# 02 DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

031 BUREAU OF INSURANCE

Chapter 270 MEDICARE SUPPLEMENT INSURANCE RULE -- REVISED

1 Purpose

The purpose of this Rule is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies and contracts; to establish minimum standards for benefits; to facilitate public understanding and comparison of such policies; to prohibit provisions contained in such policies which are unjust, unfair, inequitable, or unfairly discriminatory to any person insured or proposed for coverage under such policies or which may be misleading or confusing; to reduce unfair, misleading, or confusing sales and claims settlement practices; and to provide for full disclosures in the sale of health insurance coverage to persons eligible for Medicare by reason of age.

2. Authority

This Rule is issued pursuant to the authority vested in the Superintendent of Insurance under 24 M.R.S.A. § 2328 and 24-A M.R.S.A. §§ 212, 2413(1)F, 4207(9), 5002, 5003, and 5005.

3. Applicability and scope

(A) Except as otherwise specifically provided, this Rule shall apply to all Medicare supplement insurance policies, subscriber contracts, and certificates, as defined in 24-A M.R.S.A. § 5001, delivered or issued for delivery in this State after the effective date of this Rule.

(B) The disclosure provisions in Section 13(A)(5) of this Rule and Section 19 of this Rule shall apply to all individual and group accident and health insurance policies and subscriber contracts, and all certificates issued thereunder, which provide hospital or medical expense coverage on an expense incurred or indemnity basis, other than incidentally, delivered or issued for delivery in this State to persons eligible for Medicare by reason of age on or after the effective date of this Rule.

(C) This Rule shall not apply to:

(1) individual policies issued pursuant to a conversion privilege under a group or individual insurance policy that includes provisions inconsistent with the requirements of this Rule; or

(2) Medicare supplement policies issued to employees or members of franchise plans in existence on the effective date of this Rule.

4. Definitions

For purposes of this Rule:

(A) "Applicant" means:

(1) in the case of an individual Medicare supplement policy, the person who seeks to contract for benefits; and

(2) in the case of a group Medicare supplement policy, the proposed certificate holder.

(B) "Certificate" means any certificate issued under a group Medicare supplement policy delivered or issued for delivery in this State.

(C) "Insurance policy" or "policy" for purposes of this Rule also includes an individual or group contract for benefits to be provided by a health maintenance organization or by a nonprofit hospital or medical service organization.

(D) "Limited benefit health insurance" means any accident or health insurance policy, issued for delivery in this State to persons eligible for Medicare by reason of age, other than a Medicare supplement policy which meets the standards contained in 24-A M.R.S.A. Chapter 67 and in this Rule or a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. § 1395 et seq.). In particular, this term includes: any disability income policy; any basic, catastrophic, or major medical expense policy; any single premium nonrenewable policy; and any policy identified in Section 3(C) of this Rule.

(E) "Medicare" means the United States Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, Public Law 89-97 as amended.

(F) "Medicare supplement policy" means a group or individual health insurance policy advertised, marketed, or designed primarily as a supplement to reimbursements made under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare by reason of age. This term does not include:

(1) a policy issued to one or more employers or labor organizations or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, or for members or former members, or combination thereof, of the labor organizations;

(2) a policy issued to any professional, trade, or occupational association for its members or former or retired members, or combination thereof, if such association:

(a) is composed of individuals all of whom are actively engaged in the same profession, trade or occupation;

(b) has been maintained in good faith for purposes other than obtaining insurance; and

(c) has been in existence for at least 2 years prior to the date of its initial offering of such policy or plan to its members; or

(3) an individual policy issued pursuant to a conversion privilege under a group or individual insurance policy that includes provisions inconsistent with the requirements of this Rule or 24-A M.R.S.A. Chapter 67.

(F) "Superintendent" means the Superintendent of Insurance.

5. Policy definitions and terms

No insurance policy may be advertised, solicited, or issued for delivery in this State as a Medicare supplement policy unless the definitions of terms in that policy conform to the requirements of this section.

(A) "Accident," "Accidental Injury," or "Accidental Means" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

(1) The definition shall not be more restrictive than the following:

Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and which occurs while insurance coverage is in force.

(2) The definition may, however, exclude injuries for which benefits are provided or available under any workers' compensation, employer's liability, or similar law, or motor vehicle no-fault plan, unless prohibited by law.

(B) "Benefit Period" or "Medicare Benefit Period" shall not be defined more restrictively than as defined in the Medicare program.

(C) "Skilled Nursing Facility" shall be defined in relation to its license status, facilities, and available services.

(1) The definition shall not be more restrictive than one requiring that a skilled nursing facility or home:

(a) be operated pursuant to law:

(b) be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;

(c) be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

(d) provide twenty-four hour nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and

(e) maintain a daily medical record of each patient.

(2) The definition may, however, exclude:

(a) boarding homes and intermediate care facilities providing rest, custodial, or maintenance care;

(b) homes and facilities for the aged, drug addicts, or alcoholics; and

(c) homes and facilities primarily used for the care and treatment of mental diseases or disorders, or for educational care.

(D) "Hospital" may be defined either in relation to its license status, facilities, and available services, or to reflect its accreditation by the Joint Commission of Accreditation of Hospitals.

(1) The definition may not be more restrictive than one requiring current accreditation or one requiring that a hospital:

(a) be an institution operated pursuant to law; and

(b) be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic, and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and

(c) provide twenty-four hour nursing service by or under the supervision of a registered graduate professional nurse (R.N.).

(2) The definition may, however, exclude:

(a) convalescent, rest, and nursing homes and facilities; or

(b) facilities primarily affording custodial, educational, or rehabilitory care;

(c) homes and facilities for the aged, drug addicts, or alcoholics;

and

(d) military and veterans' hospitals, soldiers' homes, and hospitals contracting with or operated by any national government or agency for the treatment of members or ex-members of the armed forces, provided that services rendered on an emergency basis at such facilities may not be excluded if the patient is legally liable to pay for the care received.

(E) "Intermediate Care Facility" shall be defined in relation to its license status, facilities, and available services. The definition shall not be more restrictive than one requiring that the facility:

(1) be operated pursuant to law;

(2) be primarily engaged in providing to residents:

(a) nursing services under the direction of a registered professional nurse or a licensed practical nurse, employed full time (at least 40 hours per week) during the day in the facility and responsible for the total nursing service; and, in addition, sufficient nursing and auxiliary personnel to provide adequate and properly supervised nursing services for its residents during all hours of each day and all days of each week;

(b) care to individuals who, because of their physical and/or mental condition, require living accommodations and care which, as a practical matter, can be made available to them only through institutional facilities; and who do not have such illness, disease, injury, or other conditions as to require the degree of care and treatment that a hospital or skilled nursing facility is designed to provide; and

(c) related services for residents who require medical or nursing care;

(3) have written policies, developed with the advice of, and with the provision for review of such policies at least semiannually by, a group of professional personnel, including the administrator, one or more physicians, one or more registered professional nurses, one or more registered pharmacists, and such other professional personnel as are necessary to govern the services it provides;

(4) have a physician or a registered professional nurse or a medical staff responsible for the execution of such policies;

(5) require that the health care of every resident must be under the supervision of a physician who sees the resident as needed and at least every 60 days, and also provide for having a physician available to furnish necessary medical care in case of emergency;

(6) maintain individual records on each resident;

(7) provide appropriate methods and procedures for dispensing and administering drugs and biologicals; and

(8) have in effect a written transfer agreement with a licensed hospital, under which the hospital will provide needed diagnostic and other services to residents of the facility, and agrees to timely acceptance, as inpatients, of acutely ill residents of the facility who are in need of hospital care.

(F) "Medicare" shall be defined in the policy. Medicare may be defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or as "Title 1, Part 1 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 by words of similar import.

(G) "Medicare Eligible Expenses" shall mean health care expenses of the kinds covered by Medicare, to the extent recognized as reasonable by Medicare. Payment of benefits by insurers, health maintenance organizations, nonprofit hospital or medical service plans, or nonprofit health care plans for Medicare eligible expenses may not be conditioned upon more restrictive payment conditions, including determinations of medical necessity, than are applicable to Medicare claims.

(H) "Mental or Nervous Disorders" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease of any kind.

(I) "Nurse" may be defined so that the description of nurse is restricted to a type of nurse, such as registered graduate professional nurse (R.N.) or licensed practical nurse (L.P.N.). If the words "nurse," "trained nurse," or "registered nurse" are used without specific definition, then the use of such terms requires the insurer to recognize the services of any individual qualified under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

(J) "Physician" shall be defined to include all licensed providers of medical care and treatment who are approved by Medicare for reimbursement.

(K) "Sickness" shall not be defined more restrictively than the following:

Sickness means sickness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force. The definition may, however, exclude sicknesses or diseases for which benefits are provided or available under any workers' compensation, occupational disease, employer's liability, or similar law.

6. Prohibited policy provisions

(A) A Medicare supplement policy may impose reasonable territorial limitations consistent with those imposed by Medicare but may otherwise limit or exclude coverage only for the following services and conditions:

(1) foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;

(2) alcoholism, drug addiction, and mental or emotional disorders other than Alzheimer's Disease and related dementias;

(3) illness, medical condition, or treatment, arising out of:

(a) war or act of war (whether declared or undeclared), service in the armed forces or units auxiliary thereto, or participation in a felony, riot, or insurrection;

(b) suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury;

(c) aviation;

(4) cosmetic surgery, other than reconstructive surgery that is incidental to or follows surgery resulting from trauma, infection, or other diseases of the involved part;

(5) treatment provided in a government hospital; any expense to the extent of benefits provided under Medicare, any state or federal workers' compensation, employer's liability, or occupational disease law, any motor vehicle no-fault law, or any other governmental program except Medicaid; services performed by a member of the covered person's immediate family; and services for which no charge is normally made in the absence of insurance;

(6) dental care or treatment;

(7) eye glasses, hearing aids, and examination and prescription for the fitting thereof; and

(8) rest cures, custodial care, transportation, and routine physical examinations;

Limitations or exclusions falling within the foregoing descriptions are permitted, but only to the extent consistent with the mandated benefit requirements of Subparagraph 8(B)(8) below and the other minimum benefit standards set forth in this Rule, provided further that no limitations of the types enumerated in subsections (1), (6), or (8) above may be more restrictive than those of Medicare.

(B) No Medicare supplement policy may use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described pre-existing diseases or physical conditions.

(C) A Medicare supplement policy shall use only the terms "skilled nursing facility" and "intermediate care facility" to refer to nursing care facilities. Terms including, but not limited to "Convalescent Nursing Facility" and "Extended Care Facility," which are not classes of health care facilities licensed under Maine law, shall not be permitted.

(D) No Medicare supplement policy shall use "nursing home," "nursing care," or words of similar generality to describe coverage provided unless coverage is provided for expenses incurred in connection with an insured person's confinement in skilled nursing facilities and intermediate care facilities.

(E) The terms "Medicare Supplement," "Medigap," and words of similar import shall not be used unless the policy is issued in compliance with this Rule.

(F) No Medicare supplement policy or certificate in force in Maine shall contain benefits which duplicate benefits provided by Medicare.

7. Benefit conversion requirements

(A) Benefits eliminated by operation of the Medicare Catastrophic Coverage Act of 1988 transition provisions shall be restored.

(B) Medicare supplement policies subject to the minimum standards adopted by the states pursuant to the Medicare Catastrophic Coverage Act of 1988 shall provide at least the minimum benefits set forth below in Subsection 8(B).

8. Minimum benefit standards

No insurance policy may be advertised, solicited, or issued for delivery in this State as a Medicare supplement policy unless it meets the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

If a nonprofit hospital or medical service plan is prohibited from issuing subscriber contracts that meet the minimum benefit standards of this Rule, the plan may issue a contract including such of those benefits as are permitted, in conjunction with some other contract or policy supplying the remaining benefits, and the combination shall be treated as a single policy for purposes of this Rule.

(A) General Standards:

(1) A Medicare supplement policy may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(2) A Medicare supplement policy shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes, provided that such modifications comply with all applicable rating requirements imposed under Maine law.

(3) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement policy shall not:

(a) provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium, or

(b) be cancelled or nonrenewed by the insurer solely on the grounds of deterioration of health or on the basis of age.

(4) Termination of a Medicare supplement policy shall be without prejudice to coverage of any continuous loss that commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

(5) Except as authorized by the Superintendent, an insurer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(6) If a group Medicare supplement insurance policy is terminated by the group policyholder, or if a certificate holder under such a policy ceases to be a member of the group, the policyholder or the insurer shall offer continuation or replacement coverage as follows:

(a) If the group policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for pre-existing conditions that would have been covered under the group policy being replaced.

(b) If a certificate holder’s group membership terminates while the group policy remains in force, the insurer shall, if the policyholder so elects, offer continuation of coverage under the group policy.

(c) If the conditions of subparagraph (a) or (b) for replacement or continuation of group coverage are not satisfied, the insurer shall offer the certificate holder at least the following choices, without any exclusion for pre-existing conditions that would have been covered under the former group policy:

(i) an individual Medicare supplement policy that provides for the continuation of the benefits contained in the group policy; and

(ii) an individual Medicare supplement policy that provides only such benefits as are required to meet the minimum standards.

(B) Minimum Benefit Standards. The following minimum benefits shall be provided under a Medicare supplement policy:

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

(3) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

(4) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

(5) Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

(6) Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible ($75) maximum benefit;

(7) Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

(8) Chiropractic services shall be covered at least to the extent required by 24 M.R.S.A. § 2303-C, 24-A M.R.S.A. § 2748, and 24-A M.R.S.A. § 2840-A. Group policies subject to the requirements of 24 M.R.S.A. §§ 2325-A and 2329 or 24-A M.R.S.A. §§ 2842 and 2843 must provide at least the minimum required benefits for treatment of substance abuse and mental illness.

9. Standards for claims payment

(A) Every entity providing Medicare supplement policies shall comply with all provisions of Section 4081 of the United States Omnibus Reconciliation Act of 1987 (P.L. 100-203).

(B) Compliance with the requirements of Subsection A must be certified on the Medicare supplement insurance experience reporting form.

10. Prohibited solicitation practices

In any advertisement or solicitation of a person eligible for Medicare by reason of age to apply for a Medicare supplement policy, no insurer, agent, or broker shall:

(A) represent or imply that the policy, insurer, agent, or broker is sponsored by or affiliated with the Federal Government, the Medicare Program, or the Social Security Administration; or

(B) use any title or initials which represent or imply that the policy, insurer, agent, or broker is affiliated with or sponsored by the Federal Government, the Medicare Program, or the Social Security Administration.

11. Loss ratio standards

As soon as practicable, but prior to the effective date of Medicare benefit changes, every insurer or other entity providing Medicare supplement insurance policies or certificates in this State shall file with the Superintendent in accordance with the applicable filing procedures of this State:

(A) Appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the applicable policies or certificates. Supporting documents as necessary to justify the adjustments shall accompany the rate filing; and

(B) Any appropriate riders, endorsements, or policy forms needed to accomplish the Medicare supplement insurance modifications necessary to eliminate benefit duplications with Medicare. Any such riders, endorsements, or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

12. Permitted compensation arrangements

(A) An insurer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than 200 percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

(B) The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for a reasonable number of renewal years.

(C) If an existing policy or certificate is replaced, no entity shall provide to its agents or other producers, and no agent or producer shall receive, compensation greater than the renewal compensation payable by the replacing insurer on renewal policies or certificates, unless benefits of the new policy or certificate are clearly and substantially greater than the benefits under the replaced policy.

(D) For purposes of this section, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate, including but not limited to bonuses, gifts, prizes, awards and finder's fees.

13. Required disclosure provisions

(A) General Rules.

(1) Medicare supplement policies shall include a renewal or continuation provision. The language or specifications of the provision must be consistent with the type of contract to be issued. The provision shall be appropriately captioned and shall appear on the first page of the policy.

(2) All riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the insured, except for riders or endorsements by which the insurer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, unless the increase in benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

(3) A Medicare supplement policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include a definition and explanation of such terms in its accompanying outline of coverage.

(4) If a Medicare supplement policy contains any limitations with respect to pre-existing conditions as permitted under 24-A M.R.S.A. § 5006, such limitations must appear as a separate paragraph of the policy and be labeled as "Pre-existing Condition Limitations."

(5) Whether or not such policies or certificates are advertised, solicited, or issued as Medicare supplement policies as defined in this Rule, all insurers and other entities issuing accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis, other than incidentally, shall provide a Medicare supplement buyer's guide to all applicants for such policies who are eligible for Medicare by reason of age. Except in the case of direct response insurers, the issuer shall deliver the buyer's guide to the applicant at the time of application and obtain written acknowledgment of receipt. Direct response insurers shall deliver the buyer's guide to the applicant upon request but not later than at the time the policy is delivered. All such buyer's guides shall reflect the Medicare deductible and coinsurance amounts current at the time of their delivery. The buyer's guide shall be in the form entitled "Guide to Health Insurance for People with Medicare" [an edition of which is reproduced as Attachment A to this Rule], unless the National Association of Insurance Commissioners or the Health Care Financing Administration of the U.S. Department of Health and Human Services discontinues its endorsement of that form, or the U.S. Government Printing Office ceases publication of that form. In that event, the Superintendent of Insurance shall prescribe the form of the buyer's guide by bulletin.

(6) The terms "Medicare supplement," "medigap," and words of similar import shall not be used to label, advertise, market, or otherwise describe any insurance policy that is not issued in compliance with Sections 5, 6, 7, and 9 of this Rule.

(B) Notice Requirements

(1) As soon as practicable, and no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, every insurer, health care service plan, or other entity providing Medicare supplement insurance or benefits to any resident of this State shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies in a format acceptable to the Superintendent. The format prescribed in Appendix A may be used if no other format is prescribed by the Superintendent. The notice shall:

(a) include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement insurance policy, and

(b) inform each covered person as to when any premium adjustment is to be made due to changes in Medicare.

(2) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

(3) Such notices shall not contain or be accompanied by any solicitation.

(4) In the event that notice substantially similar to Appendix A has been provided to residents of this State who are Medicare supplement insurance policyholders or certificate holders prior to the effective date of this Rule, the notice requirements of this section for the benefits commencing January 1, 1990, shall be deemed to be satisfied.

(C) Outline of Coverage Requirements for Medicare Supplement Policies and Certificates.

(1) Insurers and other entities issuing Medicare supplement policies or certificates for delivery in this State shall provide an outline of coverage to each applicant. Except for direct response insurers, which may deliver the outline of coverage with the policy, the issuer shall provide the outline of coverage at the time application is made and obtain a written acknowledgment of receipt.

(2) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered and contain the following statement, in no less than twelve (12) point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

(3) The outline of coverage provided to applicants pursuant to subsections (1) and (2) shall be in the form prescribed below, except that terms such as "policy" or "insurance company," if inappropriate to the certificate or contract being described, shall be replaced with the appropriate term. Where language to be used is not specifically prescribed, directions governing the type or description of information which the issuer is to provide are set forth in brackets. Language supplied by the issuer in response to these requirements is subject to review by the Superintendent and shall be disapproved if the Superintendent determines that such language fails to comply with the requirements of this Rule or is in violation of 24-A M.R.S.A. Chapter 23 or Chapter 67. Bracketed dollar amounts representing Medicare deductible and coinsurance amounts shall be appropriately modified when the Medicare deductible or coinsurance amounts change:

[COMPANY NAME]

OUTLINE OF MEDICARE

SUPPLEMENT COVERAGE

(1) Read Your Policy Carefully -- This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) Medicare Supplement Coverage -- Policies of this category are designed to supplement Medicare by covering some hospital, medical, and surgical services which are partially covered by Medicare. Coverage is provided for hospital inpatient charges and some physician charges, subject to any deductibles and copayment provisions which may be in addition to those provided by Medicare, and subject to other limitations which may be set forth in the policy. The policy does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing, and taking medicine [delete to the extent such coverage is provided].

(3) [for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct responses:]

[insert company's name] is not connected with Medicare.

(4) [A brief summary of the major benefit gaps in Medicare Parts A & B with a parallel description of supplemental benefits, including dollar amounts (and indexed copayments or deductibles as appropriate), provided by the Medicare supplement coverage in the following order:]

Description This Policy Pays You Pay

|  |  |  |
| --- | --- | --- |
| I. MINIMUM STANDARDS SERVICE  PART A  INPATIENT HOSPITAL SERVICES:  Semiprivate Room & Board Miscellaneous Hospital Services & Supplies, such as Drugs, X-Rays, Lab Tests & Operating Room |  |  |
| BLOOD |  |  |
| MEDICAL EXPENSE:  Services of Physician/out-Patient Services Medical Supplies other than Prescribed Drugs |  |  |
| BLOOD |  |  |
| MISCELLANEOUS  Immunosuppressive Drugs |  |  |
| II. Additional Benefits  PART A  Part A Deductible  Private Rooms  In-Hospital Private Nurses  Skilled Nursing Facility |  |  |
| PARTS A& B  Home Health Services |  |  |
| PART B |  |  |
| Part B Deductible Medical Charges in Excess of Medicare Allowable Expenses (Percentage Paid) |  |  |
| OUT-OF POCKET MAXIMUM |  |  |
| Prescription Drugs |  |  |
| Miscellaneous |  |  |
| Respite Care Benefits |  |  |
| Expenses Incurred in Foreign County |  |  |
| Other  Total Premium |  | $ |

IN ADDITION TO THIS OUTLINE OF COVERAGE,

[COMPANY NAME] WILL SEND AN

ANNUAL NOTICE TO YOU 30 DAYS PRIOR TO THE EFFECTIVE DATE OF MEDICARE

CHANGES WHICH WILL DESCRIBE THESE CHANGES AND THE CHANGES IN YOUR

MEDICARE SUPPLEMENT COVERAGE.

\*\*If this policy does not provide coverage for a benefit listed above,

the insurer must state "No

coverage" beside that benefit in the first column.

(5) [A chart describing recent changes in benefits, in the form set forth in Appendix A, shall accompany the outline of coverage]

(6) [A statement that the policy does or does not cover the following:

(a) Private duty nursing,

(b) Skilled nursing home care costs beyond what is covered by Medicare,

(c) Custodial nursing home care costs,

(d) Intermediate nursing home care costs,

(e) Home health care above number of visits covered by Medicare.

(f) Physician charges above Medicare's reasonable charge,

(g) Drugs other than prescription drugs furnished during a hospital or skilled nursing facility stay,

(h) Care received outside of U.S.A., [This statement shall also clearly state that care is provided outside the U.S.A. in those instances when Medicare provides benefits.]

(i) Dental care or dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for the cost of eyeglasses or hearing aids.]

(7) [A description of any policy provisions which exclude, eliminate, reduce, limit, delay, or in any other manner operate to qualify payments of the benefits described in (4) above, including conspicuous statements:

(a) That the chart summarizing Medicare benefits only briefly describes such benefits.

(b) That the Health Care Financing Administration or its Medicare publications should be consulted for further details and limitations.]

(8) [A description of policy provisions respecting renewability or continuation of coverage, including any reservation of rights to change premium.]

14. Requirements for replacement

(A) Application forms shall include the following questions designed to elicit information as to whether the applicant has another Medicare supplement insurance policy or certificate in force, as of the date of the application, or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate. This requirement may be satisfied through use of a supplementary application or other form to be signed by the applicant and, except where the coverage is sold without an agent, by the agent:

(1) Do you have another Medicare supplement insurance policy or certificate in force (including health care service contract or health maintenance organization contract)?

(2) Did you have another Medicare supplement 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) Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold which are still in force.

(2) List policies sold in the past five (5) years which are no longer in force.

(C) Upon determining that a sale will involve replacement, an issuer or agent shall deliver to the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of accident and sickness coverage, except that a direct response insurer shall deliver such notice at the time the policy is issued. One copy of the notice signed by the applicant, and by the agent except where the coverage is sold without an agent, shall be provided to the applicant, and an additional signed copy shall be retained by the issuer. The required notice, if the issuer is not a direct response insurer, shall be provided in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT

OF MEDICARE SUPPLEMENT 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 Medicare Supplement insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy provides thirty (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 coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [BROKER 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 which you may presently have, which may be referred to in the policy as pre-existing conditions, may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

[This subsection may be modified if pre-existing conditions are covered under the new policy.]

(2) State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

(3) If you are replacing existing Medicare supplement 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 you sign it, reread it carefully to be certain that all information has been properly recorded.

[Signature of Agent, Broker or Other Representative]

[Typed Name and Address of Agent or Broker]

The above "Notice to Applicant" was delivered

to me on:

\_\_\_\_\_\_\_\_\_\_\_\_\_

(Date)

\_\_\_\_\_\_\_\_\_\_\_\_\_

(Applicant's Signature)

(D) The notice required by subsection (C) above for a direct response insurer shall be in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT 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 Medicare supplement insurance and replace it with the policy delivered herewith issued by [Company Name] Insurance Company. Your new policy provides thirty (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 coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

(1) Health conditions which you may presently have, which may be referred to in the policy as pre-existing conditions, may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy. [This subsection may be modified if pre-existing conditions are covered under the new policy.]

(2) State law provides that your replacement policy or certificate may not contain pre-existing conditions, waiting periods, elimination periods, or probationary periods. Your insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

(3) If you are replacing existing Medicare supplement 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) [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [Company Name and Address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

\_\_\_\_\_\_\_\_\_\_\_\_\_

[Company Name]

15. Standards for marketing

(A) Every insurer, health care service plan, or other entity marketing Medicare supplement insurance coverage in this State, directly or through its producers, shall:

(1) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate;

(2) Establish marketing procedures to assure that excessive insurance is not sold or issued. The procedures shall include a specific standard for persons covered by Medicaid;

(3) Establish marketing procedures which set forth a mechanism or formula for determining whether a replacement policy or certificate contains benefits clearly and substantially greater than the benefits under the replaced policy;

(4) Display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and policy the following:

"Notice to buyer: This policy may not cover all of the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

(5) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance; and

(6) Establish auditable procedures for verifying compliance with the foregoing standards.

(B) In addition to the practices prohibited in 24-A M.R.S.A. Chapter 23, the following acts and practices are prohibited:

(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

(2) 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.

(3) 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.

16. Appropriateness of recommended purchase and excessive insurance

(A) In recommending the purchase or replacement of any Medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(B) Any sale of Medicare supplement coverage which will provide an individual more than one Medicare supplement policy or certificate is prohibited; provided, however, that additional Medicare supplement coverage may be sold if, when combined with that individual's health coverage already in force, it would insure no more than 100 percent of the individual's actual medical expenses covered under the combined policies.

17. Reporting of multiple policies

On or before March 1 of each year, every insurer or other entity providing Medicare supplement insurance coverage in this state shall inform the Superintendent of every individual resident of this State for which the insurer has in force more than one Medicare supplement insurance policy or certificate. For each such individual, the insurer shall report all policy and certificate numbers and dates of issuance.

18. Prohibition against pre-existing conditions, waiting periods, elimination periods, and probationary periods in replacement policies or certificates

If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate or is offered as a conversion or continuation from a group health insurance plan, the replacing insurer shall waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy for similar benefits to the extent such time was spent under the original policy.

19 Limited benefit health coverage

Any limited benefit health insurance policy or certificate, as defined in Section 4(C) of this Rule, issued in Maine to persons eligible for Medicare by reason of age, shall notify insureds that the policy is not a Medicare supplement policy or contract. Such notice shall either be printed or attached to the first page of an outline of coverage, if any, delivered to insureds or to the first page of the policy or certificate delivered to insureds. Such notice shall be in no less than twelve (12) point type and shall contain the following language:

"THIS [POLICY, CERTIFICATE OR SUBSCRIBER CONTRACT] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CERTIFICATE]. If you are eligible for Medicare review the Medicare Supplement Buyer's Guide available from the [company or plan].

20. Transition rules

Prior to advertising, marketing, issuing, or delivering for issuance any policy as Medicare supplement insurance following the effective date of this revised Rule, all insurers, health maintenance organizations, nonprofit hospital and medical service plans, and nonprofit health care plans shall file with the Superintendent a statement of all forms previously approved for use in Maine which they intend to use in marketing Medicare supplement insurance after the effective date of this Rule. The statement shall identify all such products by form number and indicate the date each such form was approved by the Maine Bureau of Insurance for use in Maine.

21. Severability

If any provision of this Rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the Rule and the application of such provision to other persons or circumstances shall not be affected thereby.

22. Buyer's guide

No insurer, health maintenance organization, or nonprofit hospital or medical service plan shall make use of or otherwise disseminate any Buyer's Guide or informational brochure which does not accurately outline current Medicare benefits.

23. Transitional form and rate filing requirements

(A) As soon as practicable, and no later than forty-five (45) days after the effective date of substantive Medicare benefit changes, every insurer, health maintenance organization, and nonprofit hospital or medical service plan providing Medicare supplement coverage in this State shall file with the Superintendent, in accordance with the applicable filing procedures of this State:

(1) Appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the applicable policies or the adjustment shall accompany the filing.

(2) Any appropriate riders, endorsements, or policy forms needed to accomplish the Medicare supplement insurance modifications necessary to eliminate benefit duplications with Medicare and to provide the minimum required benefits. Any such riders, endorsements, or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy.

(B) Upon satisfying the filing and approval requirements of this State, every insurer or nonprofit hospital or medical service plan providing Medicare supplement insurance in this State shall provide each covered person with any rider, endorsement, or policy form necessary to make the necessary adjustments.

(C) Any premium adjustments shall produce an expected loss ratio at least as great as that originally anticipated, and that will conform with minimum loss ratio standards for Medicare supplement policies. Premium adjustments may be calculated for the period commencing with Medicare benefit changes.

24. Effective date

The revised Rule shall be effective August 15, 1990. This Rule does not apply to policies or certificates issued for delivery on or after the effective date of Bureau of Insurance Rule Chapter 275.

EFFECTIVE DATE (ELECTRONIC CONVERSION): January 14, 1997

APAO WORD VERSION CONVERSION (IF NEEDED) AND ACCESSIBILITY CHECK: July 18, 2025

APPENDIX A

[COMPANY NAME]

NOTICE OF CHANGES IN MEDICARE

AND YOUR MEDICARE SUPPLEMENT COVERAGE -- 1990

THE FOLLOWING CHART BRIEFLY DESCRIBES THE MODIFICATIONS IN MEDICARE AND IN YOUR MEDICARE SUPPLEMENT COVERAGE. PLEASE READ THIS CAREFULLY!

[A BRIEF DESCRIPTION, IN SUBSTANTIALLY THE FOLLOWING FORMAT, OF THE REVISIONS TO MEDICARE PARTS A & B, WITH A PARALLEL DESCRIPTION OF BENEFITS PROVIDED BY THE MEDICARE SUPPLEMENT COVERAGE AND SUBSEQUENT CHANGES, INCLUDING DOLLAR AMOUNTS.]

SERVICES MEDICARE BENEFITS YOUR MEDICARE SUPPLEMENT COVERAGE

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | In 1989 Medicare Pays per calendar Year | Effective January 1, 1990, Medicare Will pay | In 1989 Your Coverage Pays | Effective January 1, 19990, Your Coverage Will Pay |
| MEDICARE PART A SERVICES SUPPLIES |  |  |  |  |
| In patient Hospital Services | Unlimited number of hospital days after $560 deductible | All but $592 for first 60 days/benefit period |  |  |
| Semi-private Room & Board |  | All but $148 a day for 61st-90th days/benefit period |  |  |
| Misc. Hospital Services & Supplies, such as Drugs, X-Rays, Lab Tests & Operating Room |  | All but $ 296 a day for 91st-10th days(if individual chooses to use 60 non renewable lifetime reserve days) |  |  |
| BLOOD | Pays all cost except payment of deductible(equal to costs for first 3 pints) each calendar year. Part A blood deductible reduced to the extent paid under Part B | Pays all cost except nonreplacement fees(blood deductible for first 3 pints in each calendar year |  |  |
| SKILLED NURSING FACILITY CARE | There is no prior confinement requirement for this benefit | 100% or cost for 1st 20 days (after a 3 day prior hospital confinement)/benefit period |  |  |
|  | First 8 days - All but 25.50 a day | All but $74.00 a day for 21st -100th days/benefit period |  |  |
|  | In 1989 Medicare Pays per Calendar Year | Effective January 1, 1990, Medicare Will Pay | In 1989 Your Coverage Pays | Effective January, 1 1990 Your Coverage Will Pay |
|  | 9th thorough 150th day - 100% of costs | Beyond 100 days - Nothing/Benefit period |  |  |
|  | Beyond 150 days -- Nothing |  |  |  |
| Medicare B Services And Supplies | 80% Of Allowable Charges (After $ 75 Deductible/calendar year |  |  |  |
| Prescription Drugs | Inpatient prescription drugs. 80% of allowable charges for immuno - suppressive drugs during the first year following covered transplant (after $74 deductible/calendar |  |  |  |
| BLOOD | 80% of all costs except not - replacement fees (blood deductible for first 3 pints in each benefit period (after $75 deductible / calendar year | 80% of all cost as except nonreplacement fees (blood deductible) for first 3 pints (after $ 75 deductible/calendar year) |  |  |

[Any other policy benefits not mentioned in this chart should be added to the chart in the order prescribed by the outline of coverage. If there are corresponding Medicare benefits, they should be shown.]

Describe any coverage provisions changing due to Medicare modifications.] [Include information about premium adjustments that may be necessary due to changes in Medicare benefits will be effective.]

THIS CHART SUMMARIZING THE CHANGES IN YOUR MEDICARE BENEFITS, AND IN YOUR MEDICARE SUPPLEMENT PROVIDED BY [COMPANY], ONLY BRIEFLY DESCRIBES SUCH BENEFITS. FOR INFORMATION ON YOUR MEDICARE BENEFITS CONTACT YOUR SOCIAL SECURITY OFFICE OR THE HEALTH CARE FINANCING ADMINISTRATION. FOR INFORMATION ON YOUR MEDICARE SUPPLEMENT [POLICY] CONTACT:

[COMPANY -- OR FOR AN INDIVIDUAL POLICY NAME OF AGENT] [ADDRESS/PHONE NUMBER]