CHAPTER 67

MEDICARE SUPPLEMENT INSURANCE POLICIES

§5001. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [PL 1981, c. 234, §4 (NEW).]

1. Applicant. "Applicant" means:

A. In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and [PL 1991, c. 740, §1 (AMD).]

B. In the case of a group Medicare supplement policy, the proposed certificate holder. [PL 1991, c. 740, §1 (AMD).]

[PL 1991, c. 740, §1 (AMD).]

2. Certificate. "Certificate" means any certificate delivered or issued for delivery in this State under a group Medicare supplement policy.
[PL 1991, c. 740, §1 (AMD).]

2-A. Certificate form. "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.
[PL 1991, c. 740, §1 (NEW).]

2-B. Issuer. "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations and any other entity delivering or issuing for delivery in this State Medicare supplement policies or certificates.
[PL 1991, c. 740, §1 (NEW).]

3. Medicare. "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as amended.
[PL 1991, c. 740, §1 (AMD).]

4. Medicare supplement policy. "Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of a nonprofit hospital or medical service organization or nonprofit health care plan or health maintenance organization other than a policy issued pursuant to a contract under the federal Social Security Act, 42 United States Code, Section 1395, et seq. or Section 1876 or an issued policy under a demonstration project specified in the 42 United States Code, Section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

A. [PL 1991, c. 740, §1 (RP).]

B. [PL 1991, c. 740, §1 (RP).]

C. [PL 1991, c. 740, §1 (RP).]

[PL 1995, c. 332, Pt. E, §1 (AMD).]

4-A. Policy form. "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.
[PL 1991, c. 740, §1 (NEW).]

4-B. Open enrollment period. "Open enrollment period" means the 6-month period beginning when an individual of any age first enrolls for benefits under Medicare Part B and the 6-month period

beginning on the 65th birthday of an individual who has enrolled for benefits under Medicare Part B before turning 65 years of age.
[PL 2001, c. 258, Pt. F, §1 (NEW).]

5. Superintendent. "Superintendent" means the Superintendent of Insurance.
[PL 1981, c. 234, §4 (NEW).]

SECTION HISTORY

PL 1981, c. 234, §4 (NEW). PL 1991, c. 740, §1 (AMD). PL 1993, c. 154, §1 (AMD). PL 1995, c. 332, §E1 (AMD). PL 2001, c. 258, §F1 (AMD).

§5001-A. Applicability and scope

1. Application. Except as otherwise specifically provided in section 5013, this chapter applies to:

A. All Medicare supplement policies delivered or issued for delivery in this State on or after the effective date of this section; and [PL 1991, c. 740, §2 (NEW).]

B. All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this State. [PL 1991, c. 740, §2 (NEW).]
[PL 1995, c. 332, Pt. E, §2 (AMD).]

2. Employers or labor organizations. This chapter does not apply to a policy of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.
[PL 1991, c. 740, §2 (NEW).]

3. Plans not marketed as Medicare supplements. Except as otherwise provided in section 5005, subsection 3-A, the provisions of this chapter are not intended to prohibit or apply to insurance policies or health care benefit plans, including group conversion policies, provided to Medicare eligible persons that are not marketed or held to be Medicare supplement policies or benefit plans.
[PL 1995, c. 332, Pt. E, §2 (AMD).]

SECTION HISTORY

PL 1991, c. 740, §2 (NEW). PL 1995, c. 332, §E2 (AMD).

§5002. Standards for policy provisions

(REPEALED)

SECTION HISTORY

PL 1981, c. 234, §4 (NEW). PL 1989, c. 27, §3 (AMD). PL 1991, c. 24, §1 (AMD). PL 1991, c. 48, §3 (AMD). PL 1991, c. 740, §3 (RP).

§5002-A. Standards for policy provisions and authority to adopt rules

1. Duplicate benefits. A Medicare supplement policy or certificate in force in the State may not contain benefits that duplicate benefits provided by Medicare.
[PL 1991, c. 740, §4 (NEW).]

2. Standardization. The superintendent may adopt rules specifying the minimum Medicare supplement contract benefits required in the State and the new and innovative benefits available for sale in the State. All other benefits or options are prohibited in a Medicare supplement contract subject to this chapter.
[PL 1993, c. 154, §2 (AMD).]

3. Preexisting conditions. Notwithstanding any other provision of law of this State, a Medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than 6

months from the effective date of coverage because the medical condition involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than as a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.
[PL 1991, c. 740, §4 (NEW).]

4. Specific standards. The superintendent shall adopt rules to establish specific standards for policy provisions of Medicare supplement policies and certificates. These standards must be in addition to and in accordance with applicable laws of this State. No requirement of the insurance laws relating to minimum required policy benefits, other than the minimum standards contained in this chapter, applies to Medicare supplement policies and certificates. The standards may cover, but are not limited to:

A. Terms of renewability; [PL 1991, c. 740, §4 (NEW).]

B. Initial and subsequent conditions of eligibility; [PL 1991, c. 740, §4 (NEW).]

C. Nonduplication of coverage; [PL 1991, c. 740, §4 (NEW).]

D. Probationary periods; [PL 1991, c. 740, §4 (NEW).]

E. Benefit limitations, exceptions and reductions, which may not be more restrictive than those of Medicare for any type of care covered under the policy; [PL 1991, c. 740, §4 (NEW).]

F. Elimination periods; [PL 1991, c. 740, §4 (NEW).]

G. Requirements for replacement; [PL 1991, c. 740, §4 (NEW).]

H. Recurrent conditions; and [PL 1991, c. 740, §4 (NEW).]

I. Definitions of terms. [PL 1991, c. 740, §4 (NEW).]
[PL 1991, c. 740, §4 (NEW).]

5. Minimum standards for benefits, claims, marketing, compensation and reporting. The superintendent shall adopt reasonable rules to establish minimum standards for benefits, claims payment, marketing practices and compensation arrangements and reporting practices for Medicare supplement policies and certificates.
[PL 1991, c. 740, §4 (NEW).]

6. Other policies not prohibited. Nothing in this section may be construed to prohibit the sale of insurance policies or contracts to persons eligible for Medicare by reason of age because those policies or contracts fail to meet the requirements of this chapter. Such policies may not be advertised, marketed or designed as Medicare supplement policies.
[PL 1991, c. 740, §4 (NEW).]

7. Method of identification. The superintendent shall prescribe the method of identification of Medicare supplement policies. The superintendent shall prescribe a method of identification of health insurance policies other than Medicare supplement policies or contracts that are advertised, marketed or designed for persons eligible for Medicare by reason of age. That method may include, but is not limited to, a requirement that such policies clearly indicate they are limited benefit health coverage policies and clearly specify that they do not meet the minimum standards for Medicare supplement policies.
[PL 1991, c. 740, §4 (NEW).]

8. Conformance of policies to federal law. The superintendent may adopt from time to time such reasonable rules as are necessary to conform Medicare supplement policies and certificates to the requirements of federal law and rules adopted pursuant to federal law, including but not limited to:

A. Requiring refunds or credits if the policies or certificates do not meet loss ratio requirements; [PL 1991, c. 740, §4 (NEW).]

B. Establishing a uniform methodology for calculating and reporting loss ratios; [PL 1991, c. 740, §4 (NEW).]

C. Assuring public access to policies, premiums and loss ratio information of issuers of Medicare supplement insurance; [PL 1991, c. 740, §4 (NEW).]

D. Establishing a process for approving or disapproving policy forms and certificate forms and proposed premium increases; [PL 1991, c. 740, §4 (NEW).]

E. Establishing a policy for holding public hearings prior to approval of premium increases; and [PL 1991, c. 740, §4 (NEW).]

F. Establishing standards for Medicare select policies and certificates. [PL 1991, c. 740, §4 (NEW).]

[PL 1991, c. 740, §4 (NEW).]

9. Prohibited policy provisions. The superintendent may adopt reasonable rules that prohibit policy provisions not specifically authorized by statute that in the opinion of the superintendent are unjust, unfair or unfairly discriminatory to any person insured or proposed to be insured under a Medicare supplement policy or certificate.

[PL 1991, c. 740, §4 (NEW).]

SECTION HISTORY

PL 1991, c. 740, §4 (NEW). PL 1993, c. 154, §2 (AMD).

§5002-B. Continuity of coverage

1. Persons provided continuity of coverage. This section provides continuity of coverage for a person who has a Medicare supplement policy and seeks coverage under a new Medicare supplement policy with the same or lesser benefits if:

A. That person, including a person entitled to Medicare benefits due to disability, has been covered under a policy that supplemented benefits under Medicare or has been covered under a Medicare Advantage plan with no gap in coverage greater than 90 days beginning with the person's open enrollment period. A policy supplementing benefits payable under Medicare may include an individual health policy, a group health plan, a Medicare supplement policy or other coverage issued by the same or a different carrier. [PL 2009, c. 244, Pt. A, §1 (AMD).]

B. [PL 2003, c. 157, §1 (RP).]

C. [PL 2003, c. 157, §1 (RP).]

[PL 2009, c. 244, Pt. A, §1 (AMD).]

2. Prohibition against discontinuity. The insurer shall, for any person described in subsection 1, waive any medical underwriting or preexisting conditions exclusion to the extent that benefits would have been payable under the prior Medicare supplement policy and any earlier Medicare supplement policy if those policies were still in effect. This subsection does not require the succeeding insurer to pay any benefits that are not within the terms of coverage of the succeeding policy solely because they would have been paid by the prior policy.

[PL 2003, c. 157, §1 (AMD).]

2-A. Low-cost drugs for the elderly or disabled program.

[PL 2013, c. 94, §1 (RP).]

3. Determination of benefits. When a determination of benefits under the prior policy is required, the issuer of the prior policy shall, at the request of the issuer of the succeeding policy, furnish a statement of benefits available or pertinent information sufficient to permit verification of the benefit determination or the determination itself by the issuer of the succeeding policy. For purposes of this

section, benefits of the prior policy are determined in accordance with the definitions, conditions and covered expense provisions of that policy rather than those of the succeeding policy. The benefit determination must be made as if coverage had not been replaced.
[PL 1999, c. 36, §4 (NEW).]

4. Rulemaking. The superintendent shall adopt rules concerning guaranteed issuance and continuity of Medicare supplement policies for certain eligible persons. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.
[PL 1999, c. 36, §4 (NEW).]

SECTION HISTORY

PL 1999, c. 36, §4 (NEW). PL 2001, c. 410, Pt. B, §7 (AMD). PL 2003, c. 157, §1 (AMD). PL 2005, c. 401, Pt. C, §7 (AMD). PL 2009, c. 244, Pt. A, §1 (AMD). PL 2013, c. 94, §1 (AMD).

§5003. Minimum standards for benefits

(REPEALED)

SECTION HISTORY

PL 1981, c. 234, §4 (NEW). PL 1989, c. 852, §1 (AMD). PL 1991, c. 740, §5 (RP).

§5004. Loss ratio standards

1. Any Medicare supplement policy or contract is subject to the minimum loss ratio standards of section 2413, subsection 1, paragraph F, as well as any other laws of this State as apply to rate filings with respect to health insurance and nonprofit hospital and medical service organizations and nonprofit health care plan contracts.
[PL 1989, c. 27, §4 (NEW).]

2. Medicare supplement policies must return to policyholders benefits that are reasonable in relation to the premium charged. The superintendent shall issue reasonable rules to establish minimum standards for loss ratios of Medicare supplement policies on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.
[PL 2001, c. 258, Pt. F, §2 (AMD).]

3.
[PL 1989, c. 852, §2 (RP); PL 1989, c. 852, §3 (AFF).]

SECTION HISTORY

PL 1981, c. 234, §4 (NEW). PL 1989, c. 27, §4 (RPR). PL 1989, c. 852, §§2,3 (AMD). PL 1991, c. 740, §6 (AMD). PL 2001, c. 258, §F2 (AMD).

§5005. Disclosure standards

1. Delivery of outline of coverage. In order to provide for full and fair disclosure in the sale of Medicare supplement policies, no Medicare supplement policy or certificate may be delivered in this State, unless an outline of coverage is delivered to the applicant at the time application is made.
[PL 1991, c. 740, §7 (AMD).]

2. Format; content or outline. The superintendent shall prescribe the format and content of the outline of coverage required by subsection 1. For purposes of this section, "format" means style, arrangements and overall appearance, including such items as the size, color and prominence of type and the arrangement of text and captions. The outline of coverage must include:

A. A description of the principal benefits and coverage provided in the policy; [PL 1981, c. 234, §4 (NEW).]

B. [PL 1991, c. 740, §7 (RP).]

C. A statement of the renewal provisions, including any reservation by the issuer of a right to change premiums; and disclosure of the existence of any automatic renewal premium increases based on the policyholder's age; and [PL 1991, c. 740, §7 (AMD).]

D. A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions. [PL 1981, c. 234, §4 (NEW).]

[PL 1991, c. 740, §7 (AMD).]

3. Standard form; contents of informational brochure. The superintendent may prescribe by rule a standard form and the contents of an informational brochure for persons eligible for Medicare, which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of Medicare. Except in the case of direct response insurance policies, the superintendent may require by regulation that the informational brochure be provided to any prospective insureds eligible for Medicare concurrently with the delivery of the outline of coverage. With respect to direct response insurance policies, the superintendent may require by rule that the prescribed brochure be provided upon request to any prospective insureds eligible for Medicare, but in no event later than the time of policy delivery.

[PL 1991, c. 740, §7 (AMD).]

3-A. Captions or notice requirements. The superintendent may adopt rules for captions or notice requirements determined to be in the public interest and designed to inform the prospective insureds that particular insurance coverages are not Medicare supplement coverages for all accident and sickness insurance policies sold to persons eligible for Medicare other than:

A. Medicare supplement policies; or [PL 1995, c. 332, Pt. E, §3 (AMD).]

B. Disability income policies. [PL 1995, c. 332, Pt. E, §3 (AMD).]

C. [PL 1995, c. 332, Pt. E, §3 (RP).]

D. [PL 1995, c. 332, Pt. E, §3 (RP).]

[PL 1995, c. 332, Pt. E, §3 (AMD).]

3-B. Application forms; health statements. Additional disclosure is required in applications or enrollment forms employed on or after January 1, 1993.

A. An issuer including health status questions in an application or enrollment form employed during an applicant's open enrollment period shall disclose that coverage in any plan offered by the issuer is guaranteed to be issued and will be provided without regard to health status. [PL 1991, c. 740, §7 (NEW).]

B. An issuer including health status questions in an application or enrollment form shall disclose to applicants enrolling after their open enrollment period, including applicants replacing coverage, that enrollment in standard Medicare Supplement Plan A is guaranteed to be issued during the annual guaranteed issue period and will be provided without regard to health status. [PL 1991, c. 740, §7 (NEW).]

C. Enrollment or application forms employed to effect the replacement of coverage provided by section 5010 must disclose that:

(1) For all persons, coverage in the standardized Medicare supplement plans that do not contain an outpatient prescription drug benefit is guaranteed to be issued and will be provided without regard to health status and without preexisting conditions exclusions, waiting periods, elimination periods or probationary periods for similar benefits to the extent time was spent under prior coverage; and

(2) For persons with existing prescription drug coverage, coverage in the standardized Medicare supplement plans that do not contain an outpatient prescription drug benefit greater than that provided by the plan that is in force is guaranteed to be issued and will be provided without regard to health status and without preexisting conditions exclusions, waiting periods, elimination periods or probationary periods for similar benefits to the extent time was spent under prior coverage. [PL 1991, c. 740, §7 (NEW).]

D. [PL 2001, c. 258, Pt. F, §3 (RP).]

[PL 2001, c. 258, Pt. F, §3 (AMD).]

4. Rules. The superintendent may adopt reasonable rules to govern the full and fair disclosure of information in connection with the replacement of accident and sickness policies, subscriber contracts or certificates by persons eligible for Medicare.

[PL 1991, c. 740, §7 (AMD).]

SECTION HISTORY

PL 1981, c. 234, §4 (NEW). PL 1991, c. 740, §7 (AMD). PL 1995, c. 332, §E3 (AMD). PL 2001, c. 258, §F3 (AMD).

§5006. Preexisting conditions

(REPEALED)

SECTION HISTORY

PL 1981, c. 234, §4 (NEW). PL 1991, c. 740, §8 (RP).

§5006-A. Filing requirements for advertising

Every issuer of Medicare supplement insurance policies or certificates in this State shall provide a copy of any Medicare supplement advertisement intended for use in this State, whether through written, radio or television medium, to the superintendent for review or approval by the superintendent at least 30 days prior to the date the advertisement will be used in this State. [PL 1991, c. 740, §9 (NEW).]

SECTION HISTORY

PL 1991, c. 740, §9 (NEW).

§5007. Notice of free examination

Medicare supplement policies and certificates must have a notice prominently printed on the first page of the policy or certificate or attached to the policy or certificate, stating in substance that the applicant has the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Any refund made pursuant to this section must be paid directly to the applicant by the issuer in a timely manner. [PL 1991, c. 740, §10 (AMD).]

SECTION HISTORY

PL 1981, c. 605 (NEW). PL 1989, c. 27, §5 (AMD). PL 1991, c. 740, §10 (AMD).

§5008. Minimum standards for benefits and claims payment

(REPEALED)

SECTION HISTORY

PL 1989, c. 27, §6 (NEW). PL 1991, c. 740, §11 (RP).

§5009. Filing requirements for advertising

(REPEALED)

SECTION HISTORY

PL 1989, c. 27, §6 (NEW). PL 1991, c. 740, §12 (RP).

§5010. Replacement of policies issued prior to January 1, 1992

1. Applicability. This section applies to individual policies and group certificates and policies issued in Maine or covering Maine residents.
[PL 1991, c. 740, §13 (NEW).]

2. Insured's right to replace coverage. Insureds under Medicare supplement policies issued prior to January 1, 1992 shall be permitted at any time to replace their coverage with any of the standardized plans offered by the same insurer, subject to the following conditions.

A. The issuer may decline to issue a particular standardized plan to an existing insured if:

(1) The standardized plan includes coverage of prescription drugs greater than that in the plan being replaced; and

(2) The insured does not otherwise qualify for the standardized plan. [PL 1991, c. 740, §13 (NEW).]

B. If the standardized plan is rated on the basis of age at issue, the issuer shall use the insured's age at the time of issue of the prior policy. [PL 1991, c. 740, §13 (NEW).]

C. The issuer shall provide at each policy anniversary, and at the time of any rate increase, a notice describing the standardized plans which are available and the rates for those plans. [PL 1991, c. 740, §13 (NEW).]
[PL 1993, c. 154, §3 (AMD).]

3. Mandatory replacement. Prior to October 1, 1992, all issuers shall submit to the superintendent a copy of each Medicare supplement policy form for which policies issued prior to January 1, 1992 are in force in Maine and a list of standardized plans offered on the effective date of this section. The issuer shall designate the standardized plan, if any, that has substantially similar benefits to the policy issued prior to January 1, 1992. For any of the policies that the superintendent determines are substantially similar to one of the offered standardized plans, the issuer shall replace the policy with the similar standardized plan or, at the option of the insured, one of the other standardized plans selected by the insured pursuant to subsection 2, on or before the first policy anniversary after June 30, 1993.
[PL 1993, c. 154, §3 (AMD).]

SECTION HISTORY

PL 1991, c. 740, §13 (NEW). PL 1993, c. 154, §3 (AMD).

§5010-A. Coverage of the disabled

An issuer offering coverage under a Medicare supplement policy in this State shall offer coverage under its standardized plans to all individuals, regardless of age, who are entitled to Medicare benefits due to disability. An issuer shall offer such coverage during an individual's open enrollment period under any of the policies offered by the issuer to persons eligible for Medicare benefits due to age. An issuer shall also offer standardized Medicare Supplement Plan A to persons entitled to Medicare benefits due to disability during the guaranteed issue period as set forth in section 5012. An individual who is entitled to Medicare benefits due to disability must be provided continuity of coverage in accordance with section 5002-B. Issuers shall give notice of Medicare supplement coverage to individuals enrolled in Medicare in advertising of Medicare supplement policies intended for use in this State. By January 1, 1994, the superintendent shall establish rules to ensure that the notice of the availability of coverage for the disabled is sufficiently advertised. [PL 2003, c. 157, §2 (AMD).]

SECTION HISTORY

PL 1993, c. 304, §1 (NEW). PL 1993, c. 547, §5 (AMD). PL 2003, c. 157, §2 (AMD).

§5011. Rating restrictions

1. Community rating. This subsection applies to any policy delivered or issued for delivery on or after January 1, 1993. It also applies, as of the first policy or certificate anniversary on or after January 1, 1993, to policies or certificates delivered or issued for delivery in 1992.

A. Rates for policies subject to this subsection may not vary based on age, gender, health status, claims experience, policy duration, industry or occupation. [PL 1991, c. 740, §13 (NEW).]

B. In revising rates for standardized plans, an issuer shall pool all experience for standardized plans under individual policies. Experience may be pooled separately for each standardized plan or experience for similar benefits in different standardized plans may be pooled, including, but not limited to, basing the component of the rate for skilled nursing coinsurance on the pooled experience of all standardized plans that include that benefit. Group plans may be rated separately. A group with credible experience may be rated differently than other groups. [PL 2001, c. 258, Pt. F, §4 (AMD).]

C. An issuer that offers both group and individual plans may not use stricter medical underwriting standards for any group plan than it uses for individual plans. [PL 2001, c. 258, Pt. F, §5 (NEW).]

D. An issuer may not use stricter medical underwriting standards than any affiliated issuer uses for its individual plans. [PL 2001, c. 258, Pt. F, §5 (NEW).]

[PL 2001, c. 258, Pt. F, §§4, 5 (AMD).]

2. Discounts. Issuers that do not vary rates for a standardized plan based on age, gender, health status, claims experience, policy duration, industry or occupation, and that do not refuse issue of that plan to any individual or group based on health status, may provide discounts on that plan to individuals who purchase coverage during their initial period of enrollment in Medicare Part B at or after 65 years of age, subject to approval by the superintendent. The superintendent may adopt rules governing the appropriate use of discounts.

[PL 2003, c. 428, Pt. H, §7 (AMD).]

SECTION HISTORY

PL 1991, c. 740, §13 (NEW). PL 2001, c. 258, §§F4,5 (AMD). PL 2003, c. 428, §H7 (AMD).

§5012. Annual guaranteed issue period

During a guaranteed issue period of at least one month each calendar year, as established by the issuer, every issuer shall offer standardized Medicare Supplement Plan A, as defined by rule, to all applicants on a basis that does not deny coverage to any individual or group based on health status, claims experience, receipt of health care, or medical condition. [PL 1991, c. 740, §13 (NEW).]

SECTION HISTORY

PL 1991, c. 740, §13 (NEW).

§5013. Notice regarding policies that are not Medicare supplement policies

Any individual accident and sickness insurance policy or group insurance certificate, including the contract of a nonprofit hospital and medical service or health care plan issued for delivery in this State to persons eligible for Medicare, must notify insureds that the policy or certificate is not a Medicare supplement policy or certificate. The notice must be either printed on or attached to the first page of the outline of coverage delivered to insureds or, if no outline of coverage is delivered, to the first page of the policy or certificate. The notice must be in no less than 12-point type and must contain the following language:

"THIS (POLICY OR CERTIFICATE) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CERTIFICATE). If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company. If you have a Medicare supplement policy or major medical policy,

this coverage may be more than you need. For information call the Bureau of Insurance at (toll-free phone number)." [PL 1995, c. 570, §8 (AMD).]

This section does not apply to a Medicare supplement policy; a policy issued pursuant to a contract under the Federal Social Security Act, 42 United States Code, Section 1395, et seq., Section 1876; a disability income policy; or a policy identified in section 5001-A, subsection 2. [PL 1995, c. 570, §8 (AMD).]

SECTION HISTORY

PL 1991, c. 740, §13 (NEW). PL 1993, c. 154, §4 (AMD). PL 1995, c. 570, §8 (AMD).

§5014. Additional penalties

1. Penalties. In addition to any other applicable penalties for violations of this Title or Title 24, the superintendent may order issuers violating any provision of this chapter or any rule adopted pursuant to this chapter to:

A. Comply with the provisions of this chapter; or [PL 1995, c. 570, §9 (NEW).]

B. Cease marketing any Medicare supplement policy or certificate in this State that is directly or indirectly related to a violation. [PL 1995, c. 570, §9 (NEW).]

[PL 1995, c. 570, §9 (NEW).]

2. Election of penalty options. The superintendent may exercise any of the penalty options provided by this section, in combination or in sequence, as the superintendent considers appropriate.
[PL 1995, c. 570, §9 (NEW).]

SECTION HISTORY

PL 1995, c. 570, §9 (NEW).

§5015. Right to repurchase

(REPEALED)

SECTION HISTORY

PL 1997, c. 370, §D1 (NEW). PL 1999, c. 36, §5 (RP).

§5016. Notification prior to cancellation; restrictions on lapse or termination due to cognitive impairment or functional incapacity

1. Notice of cancellation. An insurer that issues Medicare supplement policies shall provide notification to the insured person and another person, if designated by the insured, prior to cancellation of a Medicare supplement policy for nonpayment of premiums.
[PL 2011, c. 123, §4 (NEW); PL 2011, c. 123, §5 (AFF).]

2. Right to reinstatement. Within 90 days after cancellation, termination or lapse of coverage 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 the policy may request reinstatement of the policy 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, termination or lapse. 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.

A policy reinstated pursuant to this subsection must cover any loss or claim occurring from the date of the termination, cancellation or lapse and must be issued without any evidence of insurability. Within 15 days after request from an insurer, a policyholder of a policy reinstated pursuant to this subsection shall pay any unpaid premium from the date of the last premium payment at the rate that would have

been in effect had the policy remained in force. If the premium is not paid as required, the policy may not be reinstated and the insurer is not responsible for claims incurred after the initial date of cancellation. If an insurer denies a request for reinstatement, the insurer shall notify the policyholder that the policyholder may request a hearing before the superintendent.
[PL 2011, c. 123, §4 (NEW); PL 2011, c. 123, §5 (AFF).]

3. Rules. The superintendent may adopt rules to implement the requirements of this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. The requirements of this section apply to all policies and certificates executed, delivered, issued for delivery, continued or renewed in this State.
[PL 2011, c. 123, §4 (NEW); PL 2011, c. 123, §5 (AFF).]

SECTION HISTORY

PL 2011, c. 123, §4 (NEW). PL 2011, c. 123, §5 (AFF).