equivalent to any coinsurance requirements or, if there are no coinsurance requirements, may not be greater than any copayment or coinsurance required under the policy or contract for a benefit or coverage for a physical illness.

(7) For the purposes of this section, a medication management visit associated with a mental illness must be covered in the same manner as a medication management visit for the treatment of a physical illness and may not be counted in the calculation of any maximum outpatient treatment visit limits. [2003, c. 20, Pt. VV, §14 (AMD); 2003, c. 20, Pt. VV, §25 (AFF).]

This subsection does not apply to policies, contracts and certificates covering employees of employers with 20 or fewer employees, whether the group policy is issued to the employer, to an association, to a multiple-employer trust or to another entity.

[2017, c. 407, Pt. A, §96 (AMD) .]

5-D. Mandated offer of coverage for certain mental illnesses. Except as otherwise provided in subsection 5-C, coverage for medical treatment for mental illnesses listed in paragraph A by all group contracts is subject to this subsection.

A. All group contracts must make available coverage providing, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following mental illnesses 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:

(1) Schizophrenia;

- (2) Bipolar disorder;
- (3) Pervasive developmental disorder, or autism;
- (4) Paranoia;
- (5) Panic disorder;
- (6) Obsessive-compulsive disorder; or
- (7) Major depressive disorder. [2003, c. 20, Pt. VV, §15 (AMD); 2003, c. 20, Pt. VV, §25 (AFF).]

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

(1) The offer of 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 group contract. [2003, c. 20, Pt. VV, §15 (AMD); 2003, c. 20, Pt. VV, §25 (AFF).]

[2003, c. 20, Pt. VV, §15 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

6. Limits; coinsurance; deductibles. Any policy or 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.

[1983, c. 515, §6 (NEW) .]

7. Reports to the Superintendent of Insurance. Every insurer subject to this section shall report its experience for each calendar year to the superintendent 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 group health care contracts, both separated between those paid for inpatient, day treatment and outpatient services. The superintendent shall compile this data for all insurers in an annual report.

[1995, c. 407, §8 (AMD) .]

8. Application. This section does not apply to accidental injury, specified disease, hospital indemnity, Medicare supplement, long-term care or other limited benefit health insurance policies. Except as otherwise provided in this section, 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.

[2003, c. 517, Pt. B, §16 (AMD) .]

SECTION HISTORY

1983, c. 515, §6 (NEW). 1983, c. 816, §B7 (AMD). 1987, c. 480, §6 (AMD). 1989, c. 490, §4 (AMD). 1991, c. 881, §§3,4 (AMD). 1991, c. 881, §§7,8 (AFF). 1993, c. 441, §§3,4 (AMD). 1993, c. 586, §§3,4 (AMD). 1995, c. 19, §2 (AMD). 1995, c. 332, §G2 (AMD). 1995, c. 407, §§6-9

(AMD). 1995, c. 560, §K82 (AMD). 1995, c. 560, §K83 (AFF). 1995, c. 625, §B8 (AMD). 1995, c. 625, §B9 (AFF). 1995, c. 637, §§4,5 (AMD). 2001, c. 354, §3 (AMD). 2003, c. 20, §§VV10-15 (AMD). 2003, c. 20, §VV25 (AFF). 2003, c. 517, §B16 (AMD). 2003, c. 689, §B6 (REV). 2017, c. 407, Pt. A, §96 (AMD).

§2844. COORDINATION OF BENEFITS

1. Authorization. Provisions contained in group and blanket health insurance contracts relating to coordination of benefits payable under the contract and under other plans of insurance or of health care coverage under which a certificate holder or the certificate holder's dependents may be covered must conform to rules adopted by the superintendent. These rules may 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, medical service and health care plans.

[1995, c. 332, Pt. H, §1 (AMD) .]

1-A. Coordination with Medicare. Coordination of benefits is governed by the following provisions.

A. The contract 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 certificate 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. [1997, c. 604, Pt. G, §2 (NEW).]

B. The contract 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 certificate was issued and, if applicable, when the insured becomes eligible for Medicare due to age. The notification must state that the contract will not pay benefits that would be payable under Medicare even if the insured fails to enroll in Medicare Part B. [1997, c. 604, Pt. G, §2 (NEW).]

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. [1997, c. 604, Pt. G, §2 (NEW).]

[1997, c. 604, Pt. G, §2 (NEW) .]

2. Medicaid and Cub Care programs. Insurers may not consider the availability or eligibility for medical assistance under 42 United States Code, Section 13969, referred to as "Medicaid," or Title 22, section 3174-T, referred to as the "Cub Care program," when considering coverage eligibility or benefit calculations for insureds and covered family members.

A. To the extent that payment for coverage expenses has been made under the Medicaid program or the Cub Care program for health care items or services furnished to an individual, the State is considered to have acquired the rights of the insured or family member to payment by the insurer for those health care items or services. Upon presentation of proof that the Medicaid program or the Cub Care program has paid for covered items or services, the insurer shall make payment to the Medicaid program or the Cub Care program according to the coverage provided in the contract or certificate. [1997, c. 777, Pt. B, §3 (AMD).]

B. An insurer may not impose requirements on a state agency that has been assigned the rights of an individual eligible for Medicaid or Cub Care coverage and covered by a subscriber contract that are different from requirements applicable to an agent or assignee of any other covered individual. [1997, c. 777, Pt. B, §3 (AMD).]

[2005, c. 683, Pt. A, §41 (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.

[2005, c. 121, Pt. D, §3 (NEW) .]

SECTION HISTORY

1985, c. 526, §2 (NEW). RR 1993, c. 2, §47 (COR). 1993, c. 666, §B2 (RPR). 1995, c. 332, §H1 (AMD). 1997, c. 604, §G2 (AMD). 1997, c. 777, §B3 (AMD). 2005, c. 121, §D3 (AMD). 2005, c. 683, §A41 (AMD).

§2845. CARDIAC REHABILITATION COVERAGE

1. Requirement. Every insurer which issues group health care contracts providing coverage for hospital care to residents of this State shall make available to groups of 20 or more persons, at the option of the policyholder, benefits as required by this section to any certificate holder or other person covered under those contracts for the expense of cardiac rehabilitation.

[1987, c. 293, §2 (NEW) .]

2. Cardiac rehabilitation. "Cardiac rehabilitation" means multidisciplinary, medically necessary treatment of persons with documented cardiovascular disease, which shall be provided in either a hospital or other setting. That treatment shall include outpatient treatment which is initiated within 26 weeks after the diagnosis of that disease and physician-recommended continuance of Phase II rehabilitation services for up to 36 sessions in a hospital or community-based setting and up to 36 Phase III sessions in a community-based setting.

[1987, c. 293, §2 (NEW) .]

3. Limitations. Benefits required to be made available pursuant to this section may be made subject to any reasonable limitation, maximum benefit, coinsurance, deductible or exclusion provisions applicable to overall benefits under the policy or certificate.

[1987, c. 293, §2 (NEW) .]

4. Application. The requirements of this section shall apply to all policies and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1988. For purposes of this section only, all group policies shall be deemed to be renewed no later than the next yearly anniversary of the contract date.

[1987, c. 293, §2 (NEW) .]

SECTION HISTORY

1987, c. 293, §2 (NEW).

§2846. ACQUIRED IMMUNE DEFICIENCY SYNDROME

A group health insurance policy or certificate delivered or issued for delivery in this State may not 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 sicknesses and diseases are treated the same. This section does not apply to a policy providing benefits for specific diseases or accidental injury only. [2003, c. 517, Pt. B, §17 (AMD) .]

SECTION HISTORY

1989, c. 176, §6 (NEW). 2003, c. 517, §B17 (AMD).

§2847. UTILIZATION REVIEW DATA

1. Report required. On or before April 1st of each year, any insurer or 3rd-party administrator which issues or administers 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 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. 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; [1989, c. 556, Pt. C, §3 (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; [1989, c. 556, Pt. C, §3 (NEW) .]
- C. The number and result of any appeals by the patients or their physicians as a result of initial review decisions to reduce benefits for services as determined through prospective evaluations; and [1989, c. 556, Pt. C, §3 (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 approximately 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. [1989, c. 556, Pt. C, §3 (NEW) .]

[1989, c. 556, Pt. C, §3 (NEW) .]

2. Residents. This section is applicable to evaluations, appeals and complaints relating to residents of this State only.

[1989, c. 556, Pt. C, §3 (NEW) .]

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

[1989, c. 556, Pt. C, §3 (NEW) .]

SECTION HISTORY

1989, c. 556, §C3 (NEW).

§2847-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. [1991, c. 695, §5 (NEW); 1991, c. 824, Pt. A, §51 (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. [1991, c. 695, §5 (NEW); 1991, c. 824, Pt. A, §51 (NEW).]

SECTION HISTORY

1991, c. 695, §5 (NEW). 1991, c. 824, §A51 (NEW).

§2847-B. JURY SERVICE

1. Prohibition. An insurer that issues group or blanket health care contracts providing coverage for medical care to residents of this State may not terminate coverage for any person covered under those contracts because the person has been summonsed for or is engaged in jury service under Title 14, chapter 305, subchapter I-A.

[1991, c. 695, §5 (NEW); 1991, c. 824, Pt. A, §51 (NEW) .]

2. Application. This section applies to all policies and any certificate executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1991. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[1991, c. 695, §5 (NEW); 1991, c. 824, Pt. A, §51 (NEW) .]

SECTION HISTORY

1991, c. 695, §5 (NEW). 1991, c. 824, §A51 (NEW).

§2847-C. NOTIFICATION PRIOR TO CANCELLATION; RESTRICTIONS ON CANCELLATION, TERMINATION OR LAPSE 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 certificate for nonpayment of premium. [2011, c. 123, §3 (AMD); 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 a 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. [2011, c. 123, §3 (NEW); 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. [2011, c. 123, §3 (NEW); 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. [2011, c. 123, §3 (AMD); 2011, c. 123, §5 (AFF).]

The requirements of this section apply to all policies and certificates executed, delivered, issued for delivery, continued or renewed in this State. [1991, c. 695, §5 (NEW); 1991, c. 824, Pt. A, §51 (NEW).]

SECTION HISTORY

1991, c. 695, §5 (NEW). 1991, c. 824, §A51 (NEW). 2011, c. 123, §3 (AMD). 2011, c. 123, §5 (AFF).

§2847-D. PENALTY FOR NONCOMPLIANCE WITH UTILIZATION REVIEW PROGRAMS

A policy or certificate issued or renewed 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. [1995, c. 332, Pt. M, §9 (AMD).]

SECTION HISTORY

1993, c. 645, §B5 (NEW). 1995, c. 332, §M9 (AMD).

§2847-E. COVERAGE FOR DIABETES SUPPLIES

All group insurance policies, contracts and certificates 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: [2003, c. 517, Pt. A, §8 (AMD); 2003, c. 517, Pt. A, §13 (AFF).]

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

[1995, c. 592, §3 (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.

[1995, c. 592, §3 (NEW) .]

The requirements of this section apply to all group 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. [2003, c. 517, Pt. A, §8 (NEW); 2003, c. 517, Pt. A, §13 (AFF).]

SECTION HISTORY

1995, c. 592, §3 (NEW). 2003, c. 517, §A8 (AMD). 2003, c. 517, §A13 (AFF).

§2847-F. GYNECOLOGICAL AND OBSTETRICAL SERVICES

(REALLOCATED FROM TITLE 24-A, SECTION 2850-A)

1. Coverage in managed care plans. With respect to managed care plans that require group members to select primary care physicians, an insurer that issues group health insurance policies, contracts and certificates must meet the following requirements.

A. The insurer must permit a physician who specializes in obstetrics and gynecology to serve as a primary care physician if the physician qualifies under the insurer's credentialing policy. [1997, c. 370, Pt. H, §1 (RAL).]

B. All group plan contracts must provide coverage for an annual gynecological examination, including routine pelvic and clinical breast examinations, performed by a physician, certified nurse practitioner or certified nurse midwife participating in the plan, without requiring the prior approval of the primary care physician. [1997, c. 370, Pt. H, §1 (RAL).]

C. If the examination specified in paragraph B reveals a gynecological condition for which another visit to the physician participating in the plan is medically required and appropriate, or for any gynecological care beyond the annual examination, the carrier may require the patient or the examining physician, certified nurse practitioner or certified nurse midwife to secure from the patient's primary care physician a referral to the participating physician, certified nurse practitioner or certified nurse midwife from whom such care may be obtained. [1997, c. 370, Pt. H, §1 (RAL).]

[2003, c. 517, Pt. A, §9 (AMD); 2003, c. 517, Pt. A, §13 (AFF) .]

2. Application. This section applies 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.

[2003, c. 517, Pt. A, §9 (AMD); 2003, c. 517, Pt. A, §13 (AFF) .]

This section does not prohibit a carrier from requiring a physician, certified nurse practitioner or certified nurse midwife participating in the plan to inform a woman's primary care physician prior to each treatment pursuant to this section. [1997, c. 370, Pt. H, §1 (RAL).]

SECTION HISTORY

1997, c. 370, §H1 (RAL). 2003, c. 517, §A9 (AMD). 2003, c. 517, §A13 (AFF).

§2847-G. COVERAGE FOR CONTRACEPTIVES

1. Coverage requirements. All group insurance 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.

[1999, c. 341, §3 (NEW); 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).

[1999, c. 341, §3 (NEW); 1999, c. 341, §5 (AFF) .]

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. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. B, §18 (NEW) .]

4. 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. [2017, c. 190, §2 (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. [2017, c. 190, §2 (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. [2017, c. 190, §2 (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. [2017, c. 190, §2 (NEW) .]

§2847-G. Coverage for services of certified nurse practitioners; certified nurse midwives

(As enacted by PL 1999, c. 396, §3 and affected by §7 is REALLOCATED TO TITLE 24-A, SECTION 2847-H)

§2847-G. Coverage for services provided by registered nurse first assistants

(As enacted by PL 1999, c. 412, §3 is REALLOCATED TO TITLE 24-A, SECTION 2847-I)

[2017, c. 190, §2 (NEW) .]

SECTION HISTORY

RR 1999, c. 1, §§34,35 (RAL). 1999, c. 341, §3 (NEW). 1999, c. 341, §5 (AFF). 1999, c. 396, §3 (NEW). 1999, c. 396, §7 (AFF). 1999, c. 412, §3 (NEW). 2003, c. 517, §B18 (AMD). 2017, c. 190, §2 (AMD).

§2847-H. COVERAGE FOR SERVICES OF CERTIFIED NURSE PRACTITIONERS; CERTIFIED NURSE MIDWIVES

(REALLOCATED FROM TITLE 24-A, SECTION 2847-G)

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

[1999, c. 1, §34 (RAL) .]

2. Required coverage for self-referred services. With respect to group 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 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 or certified nurse midwife.

[1999, c. 1, §34 (RAL) .]

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.

[1999, c. 1, §34 (RAL) .]

4. Application. The requirements of this section apply to all group 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.

[2003, c. 517, Pt. B, §19 (NEW) .]

SECTION HISTORY

RR 1999, c. 1, §34 (RAL). 2003, c. 517, §B19 (AMD).

§2847-I. COVERAGE FOR SERVICES PROVIDED BY REGISTERED NURSE FIRST ASSISTANTS

(REALLOCATED FROM TITLE 24-A, SECTION 2847-G)

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. [1999, c. 1, §35 (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. [1999, c. 1, §35 (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. [1999, c. 1, §35 (RAL).]

[1999, c. 1, §35 (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.

[1999, c. 1, §35 (RAL) .]

3. Required coverage for services. Notwithstanding any other provisions of this chapter, an insurer that issues group 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.

[1999, c. 1, §35 (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.

[1999, c. 1, §35 (RAL) .]

5. Application. The requirements of this section apply to all group 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.

[2003, c. 517, Pt. B, §20 (NEW) .]

SECTION HISTORY

RR 1999, c. 1, §35 (RAL). 2003, c. 517, §B20 (AMD).

§2847-J. 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. [2001, c. 358, Pt. LL, §3 (NEW); 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. [2001, c. 358, Pt. LL, §3 (NEW); 2001, c. 358, Pt. LL, §5 (AFF).]

[2001, c. 358, Pt. LL, §3 (NEW); 2001, c. 358, Pt. LL, §5 (AFF) .]

2. Coverage for hospice care services. All group insurance policies and contracts 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.

[2001, c. 358, Pt. LL, §3 (NEW); 2001, c. 358, Pt. LL, §5 (AFF) .]

3. Application. The requirements of this section apply to all group 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.

§2847-J. Coverage for general anesthesia for dentistry

(As enacted by PL 2001, c. 423, §3 and affected by §5 is REALLOCATED TO TITLE 24-A, SECTION 2847-K)

[2003, c. 517, Pt. B, §21 (NEW) .]

SECTION HISTORY

RR 2001, c. 1, §33 (RAL). 2001, c. 358, §LL3 (NEW). 2001, c. 358, §LL5 (AFF). 2001, c. 423, §3 (NEW). 2001, c. 423, §5 (AFF). 2003, c. 517, §B21 (AMD).

§2847-K. COVERAGE FOR GENERAL ANESTHESIA FOR DENTISTRY

(REALLOCATED FROM TITLE 24-A, SECTION 2847-J)

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

[2001, c. 1, §33 (RAL) .]

2. General anesthesia and associated facility charges. An insurer that issues group 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.

[2001, c. 1, §33 (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; [2001, c. 1, §33 (RAL) .]

B. Enrollees demonstrating dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy; [2001, c. 1, §33 (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 [2001, c. 1, §33 (RAL) .]

D. Enrollees who have sustained extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised. [2001, c. 1, §33 (RAL) .]

[2001, c. 1, §33 (RAL) .]

4. Dental procedures and dentist's fee not covered. This section does not require an insurer that issues group 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 group contract that apply generally to other benefits.

[2001, c. 1, §33 (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 group health insurance is the secondary payer.

[2001, c. 1, §33 (RAL) .]

6. Application. The requirements of this section apply to all group 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.

[2003, c. 517, Pt. B, §22 (NEW) .]

SECTION HISTORY

RR 2001, c. 1, §33 (RAL). 2003, c. 517, §B22 (AMD).

§2847-L. OFFER OF COVERAGE FOR BREAST REDUCTION SURGERY AND SYMPTOMATIC VARICOSE VEIN SURGERY

All group 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. [2005, c. 128, §3 (NEW); 2005, c. 128, §5 (AFF).]

SECTION HISTORY

2005, c. 128, §3 (NEW). 2005, c. 128, §5 (AFF).

§2847-M. ENROLLMENT FOR INDIVIDUALS OR FAMILIES ESTABLISHING ELIGIBILITY FOR MAINECARE

(CONTAINS TEXT WITH VARYING EFFECTIVE DATES)

When an individual or family is eligible for MaineCare and is also eligible for health insurance coverage provided by an employer, the insurer must permit the individual or family to enroll in the health insurance coverage without regard to any enrollment season restrictions. [2007, c. 448, §11 (NEW).]

§2847-M. Coverage for hearing aids

(As enacted by PL 2007, c. 452, §3 is REALLOCATED TO TITLE 24-A, SECTION 2847-O)

SECTION HISTORY

2007, c. 448, §11 (NEW). 2007, c. 452, §3 (NEW). 2007, c. 695, Pt. A, §29 (RAL).

§2847-N. COVERAGE FOR COLORECTAL CANCER SCREENING

1. Colorectal cancer screening. For the purposes of this section, "colorectal cancer screening" means a colorectal cancer examination and laboratory test recommended by a health care provider in accordance with the most recently published colorectal cancer screening guidelines of a national cancer society.

[2007, c. 516, §3 (NEW); 2007, c. 516, §5 (AFF) .]

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

A. Fifty years of age or older; or [2007, c. 516, §3 (NEW); 2007, c. 516, §5 (AFF) .]

B. Less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society. [2007, c. 516, §3 (NEW); 2007, c. 516, §5 (AFF) .]

[2007, c. 516, §3 (NEW); 2007, c. 516, §5 (AFF) .]

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.

§2847-N. Coverage for medically necessary infant formula

(As enacted by PL 2007, c. 595, §3 is REALLOCATED TO TITLE 24-A, SECTION 2847-P)

[2007, c. 516, §3 (NEW); 2007, c. 516, §5 (AFF) .]

SECTION HISTORY

2007, c. 516, §3 (NEW). 2007, c. 516, §5 (AFF). 2007, c. 595, §3 (NEW).
2007, c. 595, §5 (AFF). 2007, c. 595, (RAL). 2007, c. 695, Pt. C, §15
(RAL).

§2847-O. COVERAGE FOR HEARING AIDS

(REALLOCATED FROM TITLE 24-A, SECTION 2847-M)

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.

[2007, c. 695, Pt. A, §29 (RAL) .]

2. Required coverage. In accordance with the application of coverage set forth in subsection 3, all group health insurance policies, contracts and certificates must provide coverage for the purchase of a hearing aid for each hearing-impaired ear for an individual covered under the policy, contract or certificate who is 18 years of age or under 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. [2015, c. 494, Pt. A, §29 (AMD).]

B. The hearing aid must be purchased from an audiologist or hearing aid dealer licensed pursuant to Title 32, chapter 137. [2015, c. 494, Pt. A, §29 (AMD).]

C. The policy, contract or certificate may limit coverage to \$1,400 per hearing aid for each hearing-impaired ear every 36 months. [2007, c. 695, Pt. A, §29 (RAL).]

[2015, c. 494, Pt. A, §29 (AMD) .]

3. Application of coverage. The requirements of subsection 2 apply to an individual:

A. From birth to 5 years of age, who is covered under a policy, contract or certificate that is issued or renewed on or after January 1, 2008; [2007, c. 695, Pt. A, §29 (RAL).]

B. From 6 to 13 years of age, who is covered under a policy, contract or certificate that is issued or renewed on or after January 1, 2009; and [2007, c. 695, Pt. A, §29 (RAL).]

C. From 14 to 18 years of age, who is covered under a policy, contract or certificate that is issued or renewed on or after January 1, 2010. [2007, c. 695, Pt. A, §29 (RAL).]

[2007, c. 695, Pt. A, §29 (RAL) .]

4. Limits; coinsurance; deductibles. Except as otherwise provided in this section, any policy, contract or certificate 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.

[2007, c. 695, Pt. A, §29 (RAL) .]

SECTION HISTORY

2007, c. 695, Pt. A, §29 (RAL). 2015, c. 494, Pt. A, §29 (AMD).

§2847-P. COVERAGE FOR MEDICALLY NECESSARY INFANT FORMULA

(REALLOCATED FROM TITLE 24-A, SECTION 2847-N)

All group 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.

[2007, c. 695, Pt. C, §15 (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.

[2007, c. 695, Pt. C, §15 (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.

[2007, c. 695, Pt. C, §15 (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; [2007, c. 695, Pt. C, §15 (RAL).]
- B. Laboratory- or biopsy-proven allergic or eosinophilic gastroenteritis; [2007, c. 695, Pt. C, §15 (RAL).]
- C. A history of anaphylaxis; [2007, c. 695, Pt. C, §15 (RAL).]
- D. Gastroesophageal reflux disease that is nonresponsive to standard medical therapies; [2007, c. 695, Pt. C, §15 (RAL).]
- E. Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider; [2007, c. 695, Pt. C, §15 (RAL).]
- F. Cystic fibrosis; or [2007, c. 695, Pt. C, §15 (RAL).]
- G. Malabsorption of cow milk-based or soy milk-based infant formula. [2007, c. 695, Pt. C, §15 (RAL).]

[2007, c. 695, Pt. C, §15 (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.

[2007, c. 695, Pt. C, §15 (RAL) .]

SECTION HISTORY

2007, c. 695, Pt. C, §15 (RAL).

§2847-Q. COVERAGE FOR SERVICES PROVIDED BY INDEPENDENT PRACTICE DENTAL HYGIENIST

1. Services provided by independent practice dental hygienist. An insurer that issues group 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.

[2015, c. 429, §13 (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.

[2009, c. 307, §3 (NEW); 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 group health insurance is the secondary payer.

[2009, c. 307, §3 (NEW); 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.

[2009, c. 307, §3 (NEW); 2009, c. 307, §6 (AFF) .]

SECTION HISTORY

2009, c. 307, §3 (NEW). 2009, c. 307, §6 (AFF). 2015, c. 429, §13 (AMD) .

§2847-R. ENROLLMENT OF DEPENDENT CHILDREN IN DENTAL COVERAGE

1. Offer of dependent coverage; enrollment period. All group dental insurance policies, contracts and certificates 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 [2009, c. 578, §3 (NEW); 2009, c. 578, §4 (AFF) .]

B. Any open or annual enrollment period. [2009, c. 578, §3 (NEW); 2009, c. 578, §4 (AFF) .]

§2847-R. Coverage for children's early intervention services

(As enacted by PL 2009, c. 634, §3; §5 is REALLOCATED TO TITLE 24-A, SECTION 2847-S)

§2847-R. Coverage for the diagnosis and treatment of autism spectrum disorders

(As enacted by PL 2009, c. 635, §3; §6 is REALLOCATED TO TITLE 24-A, §2847-T)

[2009, c. 578, §3 (NEW); 2009, c. 578, §4 (AFF) .]

SECTION HISTORY

2009, c. 578, §3 (NEW). 2009, c. 578, §4 (AFF). 2009, c. 634, §3 (NEW).
 2009, c. 634, §5 (AFF). 2009, c. 635, §3 (NEW). 2009, c. 635, §6 (AFF).
 2011, c. 420, Pt. A, §25 (RAL). 2011, c. 420, Pt. A, §26 (RAL).

§2847-S. COVERAGE FOR CHILDREN'S EARLY INTERVENTION SERVICES *(REALLOCATED FROM TITLE 24-A, SECTION 2847-R)*

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.

[2011, c. 420, Pt. A, §25 (RAL) .]

2. Required coverage. All group 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. [2011, c. 420, Pt. A, §25 (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. [2011, c. 420, Pt. A, §25 (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. [2011, c. 420, Pt. A, §25 (RAL) .]

[2011, c. 420, Pt. A, §25 (RAL) .]

SECTION HISTORY

2011, c. 420, Pt. A, §25 (RAL).

§2847-T. COVERAGE FOR THE DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDERS *(REALLOCATED FROM TITLE 24-A, SECTION 2847-R)*

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. [2011, c. 420, Pt. A, §26 (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. [2011, c. 420, Pt. A, §26 (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. [2011, c. 420, Pt. A, §26 (RAL).]

[2011, c. 420, Pt. A, §26 (RAL) .]

2. Required coverage. All group health insurance policies, contracts and certificates must provide coverage for autism spectrum disorders for an individual covered under a policy, contract or certificate who is 10 years of age or under in accordance with the following.

A. The policy, contract or certificate 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. [2011, c. 420, Pt. A, §26 (RAL).]

B. The policy, contract or certificate 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. [2011, c. 420, Pt. A, §26 (RAL).]

C. The policy, contract or certificate may not include any limits on the number of visits. [2011, c. 420, Pt. A, §26 (RAL).]

D. Notwithstanding section 2843 and to the extent allowed by federal law, the policy, contract or certificate 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. [2011, c. 420, Pt. A, §26 (RAL).]

E. This subsection may not be construed to require coverage for prescription drugs if prescription drug coverage is not provided by the policy, contract or certificate. 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, contract or certificate. [2011, c. 420, Pt. A, §26 (RAL).]

[2013, c. 597, §2 (AMD); 2013, c. 597, §4 (AFF) .]

3. Limits; coinsurance; deductibles. Except as otherwise provided in this section, any policy, contract or certificate 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.

[2011, c. 420, Pt. A, §26 (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.

[2011, c. 420, Pt. A, §26 (RAL) .]

SECTION HISTORY

2011, c. 420, Pt. A, §26 (RAL). 2013, c. 597, §2 (AMD). 2013, c. 597, §4 (AFF).

§2847-U. COVERAGE FOR SERVICES PROVIDED BY DENTAL HYGIENE THERAPIST

1. Services provided by dental hygiene therapist. An insurer that issues group dental insurance or health insurance that includes coverage for dental services shall provide coverage for dental services performed by a dental hygiene 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 hygiene therapist.

[2015, c. 429, §14 (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.

[2013, c. 575, §6 (NEW); 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 group health insurance is the secondary payer.

[2013, c. 575, §6 (NEW); 2013, c. 575, §10 (AFF) .]

SECTION HISTORY

2013, c. 575, §6 (NEW). 2013, c. 575, §10 (AFF). 2015, c. 429, §14 (AMD) .

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