

Table of Contents

Section 1. Purpose.....3
Section 2. Authority.....3
Section 3. Applicability and Scope.....3
Section 4. Rule Definitions3
Section 5. Policy Definitions6
Section 6. Meaning of “Guaranteed Renewable” and “Noncancelable”;
Allowed Limitations and Exclusions7
Section 7. Preventing Unintentional Lapse of Coverage13
Section 8. Policy Disclosures14
Section 9. Disclosing Rating Practices to Applicants16
Section 10. Initial Rate Filing with Superintendent.....19
Section 11. Prohibition Against Post-Claims Underwriting.....22
Section 12. Minimum Home Care and Community Care Benefits23
Section 13. Required Offer of Inflation Benefit24
Section 14. Replacing Existing Insurance: Cautionary Notice to Applicant25
Section 15. Prohibition Against New Waiting Periods in Replacement Plans27
Section 16. Annual Reports to Superintendent: Lapsed and Replaced Policies27
Section 17. Licensing of Producers.....30
Section 18. Discretionary Powers of Superintendent30
Section 19. Reserve Standards30
Section 20. Premium Rate Increase Procedures.....32
Section 21. Filing of Advertising with Superintendent39
Section 22. Standards for Marketing.....39
Section 23. Applicant’s Suitability for Long-Term Care Insurance42
Section 24. Availability of New Services or Providers44
Section 25. Right to Reduce Coverage and Lower Premiums45
Section 26. Required Offer of Nonforfeiture Benefit; Contingent Nonforfeiture
Benefit Upon Lapse46
Section 27. Standards for Benefit Triggers51
Section 28. Additional Standards for Benefit Triggers for Federally Qualified
Long-Term Care Insurance Contracts.....53
Section 29. Delivery of Outline of Coverage; Standard Format for Outline54
Section 30. Delivery of Shopper’s Guide55
Section 31. Payment of Claims56
Section 32. Appealing a Claims Denial58

Section 33.	External Review	61
Section 34.	Transition.....	64
Section 35.	Effective Date	64
APPENDIX A	Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance	65
APPENDIX B	Applicant Suitability Worksheet.....	67
APPENDIX C	Suitability Disclosure to Applicant:.....	70
APPENDIX D	Producer’s or Insurer’s Suitability Letter to Applicant.....	72
APPENDIX E	Contingent Nonforfeiture Benefit Upon Lapse Occasioned by Substantial Rate Increase; Schedule of Rate Increases that Trigger Contingent Benefit.....	73
APPENDIX F	Contents and Format of Outline of Coverage	78

Section 1. Purpose

The purposes of this rule are to implement the Long-Term Care Insurance law, 24-A M.R.S.A. §§ 5071-5083, to promote the public interest, to increase the availability of long-term care insurance coverage, to protect applicants for long-term care insurance from unfair or deceptive sales and enrollment practices, to facilitate public understanding and comparison of long-term care coverages, and to encourage flexibility and innovation in the development of long-term care insurance.

Section 2. Authority

The Superintendent of Insurance (the superintendent) adopts this rule pursuant to the authority vested in him by 24 M.R.S.A. §§ 2316 and 2321 and by 24-A M.R.S.A. §§ 212, 2412, 2413, 2414, 2736, 5071, 5072, 5073, 5074, 5075, 5077, 5078, 5080, 5083, and 5084.

Section 3. Applicability and Scope

Except as otherwise provided in 24-A M.R.S.A. §§ 5072(4)(A)-(C) and 5073, this rule applies to: all individual and group long-term care insurance policies; to long-term care insurance group certificates; and to individual and group annuities and life insurance policies or riders that provide or supplement coverage for long-term care insurance. The rule applies to any such instrument delivered or issued for delivery in this state on and after the effective date of this rule and to any product advertised, marketed or offered in this state as long-term care insurance. The entities subject to this rule are: insurers; fraternal benefit societies; non-profit health care, hospital and medical service corporations; health maintenance organizations; prepaid health plan organizations; and other similar entities as defined in 24-A M.R.S.A. §5072(4). The rule does not apply to certificates delivered under policies issued in other states to employer groups described in 24-A M.R.S.A. §2804, and to labor union groups described in 24-A M.R.S.A. §2805.

(Drafting Note: This rule does not apply to contracts issued or issued for delivery in other states even if the insured becomes a resident of this state.)

Section 4. Rule Definitions

As used in this rule, unless the context otherwise indicates, the following terms have the following meanings:

- A. “Adverse benefit trigger determination” means a claims denial determining that the insured has not satisfied a required clinical standard for benefit eligibility, as described more fully in Sections 27 and 28, including, when applicable under the

contract, the existence or degree of cognitive impairment, chronic illness, or inability to perform one or more specified activities of daily living.

- B. “Authorized representative” means:
- (1) A person to whom an insured has given express written consent to represent the insured in a standard appeal or an external review;
 - (2) A person authorized by law to provide consent to request an internal appeal or an external review for an insured; or
 - (3) A family member of an insured or an insured’s treating health care professional when the insured is unable to provide consent to request an internal appeal or an external review.
- C. “Bureau” means the Maine Bureau of Insurance.
- D. “Claims denial” means any reduction of a benefit, termination of a benefit, or failure to provide or make payment (in whole or in part) for a benefit, including a determination of an insured’s ineligibility for benefits. The term “claims denial” includes both clinical decisions and benefit determinations that do not involve clinical decisions.
- E. “Claims denial eligible for external review” means an adverse benefit trigger determination or a claims denial that requires the exercise of professional judgment within the scope of practice of a health care professional on the applicability of the following policy limitations or exclusions:
- (1) A preexisting condition or disease;
 - (2) Mental or nervous disorders;
 - (3) Alcoholism and drug addiction;
 - (4) Illness, medical condition or treatment arising from:
 - (a) War or act of war (whether declared or undeclared);
 - (b) Participation in a felony, riot or insurrection;
 - (c) Service in the armed forces or units auxiliary thereto;
 - (d) Suicide, attempted suicide or any intentionally self-inflicted injury; or
 - (e) Aviation.

- F. “Exceptional increase” in premiums means a rate increase the insurer designates as exceptional, and that the superintendent determines is justified because it arises from any of the following causes:
- (1) Changes in laws or regulations applicable to long-term care insurance in this state; or
 - (2) Increased and unexpected utilization that affects at least a majority of insurers of similar products.
- G. “Incidental,” as used in Section 20(J), means that the value of the long-term care benefits is less than ten percent of the total value of benefits provided over the life of the policy. These values shall be measured as of the date of issue.
- H. “Qualified actuary” means a member in good standing of the American Academy of Actuaries.
- I. “Similar policy forms” means all of the long-term care policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of employee groups as defined in 24-A M.R.S.A. §2804, labor union groups as defined in 24-A M.R.S.A. §2805, or trustee groups as defined in 24-A M.R.S.A. §2806 are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. The different benefit classifications are: institutional benefits only; non-institutional benefits only; and comprehensive (institutional and non-institutional) benefits.
- J. “Substantive issue” means a matter that is integral to the determination of whether the insured is eligible for benefits under a policy and that involves information essential for the insurer to have prior to paying the claim. A substantive issue includes the issues generated by the items described in Sections 31(A)(1) through 31(A)(5). A substantive issue also includes information necessary to pay the claim that the insurer is unable to obtain because the provider refuses to provide it or because it is not available from sources other than the insured or the insured’s authorized representative.
- K. “Technical issue” means a matter that is procedural in nature or not integral to the determination of whether the insured is entitled to benefits under the policy. Examples of a technical issue are an insurer’s lack of receipt of completed forms that duplicate information that the insurer already has or the license number for a long-term care facility.

Section 5. Policy Definitions

No long-term care insurance policy shall use the terms set forth in this section unless the terms are defined in the policy and are consistent with the following definitions:

- A. “Activities of daily living” means, at a minimum, bathing, continence, dressing, eating, toileting and transferring.
- B. “Acute condition” means that the individual is medically unstable and requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.
- C. “Adult day care” means a program for six or more individuals of social and health-related services provided during the day in a community group setting, for the purpose of supporting frail, impaired, elderly or other disabled adults who can benefit from care in a group setting outside the home.
- D. “Bathing” means washing oneself by sponge bath, or in a tub or shower, including the task of getting into or out of the tub or shower.
- E. “Cognitive impairment” means a deficiency in a person’s short-term or long-term memory, orientation as to person, place or time, deductive or abstract reasoning, or judgment as it relates to safety awareness.
- F. “Continence” means the ability to maintain control of bowel or bladder functions, or, when unable to maintain such control, the ability to perform associated personal hygiene, including caring for a catheter or colostomy bag.
- G. “Dressing” means putting on and taking off all items of clothing and any necessary brace, fastener or artificial limb.
- H. “Eating” means feeding by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenous line.
- I. “Hands-on assistance” means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activity of daily living.
- J. “Home health care services” means medical and non-medical services rendered in their residences to ill, disabled or infirm persons, including homemaker services, assistance with activities of daily living and respite care.
- K. “Medicare” means “The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended,” or “Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the *Health Insurance for*

the Aged Act, as then constituted and any later amendments or substitutes thereof,” or words of similar import.

- L. “Mental or nervous disorder” means any one of the following: neurosis, psychoneurosis, psychopathy, psychosis, or other mental or emotional disease or disorder.
- M. “Personal care” means the rendering of hands-on services by another person to assist the individual in the activities of daily living.
- N. “Skilled nursing care,” “personal care,” “home care,” “specialized care,” “assisted living care” and other service described in the policy shall be defined in relation to the level of skill required, the nature of the care and the setting in which the services are provided.
- O. “Skilled nursing facility,” “extended care facility,” “convalescent nursing home,” “personal care facility,” “specialized care providers,” “assisted living facility,” and “home care agency” and all other service providers shall be defined in relation to the facilities and the required available services, together with the licensure, certification, registration or degree status of the persons who provide services and those who supervise the services. When the definition requires that the provider be appropriately licensed, certified or registered, it shall also state what requirements a provider must meet in lieu of licensure, certification or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified or registered, or when the state licenses, certifies or registers the provider of services under another name.
- P. “Toileting” means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- Q. “Transferring” means moving into or out of a bed, chair or wheelchair.

Section 6. Meaning of “Guaranteed Renewable” and “Noncancelable”; Allowed Limitations and Exclusions

- A. **Renewability.** The terms “guaranteed renewable” or “noncancelable” shall be used in any long-term care insurance policy along with a disclosure, as required by Section 8, defining or explaining the terms.
 - (1) No policy shall contain any renewal provision other than “guaranteed renewable” or “noncancelable.”
 - (2) The term “guaranteed renewable” may be used only if the insured has the right to continue the insurance in force by the timely payment of premiums and if the insurer (a) has no unilateral contractual right to

change any policy provision while the insurance is in force or (b) has no right to decline renewal, except on prior approval from the superintendent to a rate change on a class basis that applies statewide. The definition of “class” may not be based on health status or claims experience.

- (3) The term “noncancelable” may be used only if the insured has the right to continue the policy in force by the timely payment of premiums and the insurer has no unilateral right to change any policy provision or the premium rate.
- (4) The term “level premium” may be used only when the insurer does not have the right to change the premium.

B. **Limitations and Exclusions.** A policy may not be issued as long-term care insurance if the policy excludes or limits coverage by the type of illness, medical condition or accident or the kind of treatment, except as follows:

- (1) A preexisting condition or disease, which shall be defined and covered as required under 24-A M.R.S.A. §5075(2);
- (2) Mental or nervous disorders; however, there shall be no exclusion or limitation for any disorder or disease, such as Alzheimer’s Disease, which demonstrably is the result of an organic cause;
- (3) Alcoholism and drug addiction;
- (4) Illness, medical condition or treatment arising from:
 - (a) War or act of war (whether declared or undeclared);
 - (b) Participation in a felony, riot or insurrection;
 - (c) Service in the armed forces or units auxiliary thereto;
 - (d) Suicide, attempted suicide or any intentionally self-inflicted injury; or
 - (e) Aviation (this exclusion applies only to non-fare paying passengers).
- (5) Treatment in a government facility (unless otherwise required by law); services for which benefits are available under Medicare or other governmental program (except Medicaid); any federal or state workers compensation, employer liability or occupational disease law; any vehicle no-fault law; services provided to the insured by a person in the insured’s immediate family; and services for which usually no charge is made in the absence of insurance coverage.

- (6) Expenses for services or items paid under another long-term care insurance or health insurance policy;
- (7) In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.
- (8)
 - (a) This Section is not intended to prevent any exclusion or limitation based on the type of provider. However, no long-term care issuer may deny a claim because services are provided in a state other than the state of policy issued under the following conditions:
 - (i) When the state other than the state of policy issue does not have the provider licensing, certification or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification or registration; or
 - (ii) When the state other than the state of policy issue licenses, certifies or registers the provider under another name.
 - (b) For purposes of this section, “state of policy issue” means the state in which the individual policy or certificate was originally issued.
- (9) This subsection is not intended to prohibit territorial limitations.

C. **Extension of Benefits.** Termination of insurance shall be without prejudice to any benefit payable for institutionalization if the institutionalization began while the insurance was in force and continues without interruption after termination. The extension of benefits beyond the date of termination may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits, and also may be made subject to any waiting period or other applicable policy provision.

D. **Continuation and Conversion of Group Coverage**

- (1) Every group long-term care insurance policy or rider shall contain a provision for continuation or conversion of the group coverage to individual coverage.
- (2) “Continuation of coverage” means a provision that maintains coverage under the group policy that would otherwise terminate and under which maintenance of coverage is subject only to the timely payment of premiums. Group policies that restrict payment of benefits or services, or that contain incentives for the insured to use certain health care providers or facilities, may provide continuation of coverage with benefits substantially equivalent to benefits under the group policy. The

superintendent may make a determination as to the substantial equivalency of benefits, taking into consideration any difference between managed care and non-managed care plans, including such factors as provider system arrangements, availability of services, benefit levels and administrative complexity.

- (3) “Conversion of coverage” means a policy provision entitling an insured, without establishing insurability, to have the group insurer issue a converted (*i.e.*, an individual) policy upon termination of the group coverage for any reason, including discontinuance of the policy in its entirety or with respect to an insured class. The right to conversion may be subject to the condition that the insured be covered under the group policy (or in combination with a group policy it replaced) continuously for at least six months prior to the termination.
- (4) “Converted policy” means an individual policy containing benefits identical to (or benefits the superintendent determines to be substantially equivalent to), or in excess of, the group policy from which conversion occurs. If the converted policy restricts benefits or services, or contains incentives for the insured to use certain health care providers or facilities, the superintendent may consider, in determining substantial equivalency, any difference between managed care and non-managed care plans, including such factors as provider system arrangements, availability of services, benefit levels and administrative complexity. There shall be credit for that portion of the waiting period satisfied, except with respect to an increase in benefits the insured voluntarily selects.
- (5) The insured shall apply in writing for conversion in a manner the insurer directs and shall pay the first premium, if it becomes due, no later than 31 days after termination of the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.
- (6) The premium for the individual policy shall be calculated based on the insurer’s age at the time of inception of coverage under the group policy unless the group policy from which conversion is made replaced previous group coverage. When the terminated group coverage replaced other group coverage, the premium for the individual policy shall be calculated on the basis of the insured’s age at the inception of coverage under the first group policy.
- (7) Continued or converted coverage is mandatory for the insurer, except when:
 - (a) Termination of the group coverage was the result of failure to timely pay the premium or contribution; or

-
- (b) The terminated coverage is replaced no later than 31 days after the termination by new group insurance, which begins no later than the day after the date of termination; the new group policy provides benefits identical (or substantially equivalent, as the superintendent may determine) to the terminated coverage; and the premium is calculated as described in Section 6.
- (8) Notwithstanding any contrary provision in Section 6, an individual policy issued pursuant to conversion may contain a reduction of benefits provision if the insured has another long-term care policy which pays benefits based on incurred expenses. The reduction of benefits may occur if the additional coverage, when combined with the benefits under the converted policy, exceeds 100% of incurred expenses. The insurer may enforce a reduction of benefits provision only if the converted policy requires a reduction or refund of premium reflecting the reduced benefits.
- (9) The converted policy may provide that its benefits together with the benefits under the terminated group policy shall not exceed benefits payable under the group coverage, had it remained in force.
- (10) Notwithstanding any provision of Section 6, an insured whose eligibility for group coverage is based on his/her relationship to another person, shall be entitled to a continuation of the group policy if the qualifying relationship ended because of death or dissolution of marriage.
- (11) For the purposes of Section 6, a managed-care plan is a health care or assisted living plan designed to coordinate patient care or to control costs through utilization review, case management or use of provider networks.
- E. **Discontinuance and Replacement.** If a group policy is replaced by another group policy issued to the same policyholder, the successor insurer shall offer long-term care coverage to all persons insured, as of the termination date, under the previous policy. Coverage and premiums under the successor policy:
- (1) Shall not result in an exclusion for any preexisting condition for which there would be coverage under the replaced policy; and
- (2) Shall not vary or depend on the insured's health or disability status, claim experience or prior use of long-term care services.
- F. **Premiums**
- (1) The premium charged to an insured shall not increase because of either:
- (a) The increasing age of the insured at ages beyond 65; or

- (b) The duration the insured has been covered under the policy.
- (2) The purchase of additional coverage shall not be considered a premium rate increase for the purpose of the calculation required by Section 26, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.
- (3) A reduction in benefits shall not be considered a premium change, but, for the purpose of the calculation under Section 26, the initial annual premium shall be based on the reduced benefits.

G. Electronic Signatures

- (1) In the case of an employee group as defined in 24-A M.R.S.A. §2804, a labor union groups as defined in 24-A M.R.S.A. §2805, or a trustee groups as defined in 24-A M.R.S.A. §2806, any requirement that an insurer or producer obtain the insured's signature shall be deemed satisfied if:
 - (a) The insurer, producer or policyholder receives the insured's consent by telephonic or electronic enrollment. A verification of enrollment information shall be provided to the enrollee;
 - (b) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records; and
 - (c) Such enrollment contains reasonable and necessary safeguards to protect the confidentiality of information which 24-A M.R.S.A. §§ 2201-2220 define as privileged information.
- (2) On request, the insurer shall make available to the superintendent records that demonstrate the insurer's ability to confirm enrollments and the amounts of coverage.

H. Certificateholder's Right to Copy of Group Policy. Every group long-term care insurance policyholder shall inform the certificateholder of the right, at his/her request to the insurer and at no charge to the certificateholder, to receive a copy of the group policy from the insurer or the policyholder. Every certificate also shall disclose that if there is any inconsistency between the policy and the certificate, the policy shall control.

Section 7. Preventing Unintentional Lapse of Coverage

As protection against unintentional lapse, each insurer offering long-term care insurance shall comply with the following requirements:

A. Notice Before Lapse or Termination Date

- (1) No individual policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's *full name* and *home address*. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice." The insurer shall notify the insured of the right to change this written designation, no less often than once every two years.
- (2) When the policyholder or certificateholder pays the premium for a policy or certificate through a payroll or pension deduction plan, the requirements of Paragraph (1) need not be met until 60 days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.
- (3) Lapse or termination for nonpayment of premium. No individual policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to Section 7(A)(1), at the address or addresses provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid. Notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of five days after the date of mailing.

- B. **Reinstatement.** In addition to the requirement in Section 7(A), a policy or certificate shall include a provision for reinstatement of coverage in the event of lapse if the insurer is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. Such reinstatement shall be available to the insured if requested within five months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

Section 8. Policy Disclosures

- A. **Renewability.** All long-term care insurance policies shall contain a renewability provision. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state that the coverage is guaranteed renewable or noncancelable. This subsection shall not apply to policies that do not contain a renewability provision and under which the right to nonrenew is reserved solely to the policyholder.
- B. **Riders and Endorsements.** Except for riders or endorsements that effectuate a request made in writing by the insured under an individual policy after date of issue or at reinstatement or renewal that reduce or eliminate the policy, all riders or endorsements added to an individual long-term care insurance policy after the date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in a writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider or endorsement.
- C. **Payment of Benefits.** A policy that provides for the payment of benefits based on standards described as “usual and customary,” “reasonable and customary,” or words of similar import, shall comply with the following requirements:
- (1) It must include a definition of these terms and an explanation of the terms in its accompanying outline of coverage.
 - (2) It must clearly disclose that the insured or enrollee may be subject to balance billing as a result of claims adjustment

- (3) It must provide a toll-free number that an insured or enrollee may call prior to receiving services to determine the maximum allowable charge permitted by the carrier for a specified service.
- (4) The carrier must provide to the superintendent on request complete information on the methodology and specific data used by the carrier or any 3rd party on behalf of the carrier in adjusting any claim submitted by or on behalf of the insured or enrollee. In considering the reasonableness of the methodology for calculating maximum allowable charges, the superintendent shall consider whether the methodology takes into account relevant data specific to this State if there is sufficient data to constitute a representative sample of charge data for the same or comparable service.

- D. **Limitations.** If a policy or certificate contains any limitations with respect to preexisting conditions defined in accordance with 24-A M.R.S.A. §5075(2), the limitations shall appear as a separate paragraph in the policy or certificate and shall be labeled as “Preexisting Condition Limitations.”
- E. **Other Limitations or Conditions on Eligibility for Benefits.** A policy or certificate containing any limitation or condition for eligibility, other than those prohibited by 24-A M.R.S.A. §5075, shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate labeled “Limitations or Conditions on Eligibility for Benefits.”
- F. **Disclosure of Federal and State Income Tax Consequences**

The face page of the policy, certificate or rider shall state prominently whether the policy or certificate is intended to qualify for income tax benefits under federal law and state law.

- (1) If the insurer intends tax qualification under federal law, the face page also shall state that the insurer intends tax qualification under Maine law. The statement for income tax qualification shall provide in substance that:

This [policy][certificate][rider] is intended to be a federally tax-qualified contract under Internal Revenue Code §7702(B)(b), and also is intended to be a state tax-qualified contract pursuant to 36 M.R.S.A. §5122(2)(L). The person who pays the premiums may be entitled to an income-tax deduction. The insured should seek the assistance of a personal tax advisor.

- (2) If the insurer does not intend tax qualification under the *Internal Revenue Code*, the policy, certificate or rider may nevertheless be eligible for tax qualification as a long-term care insurance policy under Maine law, pursuant to 24-A M.R.S.A. §5075-A. If the policy, certificate or rider does

not qualify under the Internal Revenue Code, but is certified under Maine law as “eligible long-term care insurance,” the statement for income tax qualification shall provide in substance that:

This [policy][certificate][rider] is intended to be a Maine state tax-qualified contract pursuant to 36 M.R.S.A. §5122(2)(L). The person who pays the premiums may be entitled to a Maine income-tax deduction. The [policy][certificate][rider] is not intended to qualify for federal income tax benefits. The insured should seek the assistance of a personal tax advisor.

- (3) Every disclosure statement, whether or not tax qualification is intended, shall provide that the insured should seek assistance from a personal tax advisor.

G. **Disclosure of Tax Consequences Arising from Accelerated Benefits in Life Insurance Policy.** In life insurance policies containing an accelerated benefit for long-term care, there shall be a prominent statement disclosing that payment of accelerated benefits may be taxable as income, and that the insured should seek the assistance of a personal tax advisor.

H. **Benefit Triggers.** Activities of daily living and cognitive impairment shall be used to measure an insured’s need for long-term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled “Eligibility for the Payment of Benefits.” Any additional benefit triggers shall also be explained in this section. If these triggers differ for different benefits, an explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this level also shall be specified.

I. **Free-Look Provision.** Every long-term care insurance policy or certificate shall contain a notice prominently printed on the face page or attached to the policy or certificate stating that the applicant or enrollee 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.

Section 9. Disclosing Rating Practices to Applicants

A. This section shall apply as follows:

- (1) Except as provided in Section 9(A)(2), this section applies to any long-term care policy or certificate delivered or issued for delivery in this state on or after October 1, 2004.

-
- (2) For certificates issued under a group long-term care policy issued to an employee group as defined in 24-A M.R.S.A. §2804, a labor union groups as defined in 24-A M.R.S.A. §2805, or a trustee groups as defined in 24-A M.R.S.A. §2806, which policy is in force on or after the effective date of this rule, the provisions of this section shall apply on or after the first policy anniversary following April 1, 2005.
- B. Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide to the applicant all the following information at the time of application or enrollment, unless the method of application does not allow for delivery at that time. The insurer shall provide all the required information no later than at the time of the delivery of the policy or certificate, as follows:
- (1) A statement that the policy may be subject to rate increases in the future;
 - (2) An explanation of potential future premium rate revisions, and a statement of the options available to the policyholder or certificateholder in the event of any revision;
 - (3) The premium rate or rate schedules for which the applicant is responsible until the insurer requests a premium increase;
 - (4) An explanation for applying rate adjustments, minimally including:
 - (a) A description of when premium rate adjustments will be effective, such as next anniversary date, next billing date, etc.; and
 - (b) The right to a revised premium as provided in Section 9(B)(2) if the premium is changed;
 - (5)
 - (a) Premium increase information for the policy form or similar policy forms occurring in the last 10 years for this state or any state, minimally identifying:
 - (i) Each policy form for which premium rates have increased;
 - (ii) Each calendar year when the form was available for purchase; and
 - (iii) The amount or percentage of each increase. The percentage may be expressed as a percent of the premium rate prior to the increase or as minimum and maximum percents if the rate increase is variable by rating characteristics.
 - (b) The insurer may provide additional rate increase information.

- (c) An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.
 - (d) If an acquiring insurer files for a rate increase on a long-term care policy form or a block of policy forms acquired from a nonaffiliated insurer on or before the later of the effective date of this rule or the end of a 24-month period following the acquisition of the policy or block, the acquiring insurer may exclude that rate increase from the disclosure. The nonaffiliated selling company, however, shall include the disclosure of each such rate increase in accordance with Section 9(B)(5)(a).
 - (e) If the acquiring insurer requests approval of any rate increase after the increase referred to in the preceding paragraph, even within the 24-month period following the acquisition, for any acquired policy form or block of forms, the acquiring insurer shall disclose all the information required by Section 9(B)(5), including the earlier rate increase to which Section 9(B)(5)(d) refers.
- C. At the time of application, an insurer shall present to an applicant, unless the method of application does not then allow for signature, an acknowledgement that the insurer made the disclosures required under Section 9(B). In instances where the insured cannot obtain the applicant's signature at the time of application, the insurer shall present the acknowledgement for signature no later than at the time of the delivery of the policy or certificate.
- D. An insurer shall provide written notice of an upcoming rate increase to all policyholders and certificateholders at least 90 days before the increase is to become effective. The notice shall contain all the information required under Paragraph B.

Section 10. Initial Rate Filing with Superintendent

- A. This section applies to any long-term care policy issued in this state on or after October 1, 2004, except that Subsection B(2)(d), Subsection B(2)(f), and Subsection B(3) apply only to policies issued on or after July 1, 2022.
- B. At least 30 days before making a long-term care insurance form available for sale, an insurer shall provide the superintendent with the following information:
 - (1) A copy of the disclosure documents required under Section 9; and

-
- (2) A certification by a qualified actuary consisting of at least:
- (a) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience, and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increase anticipated;
 - (b) A statement that the policy design and coverage provided have been reviewed and taken into consideration;
 - (c) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;
 - (d) A statement that the premiums contain a margin for moderately adverse experience that is not less than 10% of lifetime claims, or a justification for a lower margin meeting the requirements of clause (i):
 - (i) A composite margin that is less than 10% may be justified for long-term care benefits provided through a life insurance policy or annuity contract rather than a stand-alone long-term care policy, or in other extraordinary circumstances. The actuarial certification must include the proposed amount, full justification of the proposed amount, and methods to monitor developing experience to evaluate the validity of the lower margin on an ongoing basis. For products that combine long-term care with other types of benefits, the justification shall address margins and volatility for the entirety of the product.
 - (ii) A greater margin may be appropriate in circumstances where the company lacks sufficient credible experience to support the assumptions used to determine its premium rates, or for participating policies where policyholders receive distributions based on favorable claims experience.
 - (e) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer, except for reasonable differences attributable to benefits; or a comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

-
- (f) A statement that reserve requirements have been reviewed and considered. Support for this statement shall include:
 - (i) Sufficient detail or sample calculations to provide a complete depiction of the reserve amounts to be held; and
 - (ii) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship.
 - (3) The rate filing shall include an actuarial memorandum prepared, dated and signed by the certifying actuary. The memorandum shall address and support each specific item required as part of the actuarial certification and provide at least the following information:
 - (a) An explanation of the review performed by the actuary before making the statements required by Paragraph (2)(b) and (c).
 - (b) A complete description of pricing assumptions; and
 - (c) Sources and levels of margins incorporated into the gross premiums that are the basis for the statement required by Paragraph (2)(a) and an explanation of the analysis and testing performed in determining the sufficiency of the margins. Deviations in margins between ages, sexes, plans or states shall be clearly described. *De minimis* variations resulting from actuarial methods for smoothing and interpolating gross premium scales are not considered “deviations” for purposes of this subparagraph.
 - (d) A demonstration that the gross premiums include the minimum composite margin specified in Paragraph (2)(d).
 - C.
 - (1) The superintendent may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit difference, relevant and credible data from other studies, or both.
 - (2) In the event the superintendent asks for such additional information, the 30-day period of Section 10(B) shall begin when an insurer provides the additional requested information.

Section 11. Prohibition Against Post-Claims Underwriting

- A. All applications for long-term care insurance policies or certificates, except those that are guaranteed issue, shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.
- B. (1) If an application for long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.
- (2) If the medications listed in the application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.
- C. Except for policies or certificates which are guaranteed issue, every policy and certificate shall meet the following requirements:
- (1) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy, certificate or rider:

Caution: If your answers on this application are incorrect or untrue, [company] may have the right to deny benefits or rescind your policy.

- (2) The following language, or language substantially similar to the following, shall be set out conspicuously in the long-term care insurance policy or certificate:

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company may have the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

- (3) Prior to issuance of a long-term care policy or certificate to an applicant age 80 or older, the insurer shall obtain one of the following:
- (a) A report of a physical examination;
- (b) An assessment of functional capacity;

- (c) An attending physician's statement; or
 - (d) Copies of medical records.
- D. A copy of the completed application or enrollment form shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

Section 12. Minimum Home Care and Community Care Benefits

- A. A long-term care insurance policy or certificate, if it provides benefits for home health care or community care services, shall not limit or exclude benefits in any of the following ways:
- (1) By requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided;
 - (2) By requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community or institutional setting before home care services are covered;
 - (3) By limiting eligible services to services provided by registered nurses or licensed practical nurses;
 - (4) By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification;
 - (5) By excluding coverage for personal care services provided by a home health aide;
 - (6) By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;
 - (7) By requiring that the insured or claimant have an acute condition before home health care services are covered;
 - (8) By limiting benefits to services provided by Medicare-certified agencies or providers; or
 - (9) By excluding coverage for adult day care services.

- B. A long-term care insurance policy or certificate, if it covers home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.
- C. Home health care coverage may be applied to the non-residential home health care benefits provided in the policy or certificate when determining maximum coverage under the policy or certificate.

Section 13. Required Offer of Inflation Benefit

- A. No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder, in addition to any other inflation protection, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:
 - (1) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent;
 - (2) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or
 - (3) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.
- B. Where the policy is issued to a group, the required offer in Section 13(A) shall be made to the group policyholder, except, if the policy is issued to a group as defined in 24-A M.R.S.A. §2808 other than to a continuing care retirement community, the offer shall be made to each certificateholder.
- C. The offer in Section 13(A) shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

- D. (1) Insurers shall include the following information in or with the outline of coverage:
- (a) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period.
 - (b) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.
- (2) An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.
- E. Inflation protection benefit increases under a policy which contains these benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.
- F. An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.
- G. (1) Inflation protection as provided in Section 13(A)(1) shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this section.
- (2) The rejection shall be considered a part of the application and shall state in substance:
- “I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. I have determined that I reject the inflation protection offered to me.”

Section 14. Replacing Existing Insurance: Cautionary Notice to Applicant

- A. Application forms shall include the following questions designed to elicit whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and the producer, except where the coverage is sold without a producer, containing the questions may be used. With regard to a group replacement policy issued to an employee group as defined in 24-A M.R.S.A. §2804, a labor union group as defined in 24-A M.R.S.A. §2805, or a trustee group

as defined in 24-A M.R.S.A. §2806, questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that certificate holders have been notified of the replacement.

- (1) Do you have another long-term care insurance policy or certificate in force (including health care service contract or health maintenance organization contract)?
 - (2) Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months?
 - (a) If so, with which company?
 - (b) If that policy lapsed, when did it lapse?
 - (3) Are you covered by Medicaid?
 - (4) Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?
- B. Producers shall list any other health insurance policies they have sold to the applicant.
- (1) List policies sold that are still in force.
 - (2) List policies sold in the past five years that are no longer in force.
- C. Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its producer, shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. The notice, which shall include the information in **Appendix A**, must be signed by the applicant and the producer. One copy of the notice shall be retained by the applicant and an additional copy shall be retained by the insurer.
- D. If it determines that a sale will involve replacement, an insurer using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall include the information in Appendix A with appropriate modifications, including deletion of the signature lines,
- E. When the applicant intends replacement, the replacing insurer in writing shall notify the insurer of the plan to be replaced. The notice shall be made within five working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner. The existing plan shall be identified in

the notice by the name of the insurer, the name and address of the insured and the policy or certificate number.

- F. Life insurance policies that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of the applicable life insurance statute and rule. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

Section 15. Prohibition Against New Preexisting Condition Exclusions and Probationary Periods in Replacement Plans

If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

Section 16. Annual Reports to Superintendent: Lapsed and Replaced Policies

- A. Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.
- B. Every insurer shall report annually by June 30, on a form prescribed by the superintendent, the number of lapsed policies as of the end of the preceding calendar year.
- C. Every insurer shall report annually by June 30, on a form prescribed by the superintendent, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied, and:
- (1) the number of denied claims appealed to a first level review;
 - (2) the number of first level appeals overturned and the number upheld;
 - (3) the number of denied claims appealed to a second level review; and
 - (4) the number of second level reviews overturned and the number upheld.

- D. For purposes of this section:
- (1) “Policy” means only long-term care insurance;
 - (2) Subject to paragraph (3), “claim” means a request for payment of benefits under an in force policy, including a request for a determination that an insured is eligible for benefits, regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;
 - (3) “Denied” means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and
 - (4) “Report” means on a statewide basis.
- E. Reports required under this section shall be filed with the superintendent.
- F. Annual rate certification requirements. For all long-term care policies issued in this state, the insurer shall file an annual actuarial certification with the superintendent, prepared, dated, and signed by a qualified actuary, no later than May 1 of each year beginning in the second year following the year in which the initial rate schedules are first used. At a minimum, the actuary shall certify the sufficiency of the current premium rate schedule and provide all additional information required by this subsection.
- (1) For currently marketed products, the certifying actuary must provide one of the following statements:
 - (a) The premium rate schedule continues to be sufficient to cover anticipated costs under moderately adverse experience and is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated; or
 - (b) If the above statement cannot be made, a statement that margins for moderately adverse experience may no longer be sufficient. In this situation, the insurer shall provide to the superintendent, within sixty (60) days after the actuarial certification is submitted to the superintendent, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience so that the ultimate premium rate schedule would be reasonably expected to be sustainable over the future life of the form with no future premium increases anticipated. Failure to submit a plan of action to the superintendent within sixty (60) days or to comply with the time frame stated in the plan of action constitutes grounds to withdraw or modify approval of the form for future sales by the superintendent.

- (2) For products that are no longer marketed, the following information must be filed:
 - (a) A statement that the premium rate schedule continues to be sufficient to cover anticipated costs under best estimate assumptions; or a statement that the premium rate schedule may no longer be sufficient. In the latter situation, the insurer shall provide to the superintendent within sixty (60) days after the actuarial certification is submitted to the superintendent, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience.
 - (b) A description of the review performed that led to the statement.
- (3) No less frequently than every third year, the certification shall include an actuarial memorandum dated and signed by the certifying actuary, providing at least the following information:
 - (a) A detailed explanation of the data sources and review performed by the actuary before making the statement required by Paragraph (1).
 - (b) A complete description of experience assumptions and their relationship to the initial pricing assumptions.
 - (c) A description of the credibility of the experience data.
 - (d) An explanation of the analysis and testing performed in determining the current margins.

Section 17. Licensing of Producers

A producer is not authorized to sell, solicit the application for, or negotiate with respect to long-term care insurance, except as authorized by the producer licensing requirements of 24-A M.R.S.A. §§ 1401 *et seq.*

Section 18. Discretionary Powers of Superintendent

Upon written request and after an administrative hearing, the superintendent may issue an order to modify or suspend a specific provision or provisions of this rule with respect to a specific long-term care insurance policy or certificate upon a written finding that:

- A. The modification or suspension would be in the best interest of the insureds;

- B. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and
- C.
 - (1) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or
 - (2) The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or
 - (3) The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

Section 19. Reserve Standards

- A. Except as provided in subsection B, an insurer that provides long-term care benefits shall determine reserves in accordance with applicable law referring to minimum health insurance reserves, or with the NAIC version which requires reserves using a table established for reserve purposes by a qualified actuary and acceptable to the superintendent.
- B. If an insurer provides long-term care benefits through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits shall be determined in accordance with 24-A M.R.S.A. §§ 951-962. Claim reserves also shall be established when the policy or rider is in claim status.

Reserves for policies and riders subject to this subsection should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

In the development and calculation of reserves for policies and riders subject to this subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

- (1) Definition of insured events;
- (2) Covered long-term care facilities;
- (3) Existence of home convalescent care coverage;
- (4) Definition of facilities;
- (5) Existence or absence of barriers to eligibility;
- (6) Premium waiver provision;
- (7) Renewability;
- (8) Ability to raise premiums;
- (9) Marketing method;
- (10) Underwriting procedures;
- (11) Claims adjustment procedures;
- (12) Waiting period;
- (13) Maximum benefit;
- (14) Availability of eligible facilities;
- (15) Margins in claim costs;
- (16) Optional nature of benefit;
- (17) Delay in eligibility for benefit;
- (18) Inflation protection provisions; and
- (19) Guaranteed insurability option.

Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

Section 20. Premium Rate Increase Procedures

- A. This section shall apply as follows:
- (1) Except as provided in Section 20(A)(2), this section applies to any long-term care policy or certificate delivered or issued for delivery in this state on or after October 1, 2004.
 - (2) For certificates issued under a group long-term care policy issued to an employee group as defined in 24-A M.R.S.A. §2804, a labor union group as defined in 24-A M.R.S.A. §2805, or a trustee group as defined in 24-A M.R.S.A. §2806, which policy is in force on or after the effective date of this rule, the provisions of this section shall apply on or after the first policy anniversary following April 1, 2005.
- B. An insurer shall request approval from the superintendent for a premium rate increase. The request shall include:
- (1) The information required under Section 9;
 - (2) Certification by a qualified actuary that the premium rate filing is in compliance with this section.
 - (a) Except as otherwise permitted by Subparagraph (b), the actuary must also certify that the underlying assumptions reflect moderately adverse conditions, and that if the requested rate increase is implemented and those assumptions are realized, no further increase is anticipated.
 - (b) The insurer may request a premium rate schedule increase less than the amount otherwise required under this section, without certifying that no further increase is anticipated, if the actuarial memorandum discloses the premium rate schedule increase necessary to make the certification otherwise required under Subparagraph (a), the premium rate schedule increase filing satisfies all other requirements of this section, and is, in the opinion of the superintendent, in the best interest of policyholders;
 - (3) An actuarial memorandum justifying the rate schedule changes that includes:
 - (a) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale:
 - (i) Annual values for the five years preceding and the three years following the valuation date shall be separately stated;

-
- (ii) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase; and
 - (iii) The projections shall comply with Section 20(C).
 - (b) Disclosures of how reserves have been incorporated in the rate increase whenever the increase will trigger contingent benefit upon lapse;
 - (c) Disclosure of the analysis used to determine why a rate adjustment is necessary, which pricing assumptions were not realized and the reasons therefore, and what other carrier actions the actuary relied on;
 - (d) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration;
 - (e) In the event it is necessary to maintain consistent premium rates for any new certificate and for certificates receiving a rate increase, the insurer shall file composite rates reflecting projections of new certificates; and
 - (f) A demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience and that the margin for adverse experience specified in Section 10(B)(2)(d) is projected to be exhausted;
 - (4) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless the insurer provides sufficient justification to the superintendent; and
 - (5) Sufficient information for the superintendent's review and approval.
- C. All premium rate schedule increases shall be determined in accordance with the following requirements:
- (1) Except as provided in this section, exceptional increases are subject to the same requirements as other premium rate schedule increases;
 - (2) Exceptional increases shall provide that 70% of the present value of projected additional premiums from the exceptional increase will be returned to the policyholders or certificateholders in benefits;

- (3) The superintendent may request that an independent actuary or professional actuarial body review an insurer's request that an increase be considered as exceptional;
 - (4) In determining whether an exceptional increase is justified, the superintendent also shall consider any potential offset to higher claim costs;
 - (5) For exceptional increases, the projected experience must be limited to increases in claims expense attributable to the approved reasons for the exceptional increase, and, if the superintendent allows offsets as described in paragraph 4 of this subsection, the insurer shall use appropriate net projected experience;
 - (6) Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:
 - (a) The accumulated value of the initial earned premium times the greater of (i) 58% and (ii) the lifetime loss ratio consistent with the original filing, including margins for moderately adverse experience;
 - (b) Eighty-five percent of the accumulated value of prior premium rate schedule increases on an earned basis;
 - (c) The present value of future projected initial earned premiums times the greater of (i) 58% and (ii) the lifetime loss ratio consistent with the original filing, including margins for moderately adverse experience; and
 - (d) Eighty-five percent of the present value of future projected premiums which are not in Section 20(C)(6)(c) on an earned basis;
 - (7) In the event a policy form has both exceptional and other increases, the values in Sections 20(C)(6)(b) and (d) additionally will include 70% for exceptional rate increase amounts; and
 - (8) All present and accumulated values used to determine rate increases shall use the maximum value interest rate for contract reserves as specified in Bureau of Insurance Rule Chapter 130. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.
- D. For each rate increase that is implemented, annually for the next three years after the date of implementation, the insurer shall file with the superintendent a request for approval of updated projections, as defined in Section 20(B)(3)(a). The annual

filing shall include a comparison of actual results to projected values. The superintendent may extend the period to more than three years if actual results are not consistent with values from earlier projections. For group policies that satisfy the conditions in Section 20(K), the insurer shall transmit the projections required in this paragraph to the policyholder in lieu of filing with the superintendent.

- E. If any premium rate in the revised premium schedule is greater than 200% of the comparable rate in the initial premium schedule, lifetime projections, as defined in Section 20(B)(3)(a), shall be filed for approval by the superintendent every five years following the end of the period described in Section 20(D). For group policies that satisfy either of the conditions of Section 20(K), the insurer shall transmit the projections required in this paragraph to the policyholder in lieu of filing with the superintendent.
- F. (1) If the superintendent determines that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in Section 20(C), the superintendent may require the insurer to take the following actions:
- (a) Make adjustments in the premium rate schedule; or
 - (b) Implement other appropriate measures to reduce the difference between the projected and actual experiences.
- (2) In determining whether the actual experience adequately matches the projected experience, the superintendent should consider Section 20(B)(3)(e), if applicable.
- G. If the majority of policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:
- (1) A plan, subject to the superintendent's prior approval, for improved administration of claims processing designed to eliminate the potential for further deterioration of the policy form or further rate increase requests, or to demonstrate that appropriate administration and claims processing are in effect. The superintendent may impose the criteria in Section 20(H) before giving approval to the insurer's plan; and
 - (2) The original anticipated loss ratio, with a rate increase in accordance with Section 20(C) that would have been arrived at by using, in the calculation described in Section 20(C), the greater of the original anticipated lifetime loss ratio or 58%.

-
- H. (1) For a rate filing that meets the following criteria, the superintendent shall review for all policies included in the filing the projected lapse rates and past lapse rates during the 12 months following each rate increase to determine whether or not significant lapses have occurred or are anticipated:
- (a) The rate increase is not the first increase requested for the policy form;
 - (b) The requested increase is not an exceptional increase; and
 - (c) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.
- (2) In the event significant adverse lapses have occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the superintendent may determine that a rate spiral exists. Following the determination that a rate spiral exists, the superintendent may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.
- (a) The offer shall:
 - (i) Be subject to the approval of the superintendent;
 - (ii) Be based on actuarially sound principles, but not be based on attained age; and
 - (iii) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.
 - (b) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. If the insurer seeks a rate increase for the form, such increase is limited to the lesser of :
 - (i) The maximum rate increase based on the combined experience; or
 - (ii) The maximum rate increase based only on the experience of the insureds who originally were issued the form plus 10%.
- I. If the superintendent determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the

superintendent may, in addition to the provisions of Subsection H of this section, prohibit the insurer from either of the following:

- (1) Filing and marketing comparable coverage for a period of up to five (5) years; or
- (2) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

J. Sections 20(A) through (I) shall not apply to policies for which the long-term care benefits under the policy are incidental, as defined in Section 4(G), if the policy complies with all of the following requirements:

- (1) The interest credited internally to determine cash value accumulations, including long-term care, if any, is guaranteed to be not less than the minimum guaranteed interest rate for cash value accumulations without long-term care benefits in the policy;
- (2) The portion of the policy covering other than long-term care meets this state's nonforfeiture requirements applicable to life insurance, individual deferred annuities or variable annuities;
- (3) The policy satisfies the disclosure requirements of 24-A M.R.S.A. §5074;
- (4) The portion of the policy covering other than long-term care meets this state's requirements for life insurance illustrations, annuity disclosures or variable disclosures;
- (5) The insurer files an actuarial memorandum that includes:
 - (a) A description of the bases for the long-term care premium rates and reserves, together with a summary of the policy type, benefits, renewability, marketing methods and any age limit on issuance;
 - (b) A description and a table of each actuarial assumption; for expenses there must be a stated percent of premium dollars per policy and dollars per unit of benefits, if any;
 - (c) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
 - (d) The estimated average annual premium per policy and the average issue age;

- (e) A statement whether underwriting is performed at the time of application. The statement shall describe the kind of any underwriting used, such as medical or functional assessment testing. For group policies, the statement shall note if and when the enrollee or any dependent will be underwritten; and
 - (f) A description of the effect on the underlying policy of the long-term care coverage on required premiums, nonforfeiture values and reserves, both for active lives and those in long-term care claim status.
- K. Sections 20(F) and (H) shall not apply to employee groups as defined in 24-A M.R.S.A. §2804, labor union groups as defined in 24-A M.R.S.A. §2805, or trustee groups as defined in 24-A M.R.S.A. §2806 if:
 - (1) The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or
 - (2) The policyholder, and not the certificateholders, pays a material portion of the premium, which is defined as not less than 20% of the total premium for the group in the calendar year prior to the year a rate increase is approved.
- L. An insurer that files a request for a rate increase shall notify all policyholders affected by the proposed increase no later than 30 days after filing the request with the superintendent. The notification must include the information required in 24-A M.R.S.A. §5084.
- M. No rate increase shall be implemented until the later of approval by the superintendent or the effective date of the increase.

Section 21. Filing of Advertising with Superintendent

- A. Every insurer, health care service plan or other entity providing long-term care insurance in this state shall file with the superintendent for prior approval a copy of any long-term care insurance advertisement intended for use in this state, whether through written, radio, television, internet or other medium. If the advertisement has not been affirmatively approved or disapproved within 30 days after filing, it will be deemed approved.
- B. The superintendent may exempt from the requirement of prior approval any advertising form or material when, in the superintendent's opinion, this requirement may not be reasonably applied.

Section 22. Standards for Marketing

- A. Every insurer, health care service plan or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:
- (1) Establish marketing procedures and producer training requirements to assure that:
 - (a) Any marketing activity, including comparison of policies by its producers, will be fair and accurate; and
 - (b) Excessive insurance is not sold or issued.
 - (2) Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following notice:

“Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.”
 - (3) Provide to the applicant copies of the disclosure forms required in Section 9(B).
 - (4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance, except that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required.
 - (5) Establish procedures, readily subject to audit by the superintendent, for verifying compliance with this section.
 - (6) Provide written notice to prospective insureds at the time of solicitation of the availability of any public or private insurance counseling program for senior citizens, such notice to include the name, address and telephone number of each program.
 - (7) Assure that any policy, certificate or rider conforms to the definitional requirements in Section 6(A) of “noncancelable,” “level premium” and any other word of similar import.
 - (8) Explain the contingent nonforfeiture benefit upon lapse described in Section 26(C) and, if applicable for policies issued or renewed on or after January 1, 2008, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying periods in Section 26(C)(4).

- B. In addition to the practices prohibited in 24-A M.R.S.A. §§ 2151 *et seq.*, the following acts and practices are prohibited:
- (1) **High pressure tactics.** Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.
 - (2) **Cold lead advertising.** Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.
- C. The following requirements apply to association groups as defined in 24-A M.R.S.A. §2805-A:
- (1) With respect to the obligations set forth in this subsection, the primary responsibility of an association when endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.
 - (2) The insurer shall file with the insurance department the following material:
 - (a) The policy and certificate,
 - (b) A corresponding outline of coverage, and
 - (c) All advertisements requested by the insurance department.
 - (3) The association shall disclose in any long-term care insurance solicitation:
 - (a) The specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and
 - (b) A brief description of the process under which the policies and the insurer issuing the policies were selected.

- (4) If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.
- (5) The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.
- (6) The association shall also:
 - (a) At the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates and update the examination thereafter in the event of material change;
 - (b) Actively monitor the marketing efforts of the insurer and its agents; and
 - (c) Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.
 - (d) Subparagraphs (a) through (c) shall not apply to qualified long-term care insurance contracts.
- (7) No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the state insurance department the information required in this subsection.
- (8) The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in this subsection.
- (9) Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice in violation of 24-A M.R.S.A. Chapter 23.

Section 23. Applicant's Suitability for Long-term Care Insurance

- A. This section shall not apply to life insurance policies that accelerate benefits for long-term care.

-
- B. Every insurer, health care service plan or other entity marketing long-term care insurance shall:
- (1) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;
 - (2) Train its producers in the use of its suitability standards; and
 - (3) Maintain a copy of its suitability standards and make them available for inspection upon request by the superintendent.
- C. (1) To determine whether the applicant meets the standards developed by the issuer, the producer and issuer shall develop procedures that take the following into consideration:
- (a) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;
 - (b) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and
 - (c) The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.
- (2) The issuer and producer, when one is involved, shall make reasonable efforts to obtain the information set out in Section 23(C)(1). The efforts shall include presentation to the applicant, at or prior to application, of the "Long-term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in **Appendix B** in not less than 12 point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet format shall be filed with the superintendent for informational purposes.
 - (3) A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.
 - (4) The issuer's or producer's sale or dissemination outside the company of information obtained through the personal worksheet is prohibited.

- D. The issuer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage for an applicant is appropriate.
- E. Producers shall use the suitability standards developed by the issuer in marketing long-term care insurance.
- F. At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled “Things You Should Know Before You Buy Long-term Care Insurance” shall be provided. The form shall be in the format contained in **Appendix C**, in not less than 12 point type.
- G. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a suitability letter similar to **Appendix D**. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant’s intent. Either the applicant’s return letter or a record of the alternative method of verification shall be made part of the applicant’s file.

Section 24. Availability of New Services or Providers

- A. An insurer shall notify policyholders of the availability of a new long-term care policy series that provides coverage for new long-term care services or providers material in nature and not previously available through the insurer to the general public. The notice shall be provided within twelve (12) months of the date the new policy series is made available for sale in this state.
- B. Notwithstanding Subsection A above, notification is not required for any policy issued prior to the effective date of this rule or to any policyholder or certificateholder who is currently eligible for benefits, within an elimination period or on claim, or who previously has been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.
- C. The insurer shall make the new coverage available in one of the following ways:
 - (1) By adding a rider to the existing policy and charging a separate premium for the new rider based on the insured’s attained age;
 - (2) By exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or

certificate. The premium credits shall be based on premiums paid or reserves held for the prior policy or certificate;

- (3) By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status shall be recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost for the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or
 - (4) By an alternative program developed by the insurer that meets the intent of this section if the program is filed with and approved by the superintendent.
- D. An insurer is not required to notify policyholders of a new proprietary policy series created and filed for use in a limited distribution channel. For purposes of this subsection, "limited distribution channel" means through a discrete entity, such as a financial institution or brokerage, for which specialized products are available that are not available for sale to the general public. Policyholders that purchased such a proprietary policy shall be notified when a new long-term care policy series that provides coverage for new long-term care services or providers material in nature is made available to that limited distribution channel.
- E. Policies issued pursuant to this section shall be considered exchanges and not replacements. These exchanges shall not be subject to Sections 14 and 23, and the reporting requirements of Section 16(A) to (E) of this rule.
- F. Where the policy is offered through an employer, labor organization, professional, trade or occupational association, the required notification in Subsection A above shall be made to the offering entity. However, if the policy is issued to a group defined in 24-A M.R.S.A. §2808, the notification shall be made to each certificateholder.
- G. Nothing in this section shall prohibit an insurer from offering any policy, rider, certificate or coverage change to any policyholder or certificateholder. However, upon request any policyholder may apply for currently available coverage that includes the new services or providers. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.
- H. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

Section 25. Right to Reduce Coverage and Lower Premiums

- A. (1) Every long-term care insurance policy and certificate shall include a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:
- (a) Reducing the maximum benefit; or
 - (b) Reducing the daily, weekly or monthly benefit amount.
- (2) The insurer may also offer other reduction options that are consistent with the policy or certificate design or the carrier's administrative processes.
- (3) If the reduction in coverage involves the reduction or elimination of the inflation protection provision, the insurer shall allow the policyholder to continue the benefit amount in effect at the time of the reduction.
- B. The provision shall include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.
- C. The premium for the reduced coverage shall:
- (1) Be based on the same age and underwriting class used to determine the premiums for the coverage currently in force, and
 - (2) Be consistent with the approved rate table.
- D. The insurer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.
- E. If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificateholder of his or her right to reduce coverage and premiums in the notice required by Section 7(A)(3) of this rule.
- F. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.
- G. The requirements of this section shall apply to any long-term care policy issued in this state on or after July 1, 2008.

Section 26. Required Offer of Nonforfeiture Benefit; Contingent Nonforfeiture Benefit Upon Lapse

- A. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.
- B. To comply with the requirement to offer a nonforfeiture benefit to policyholders and certificateholders pursuant to 24-A M.R.S.A. §§ 5077(1) and 5077(2):
 - (1) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in Section 26(D); and
 - (2) The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder.
- C.
 - (1) After a rejection of the nonforfeiture benefit offer required under 24-A M.R.S.A. §5077, for individual and group policies without nonforfeiture benefits issued after the effective date of this rule, the insurer shall provide a contingent benefit upon lapse. For policies issued or renewed on or after January 1, 2008, even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in Section 26(C)(3) shall still apply.
 - (2) In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.
 - (3) A contingent benefit on lapse shall be triggered, as shown in **Appendix E**, every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in the table in **Appendix E**, based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least 30 days prior to the due date of the premium reflecting the rate increase.
 - (4) For policies issued or renewed on or after January 1, 2008, a contingent benefit on lapse shall also be triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, the policy or certificate lapses within 120 days of the due date of the premium so increased, and

the ratio in Paragraph (6)(b) below is forty percent (40%) or more. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase	
Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

This provision shall be in addition to the contingent benefit provided by Paragraph (3) above and where both are triggered, the benefit provided shall be at the option of the insured.

- (5) On or before the effective date of a substantial premium increase as defined in Paragraph (3), the insurer shall:
- (a) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;
 - (b) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of Subsection D. This option may be elected at any time during the 120-day period referenced in Paragraph (3); and
 - (c) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in Paragraph (3) shall be deemed to be the election of the offer to convert in Subparagraph (b) unless the automatic option in Paragraph (6)(c) applies.
- (6) For policies issued or renewed on or after January 1, 2008, on or before the effective date of a substantial premium increase as defined in Paragraph (4), the insurer shall:
- (a) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;
 - (b) Offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety percent (90%) of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may

be elected at any time during the 120-day period referenced in Paragraph (4); and

- (c) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in Paragraph (4) shall be deemed to be the election of the offer to convert in Subparagraph (b) above if the ratio is forty percent (40%) or more.
- (7) For any long-term care policy issued in this state on or after January 1, 2021:
- (a) If the policy or certificate was issued at least twenty (20) years before the effective date of the increase, a value of 0% shall be used in place of all values in the table in **Appendix E**.
 - (b) Values above 100% in the table in **Appendix E** shall be reduced to 100%.

D. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse provided in accordance with Subsection C(3) but not those provided in accordance with Subsection C(4), are described in this ~~Section~~ Subsection:

- (1) For purposes of this Subsection, “attained age rating” is defined as a schedule of premiums starting from the issue date which increases age at least one percent per year prior to age 50, and at least three percent per year beyond age 50.
- (2) For purposes of this Subsection, the contingent nonforfeiture benefit shall be for a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in Section 26(D)(3).
- (3) The standard nonforfeiture credit will be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of Section 26(E).
- (4) (a) The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The

contingent benefit upon lapse shall be effective immediately on the policy or certificate issue date.

- (b) Notwithstanding Section 26(D)(4)(a), for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:
 - (i) The end of the tenth year following the policy or certificate issue date; or
 - (ii) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.
 - (5) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.
- E. All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status.
- F. There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.
- G. The requirements of this section shall become effective on April 1, 2005, and shall apply as follows:
 - (1) Except as provided in Sections 26 (G)(2) and (3), this section shall apply to any long-term care policy issued in this state on or after the effective date of this rule.
 - (2) For certificates issued on or after the effective date of this rule under employee groups as defined in 24-A M.R.S.A. §2804, labor union groups as defined in 24-A M.R.S.A. §2805, or trustee groups as defined in 24-A M.R.S.A. §2806, the provisions of this section shall not apply if the group policy was in force at the time this rule became effective.
 - (3) The last sentence in Section 26(C)(1) and Sections 26(C)(4) and 26(C)(6) shall apply only to long-term care insurance policies or certificates issued in this state after six months after the effective date of such sections, and only to new certificates on a group policy as defined in 24-A M.R.S.A. §5072 issued in this state after one year after the effective dates of such sections.

- H. To determine whether contingent nonforfeiture upon lapse provisions are triggered under Section 26(C)(3) or (4), a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.
- I. A nonforfeiture benefit for federally qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:
- (1) The nonforfeiture provision shall be appropriately captioned;
 - (2) The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium paying contracts approved by the superintendent for the same contract form; and
 - (3) The nonforfeiture provision shall provide at least one of the following:
 - (a) Reduced paid-up insurance;
 - (b) Extended term insurance;
 - (c) Shortened benefit period; or
 - (d) Other similar offerings approved by the superintendent.

Section 27. Standards for Benefit Triggers

- A. A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three of at least five of the activities of daily living or the presence of cognitive impairment.
- B. Insurers may use activities of daily living, other than those listed in Section 5, to trigger covered benefits as long as they are defined in the policy.
- C. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in Sections 27(A) and (B).

- D. For purposes of this section the determination of a deficiency shall not be more restrictive than:
- (1) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or
 - (2) If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.
- E. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.
- F. Long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.
- G. The requirements set forth in this section shall be effective April 1, 2005, and shall apply as follows:
- (1) Except as provided in Section 27 (G)(2), the provisions of this section apply to a policy, certificate or rider delivered or issued for delivery in this state on or after the effective date of this rule.
 - (2) For certificates issued on or after the effective date of this section, under employee groups as defined in 24-A M.R.S.A. §2804, labor union groups as defined in 24-A M.R.S.A. §2805, or trustee groups as defined in 24-A M.R.S.A. §2806, in force at the time this rule became effective, the provisions of this section shall not apply if the group policy was in force at the time this rule became effective.
- H. A premium increase notice required by Section 9(D) of this rule shall include:
- (1) An offer to reduce policy benefits provided by the current coverage consistent with the requirements of this section;
 - (2) A disclosure stating that all options available to the policyholder may not be of equal value; and
 - (3) In the case of a policy offered with the intent to meet the requirements of the Long-term Care Partnership Program, a disclosure that some benefit reduction options may result in a loss in Partnership status.

Section 28. Additional Standards for Benefit Triggers for Federally Qualified Long-term Care Insurance Contracts

- A. For purposes of this section the following definitions apply:
- (1) “Federally qualified long-term care services” means services that meet the requirements of Section 7702B(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.
 - (2) (a) “Chronically ill individual” has the meaning prescribed for this term by section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:
 - (i) Being unable to perform (without substantial assistance from another individual) at least two (2) activities of daily living for a period of at least ninety (90) days due to a loss of functional capacity; or
 - (ii) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.
 - (b) The term “chronically ill individual” shall not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner has certified that the individual meets these requirements.
 - (3) “Licensed health care practitioner” means a physician, as defined in Section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the Secretary of the Treasury.
 - (4) “Maintenance or personal care services” means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).
- B. A federally qualified long-term care insurance contract shall pay only for federally qualified long-term care services received by a chronically ill individual

provided pursuant to a plan of care prescribed by a licensed health care practitioner.

- C. A federally qualified long-term care insurance contract shall condition the payment of benefits on a certification of either the insured's inability to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity or the insured's severe cognitive impairment.
- D. Certifications regarding activities of daily living and cognitive impairment required pursuant to Subsection C shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the Treasury.
- E. Certifications required pursuant to Subsection C may be performed by a licensed health care practitioner at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the ninety-day period.
- F. Federally qualified long-term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

Section 29. Delivery of Outline of Coverage; Standard Format for Outline

- A. Every solicitation or marketing of a long-term care insurance policy, rider or certificate must include delivery of an outline of each long-term care product the producer or insurer is soliciting or marketing to the individual. The outline(s) shall be delivered to the prospective applicant or enrollee no later than the time of "first solicitation," through means that prominently direct the attention of the recipient to the document.
- B. "First solicitation" means, in the case of producer solicitations, the time when the producer initially sends or presents to the individual any document materially relating to the long-term care insurance coverage the producer is soliciting. Procedural communications, such as setting up an appointment or direct mail asking the consumer to return a post card if he wishes further information, are not material, and therefore not first solicitations. For direct response solicitations, the "first solicitation" is the time the insurer initially sends or presents to the individual any document the prospective applicant requested in the response. The producer in any event shall deliver the outline(s) at the earliest possible time

before sending or presenting an application or enrollment form, and the insurer shall deliver the outline(s) no later than the time it submits the application or enrollment form for signature.

- C. Every application, enrollment or similar form shall contain an acknowledgement of receipt of the outline of coverage. The acknowledgement shall provide for the applicant's signature, the date the applicant receives the outline, and a statement that the outline was received on the first solicitation by the producer or insurer.
- D. For every producer-solicited application there shall be a producer's statement in the application, enrollment or similar form. The producer's statement shall include the producer's signature, the date the producer delivers the outline, and a statement that the delivery was made at the time of the first solicitation.
- E. For group insurance, the insurer may request the superintendent to allow use of a substitute form in place of the outline of coverage.
- F. The mandatory contents for the outline of coverage appear in **Appendix F**. The outline of coverage shall be a free-standing document, using no smaller than 12 point type, and shall contain no material of an advertising nature. Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring.

Section 30. Delivery of Shopper's Guide

- A. A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners shall be provided to all prospective applicants of a long-term care insurance policy or certificate.
- B. In the case of producer solicitations, a producer shall deliver the shopper's guide at the producer's "first solicitation," as defined in Section 29(B).
- C. In the case of direct response solicitations, the insurer shall deliver the shopper's guide no later than the time of its "first solicitation," as defined in Section 29(B).
- D. For life insurance policies or riders containing accelerated long-term care benefits, insurers and producers are not required to furnish the shopper's guide; however, they shall furnish a life insurance policy summary as required by 24-A M.R.S.A. §5074(4).

Section 31. Payment of Claims

Upon receipt of a notice of claim for benefits under a policy or certificate of long-term

care insurance delivered or issued for delivery in this State, and after the insurer has sent the written statement required by 24-A M.R.S.A. §5083(1) and received the information identified in 24-A M.R.S.A. §5083(2), a long-term care insurer shall pay or deny the claim within 30 days, except as otherwise permitted by this section. If the insurer is unable to decide the claim because more information is needed, it may request necessary additional documentation, consistent with Subsection A, with sufficient detail to permit the insured to understand and respond. The written request must be provided by the insurer within 10 business days after receipt of the notice of claim. For purposes of this section, “insured” includes the insured’s authorized representative.

A. Documentation

The documentation an insurer may require of an insured following the submission of a claim for benefits under a policy or certificate of long-term care insurance is as follows:

- (1) A brief statement by or on behalf of the insured describing the basis of the claim for benefits;
- (2) A signed release permitting the insurer to obtain personal health information about the insured pursuant to the federal *Health Insurance Portability and Accountability Act of 1996*;
- (3) A statement from the insured’s physician, including the appropriate diagnosis and a treatment and care plan for the insured;
- (4) A statement from the long-term care provider rendering services to the insured, including an itemized bill for services, the provider’s license number, and any daily nursing notes;
- (5) A copy of any power of attorney executed by the insured; and
- (6) Other information that the insurer determines is reasonably necessary to evaluate before making a determination on the claim and is not readily available from sources other than the insured.

B. Burden on Insurer

Except for information solely in the possession of the insured, the burden is on the insurer to obtain any information other than that described in Paragraphs (A)(1) to (A)(6) that is reasonably necessary to pay or continue paying the claim.

C. Delay or Denial of Claim

If the insurer denies a claim in whole or part, the insurer shall promptly issue a written notice to the insured explaining the specific reason or reasons for the

denial. If the insurer cannot pay the claim within 30 days because it does not have sufficient information to make a decision, the insurer shall decide the claim and notify the insured in accordance with the following requirements.

- (1) An insurer may not extend the time for resolution of a claim beyond 30 days after receipt of documentation and information related to a technical issue. The insurer may not extend the time period beyond 30 days for documentation that the insurer already possesses.
- (2) An insurer may not extend the time for resolution of a claim beyond 30 days after receipt of all documentation and information initially requested from the insured unless the insurer determines, as a result of its review of that information, that the insurer cannot reasonably decide the claim without additional information relating to a substantive issue.
 - (a) The insurer may not delay the resolution of the claim any longer than is reasonably necessary and must act expeditiously to obtain all necessary information.
 - (b) If the resolution of the claim is being delayed because a source other than the insured is failing to provide necessary information, the insurer shall notify the insured of the reason for the delay and the nature of the missing information, unless such notice might prejudice the insurer's investigation of suspected fraud or other misconduct.

D. Ongoing Claim

Except for information solely in the possession of the insured, if, during the course of an ongoing claim for benefits paid on a monthly or recurring basis, the insurer identifies additional documentation that is reasonably necessary to verify that the insured remains entitled to benefits under the policy or certificate of long-term care insurance, the burden is on the insurer to obtain that information.

E. Appeals of Claims Denials

An insured who receives a claims denial has the right to internal appeal. In addition, if the claims denial is eligible for external review, the insured has the right to request an external review under Section 33 of this rule. The written notice to the insured of the claims denial as required by Subsection C must include: a statement informing the insured of the insured's right to internal appeal, and of the right to external review in the case of a claims denial eligible for external review; a statement of the insured's right to seek assistance or file a complaint with the superintendent; and contact information for the bureau, including its toll-free telephone number and Internet address.

(Drafting Note: Although this section does not apply to contracts issued or issued for delivery in other states even if the insured becomes a resident of this state, insurers are encouraged to voluntarily adopt these standards for insureds who obtain long-term care services in this state. Nothing in this rule prohibits insurers from voluntarily complying with this section.)

Section 32. Appealing a Claims Denial

- A. **Representation.** For purposes of this section and for section 33, “insured” includes the insured’s authorized representative.
- B. **Notice.** An insurer shall provide clear written notice to the insured of any claims denial. The notice shall include:
- (1) The reason or reasons for the decision;
 - (2) Reference to the specific contract provision on which the decision is based;
 - (3) A description of any additional material or information necessary for the insured to perfect the claim and an explanation of why such material or information is necessary;
 - (4) The insured’s right to internal appeal in accordance with subsection C, including instructions and time limits for initiating the appeal, and the right to submit new or additional information relating to the claims denial with the appeal request;
 - (5) The insured’s right, after completion of the insurer’s internal appeal process, to have the claims denial reviewed under the independent review process in accordance with Section 33 if the claims denial is eligible for external review, and the right to file a complaint with the superintendent after completion of at least one level of the insurer’s internal review process.
- C. **Standard Appeal.** The insured may appeal the claims denial by sending a written request to the insurer within 120 days after receipt of the claims denial along with any additional supporting information. The internal appeal shall be considered by a panel of one or more qualified individuals, designated by the insurer, who did not participate in making the initial benefit determination.
- (1) **Timeline for Appeal.** The internal appeal shall be completed and written notice of the internal appeal decision shall be sent to the insured within thirty (30) calendar days after the insurer’s receipt of all necessary information upon which a final determination can be made. Additional time is permitted when the insurer can establish the 30-day time frame

cannot reasonably be met due to the insurer's inability to obtain necessary information from a person not affiliated with or under contract with the insurer. The insurer shall provide written notice of the delay to the insured. In such instances, decisions must be issued within 30 days after the insurer's receipt of all necessary information.

- (2) **Notice of Decision.** If the claims denial appeal decision is adverse to the insured, the written decision shall contain:
- (a) The qualifying credentials of the person or persons evaluating the appeal;
 - (b) A statement of the reviewers' understanding of the reason for the insured's request for an appeal;
 - (c) Reference to the specific policy provisions upon which the decision is based;
 - (d) The reviewers' decision in clear terms and the rationale in sufficient detail for the insured to respond further to the insurer's position;
 - (e) A reference to the evidence or documentation used as the basis for the decision, including any clinical review criteria used to make the determination. The decision shall include instructions for requesting copies, free of charge, of information relevant to the claim, including any referenced evidence, documentation, or clinical review criteria not previously provided to the insured.
 - (f) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the claims denial decision, either the specific rule, guideline, protocol or other similar criterion that was relied upon in making the claims denial decision or an explanation that a copy will be provided free of charge to the insured upon request;
 - (g) Notice of any subsequent appeal rights and the procedure and time limitation for exercising those rights. Notice of external review rights must be provided for decisions on claims denials eligible for external review.
 - (h) Notice of the insured's right to contact the superintendent's office. The notice shall contain the toll free telephone number, website address and mailing address of the bureau.

D. Second Level Review

- (1) An insurer shall provide a second level appeal process to an insured who is dissatisfied with a first level review determination under Subsection C. The insured has the right to appear before authorized representatives of the insurer and shall be provided adequate notice of that option by the insurer. The insured may appeal the standard appeal decision by sending a written request to the insurer within 120 days after receipt of the standard appeal decision letter.
- (2) The insurer shall appoint a second level appeal review panel for each appeal subject to review under this subsection. A majority of the panel shall consist of employees or representatives of the insurer who were not previously involved in the appeal.
- (3) If an insured initiates a second level appeal without requesting to appear before authorized representatives of the insurer, the second level appeal shall be completed and written notice of the final internal appeal decision shall be sent to the insured within thirty (30) calendar days after the insurer's receipt of all necessary information upon which a final determination can be made. Additional time is permitted when the insurer can establish that the 30-day time frame cannot reasonably be met due to the insurer's inability to obtain necessary information from a person not affiliated with or under contract with the insurer. The insurer shall provide written notice of the delay to the insured. In such instances, decisions must be issued within 30 days after the insurer's receipt of all necessary information. A decision adverse to the insured shall include the information specified in Subparagraph C(2).
- (4) Whenever an insured has requested the opportunity to appear before authorized representatives of the insurer, an insurer's procedures for conducting a second level panel review shall include the following:
 - (a) The review panel shall schedule and hold a review meeting within 45 days after receiving a request from the insured for a second level review. The review meeting shall be held at a time reasonably accessible to the insured. The insurer shall offer the insured the opportunity to appear before the review panel, at the insurer's expense, by conference call, video conferencing, or other appropriate technology. The insured shall be notified in writing at least 15 days in advance of the review date. The insurer shall not unreasonably deny a request for postponement of the review made by the insured.

- (b) Upon the request of an insured, the insurer shall provide to the insured, free of charge, all relevant information that is not confidential and privileged from disclosure to the insured.
- (c) The insured has the right to:
 - i) Attend the second level review by conference call, video conferencing, or other appropriate technology;
 - ii) Present his or her case to the review panel;
 - iii) Submit supporting material both before and at the review meeting;
 - iv) Ask questions of any representative of the insurer who has provided information to the panel; and
 - v) Be assisted or represented by a person of his or her choice.
- (d) If the insurer will have an attorney present to argue its case against the insured, the insurer shall so notify the insured at least 15 days in advance of the review and shall advise the insured of his or her right to obtain legal representation.
- (e) The insured's right to a fair review shall not be made conditional on his or her appearance at the review.
- (f) The review panel shall issue a written decision to the insured within 5 working days after completing the review meeting. A decision adverse to the insured shall include the information specified in Subparagraph C(2).

Section 33. External Review

- A. **Notice of External Review.** If the insurer's claims denial eligible for external review is upheld after completion of the insurer's internal appeal process outlined in section 32, the insurer shall provide a written description of the insured's right to request an external review. The notice must include:
- (1) A description of the external review procedure and the requirements for making a request for external review;
 - (2) A statement informing the insured how to request assistance from the insurer in filing a request for external review;

-
- (3) A statement informing the insured of the right to participate in the external review proceeding by teleconference or other reasonable means, to obtain and submit material in support of the claim, to ask questions of the insurer, and to have outside assistance; and
 - (4) A statement informing the insured of the right to seek assistance or file a complaint with the bureau and the toll-free number for the bureau.
- B. **Request.** The insured may request an external review of the claims denial eligible for external review after completion of both levels of the insurer's internal appeal process outlined in Section 32. A written request for external review may be made by the insured to the bureau within 120 days after the insurer's written notice of the final internal appeal decision is received by the insured. The insured may not be required to pay any filing fee as a condition of processing a request for external review.
- C. **Cost.** The cost of the external review shall be borne by the insurer.
- D. **Insured's Right to Alternative Formats.** The insurer shall provide auxiliary telecommunications devices or qualified interpreter services by a person proficient in American Sign Language, when requested by an insured who is deaf or hard-of-hearing; shall provide printed materials in an accessible format, including Braille, large-print materials, computer diskette, audio cassette or a reader, when requested by an insured who is visually impaired; and shall make such other reasonable accommodations as may be necessary to allow an insured to exercise the right to external review under this section.
- E. **Bureau Oversight.** The bureau shall oversee the external review process and shall contract with approved independent review organizations to conduct external reviews and render external review decisions. At a minimum, an independent review organization approved by the bureau shall ensure the selection of qualified and impartial reviewers who have no professional, familial, or financial conflict of interest relating to the insurer, the insured, or the insured's authorized representative or long-term care provider involved in the external review.
- F. **Independent External Review Decision; Timelines.** An external review decision must be made in accordance with the following requirements.
- (1) In rendering an external review decision, the independent review organization must give consideration to the following:
 - (a) All relevant clinical information relating to the insured's physical and mental condition, including any competing clinical information;

-
- (b) All relevant clinical standards and guidelines, including, but not limited to, those standards and guidelines relied upon by the insurer.
 - (2) If the independent review organization rules in favor of the claimant in a dispute arising out of a federally tax-qualified contract, it shall provide a certification by a licensed health care practitioner (as defined in Section 7702B(c)(4) of the Internal Revenue Code) that the insured is chronically ill.
 - (3) An external review decision must be rendered by an independent review organization within 30 days of receipt of a completed request for external review from the bureau.
 - (4) **Binding nature of decision.** An external review decision is binding on the insurer. An insured may not file a request for a subsequent external review involving the same claims denial for which the insured has already received an external review decision pursuant to this section. An external review decision made under this section is not considered final agency action pursuant to Title 5, chapter 375, subchapter II.
- G. **Additional Rights.** Nothing contained in this section shall limit the ability of an insurer to assert any rights an insurer may have under the policy related to:
- (1) An insured's misrepresentation;
 - (2) Changes in the insured's benefit eligibility; and
 - (3) Terms, conditions, and exclusions of the policy, other than the failure to meet the requirements to pay the claim.
- H. **Long-Term Care Insurance Independent Review Organizations.** The superintendent shall contract with qualified long-term care insurance independent review organizations. To be considered qualified, an organization must meet the following criteria:
- (1) Have on staff, or contract with, a qualified and licensed health care professional in an appropriate field for determining an insured's functional or cognitive impairment (e.g., physical therapy, occupational therapy, neurology, physical medicine and rehabilitation), to conduct the review.
 - (2) Neither it nor any of its licensed health care professionals may, in any manner, be related to or affiliated with a person or entity that previously provided medical care to the insured.
 - (3) Utilize a licensed health care professional who is not an employee of the insurer or related in any manner to the insured.

- (4) Neither it nor its licensed health care professional who conducts the reviews may receive compensation of any type that is dependent on the outcome of the review.
- (5) Provide a description of the fees it charges for external reviews of a long-term care insurance adverse benefit determination. Such fees shall be reasonable and customary for the type of long-term care insurance adverse benefit determination under review.
- (6) Provide the name of the medical director or health care professional responsible for the supervision and oversight of the external review procedure.
- (7) Have on staff or contract with a licensed health care practitioner, who is qualified to certify that an individual is chronically ill for purposes of a qualified long-term care insurance contract.

(Drafting Note: Although this section does not apply to contracts issued or issued for delivery in other states even if the insured becomes a resident of this state, insurers are encouraged to voluntarily adopt these standards for insureds who obtain long-term care services in this state. Nothing in this rule prohibits insurers from voluntarily complying with this section.)

Section 34. Transition.

- A. Within four months after the effective date of the 2015 amendments to this rule, every insurer shall file with the superintendent any new forms or contract provisions, and all revisions to existing forms or contracts, which it will be using as a result of the amendments.
- B. Every insurer required to file forms with the superintendent and subject to this rule shall send all applicable forms and amended contract provisions to existing individual and group contract holders within 60 days after the first billing date after the form or contract provision has been approved by the superintendent.

Section 35. Effective Date

This rule is effective July 1, 2004. Unless otherwise noted, the 2007 amendments are effective December 15, 2007. The 2015 amendments are effective March 30, 2015. The 2022 amendments are effective May 9, 2022 (filing 2022-076).

APPENDIX A

Cautions about Replacing Existing Insurance:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY PRODUCER OR OTHER REPRESENTATIVE:
(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions that you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new waiting periods for coverage if the replacement policy or certificate is issued by the same insurer and you have not increased your level of benefits. If that is the case, your insurer will waive any period applicable to waiting periods in the new policy or certificate to the extent that such time was depleted under the original policy or certificate.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before your sign it, reread it carefully to be certain that all information has been properly recorded.

(Signature of Producer or Other Representative)

[Typed Name and Address of Producer of Other Representative]

The above "Notice to Applicant" was delivered to me on:

(Applicant's Signature)

(Date)

APPENDIX B

Applicant Suitability Worksheet:

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Number(s) _____

The premium for the coverage you are considering will be [\$_____ per month, or \$_____ per year.]
[a one-time single premium of \$_____.]

Type of Policy (noncancelable/guaranteed renewable): _____

The Company's Right to Increase Premiums:

[Insurer shall use appropriate bracketed statement, but shall not show rate guarantees on this form]:
[The company can never raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided that it raises rates for all policies in the same class in this state.]

Rate Increase History

[A company may use the first bracketed sentence only if it has never increased rates under any prior policy form in this state or any other state.]

The company has sold long-term care insurance since [year] and has sold this policy form since [year].
[The company has never raised its rates for any long-term care policy it has sold in this state or in any other state.] [The company has not raised its premium rates for this policy form or similar policy forms in this state or in any other state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. The following summary includes all such rate increases in the last 10 years: []. [Instructions to issuer: The issuer shall list each premium increase it has instituted on this policy form or any similar policy form issued in this state or any other state during the 10 years immediately preceding the date of first solicitation of the applicant. The summary shall list the policy form identification number, each calendar year the form was available for sale in any state, and the calendar year and the amount (percentage) of each increase. The issuer shall provide minimum and maximum percentages if the rate increase is variable by rating characteristics. The issuer may provide, in a clear and fair manner, additional explanatory information which will assist the applicant in understanding the rate increase history concerning the described form(s).]

Questions Related to Your Income

How will you pay each year's premium?

- From my Income From my Savings/Investments My Family Will Pay

[Have you considered whether you could afford to keep this policy if the premiums were raised, for example, by 20%?]

[The issuer shall use the bracketed sentence unless the policy is fully paid up or is a noncancelable policy.]

What is your annual income? (check one)

- Under \$10,000 \$[10-20,000] \$[20-30,000] \$[30-50,000] Over \$50,000

[The issuer may choose the numbers to put in the brackets to fit its suitability standards.]

How do you expect your income to change over the next 10 years? (check one)

- No change Increase Decrease

*If you will be paying premiums with money received **only from your own income**, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.*

Will you buy inflation protection? (check one) Yes No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

- From my Income From my Savings/Investments My Family Will Pay

The national average annual cost of care in [insert year] was [insert \$ amount], but this figure varies across the country. In 10 years the national average annual cost will be approximately [insert \$ amount] if costs increase 5% each year.

What elimination period are you considering? Number of days:

Approximate \$ cost is for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

- From my Income From my Savings/Investments My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, approximately how much are all your assets (your savings and investments) worth? (check one)

- Under \$20,000 \$20,000-\$30,000 \$30,000-\$50,000 Over \$50,000

How do you expect your assets to change over the next ten years? (check one)

- Stay about the same Increase Decrease

If you are buying this policy to protect your assets and your assets are less than \$30,000, you may wish to consider other options for financing your long-term care.

APPENDIX C

Things You Should Know Before You Buy Long-Term Care Insurance

- Long-term Care Insurance**
- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
 - [You should **not** buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]

(Drafting Note: For single premium policies, delete this bullet; for noncancelable policies, delete the second sentence only.)

- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.
- Medicare**
- Medicare does **not** pay for most long-term care.
- Medicaid**
- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.
 - Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
 - When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
 - Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.
- Shopper's Guide**
- Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.
- Counseling**
- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

Facilities

- Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy

APPENDIX D

Producer's or Insurer's Suitability Letter to Applicant:

Dear [Applicant]:

Your recent application for long-term care insurance included a "personal worksheet," which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet the "Shopper's Guide to Long-term Care Insurance" and the page titled "Things You Should Know Before Buying Long-term Care Insurance." The Maine Bureau of Insurance also has information about long-term care insurance, and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

Drafting Note: Choose the paragraph that applies.

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

- Yes,** [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

Drafting Note: Delete the phrase in brackets if the applicant did not answer the questions about income.

- No,** I have decided not to buy a policy at this time.

APPLICANT'S SIGNATURE

DATE

APPENDIX E

Instructions:

This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

Insurers shall provide all of the following information to the applicant:

Long-term Care Insurance Potential Rate Increase Disclosure Form

1. **[Premium Rate] [Premium Rate Schedules]:** [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and approved for an increase [is][are] [on the application][(\$_____)]
2. **The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.**
3. **Rate Schedule Adjustments:**
The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): _____.
4. **Potential Rate Revisions:**
This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
- Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

Turn the Page

*** Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the \$1,000 annual premium for 10 years, so you have paid a total of \$10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or \$500 for a new annual premium of \$1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are \$10,000 (provided you have a least \$10,000 of benefits remaining under your policy.)

Turn the Page

Contingent Nonforfeiture
Cumulative Premium Increase over Initial Premium
That qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%

88	12%
89	11%
90 and over	10%

[The following contingent nonforfeiture disclosure need only be included for those limited pay policies to which Sections 28(D)(4) and 28(D)(6) of the rule are applicable.]

In addition to the contingent nonforfeiture benefits described above, the following reduced “paid-up” contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced “paid up” benefit AND the contingent benefit described above are triggered by the same rate increase, you can choose either of the two benefits.

You are eligible for the reduced “paid up” contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below;

Triggers for a Substantial Premium Increase	
Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

2. You stop paying your premiums within 120 days of when the premium increase took effect; AND
3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option your coverage will be converted to reduced “paid-up” status. That means there will be no additional premiums required. Your benefits will change in the following ways:

- a. The total lifetime amount of benefits your reduced paid up policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.
- b. The daily benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.

Example:

- You bought the policy at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.
- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your “paid-up” policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced “paid-up” policy.

APPENDIX F

Contents and Format of Outline of Coverage:

[on face page of outline]

IF YOU NEED ASSISTANCE, CONTACT:

Maine State Health Insurance Assistance Program

MAINE BUREAU OF INSURANCE

CONSUMER HEALTH CARE DIVISION

34 STATE HOUSE STATION, AUGUSTA, ME 04333-0034

Tel. 207-624-8475 or 1-800-300-5000; Fax: 207-624-8599

INTERNET WEBSITE: www.maine.gov/insurance

IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. IN MAINE, CALL TOLL-FREE 1-877-ELDERS-1 (1-877-353-3771).

IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE, CONTACT:

[COMPANY NAME]

[ADDRESS - CITY & STATE]

[TELEPHONE NUMBER]

**LONG-TERM CARE INSURANCE
OUTLINE OF COVERAGE**

[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following cautionary statement, or language substantially similar, must appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises. If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance][a group policy] which was issued in the [indicate jurisdiction in which group policy was issued].
2. **PURPOSE OF OUTLINE OF COVERAGE.** This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY (OR CERTIFICATE) CAREFULLY.**
3. **TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE, DISCONTINUED OR CHANGED.**
 - (a) [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:
 - (1) Policies and certificates that are guaranteed renewable shall contain the following statement:] **RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE.** This means you have the right, subject to the terms of your policy, [certificate] to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, **IT MAY INCREASE THE PREMIUM YOU PAY.**
 - (2) [Policies and certificates that are noncancelable shall contain the following statement:] **RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELABLE.** This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.
 - (b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]
 - (c) [Describe waiver of premium provisions or state that there are not such provisions;]
 - (d) [State whether or not the company has a right to change premium, and if such right exists, describe clearly and concisely each circumstance under which premium may change.]

- (e) The terms of the policy or certificate may change from time to time, to conform to changes in the applicable laws or rules.

4. **TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.**

- (a) [Provide a brief description of the 30-day right to return, or “free-look”, provision of the policy.]
- (b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

5. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.** If you are eligible for Medicare, review the Medicare Supplement Buyer’s Guide available from the insurance company.

- (a) [For producers] Neither [insert company name] nor its producers represent Medicare, the federal government or any state government.
- (b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

6. **LONG-TERM CARE COVERAGE.** Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

7. **BENEFITS PROVIDED BY THIS POLICY.**

- (a) [Covered services, related deductibles, waiting periods, elimination periods and benefit maximums.]
- (b) [Institutional benefits, by skill level.]
- (c) [Non-institutional benefits, by skill level.]
- (d) Eligibility for payment of benefits

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.]

[Any additional benefit triggers must also be explained. If these triggers differ for different benefits, an explanation of the triggers should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.]

8. FEDERAL AND STATE INCOME TAX CONSEQUENCES.

This [POLICY][CERTIFICATE][RIDER] is intended to be a federally tax-qualified long-term care insurance contract under Internal Revenue Code §7702B(b), and also is intended to be a Maine tax-qualified long-term care insurance contract pursuant to 36 M.R.S.A. §5122(2)(L). The person who pays premiums may be entitled to an income tax deduction. The insured should seek the assistance of a personal tax advisor.

or

This [POLICY][CERTIFICATE] is intended to be a Maine state tax-qualified contract pursuant to 36 M.R.S.A. §5122(2)(L). The person who pays the premiums may be entitled to a Maine income-tax deduction. The [policy][certificate][rider] is not intended to qualify for federal income tax benefits. The insured should seek the assistance of a personal tax advisor.

9. TAX ADVICE.

You should obtain advice from your personal tax advisor.

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

- (a) Preexisting conditions;
- (b) Non-eligible facilities and provider;
- (c) Non-eligible levels of care (*e.g.*, unlicensed providers, care or treatment provided by a family member, etc.);
- (d) Exclusions and exceptions;
- (e) Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in Number 6 above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. **RELATIONSHIP OF COST OF CARE AND BENEFITS.** Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

- (a) That the benefit level will not increase over time;
- (b) Any automatic benefit adjustment provisions;
- (c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;
- (d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;
- (e) Describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

12. **ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.**

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative diseases and dementias. Specifically, describe each benefit screen or other policy provision which preconditions the availability of policy benefits for such an insured.]

13. **PREMIUM.**

- [(a) State the total annual premium for the policy;
- (b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

14. **ADDITIONAL FEATURES.**

- [(a) Indicate if medical underwriting is used;
- (b) Describe other important features.]