

ARTICLE 3. MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

Rule 1. General Provisions

760 IAC 3-1-1 Applicability and scope

Authority: IC 27-8-13-10

Affected: IC 27-8-13-1

Sec. 1. (a) Except as otherwise specifically provided in 760 IAC 3-5, 760 IAC 3-10, 760 IAC 3-11, 760 IAC 3-14, 760 IAC 3-18, and 760 IAC 3-19, this article shall apply to the following:

(1) All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this regulation.

(2) All certificates issued under group Medicare supplement policies which certificates have been delivered or issued for delivery in this state.

(b) This article shall not apply to a policy or contract of:

(1) one (1) or more employers or labor organizations; or

(2) the trustees of a fund established by one (1) or more employers or labor organizations, or combination thereof;

for employees or former employees, or a combination thereof, or members or former members, or a combination thereof, of the labor organizations. (*Department of Insurance; 760 IAC 3-1-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2563; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3412; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 14, 2005, 3:00 p.m.: 29 IR 517; readopted filed Nov 29, 2011, 9:14 a.m.: 20111228-IR-760110553RFA*)

Rule 2. Definitions

760 IAC 3-2-1 Applicability

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 1. The definitions in this rule apply throughout this article. (*Department of Insurance; 760 IAC 3-2-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2563; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA*)

760 IAC 3-2-1.2 "1990 Standardized Medicare supplement benefit plan", "1990 Standardized benefit plan", or "1990 plan" defined

Authority: IC 27-8-13

Affected: IC 27-8-13-1

Sec. 1.2. "1990 Standardized Medicare supplement benefit plan", "1990 Standardized benefit plan", or "1990 plan" means a group or individual policy of Medicare supplement insurance issued on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010. The term includes Medicare supplement insurance policies renewed on or after that date that are not replaced by the insurer at the request of the insured. (*Department of Insurance; 760 IAC 3-2-1.2; filed Jul 27, 2009, 10:36 a.m.: 20090826-IR-760090211FRA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA*)

760 IAC 3-2-1.4 "2010 Standardized Medicare supplement benefit plan", "2010 Standardized benefit plan", or "2010 plan" defined

Authority: IC 27-8-13

Affected: IC 27-8-13-1

Sec. 1.4. "2010 Standardized Medicare supplement benefit plan", "2010 Standardized benefit plan", or "2010 plan" means a group or individual policy of Medicare supplement insurance issued with an effective date for coverage on or after June 1, 2010. (*Department of Insurance; 760 IAC 3-2-1.4; filed Jul 27, 2009, 10:36 a.m.: 20090826-IR-760090211FRA; readopted filed Nov*

26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA)

760 IAC 3-2-2 "Applicant" defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 2. "Applicant" means:

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

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

(Department of Insurance; 760 IAC 3-2-2; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2563; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA)

760 IAC 3-2-2.5 "Bankruptcy" defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 2.5. As used in this rule, "bankruptcy" means when a Medicare Advantage organization that is not an issuer has:

(1) filed, or has had filed against it, a petition for declaration of bankruptcy; and

(2) ceased doing business in Indiana.

(Department of Insurance; 760 IAC 3-2-2.5; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1972; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 14, 2005, 3:00 p.m.: 29 IR 517; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA)

760 IAC 3-2-3 "Certificate" defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 3. "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy. *(Department of Insurance; 760 IAC 3-2-3; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2564; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA)*

760 IAC 3-2-4 "Certificate form" defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 4. "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer. *(Department of Insurance; 760 IAC 3-2-4; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2564; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA)*

760 IAC 3-2-4.5 "Continuous period of creditable coverage" defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 4.5. As used in this rule, "continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days. *(Department of Insurance; 760 IAC 3-2-4.5; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1972; readopted filed Sep 14,*

2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA)

760 IAC 3-2-4.6 "Creditable coverage" defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 4.6. (a) As used in this rule, "creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

- (1) A group health plan.
- (2) Health insurance coverage.
- (3) Part A or Part B of Title XVIII of the Social Security Act (Medicare).
- (4) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928.
- (5) Chapter 55 of Title 10, United States Code (CHAMPUS).
- (6) A medical care program of the Indian Health Service or of a tribal organization.
- (7) A state health benefits risk pool.
- (8) A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefits Program).
- (9) A public health plan as defined in federal regulation.
- (10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

(b) The term shall not include one (1) or more, or any combination of, the following:

- (1) Coverage only for accident or disability income insurance, or any combination thereof.
- (2) Coverage issued as a supplement to liability insurance.
- (3) Liability insurance, including general liability insurance and automobile liability insurance.
- (4) Workers' compensation or similar insurance.
- (5) Automobile medical payment insurance.
- (6) Credit-only insurance.
- (7) Coverage for on-site medical clinics.
- (8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(c) The term shall not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

- (1) Limited scope dental or vision benefits.
- (2) Benefits for long term care, nursing home care, home health care, community-based care, or any combination thereof.
- (3) Such other similar, limited benefits as are specified in federal regulations.

(d) The term shall not include the following benefits if offered as independent, noncoordinated benefits:

- (1) Coverage only for a specified disease or illness.
- (2) Hospital indemnity or other fixed indemnity insurance.

(e) The term shall not include the following if it is offered as a separate policy, certificate, or contract of insurance:

- (1) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act.
- (2) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code.
- (3) Similar supplemental coverage provided to coverage under a group health plan.

(Department of Insurance; 760 IAC 3-2-4.6; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1972; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA)

760 IAC 3-2-4.7 "Employee welfare benefit plan" defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 4.7. As used in this rule, "employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in 29 U.S.C. 1002 (Employee Retirement Income Security Act). (*Department of Insurance; 760 IAC 3-2-4.7; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1973; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA*)

760 IAC 3-2-4.8 "Insolvency" defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 4.8. As used in this rule, "insolvency" means when an issuer, licensed to transact the business of insurance in Indiana, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile. (*Department of Insurance; 760 IAC 3-2-4.8; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1973; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA*)

760 IAC 3-2-5 "Issuer" defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 5. "Issuer" means insurance companies, fraternal benefit societies, prepaid health care delivery plans, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates. (*Department of Insurance; 760 IAC 3-2-5; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2564; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA*)

760 IAC 3-2-6 "Medicare" or "Medicare program" defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 6. "Medicare" or "Medicare program" means the "Health Insurance for the Aged Act", Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended. (*Department of Insurance; 760 IAC 3-2-6; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2564; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA*)

760 IAC 3-2-6.1 "Medicare Advantage" defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 6.1. As used in this rule, "Medicare Advantage" has the meaning set forth in 42 U.S.C. 1395w-28. (*Department of Insurance; 760 IAC 3-2-6.1; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1973; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 14, 2005, 3:00 p.m.: 29 IR 517; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA*)

760 IAC 3-2-6.2 "Medicare Advantage plan" defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 6.2. As used in this rule, "Medicare Advantage plan" has the meaning set forth in 42 U.S.C. 1395w-28. (*Department of Insurance; 760 IAC 3-2-6.2; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1973; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531;*

filed Sep 14, 2005, 3:00 p.m.: 29 IR 517; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA)

760 IAC 3-2-6.3 "Medicare Advantage supplemental plan" defined

Authority: IC 27-8-13
Affected: IC 27-8-13-1

Sec. 6.3. "Medicare Advantage supplemental plan" means a policy that is advertised, marketed, or designed primarily to cover out-of-pocket costs under a Medicare Advantage plan. (*Department of Insurance; 760 IAC 3-2-6.3; filed Jul 27, 2009, 10:36 a.m.: 20090826-IR-760090211FRA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA*)

760 IAC 3-2-7 "Medicare supplement policy" defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 7. "Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than:

- (1) a policy issued pursuant to a contract under Section 1876 of the Social Security Act (42 U.S.C. 1395 et seq.); or
- (2) an issued policy under a demonstration project specified in 42 U.S.C. 1395ss(g)(1);

that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare. The term does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any health care prepayment plan that provides benefits pursuant to an agreement under Section 1833(a)(1)(A) of the Social Security Act. (*Department of Insurance; 760 IAC 3-2-7; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2564; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3413; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 14, 2005, 3:00 p.m.: 29 IR 517; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA*)

760 IAC 3-2-8 "Policy form" defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 8. "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer. (*Department of Insurance; 760 IAC 3-2-8; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2564; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA*)

760 IAC 3-2-8.5 "Pre-Standardized Medicare supplement benefit plan", "Pre-Standardized benefit plan", or "Pre-Standardized plan" defined

Authority: IC 27-8-13
Affected: IC 27-8-13-1

Sec. 8.5. "Pre-Standardized Medicare supplement benefit plan", "Pre-Standardized benefit plan", or "Pre-Standardized plan" means a group or individual policy of Medicare supplement insurance issued prior to January 1, 1992. (*Department of Insurance; 760 IAC 3-2-8.5; filed Jul 27, 2009, 10:36 a.m.: 20090826-IR-760090211FRA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA*)

760 IAC 3-2-9 "Secretary" defined

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1
Affected: IC 27-8-13-1

Sec. 9. As used in this rule, "Secretary" means the Secretary of the United States Department of Health and Human Services. (*Department of Insurance; 760 IAC 3-2-9; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1974; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA*)

Rule 3. Policy Definitions and Terms

760 IAC 3-3-1 Policy definitions and terms

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 1. (a) No policy or certificate may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy or certificate unless such policy or certificate contains definitions or terms that conform to the requirements of this article.

(b) "Accident", "accidental injury", or "accidental means" means to employ "result" language and shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization and as follows:

(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 person, which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(2) The definition may provide that injuries shall not include 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.

(c) "Benefit period" or "Medicare benefit period" shall not be defined more restrictively than as defined in the Medicare program.

(d) "Convalescent nursing home", "extended care facility", or "skilled nursing facility" shall not be defined more restrictively than as defined in the Medicare program.

(e) "Health care expenses" means expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers. Such expenses shall not include the following:

(1) Home office and overhead costs.

(2) Advertising costs.

(3) Commissions and other acquisition costs.

(4) Taxes.

(5) Capital costs.

(6) Administrative costs.

(7) Claims processing costs.

(f) "Hospital" may be defined:

(1) in relation to its status, facilities, and available services; or

(2) to reflect its accreditation by the Joint Commission on Accreditation of Hospitals;

but not more restrictively than as defined in the Medicare program.

(g) "Medicare" shall be defined in the policy and certificate. Medicare may be substantially 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 "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.

(h) "Medicare eligible expenses" means expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare Parts A and B.

(i) "Physician" shall not be defined more restrictively than as defined by Medicare.

(j) "Sickness" shall not be defined to be more restrictive than the following:

(1) "Sickness means illness or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force."

(2) The definition in subdivision (1) may be further modified to exclude sicknesses or diseases for which benefits are

provided under any workers' compensation, occupational disease, employer's liability, or similar law. (*Department of Insurance; 760 IAC 3-3-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2564; errata filed Sep 20, 1993, 5:00 p.m.: 17 IR 200; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Nov 21, 2006, 7:19 a.m.: 20061220-IR-760060077FRA; readopted filed Nov 21, 2012, 4:15 p.m.: 20121219-IR-760120454RFA*)

Rule 4. Policy Provisions

760 IAC 3-4-1 Policy provisions

Authority: IC 27-8-13

Affected: IC 27-8-13-1

Sec. 1. (a) Except for permitted preexisting condition clauses as described in 760 IAC 3-5-1(b)(1)(A), 760 IAC 3-5-1(b)(1)(B), and 760 IAC 3-6-1(b), no policy or certificate shall be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

(b) No Medicare supplement policy or certificate may use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

(c) No Medicare supplement policy or certificate in force in the state shall contain benefits that duplicate benefits provided by Medicare.

(d) Subject to 760 IAC 3-5-1(b)(3) through 760 IAC 3-5-1(b)(7), 760 IAC 3-5-1(b)(9), 760 IAC 3-6-1(b)(3), and 760 IAC 3-6-1(b)(4), a Medicare supplement policy with benefits for outpatient prescription drugs in existence before January 1, 2006, shall be renewed for current policyholders who do not enroll in Part D at the option of the policyholder.

(e) A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

(f) After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless:

(1) the policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Part D plan; and

(2) premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

(g) A Medicare Advantage supplemental plan must comply with the Medicare Supplement requirements of Section 1882(6) of the Social Security Act. (*Department of Insurance; 760 IAC 3-4-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2565; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 14, 2005, 3:00 p.m.: 29 IR 518; filed Jul 27, 2009, 10:36 a.m.: 20090826-IR-760090211FRA*)

Rule 5. Minimum Benefit Standards

760 IAC 3-5-1 Minimum benefit standards for policies or certificates issued for delivery before January 1, 1992 (Expired)

Sec. 1. (*Expired under IC 4-22-2.5, effective January 1, 2012.*)

Rule 6. Benefit Standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery after December 31, 1991, and with an Effective Date for Coverage Prior to June 1, 2010

760 IAC 3-6-1 Benefit standards for policies or certificates issued or delivered after December 31, 1991, and with an effective date for coverage prior to June 1, 2010

Authority: IC 27-8-13

Affected: IC 27-8-13-1

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

Sec. 1. (a) The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state after December 31, 1991, and prior to June 1, 2010. No policy or certificate may be:

- (1) advertised;
- (2) solicited;
- (3) delivered; or
- (4) issued for delivery;

in this state as a Medicare supplement policy or certificate unless the policy or certificate complies with the benefit standards in this section.

(b) The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this article:

- (1) A Medicare supplement policy or certificate:
 - (A) shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition;
 - (B) may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage; and
 - (C) shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.
- (2) A Medicare supplement policy or certificate 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.
- (3) No Medicare supplement policy or certificate shall 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.
- (4) Each Medicare supplement policy shall be guaranteed renewable and shall meet the following requirements:
 - (A) The issuer shall not cancel or nonrenew the policy:
 - (i) solely on the ground of health status of the individual; or
 - (ii) for any reason other than nonpayment of premium or material misrepresentation.
 - (B) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under clause (D), the issuer shall offer certificate holders an individual Medicare supplement policy that, at the option of the certificate holder, provides for:
 - (i) continuation of the benefits contained in the group policy; or
 - (ii) such benefits as otherwise meet the requirements of this subsection.
 - (C) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall offer the certificate holder:
 - (i) the conversion opportunity described in clause (B); or
 - (ii) at the option of the group policyholder, continuation of coverage under the group policy.
 - (D) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.
 - (E) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug Improvement and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subsection.
- (5) Termination of a Medicare supplement policy or certificate shall be without prejudice to 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 conditioned upon the continuous total disability of the insured, limited to:
 - (A) the duration of the policy benefit period, if any; or
 - (B) payment of the maximum benefits.Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.
- (6) Each Medicare supplement policy shall do the following:

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

(A) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to the assistance.

(B) If the suspension occurs and if the policyholder or certificate holder loses entitlement to the medical assistance, the policy or certificate shall be automatically reinstated effective as of the date of termination of the entitlement if the policyholder or certificate holder:

- (i) provides notice of loss of the entitlement within ninety (90) days after the date of the loss; and
- (ii) pays the premium attributable to the period.

(C) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended for any period that may be provided by federal regulation at the request of the policyholder if the policyholder:

- (i) is entitled to benefits under Section 226(b) of the Social Security Act; and
- (ii) is covered under a group health plan as defined in Section 1862(b)(1)(A)(v) of the Social Security Act.

If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstated, effective as of the date of loss of coverage, if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss.

(D) Reinstatement of the coverages shall do all of the following:

- (i) Not provide for any waiting period with respect to treatment of preexisting conditions.
- (ii) Provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of the suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstatement of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension.
- (iii) Provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(c) Every issuer shall make available a policy or certificate including only the following basic core package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic core package, but not in lieu thereof. The standards for basic core benefits common to all benefit plans are as follows:

- (1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period.
- (2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.
- (3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.
- (4) Coverage under Medicare Parts A and B for the reasonable cost of:
 - (A) the first three (3) pints of blood; or
 - (B) equivalent quantities of packed red blood cells, as defined under federal regulations;unless replaced in accordance with federal regulations.
- (5) Coverage for the coinsurance amount of Medicare eligible expenses under Part B, regardless of hospital confinement, subject to the Medicare Part B deductible.
- (d) The additional benefits shall be included in Medicare supplement benefit Plans B through J only as provided by 760 IAC

3-7. The standards for additional benefits are as follows:

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- (1) Medicare Part A deductible, coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.
- (2) Skilled nursing facility care, coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A.
- (3) Medicare Part B deductible, coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.
- (4) Eighty percent (80%) of the Medicare Part B excess charges, coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law and the Medicare approved Part B charge.
- (5) One hundred percent (100%) of the Medicare Part B excess charges, coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law and the Medicare approved Part B charge.
- (6) Basic outpatient prescription drug benefit, coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar (\$250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars (\$1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.
- (7) Extended outpatient prescription drug benefit, coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar (\$250) calendar year deductible to a maximum of three thousand dollars (\$3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.
- (8) Medically necessary emergency care in a foreign country, coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care:
 - (A) would have been covered by Medicare if provided in the United States; and
 - (B) began during the first sixty (60) consecutive days of each trip outside the United States;subject to a calendar year deductible of two hundred fifty dollars (\$250) and a lifetime maximum benefit of fifty thousand dollars (\$50,000). For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.
- (9) Preventive medical care benefit, coverage for the following preventive health services not covered by Medicare:
 - (A) An annual clinical preventive medical history and physical examination that may include tests and services from clause (B) and patient education to address preventive health care measures.
 - (B) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of one hundred twenty dollars (\$120) annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.
- (10) At-home recovery benefit, coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery, including the following requirements:
 - (A) For purposes of this subdivision, the following definitions shall apply:
 - (i) "Activities of daily living" include, but are not limited to, the following:
 - (AA) Bathing.
 - (BB) Dressing.
 - (CC) Personal hygiene.
 - (DD) Transferring.
 - (EE) Eating.
 - (FF) Ambulating.
 - (GG) Assistance with drugs that are normally self-administered.

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- (HH) Changing bandages or other dressings.
 - (ii) "At-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a twenty-four (24) hour period of services provided by a care provider is one (1) visit.
 - (iii) "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide, or nurse:
 - (AA) provided through a licensed home health care agency; or
 - (BB) referred by a licensed referral agency or licensed nurses registry.
 - (iv) "Home" means any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.
- (B) Coverage requirements and limitations are as follows:
- (i) At-home recovery services provided must be primarily services that assist in activities of daily living.
 - (ii) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.
 - (iii) Coverage is limited to the following:
 - (AA) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment.
 - (BB) The actual charges for each visit up to a maximum reimbursement of forty dollars (\$40) per visit.
 - (CC) One thousand six hundred dollars (\$1,600) per calendar year.
 - (DD) Seven (7) visits in any one (1) week.
 - (EE) Care furnished on a visiting basis in the insured's home.
 - (FF) Services provided by a care provider as defined in clause (A)(iii).
 - (GG) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.
 - (HH) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight (8) weeks after the service date of the last Medicare approved home health care visit.
 - (iv) Coverage is excluded for the following:
 - (AA) Home care visits paid for by Medicare or other government programs.
 - (BB) Care provided by family members, unpaid volunteers, or providers who are not care providers.
- (e) Standardized Medicare supplement benefit plan "K" shall consist of the following:
- (1) Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the sixty-first day through the ninetieth day in any Medicare benefit period.
 - (2) Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first day through the one hundred fiftieth day in any Medicare benefit period.
 - (3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or the appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.
 - (4) Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subdivision (10).
 - (5) Coverage for fifty percent (50%) of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subdivision (10).
 - (6) Coverage for fifty percent (50%) of the cost sharing for all Part A Medicare eligible expenses and respite care until the

out-of-pocket limitation is met as described in subdivision (10).

(7) Coverage for fifty percent (50%) under Medicare Part A or B of the reasonable cost of:

(A) the first three (3) pints of blood; or

(B) equivalent quantities of packed red blood cells, as defined under federal regulations;

unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subdivision (10).

(8) Except for coverage provided in subdivision (9), coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in subdivision (10).

(9) Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible.

(10) Coverage for one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of four thousand dollars (\$4,000) in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(f) Standardized Medicare supplement benefit plan "L" shall consist of the following:

(1) The benefits described in subsection (e)(1) through (e)(3) and (e)(9).

(2) The benefits described in subsection (e)(4) through (e)(8), but substituting seventy-five percent (75%) for fifty percent (50%).

(3) The benefit described in subsection (e)(10), but substituting two thousand dollars (\$2,000) for four thousand dollars (\$4,000).

(Department of Insurance; 760 IAC 3-6-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2566; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3414; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 14, 2005, 3:00 p.m.: 29 IR 519; filed Jul 27, 2009, 10:36 a.m.: 20090826-IR-760090211FRA)

Rule 6.1. Benefit Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery with an Effective Date for Coverage on or after June 1, 2010

760 IAC 3-6.1-1 Benefit standards for 2010 Standardized Medicare supplement benefit plan policies or certificates issued for delivery with an effective date for coverage on or after June 1, 2010

Authority: IC 27-8-13

Affected: IC 27-8-13-1

Sec. 1. (a) The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date of coverage on or after June 1, 2010. No policy or certificate may be:

(1) advertised;

(2) solicited;

(3) delivered; or

(4) issued for delivery;

in this state as a Medicare supplement policy or certificate unless the policy or certificate complies with the benefit standards in this section. Benefit plan standards applicable to Medicare supplement policies and certificates with an effective date of coverage before June 1, 2010, remain subject to the requirements of 760 IAC 3-6-1.

(b) The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this article:

(1) A Medicare supplement policy or certificate:

(A) shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition;

(B) may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of

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coverage; and

(C) shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(2) A Medicare supplement policy or certificate 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.

(3) No Medicare supplement policy or certificate shall 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.

(4) Each Medicare supplement policy shall be guaranteed renewable and shall meet the following requirements:

(A) The issuer shall not cancel or nonrenew the policy:

- (i) solely on the ground of health status of the individual; or
- (ii) for any reason other than nonpayment of premium or material misrepresentation.

(B) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under clause (D), the issuer shall offer certificate holders an individual Medicare supplement policy that, at the option of the certificate holder, provides for:

- (i) continuation of the benefits contained in the group policy; or
- (ii) such benefits as otherwise meet the requirements of this subsection.

(C) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall offer the certificate holder:

- (i) the conversion opportunity described in clause (B); or
- (ii) at the option of the group policyholder, continuation of coverage under the group policy.

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

(5) Termination of a Medicare supplement policy or certificate shall be without prejudice to 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 conditioned upon the continuous total disability of the insured, limited to:

- (A) the duration of the policy benefit period, if any; or
- (B) payment of the maximum benefits.

Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(6) Each Medicare supplement policy shall do the following:

(A) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to the assistance.

(B) If the suspension occurs and if the policyholder or certificate holder loses entitlement to the medical assistance, the policy or certificate shall be automatically reinstated effective as of the date of termination of the entitlement if the policyholder or certificate holder:

- (i) provides notice of loss of the entitlement within ninety (90) days after the date of the loss; and
- (ii) pays the premium attributable to the period.

(C) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended for any period that may be provided by federal regulation at the request of the policyholder if the policyholder:

- (i) is entitled to benefits under Section 226(b) of the Social Security Act; and
- (ii) is covered under a group health plan as defined in Section 1862(b)(1)(A)(v) of the Social Security Act.

If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstated, effective as of the date of loss of coverage, if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss.

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(D) Reinstitution of the coverages shall do all of the following:

- (i) Not provide for any waiting period with respect to treatment of preexisting conditions.
- (ii) Provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of the suspension.
- (iii) Provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(c) Every issuer shall make available a policy or certificate including only the following basic core package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic core package, but not in lieu thereof. The standards for basic core benefits common to all benefit plans are as follows:

- (1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period.
- (2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.
- (3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

(4) Coverage under Medicare Parts A and B for the reasonable cost of:

- (A) the first three (3) pints of blood; or
- (B) equivalent quantities of packed red blood cells, as defined under federal regulations;

unless replaced in accordance with federal regulations.

(5) Coverage for the coinsurance amount of Medicare eligible expenses under Part B, regardless of hospital confinement, subject to the Medicare Part B deductible.

(d) The following additional benefits shall be included in Medicare supplement benefit Plans B, C, D, F, F with high deductible, G, M, and N as provided by 760 IAC 3-7.1. The standard for additional benefits are as follows:

- (1) Medicare Part A deductible, coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital deductible amount per benefit period.
- (2) Medicare Part A deductible, coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period.
- (3) Skilled nursing facility care, coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.
- (4) Medicare Part B deductible, coverage for one hundred percent (100%) of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.
- (5) One hundred percent (100%) of the Medicare Part B excess charges, coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.
- (6) Medically necessary emergency care in a foreign country, coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care:

- (A) would have been covered by Medicare if provided in the United States; and
- (B) began during the first sixty (60) consecutive days of each trip outside the United States;

subject to a calendar year deductible of two hundred fifty dollars (\$250) and a lifetime maximum benefit of fifty thousand dollars (\$50,000). For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

(7) Extended outpatient prescription drug benefit, coverage for fifty percent (50%) of outpatient prescription drug charges,

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after a two hundred fifty dollar (\$250) calendar year deductible to a maximum of three thousand dollars (\$3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

(8) For policies written or issued prior to June 30, 2010, coverage for the following preventive health services not covered by Medicare:

(A) An annual clinical preventive medical history and physical examination that may include tests and services from clause (B) and patient education to address preventive health care measures.

(B) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of one hundred twenty dollars (\$120) annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare. This subdivision is only applicable to policies or certificates issued for delivery with an effective date for coverage before May 30, 2010.

(9) At-home recovery benefit, coverage for services to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery, including the following requirements:

(A) For purposes of this subdivision, the following definitions shall apply:

(i) "Activities of daily living" include, but are not limited to, the following:

(AA) Bathing.

(BB) Dressing.

(CC) Personal hygiene.

(DD) Transferring.

(EE) Eating.

(FF) Ambulating.

(GG) Assistance with drugs that are normally self-administered.

(HH) Changing bandages or other dressings.

(ii) "At-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a twenty-four (24) hour period of services provided by a care provider is one (1) visit.

(iii) "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide, or nurse:

(AA) provided through a licensed home health care agency; or

(BB) referred by a licensed referral agency or licensed nurses registry.

(iv) "Home" means any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

(B) Coverage requirements and limitations are as follows:

(i) At-home recovery services provided must be primarily services that assist in activities of daily living.

(ii) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(iii) Coverage is limited to the following:

(AA) Not more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment.

(BB) The actual charges for each visit up to a maximum reimbursement of forty dollars (\$40) per visit.

(CC) One thousand six hundred dollars (\$1,600) per calendar year.

(DD) Seven (7) visits in any one (1) week.

(EE) Care furnished on a visiting basis in the insured's home.

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(FF) Services provided by a care provider as defined in clause (A)(iii).

(GG) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.

(HH) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or not more than eight (8) weeks after the service date of the last Medicare approved home health care visit.

(iv) Coverage is excluded for the following:

(AA) Home care visits paid for by Medicare or other government programs.

(BB) Care provided by family members, unpaid volunteers, or providers who are not care providers.

This subdivision is only applicable to policies or certificates issued for delivery with an effective date for coverage before May 30, 2010.

(e) Standardized Medicare supplement benefit plan "K" shall consist of the following:

(1) Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the sixty-first day through the ninetieth day in any Medicare benefit period.

(2) Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first day through the one hundred fiftieth day in any Medicare benefit period.

(3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or the appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

(4) Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subdivision (10).

(5) Coverage for fifty percent (50%) of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subdivision (10).

(6) Coverage for fifty percent (50%) of the cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subdivision (10).

(7) Coverage for fifty percent (50%) under Medicare Part A or B of the reasonable cost of:

(A) the first three (3) pints of blood; or

(B) equivalent quantities of packed red blood cells, as defined under federal regulations;

unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subdivision (10).

(8) Except for coverage provided in subdivision (9), coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in subdivision (10).

(9) Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible.

(10) Coverage for one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of four thousand dollars (\$4,000) in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(f) Standardized Medicare supplement benefit plan "L" shall consist of the following:

(1) The benefits described in subsection (e)(1) through (e)(3) and (e)(9).

(2) The benefits described in subsection (e)(4) through (e)(8), but substituting seventy-five percent (75%) for fifty percent (50%).

(3) The benefit described in subsection (e)(10), but substituting two thousand dollars (\$2,000) for four thousand dollars (\$4,000).

(g) Notwithstanding the foregoing, insurers are permitted to continue to use approved forms through December 31, 2005.

Insurers may offer any authorized plan upon approval of the commissioner. (*Department of Insurance; 760 IAC 3-6.1-1; filed Jul 27, 2009, 10:36 a.m.: 20090826-IR-760090211FRA*)

Rule 7. Standard Medicare Supplement Benefit Plans

760 IAC 3-7-1 Standard Medicare supplement benefit plans

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 1. (a) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core benefits as defined in 760 IAC 3-6-1(c).

(b) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in 760 IAC 3-8.

(c) Benefit plans shall be uniform in structure, language, designation, and format to the standard benefit Plans A through J listed in this section and conform to the definitions in 760 IAC 3-2 and 760 IAC 3-3. Each benefit shall:

- (1) be structured in accordance with the format provided in 760 IAC 3-6-1(c) through 760 IAC 3-6-1(d); and
- (2) list the benefits in the order shown in subsection (e).

As used in this section, "structure, language, and format" means style, arrangement, and overall content of a benefit.

(d) An issuer may use, in addition to the benefit plan designations required in subsection (c), other designations to the extent permitted by law.

(e) The makeup of benefit plans shall be as follows:

(1) Standardized Medicare supplement benefit Plan A shall be limited to the basic (core) benefits common to all benefit plans as defined in 760 IAC 3-6-1(c).

(2) Standardized Medicare supplement benefit Plan B shall include only the core benefit as defined in 760 IAC 3-6-1(c), plus the Medicare Part A deductible as defined in 760 IAC 3-6-1(d)(1).

(3) Standardized Medicare supplement benefit Plan C shall include only the core benefit as defined in 760 IAC 3-6-1(c), plus:

- (A) the Medicare Part A deductible;
- (B) skilled nursing facility care;
- (C) the Medicare Part B deductible; and
- (D) medically necessary emergency care in a foreign country;

as defined in 760 IAC 3-6-1(d)(1) through 760 IAC 3-6-1(d)(3) and 760 IAC 3-6-1(d)(8), respectively.

(4) Standardized Medicare supplement benefit Plan D shall include only the core benefit as defined in 760 IAC 3-6-1(c), plus:

- (A) the Medicare Part A deductible;
- (B) skilled nursing facility care;
- (C) medically necessary emergency care in a foreign country; and
- (D) the at-home recovery benefit;

as defined in 760 IAC 3-6-1(d)(1), 760 IAC 3-6-1(d)(2), 760 IAC 3-6-1(d)(8), and 760 IAC 3-6-1(d)(10), respectively.

(5) Standardized Medicare supplement benefit Plan E shall include only the core benefit as defined in 760 IAC 3-6-1(c), plus:

- (A) the Medicare Part A deductible;
- (B) skilled nursing facility care;
- (C) medically necessary emergency care in a foreign country; and
- (D) preventive medical care;

as defined in 760 IAC 3-6-1(d)(1), 760 IAC 3-6-1(d)(2), 760 IAC 3-6-1(d)(8), and 760 IAC 3-6-1(d)(9), respectively.

(6) Standardized Medicare supplement benefit Plan F shall include only the core benefit as defined in 760 IAC 3-6-1(c), plus:

- (A) the Medicare Part A deductible;
- (B) skilled nursing facility care;
- (C) the Medicare Part B deductible;

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- (D) one hundred percent (100%) of the Medicare Part B excess charges; and
 - (E) medically necessary emergency care in a foreign country;
- as defined in 760 IAC 3-6-1(d)(1) through 760 IAC 3-6-1(d)(3), 760 IAC 3-6-1(d)(5), and 760 IAC 3-6-1(d)(8), respectively.
- (7) Standardized Medicare supplement benefit high deductible Plan F shall include one hundred percent (100%) of covered expenses following the payment of the annual high deductible Plan F deductible. The covered expenses include the core benefit as defined in 760 IAC 3-6-1(c), plus:
- (A) the Medicare Part A deductible;
 - (B) skilled nursing facility care;
 - (C) the Medicare Part B deductible;
 - (D) one hundred percent (100%) of the Medicare Part B excess charges; and
 - (E) medically necessary emergency care in a foreign country;
- as defined in 760 IAC 3-6-1(d)(1), 760 IAC 3-6-1(d)(2), 760 IAC 3-6-1(d)(8), and 760 IAC 3-6-1(d)(9), respectively. The annual high deductible Plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement Plan F policy and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan F deductible shall be one thousand five hundred dollars (\$1,500) for 1999 and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve (12) month period ending with August of the preceding year and rounded to the nearest multiple of ten dollars (\$10).
- (8) Standardized Medicare supplement benefit Plan G shall include only the core benefit as defined in 760 IAC 3-6-1(c), plus:
- (A) the Medicare Part A deductible;
 - (B) skilled nursing facility care;
 - (C) eighty percent (80%) of the Medicare Part B excess charges;
 - (D) medically necessary emergency care in a foreign country; and
 - (E) the at-home recovery benefit;
- as defined in 760 IAC 3-6-1(d)(1), 760 IAC 3-6-1(d)(2), 760 IAC 3-6-1(d)(4), 760 IAC 3-6-1(d)(8), and 760 IAC 3-6-1(d)(10), respectively.
- (9) Standardized Medicare supplement benefit Plan H shall consist of only the core benefit as defined in 760 IAC 3-6-1(c), plus:
- (A) the Medicare Part A deductible;
 - (B) skilled nursing facility care;
 - (C) the basic prescription drug benefit; and
 - (D) medically necessary emergency care in a foreign country;
- as defined in 760 IAC 3-6-1(d)(1), 760 IAC 3-6-1(d)(2), 760 IAC 3-6-1(d)(6), and 760 IAC 3-6-1(d)(8), respectively. The outpatient prescription drug benefit shall not be included in a Medicare Supplement policy sold after December 31, 2005.
- (10) Standardized Medicare supplement benefit Plan I shall consist of only the core benefit as defined in 760 IAC 3-6-1(c), plus:
- (A) the Medicare Part A deductible;
 - (B) skilled nursing facility care;
 - (C) one hundred percent (100%) of the Medicare Part B excess charges;
 - (D) the basic prescription drug benefit;
 - (E) medically necessary emergency care in a foreign country; and
 - (F) the at-home recovery benefit;
- as defined in 760 IAC 3-6-1(d)(1), 760 IAC 3-6-1(d)(2), 760 IAC 3-6-1(d)(5), 760 IAC 3-6-1(d)(6), 760 IAC 3-6-1(d)(8), and 760 IAC 3-6-1(d)(10), respectively. The outpatient prescription drug benefit shall not be included in a Medicare Supplement policy sold after December 31, 2005.
- (11) Standardized Medicare supplement benefit Plan J shall consist of only the core benefit as defined in 760 IAC 3-6-1(c), plus:
- (A) the Medicare Part A deductible;

- (B) skilled nursing facility care;
- (C) the Medicare Part B deductible;
- (D) one hundred percent (100%) of the Medicare Part B excess charges;
- (E) the extended prescription drug benefit;
- (F) medically necessary emergency care in a foreign country;
- (G) preventive medical care; and
- (H) the at-home recovery benefit;

as defined in 760 IAC 3-6-1(d)(1) through 760 IAC 3-6-1(d)(3), 760 IAC 3-6-1(d)(5), and 760 IAC 3-6-1(d)(7) through 760 IAC 3-6-1(d)(10), respectively.

(12) Standardized Medicare supplement benefit high deductible Plan J shall consist of one hundred percent (100%) of covered expenses following the payment of the annual high deductible Plan J deductible. The covered expenses include the core benefit as defined in 760 IAC 3-6-1(c), plus:

- (A) the Medicare Part A deductible;
- (B) skilled nursing facility care;
- (C) the Medicare Part B deductible;
- (D) one hundred percent (100%) of the Medicare Part B excess charges;
- (E) the extended outpatient prescription drug benefit;
- (F) medically necessary emergency care in a foreign country;
- (G) preventive medical care benefit; and
- (H) the at-home recovery benefit;

as defined in 760 IAC 3-6-1(d)(1) through 760 IAC 3-6-1(d)(3), 760 IAC 3-6-1(d)(5), and 760 IAC 3-6-1(d)(7) through 760 IAC 3-6-1(d)(10), respectively. The outpatient prescription drug benefit shall not be included in a Medicare Supplement policy sold after December 31, 2005. The annual high deductible Plan J deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement Plan J policy and shall be in addition to any other specific benefit deductibles. The annual high deductible shall be one thousand five hundred dollars (\$1,500) for 1999 and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve (12) month period ending with August of the preceding year and rounded to the nearest multiple of ten dollars (\$10). The outpatient prescription drug benefit shall not be included in a Medicare Supplement policy sold after December 31, 2005.

(f) The makeup of the two (2) Medicare supplement plans mandated by the Medicare Prescription Drug Improvement and Modernization Act of 2003 are as follows:

- (1) Standardized Medicare supplement benefit plan "K" shall consist of only those benefits described in 760 IAC 3-6-1(e).
- (2) Standardized Medicare supplement benefit plan "L" shall consist of only those benefits described in 760 IAC 3-6-1(f).

(g) An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are as follows:

- (1) Appropriate to Medicare supplement insurance.
- (2) New or innovative.
- (3) Not otherwise available.
- (4) Cost-effective.
- (5) Offered in a manner that is consistent with the goal of simplification of Medicare supplement policies.

After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

(h) Insurers are permitted to continue to use approved forms through December 31, 2005. Insurers may offer any authorized plan upon approval of the commissioner. (*Department of Insurance; 760 IAC 3-7-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2569; errata filed Sep 20, 1993, 5:00 p.m.: 17 IR 200; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1974; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 14, 2005, 3:00 p.m.: 29 IR 523; readopted filed Nov 29, 2011, 9:14 a.m.: 20111228-IR-760110553RFA*)

Rule 7.1. Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery with an Effective Date for Coverage on or after

June 1, 2010

760 IAC 3-7.1-1 Standard Medicare supplement benefit plans for 2010 Standardized Medicare supplement benefit plan policies or certificates issued for delivery with an effective date for coverage on or after June 1, 2010

Authority: IC 27-8-13

Affected: IC 27-8-13-1

Sec. 1. (a) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core benefits as defined in 760 IAC 3-6-1(c).

(b) If an issuer makes available any of the additional benefits described in 760 IAC 3-6.1-1(d) or offers standardized benefit Plans K or L, then the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic core benefits as described in 760 IAC 3-6.1-1(c), a policy form or certificate form containing either standardized benefit Plan C or standardized benefit Plan F.

(c) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in 760 IAC 3-8.

(d) Benefit plans shall be uniform in structure, language, designation, and format to the standard benefit plans listed in this section and conform to the definitions in 760 IAC 3-2 and 760 IAC 3-3. Each benefit shall:

- (1) be structured in accordance with the format provided in 760 IAC 3-6-1(c) through 760 IAC 3-6-1(d); and
- (2) list the benefits in the order shown in subsection (f).

As used in this section, "structure, language, and format" means style, arrangement, and overall content of a benefit.

(e) An issuer may use, in addition to the benefit plan designations required in subsection (d), other designations to the extent permitted by law.

(f) The makeup of 2010 standardized benefit plans shall be as follows:

(1) Standardized Medicare supplement benefit Plan A shall be limited to the basic (core) benefits common to all benefit plans as defined in 760 IAC 3-6-1(c).

(2) Standardized Medicare supplement benefit Plan B shall include only the core benefit as defined in 760 IAC 3-6-1(c), plus the Medicare Part A deductible as defined in 760 IAC 3-6-1(d)(1).

(3) Standardized Medicare supplement benefit Plan C shall include only the core benefit as defined in 760 IAC 3-6-1(c), plus:

- (A) the Medicare Part A deductible;
- (B) skilled nursing facility care;
- (C) the Medicare Part B deductible; and
- (D) medically necessary emergency care in a foreign country;

as defined in 760 IAC 3-6-1(d)(1) through 760 IAC 3-6-1(d)(3) and 760 IAC 3-6-1(d)(8), respectively.

(4) Standardized Medicare supplement benefit Plan D shall include only the core benefit as defined in 760 IAC 3-6-1(c), plus:

- (A) the Medicare Part A deductible;
- (B) skilled nursing facility care; and
- (C) medically necessary emergency care in a foreign country.

(5) Standardized Medicare supplement benefit Plan F shall include only the core benefit as defined in 760 IAC 3-6-1(c), plus:

- (A) the Medicare Part A deductible;
- (B) skilled nursing facility care;
- (C) the Medicare Part B deductible;
- (D) one hundred percent (100%) of the Medicare Part B excess charges; and
- (E) medically necessary emergency care in a foreign country;

as defined in 760 IAC 3-6-1(d)(1) through 760 IAC 3-6-1(d)(3), 760 IAC 3-6-1(d)(5), and 760 IAC 3-6-1(d)(8), respectively.

(6) Standardized Medicare supplement benefit high deductible Plan F shall include one hundred percent (100%) of covered expenses following the payment of the annual high deductible Plan F deductible. The covered expenses include the core benefit as defined in 760 IAC 3-6-1(c), plus:

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- (A) the Medicare Part A deductible;
- (B) skilled nursing facility care;
- (C) the Medicare Part B deductible;
- (D) one hundred percent (100%) of the Medicare Part B excess charges; and
- (E) medically necessary emergency care in a foreign country;

as defined in 760 IAC 3-6-1(d)(1), 760 IAC 3-6-1(d)(2), 760 IAC 3-6-1(d)(8), and 760 IAC 3-6-1(d)(9), respectively. The annual high deductible Plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement Plan F policy and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan F deductible shall be one thousand five hundred dollars (\$1,500) for 1999 and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve (12) month period ending with August of the preceding year and rounded to the nearest multiple of ten dollars (\$10).

(7) Standardized Medicare supplement benefit Plan G shall include only the core benefit as defined in 760 IAC 3-6-1(c), plus:

- (A) the Medicare Part A deductible;
- (B) skilled nursing facility care;
- (C) one hundred percent (100%) of the Medicare Part B excess charges; and
- (D) medically necessary emergency care in a foreign country.

(8) Standardized Medicare supplement Plan M shall include only the basic core benefit as defined in 760 IAC 3-6-1(c), plus:

- (A) fifty percent (50%) of the Medicare Part A deductible;
- (B) skilled nursing facility care; and
- (C) medically necessary emergency care in a foreign country.

(9) Standardized Medicare supplement Plan N shall include only the basic core benefit as defined in 760 IAC 3-6-1(c), plus:

- (A) one hundred percent (100%) of the Medicare Part A deductible;
- (B) skilled nursing facility care; and
- (C) medically necessary emergency care in a foreign country.

(10) Copayments shall be the following amounts:

- (A) The lesser of:
 - (i) twenty dollars (\$20); or
 - (ii) the Medicare Part B coinsurance or copayment for each covered health *[sic]* care provider office visit, including visits to medical specialists; and
- (B) The lesser of:
 - (i) fifty dollars (\$50); or
 - (ii) the Medicare Part B coinsurance or copayment for each covered emergency room visit.

The copayment set forth in clause (B) shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

(g) The makeup of the two (2) Medicare supplement plans mandated by the Medicare Prescription Drug Improvement and Modernization Act of 2003 are as follows:

- (1) Standardized Medicare supplement benefit plan "K" shall consist of only those benefits described in 760 IAC 3-6-1(e).
- (2) Standardized Medicare supplement benefit plan "L" shall consist of only those benefits described in 760 IAC 3-6-1(f).

(h) An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are as follows:

- (1) Appropriate to Medicare supplement insurance.
- (2) New or innovative.
- (3) Not otherwise available.
- (4) Cost effective.
- (5) Offered in a manner that is consistent with the goal of simplification of Medicare supplement policies.

After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

(6) New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

(i) The standards set forth in this section are applicable to all Medicare supplement policies delivered or issued for delivery with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery as a Medicare supplement policy unless it complies with this section. No issuer may offer any 1990 Standardized Medicare supplement benefit plan for sale on or after 2010. Benefit standards applicable to Medicare supplement policies issued with an effective date for coverage prior to June 1, 2010, remain subject to the requirements of 760 IAC 3-6-1. (*Department of Insurance; 760 IAC 3-7.1-1; filed Jul 27, 2009, 10:36 a.m.: 20090826-IR-760090211FRA*)

Rule 8. Medicare Select Policies and Certificates

760 IAC 3-8-1 Medicare select policies and certificates

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 1. (a) This section shall apply to Medicare select policies and certificates as defined in this section.

(b) No policy or certificate may be advertised as a Medicare select policy or certificate unless it meets the requirements of this section.

(c) The following definitions apply throughout this section:

(1) "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare select issuer or its network providers.

(2) "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare select policy or certificate with the:

(A) administration;

(B) claims practices; or

(C) provision of services;

concerning a Medicare select issuer or its network providers.

(3) "Medicare select issuer" means an issuer offering, or seeking to offer, a Medicare select policy or certificate.

(4) "Medicare select policy" or "Medicare select certificate" means, respectively, a Medicare supplement policy or certificate that contains restricted network provisions.

(5) "Network provider" means a provider of health care, or a group of providers of health care, that has entered into a written agreement with the issuer to provide benefits insured under a Medicare select policy.

(6) "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

(7) "Service area" means the geographic area approved by the commissioner of the department of insurance within which an issuer is authorized to offer a Medicare select policy.

(d) The commissioner may authorize an issuer to offer a Medicare select policy or certificate, under this section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, if the commissioner of the department of insurance finds that the issuer has satisfied all of the requirements of this article.

(e) A Medicare select issuer shall not issue a Medicare select policy or certificate in this state until its plan of operation has been approved by the commissioner of the department of insurance.

(f) A Medicare select issuer shall file a proposed plan of operation with the commissioner of the department of insurance in a format prescribed by the commissioner of the department of insurance. The plan of operation shall contain at least the following information:

(1) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration of the following:

(A) The services can be provided by network providers with reasonable promptness with respect to the following:

(i) Geographic location.

(ii) Hours of operation.

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(iii) After-hour care.

The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(B) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either to:

- (i) deliver adequately all services that are subject to a restricted network provision; or
- (ii) make appropriate referrals.

(C) There are written agreements with network providers describing specific responsibilities.

(D) Emergency care is available twenty-four (24) hours per day and seven (7) days per week.

(E) In the case of covered services that are:

- (i) subject to a restricted network provision; and
- (ii) provided on a prepaid basis;

there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare select policy or certificate. This clause shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare select policy or certificate.

(2) A statement or map providing a clear description of the service area.

(3) A description of the following:

- (A) The grievance procedure to be utilized.
- (B) The quality assurance program, including the following:
 - (i) The formal organizational structure.
 - (ii) The written criteria for selection, retention, and removal of network providers.
 - (iii) The procedures for evaluating quality of care provided by network providers.
 - (iv) The process to initiate corrective action when warranted.

(4) A list and description, by specialty, of the network providers.

(5) Copies of the written information proposed to be used by the issuer to comply with subsection (k).

(6) Any other information requested by the commissioner of the department of insurance.

(g) A Medicare select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner of the department of insurance before implementing the changes. The changes shall be considered approved by the commissioner of the department of insurance after thirty (30) days unless specifically disapproved.

(h) An updated list of network providers shall be filed with the commissioner of the department of insurance at least quarterly.

(i) A Medicare select policy or certificate shall not restrict payment for covered services provided by nonnetwork providers if:

(1) the services are:

- (A) for symptoms requiring emergency care; or
- (B) immediately required for an unforeseen:
 - (i) illness;
 - (ii) injury; or
 - (iii) condition; and

(2) it is not reasonable to obtain the services through a network provider.

(j) A Medicare select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

(k) A Medicare select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare select policy or certificate to each applicant. This disclosure shall include at least the following:

(1) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare select policy or certificate with the following:

- (A) Other Medicare supplement policies or certificates offered by the issuer.
- (B) Other Medicare select policies or certificates.

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- (2) A description, including address, phone number, and hours of operation of the network providers, including the following:
 - (A) Primary care physicians.
 - (B) Specialty physicians.
 - (C) Hospitals.
 - (D) Other providers.
- (3) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out of network providers do not count toward the out-of-pocket annual limit contained in plans K and L.
- (4) A description of coverage for the following:
 - (A) Emergency and urgently needed care.
 - (B) Other out-of-service area coverage.
- (5) A description of limitations on referrals to the following:
 - (A) Restricted network providers.
 - (B) Other providers.
- (6) A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.
- (7) A description of the Medicare select issuer's:
 - (A) quality assurance program; and
 - (B) grievance procedure.
- (1) Before the sale of a Medicare select policy or certificate, a Medicare select issuer shall obtain from the applicant a signed and dated form stating that the applicant:
 - (1) has received the information provided under subsection (k); and
 - (2) understands the restrictions of the Medicare select policy or certificate.
- (m) A Medicare select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures as follows:
 - (1) The grievance procedure shall be described in the:
 - (A) policies and certificates; and
 - (B) outline of coverage.
 - (2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.
 - (3) Grievances shall be:
 - (A) considered in a timely manner; and
 - (B) transmitted to appropriate decision makers who have authority to:
 - (i) fully investigate the issue; and
 - (ii) take corrective action.
 - (4) If a grievance is found to be valid, corrective action shall be taken promptly.
 - (5) All concerned parties shall be notified about the results of a grievance.
 - (6) The issuer shall report not later than each March 31 to the commissioner of the department of insurance regarding its grievance procedure. The report shall:
 - (A) be in a format prescribed by the commissioner of the department of insurance; and
 - (B) contain:
 - (i) the number of grievances filed in the past year; and
 - (ii) a summary of the subject, nature, and resolution of the grievances.
- (n) At the time of initial purchase, a Medicare select issuer shall make available to each applicant for a Medicare select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.
- (o) At the request of an individual insured under a Medicare select policy or certificate, a Medicare select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer

that:

- (1) has comparable or lesser benefits; and
- (2) does not contain a restricted network provision.

The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare select policy or certificate has been in force for six (6) months.

(p) For purposes of subsection (o), a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one (1) or more significant benefits not included in the Medicare select policy or certificate being replaced. As used in this subsection, "significant benefit" means coverage for:

- (1) the Medicare Part A deductible;
- (2) at-home recovery services; or
- (3) Medicare Part B excess charges.

(q) Medicare select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare select policies and certificates issued under this section should be discontinued due to either the failure of the Medicare select program to be reauthorized under law or its substantial amendment and as follows:

(1) Each Medicare select issuer shall make available to each individual insured under a Medicare select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer that:

- (A) has comparable or lesser benefits; and
- (B) does not contain a restricted network provision.

The issuer shall make the policies and certificates available without requiring evidence of insurability.

(2) For purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one (1) or more significant benefits not included in the Medicare select policy or certificate being replaced. As used in this subdivision, "significant benefit" means coverage for:

- (A) the Medicare Part A deductible;
- (B) at-home recovery services; or
- (C) Medicare Part B excess charges.

(r) A Medicare select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare select program. (*Department of Insurance; 760 IAC 3-8-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2570; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3417; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 14, 2005, 3:00 p.m.: 29 IR 525; readopted filed Nov 29, 2011, 9:14 a.m.: 20111228-IR-760110553RFA*)

Rule 9. Open Enrollment

760 IAC 3-9-1 Open enrollment

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 1. (a) No issuer shall:

- (1) deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state; or
- (2) discriminate in the pricing of the policy or certificate;

because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted before or during the six (6) month period beginning with the first day of the first month in which an individual is both at least sixty-five (65) years of age and enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.

(b) If an applicant:

- (1) qualifies under subsection (a);
- (2) submits an application during the time period referenced in subsection (a); and

(3) as of the date of application, has had a continuous period of creditable coverage of at least six (6) months; the issuer shall not exclude benefits based on a preexisting condition.

(c) If an applicant:

(1) qualifies under subsection (a);

(2) submits an application during the time period referenced in subsection (a); and

(3) as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months; the issuer shall reduce the period of any preexisting condition exclusion by the sum of the period of creditable coverage applicable to the applicant as of the enrollment date.

(d) Except as provided in this section, section 2 of this rule, and 760 IAC 3-19-1, subsection (a) shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective. (*Department of Insurance; 760 IAC 3-9-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2573; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3419; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1975; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 14, 2005, 3:00 p.m.: 29 IR 528; readopted filed Nov 29, 2011, 9:14 a.m.: 20111228-IR-760110553RFA*)

760 IAC 3-9-2 Guaranteed issue for eligible persons

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 2. (a) As used in this section, "eligible person" means an individual described in any of the following:

(1) An individual enrolled under an employee welfare benefit plan that:

(A) provides health benefits that supplement the benefits under Medicare and the plan:

(i) terminates; or

(ii) implements a material reduction of supplemental health benefits to the individual; or

(B) is primary to Medicare and the plan:

(i) terminates; or

(ii) ceases to provide health benefits to the individual because the individual leaves the plan.

(2) An individual enrolled with a Medicare Advantage organization under a Medicare Advantage plan and any of the following circumstances apply:

(A) The organization's or plan's certification has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides.

(B) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act, where the individual has:

(i) not paid premiums on a timely basis; or

(ii) engaged in disruptive behavior as specified in standards under Section 1856;

or the plan is terminated for all individuals within a residence area.

(C) The individual demonstrates, in accordance with guidelines established by the Secretary, that:

(i) the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide:

(AA) an enrollee on a timely basis medically necessary care for which benefits are available under the plan; or

(BB) covered care in accordance with applicable quality standards; or

(ii) the organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual.

(D) The individual meets other exceptional conditions as the Secretary may provide.

(3) An individual enrolled in:

(A) an eligible organization under a contract under Section 1876 (Medicare risk or cost);

(B) a similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

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or

(C) an organization under:

- (i) an agreement under Section 1833(a)(1)(A) (health care prepayment plan); or
- (ii) a Medicare Select policy;

and the enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under subdivision (2).

(4) An individual enrolled under a Medicare supplement policy and the enrollment ceases due to one (1) of the following:

- (A) Insolvency of the issuer.
- (B) Bankruptcy of the organization.
- (C) Other involuntary termination of coverage or enrollment under the policy.
- (D) The issuer of the policy substantially violated a material provision of the policy.
- (E) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.

(5) An individual enrolled under a Medicare supplement policy who:

(A) terminates enrollment and subsequently enrolls with:

- (i) any Medicare Advantage organization under Medicare Advantage plans;
- (ii) any:
 - (AA) eligible organization under a contract under Section 1876 (Medicare risk or cost); or
 - (BB) similar organization operating under demonstration project authority;
- (iii) an organization under an agreement under Section 1833(a)(1)(A) (health care prepayment plan); or
- (iv) a Medicare Select policy; and

(B) during the first twelve (12) months after the initial termination of enrollment from the Medicare supplement policy under clause (A), the individual:

- (i) terminates any subsequent enrollments in any plans or organizations described in clause (A); and
- (ii) applies to enroll with a Medicare supplement policy.

(6) An individual who, upon first enrolling in Medicare Part B:

- (A) enrolls in any Medicare Advantage plans; and
- (B) disenrolls from the plans not later than twelve (12) months after the effective date of the individual's first enrollment.

(7) An individual who:

- (A) enrolls in a Medicare Part D plan during the initial enrollment period;
- (B) at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs;
- (C) terminates enrollment in the Medicare supplement policy; and
- (D) submits evidence of enrollment in Medicare Part D along with the application for a policy described in subsection (d).

(b) With respect to eligible persons who apply to enroll under the policy not later than sixty-three (63) days after the date of the termination of enrollment described in subsection (a) and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy, an issuer shall not:

- (1) deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection (c) that is offered and is available for issuance to new enrollees by the issuer;
- (2) discriminate in the pricing of such a Medicare supplement policy because of:
 - (A) health status;
 - (B) claims experience;
 - (C) receipt of health care; or
 - (D) medical condition; and
- (3) impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

(c) An eligible person as defined by subsection (a)(1), (a)(2), (a)(3), or (a)(4) is guaranteed issuance of a standardized Medicare supplement benefit:

- (1) Plan A;
- (2) Plan B;
- (3) Plan C;
- (4) Plan F (including Plan F with a high deductible);
- (5) Plan K; or
- (6) Plan L;

offered by any issuer.

(d) An eligible person as defined by subsection (a)(5) is guaranteed issuance of the same standardized Medicare supplement policy in which the individual was most recently enrolled, if available from the same issuer, or, if not available, a policy described in subsection (c). After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy referenced above is:

- (1) the policy available from the same issuer but modified to remove outpatient prescription drug coverage; or
- (2) at the election of the policyholder, a:
 - (A) Plan A;
 - (B) Plan B;
 - (C) Plan C;
 - (D) Plan F (including Plan with a high deductible);
 - (E) Plan K; or
 - (F) Plan L;

policy that is offered by any issuer.

(e) In the case of an individual described in subsection (a)(7), the guaranteed issue period:

(1) begins on the date the individual receives notice under Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty (60) day period immediately preceding the initial Part D enrollment period; and

(2) ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D.

An eligible person as defined by subsection (a)(7) is guaranteed issuance of a Medicare supplement Plan A, B, C, F (including F with a high deductible), K, or L that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

(f) An eligible person as defined by subsection (a)(6) is guaranteed issuance of any standardized Medicare supplement policy offered by any issuer.

(g) At the time of an event described in subsection (a), either the:

- (1) organization that terminates the contract or agreement;
- (2) employee welfare benefit plan;
- (3) issuer of the policy; or
- (4) administrator of the plan being terminated;

shall notify the individual of his or her rights under this section.

(h) At the time of an event described in subsection (a), because of which an individual ceases enrollment under a contract or agreement, policy, or plan, either the:

- (1) organization that offers the contract or agreement;
- (2) issuer offering the policy; or
- (3) administrator of the plan;

shall notify the individual of his or her rights under this section. The notice shall be communicated to the individual within ten (10) working days of the issuer receiving notification of disenrollment. (*Department of Insurance; 760 IAC 3-9-2; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1976; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 14, 2005, 3:00 p.m.: 29 IR 528; readopted filed Nov 29, 2011, 9:14 a.m.: 20111228-IR-760110553RFA*)

Rule 10. Standards for Claims Payment

760 IAC 3-10-1 Claims payment

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 1. (a) An issuer shall comply with Section 1882(c)(3) of the Social Security Act (as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by doing the following:

- (1) Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice.
- (2) Notifying the participating physician or supplier and the beneficiary of the payment determination.
- (3) Paying the participating physician or supplier directly.
- (4) Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number, and a central mailing address to which notices from a Medicare carrier may be sent.
- (5) Paying user fees for claim notices that are transmitted electronically or otherwise.
- (6) Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

(b) Compliance with the requirements set forth in subsection (a) shall be certified on the Medicare supplement insurance experience reporting form. (*Department of Insurance; 760 IAC 3-10-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2573; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA*)

Rule 11. Loss Ratio Standards and Refund or Credit of Premium

760 IAC 3-11-1 Loss ratio standards and refund or credit of premium

Authority: IC 27-8-13-10; IC 27-8-13-12

Affected: IC 27-8-13-1

Sec. 1. (a) Loss ratio standards are as follows:

(1) A Medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form at least either of the following:

(A) Seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies.

(B) Sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies, calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include the following:

- (i) Home office and overhead costs.
- (ii) Advertising costs.
- (iii) Commissions and other acquisition costs.
- (iv) Taxes.
- (v) Capital costs.
- (vi) Administrative costs.
- (vii) Claims processing costs.

(2) All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

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- (3) For policies issued any time before January 1, 1992, expected claims in relation to premiums shall meet the following:
- (A) The originally filed anticipated loss ratio when combined with the actual experience since inception.
 - (B) The appropriate loss ratio requirements from subdivision (1):
 - (i) when combined with actual experience beginning with April 1, 1996, to date; and
 - (ii) over the entire future period for which the rates are computed to provide coverage.
 - (C) In meeting the tests in clauses (A) and (B) and for purposes of attaining credibility, an issuer may combine experience under policy forms that provide substantially similar coverage. Once a combined form is adopted, the issuer may not separate the experience except with the approval of the commissioner.

(b) Refund or credit calculation is as follows:

(1) An issuer shall collect and file with the commissioner of the department of insurance by May 31 of each year the data contained in the applicable reporting form contained in this section for each type in a standard Medicare supplement benefit plan.

(2) If, on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(3) For purposes of this section, the issuer of policies or certificates issued before January 1, 1992, shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after April 1, 1996. The first report shall be due by May 31, 1998.

(4) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

(c) An issuer of Medicare supplement policies and certificates issued before or after the effective date of this article in this state shall file annually its rates, rating schedule, and supporting documentation, including ratios of incurred losses to earned premiums by policy duration for approval by the commissioner of the department of insurance in accordance with the filing requirements and procedures prescribed by the commissioner of the department of insurance. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio, which is greater than or equal to the applicable percentage, shall be demonstrated for policies or certificates in force less than three (3) years.

(d) As soon as practicable, but before the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the commissioner of the department of insurance, in accordance with the applicable filing procedures of this state, the following:

(1) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. Supporting documents as necessary to justify the adjustment shall accompany the filing.

(2) An issuer shall make premium adjustments as are:

(A) necessary to produce an expected loss ratio under the policy or certificate as will conform with minimum loss ratio standards for Medicare supplement policies; and

(B) expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates.

No premium adjustment, which would modify the loss ratio experience under the policy other than the adjustments described in this subdivision, shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(3) If an issuer fails to make premium adjustments acceptable to the commissioner of the department of insurance, the commissioner of the department of insurance may order:

(A) premium adjustments;

(B) refunds; or

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(C) premium credits;
deemed necessary to achieve the loss ratio required by this section.

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

(e) The commissioner of the department of insurance may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this article if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the commissioner of the department of insurance.

(f) The following forms shall be used for the calculations and reporting requirements of this rule:

**MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____**

TYPE ¹ _____	SMSBP ² _____
For the State of _____	Company Name _____
NAIC Group Code _____	NAIC Company Code _____
Address _____	Person Completing Exhibit _____
Title _____	Telephone Number _____

	(a) Earned Premium ³	(b) Incurred Claims ⁴
Line		
1. Current Year's Experience		
a. Total (all policy years)		
b. Current year's issues ⁵		
c. Net (for reporting purposes = 1a - 1b)	_____	_____
2. Past Years' Experience (All Policy Years)	_____	_____
3. Total Experience (Net Current Year + Past Year's Experience)	_____	_____
4. Refunds Last Year (Excluding Interest) _____		
5. Previous Since Inception (Excluding Interest) _____		
6. Refunds Since Inception (Excluding Interest) _____		
7. Benchmark Ratio Since Inception (SEE WORKSHEET FOR RATIO 1) _____		
8. Experienced Ratio Since Inception _____		
$\frac{\text{Total Actual Incurred Claims (line 3, col. b)}}{\text{Total Earned Prem. (line 3, col. a) - Refunds Since Inception (line 6)}} = \text{Ratio 2}$		

9. Life Years Exposed Since Inception _____
If the Experience Ratio is less than the Benchmark Ratio, and there are more than five hundred (500) life years exposure, then proceed to calculation of refund.

10. Tolerance Permitted (obtained from credibility table) _____

Medicare Supplement Credibility Table

Life Years Exposed	
Since Inception	Tolerance
10,000 +	0.0%
5,000-9,999	5.0%
2,500-4,999	7.5%
1,000-2,499	10.0%
500-999	15.0%
If less than 500, no credibility.	

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**MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____**

TYPE ¹ _____	SMSBP ² _____
For the State of _____	Company Name _____
NAIC Group Code _____	NAIC Company Code _____
Address _____	Person Completing Exhibit _____
Title _____	Telephone Number _____

11. Adjustment to Incurred Claims for Credibility _____

Ratio 3 = Ratio 2 + Tolerance

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required.

If Ratio 3 is less than the Benchmark Ratio, then proceed.

12. Adjusted Incurred Claims _____

[Total Earned Premiums (line 3, col. a) - Refunds Since Inception (line 6)] × Ratio 3 (line 11)

13. Refund = Total Earned Premiums (line 3, col. a) - Refunds Since Inception (line 6).

Adjusted Incurred Claims (line 12)

Benchmark Ratio (Ratio 1)

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premiums to be used must be attached to this form.

¹Individual, group, individual Medicare Select, or group Medicare Select only.

²"SMSBP" = Standardized Medicare Supplement Benefit Plan.

³Includes Modal Loadings and Fees Charged.

⁴Excluded Active Life Reserves.

⁵This is to be used as "Issue Year Earned Premium" for Year 1 of the next year's "Worksheet for Calculation of Benchmark Ratios".

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

Signature

Name—Please Type

Title

Date

**REPORTING FORM FOR THE CALCULATION OF BENCHMARK
RATIO SINCE INCEPTION FOR GROUP POLICIES
FOR CALENDAR YEAR _____**

TYPE ¹ _____	SMSBP ² _____
For the State of _____	Company Name _____
NAIC Group Code _____	NAIC Company Code _____
Address _____	Person Completing Exhibit _____
Title _____	Telephone Number _____

(a) ³	(b) ⁴	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o) ⁵
Year	Earned Premium	Factor	(b)×(c)	Cumulative Loss Ratio	(d)×(e)	Factor	(b)×(g)	Cumulative Loss Ratio	(h)×(i)	Policy Year Loss Ratio

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1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: $(l + n)/(k + m)$: _____

¹Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

²"SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.

³Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)

⁴For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

⁵These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

**REPORTING FORM FOR THE CALCULATION OF BENCHMARK
RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR _____**

TYPE¹ _____ SMSBP² _____
 For the State of _____ Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Address _____ Person Completing Exhibit _____
 Title _____ Telephone Number _____

(a) ³	(b) ⁴	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o) ⁵
Year	Earned Premium	Factor	(b)×(c)	Cumulative Loss Ratio	(d)×(e)	Factor	(b)×(g)	Cumulative Loss Ratio	(h)×(i)	Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75

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9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15		4.175		0.493		8.684		0.725		0.77
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: $(1 + n)/(k + m)$: _____

¹Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

²"SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.

³Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)

⁴For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

⁵These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

(Department of Insurance; 760 IAC 3-11-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2573; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3419; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 14, 2005, 3:00 p.m.: 29 IR 530; errata filed Oct 5, 2005, 2:25 p.m.: 29 IR 548; readopted filed Nov 29, 2011, 9:14 a.m.: 20111228-IR-760110553RFA)

Rule 12. Filing and Approval of Policies and Certificates and Premium Rates

760 IAC 3-12-1 Filing and approval of policies and certificates and premium rates

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1; IC 27-8-13-12

Affected: IC 27-8-13-1

Sec. 1. (a) An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the commissioner of the department of insurance in accordance with filing requirements and procedures prescribed by the commissioner of the department of insurance.

(b) An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the commissioner in the state in which the policy or certificate was issued.

(c) An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with and approved by the commissioner of the department of insurance in accordance with the filing requirements and procedures prescribed by the commissioner of the department of insurance.

(d) Except as provided in subsection (e), an issuer shall not file for approval more than one (1) form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

(e) An issuer may offer, with the approval of the commissioner of the department of insurance, up to four (4) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one (1) for each of the following cases:

- (1) The inclusion of new or innovative benefits.
- (2) The addition of either:
 - (A) direct response or agent marketing methods; or
 - (B) guaranteed issue or underwritten coverage.
- (3) The offering of coverage to individuals eligible for Medicare by reason of disability.
- (f) As used in this section, "type" means:

- (1) an individual policy;
- (2) a group policy;
- (3) an individual Medicare select policy; or
- (4) a group Medicare select policy.

(g) Except as provided in subdivision (1), an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this article that has been approved by the commissioner of the department of insurance. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months and as follows:

(1) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner of the department of insurance in writing its decision at least thirty (30) days before discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner of the department of insurance, the issuer shall no longer offer for sale the policy form or certificate form in this state.

(2) An issuer that discontinues the availability of a policy form or certificate form under subdivision (1) shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the commissioner of the department of insurance of the discontinuance. The period of discontinuance may be reduced if the commissioner of the department of insurance determines that a shorter period is appropriate.

(h) For purposes of subsection (g), this subsection, and subsection (i), the sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance.

(i) A change in the rating structure or methodology shall be considered a discontinuance under subsection (g) unless the issuer:

(1) provides an actuarial memorandum, in a form and manner prescribed by the commissioner of the department of insurance, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates; and

(2) does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner of the department of insurance may approve a change to the differential that is in the public interest.

(j) Except as provided in subsection (k), the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in 760 IAC 3-11.

(k) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation. (*Department of Insurance; 760 IAC 3-12-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2580; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3430; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 14, 2005, 3:00 p.m.: 29 IR 534; readopted filed Nov 29, 2011, 9:14 a.m.: 20111228-IR-760110553RFA*)

Rule 13. Permitted Compensation Arrangements

760 IAC 3-13-1 Permitted compensation arrangements

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 1. (a) An issuer 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 two hundred 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 no fewer than five (5) renewal years.

(c) No issuer or other entity shall provide compensation to its agents or other producers, and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

(d) No issuer or other entity shall provide to its agents or other producers, and no agent or producer shall receive:

(1) compensation for the sale of a Medicare supplement policy or certificate that differs from the compensation for the sale of any other Medicare supplement policy or certificate because of the level, type, or nature of benefits; or

(2) compensation for the sale of any Medicare supplement policy or certificate to a person that differs from the compensation that applies to the sale of any Medicare supplement policy or certificate to any other person because of the age, health status, claims experience, receipt of health care, or medical condition of that person.

(e) As used in this section, "compensation" includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate, including, but not limited to, the following:

(1) Bonuses.

(2) Gifts.

(3) Prizes.

(4) Awards.

(5) Finders fees.

(Department of Insurance; 760 IAC 3-13-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2581; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3430; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1977; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-76007071RFA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA)

Rule 14. Required Disclosure Provisions

760 IAC 3-14-1 Required disclosure provisions

Authority: IC 27-8-13

Affected: IC 27-8-13-1

Sec. 1. (a) General provisions are as follows:

(1) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall:

(A) be appropriately captioned;

(B) appear on the first page of the policy; and

(C) include any:

(i) reservation by the issuer of the right to change premiums; and

(ii) automatic renewal premium increases based on the policyholder's age.

(2) Except for riders or endorsements by which the issuer:

(A) effectuates a request made in writing by the insured;

(B) exercises a specifically reserved right under a Medicare supplement policy; or

(C) is required to reduce or eliminate benefits to avoid duplication of Medicare benefits;

all riders or endorsements added to a Medicare supplement policy after the date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies or if the increased benefits or coverage is 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.

(3) Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as:

(A) "usual and customary";

(B) "reasonable and customary"; or

(C) words of similar import.

(4) If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall:

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

- (A) appear as a separate paragraph of the policy; and
- (B) be labeled as "Preexisting Condition Limitations".

(5) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder shall have the right to:

- (A) return the policy or certificate within thirty (30) days of its delivery; and
- (B) have the premium refunded;

if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(6) Issuers of accident and sickness policies or certificates that provide hospital or medical expense coverage on an expense incurred or indemnity basis to a person eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare (Guide) in:

- (A) the form developed jointly by the National Association of Insurance Commissioners and the Center for Medicare Services; and
- (B) a type size no smaller than 12-point type.

Delivery of the Guide shall be made whether or not the policies or certificates are advertised, solicited, or issued as Medicare supplement policies or certificates as defined in this article. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgement of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request, but not later than at the time the policy is delivered.

As used in this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

(b) Notice requirements are as follows:

(1) As soon as practicable, but not later than thirty (30) days before the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the commissioner of the department of insurance. The notice shall do the following:

- (A) Include a description of the following:
 - (i) Revisions to the Medicare program.
 - (ii) Each modification made to the coverage provided under the Medicare supplement policy or certificate.
- (B) Inform each policyholder or certificate holder 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:

- (A) outline form; and
- (B) clear and simple terms;

so as to facilitate comprehension.

(3) The notices shall not:

- (A) contain; or
- (B) be accompanied by;

any solicitation.

(c) Issuers shall comply with any notice requirements of the Medicare Prescription Drug Improvement and Modernization Act of 2003.

(d) The outline of coverage requirements for Medicare supplement policies are as follows:

(1) Issuers shall:

- (A) provide an outline of coverage to all applicants at the time application is presented to the prospective applicant; and
- (B) except for direct response policies, obtain an acknowledgement of receipt of the outline from the applicant.

(2) If:

- (A) an outline of coverage is provided at the time of application; and
- (B) the Medicare supplement policy or certificate is issued on a basis that would require revision of the outline;

a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in not smaller than 12-point type, immediately above the company name:

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"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 under this section consists of the following:
- (A) The cover page described in subsection (f).
 - (B) Premium information on or immediately following the cover page.
 - (C) Disclosure pages described in subsection (g).
 - (D) Charts displaying the features of each benefit plan offered by the issuer described in subsection (h).

The outline of coverage shall be in the language and format prescribed in subsections (f) through (h) in not smaller than 12-point type. Plans A through J, described in 760 IAC 3-7, shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(e) The following are notices regarding policies or certificates that are not Medicare supplement policies:

(1) Any:

- (A) accident and sickness insurance policy or certificate, other than a Medicare supplement policy;
- (B) policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. 1395 et seq.);
- (C) disability income policy; or
- (D) other policy identified in 760 IAC 3-1-1(b);

issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy or, if no outline of coverage is delivered, to the first page of the policy or certificate delivered to insureds. The notice shall be in not smaller than 12-point type and shall contain the following language:

"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

(2) Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in subdivision (1) shall disclose, using the applicable statement in this subdivision, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as part of, or together with, the application for the policy or certificate. The following instructions and forms shall be used for the disclosure statement regarding duplication of Medicare:

DISCLOSURE STATEMENTS

Instructions for Use of the Disclosure Statements for

Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare

1. Section 1882(d) of the federal Social Security Act, 42 U.S.C. 1395ss, prohibits the sale of a health insurance policy (the term "policy" or "policies" includes certificates) that duplicates Medicare benefits unless it will pay benefits without regard to other health coverage and it includes the prescribed disclosure statement on or together with the application.
2. All types of health insurance policies that duplicate Medicare shall include one (1) of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).
3. State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement.
4. Property/casualty and life insurance policies are not considered health insurance.
5. Disability income policies are not considered to provide benefits that duplicate Medicare.
6. Long term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.
7. The federal law does not preempt state laws that are more stringent than the federal requirements.
8. The federal law does not preempt existing state form filing requirements.

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

9. Section 1882 of the federal Social Security Act was amended to allow for alternative disclosure statements. Carriers may use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that reimburse expenses incurred for specified disease(s) or other specified impairment(s). This includes expense incurred cancer, specified disease, and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one (1) of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that provide benefits for specified limited services.]

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one (1) of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that provide benefits for both expenses incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items and services

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductible or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items and services

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for other health insurance policies not specifically identified in the previous statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

- physician services
- hospice
- other approved items and services

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense incurred cancer, specified disease, and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one (1) of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one (1) of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that provide benefits upon both an expense incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(f) The cover page of the outline described in subsection (d) shall be in the format as follows:

(COMPANY NAME)

Outline of Medicare Supplement Coverage-Cover Page:

Benefit Plan(s) _____(insert letter(s) of plan(s) being offered)

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A". Some of the other plans may not be available from every company.

Plans E, H, I, and J are no longer available for sale.

Basic Benefits

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.

Blood: First three pints of blood each year.

Hospice: Part A coinsurance.

A	B	C	D	F / F*	G
Basic Benefits, including 100% Part B Coinsurance	Basic Benefits, including 100% Part B Coinsurance	Basic Benefits, including 100% Part B Coinsurance Skilled Nursing Facility Coinsurance	Basic Benefits, including 100% Part B Coinsurance Skilled Nursing Facility Coinsurance	Basic Benefits, including 100% Part B Coinsurance* Skilled Nursing Facility Coinsurance	Basic Benefits, including 100% Part B Coinsurance Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible Part B Deductible	Part A Deductible	Part A Deductible Part B Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency	Part B Excess (100%) Foreign Travel Emergency	Part B Excess (100%) Foreign Travel Emergency
K	L	M	N		
Hospitalization and preventative care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventative care paid at 100%; other basic benefits paid at 75%	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER	
50% Skilled Nursing Facility Coinsurance 50% Part A Deductible	75% Skilled Nursing Facility Coinsurance 75% Part A Deductible	50% Skilled Nursing Facility Coinsurance 50% Part A Deductible	50% Skilled Nursing Facility Coinsurance 50% Part A Deductible	Skilled Nursing Facility Coinsurance Part A Deductible	

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Out-of-pocket limit \$[4620]; paid at 100% after limit reached	Out-of-pocket limit \$[2310]; paid at 100% after limit reached	Foreign Travel Emergency	Foreign Travel Emergency
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*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2,000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [\$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

Basic Benefits for Plans K and L include cost-sharing for the basic benefits at different levels.

K**	L**
100% of Part A Hospitalization coinsurance plus coverage for 365 days after Medicare benefits end; 50% hospice cost-sharing; 50% of Medicare-eligible expenses for the first three pints of blood; 50% Part B coinsurance, except 100% coinsurance for Part B Preventive Services	100% of Part A Hospitalization coinsurance plus coverage for 365 days after Medicare benefits; 75% hospice cost-sharing; 75% of Medicare-eligible expenses for the first three pints of blood; 75% Part B coinsurance, except 100% coinsurance for Part B Preventive Services
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible
[\$4000] Out-of-Pocket Annual Limit***	[\$2000] Out-of-Pocket Annual Limit***

**Plans K and L provide for different cost-sharing for items and services than *[sic]*

Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare approved amounts, called "Excess Charges". You will be responsible for paying excess charges.

***The out-of-pocket annual limit will increase each year for inflation.

(g) The following items shall be included in the outline of coverage in the order prescribed:

PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state. [If the premium is based on the increasing age of the insured, include information specifying when the premiums will change.]

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

The policy may not fully cover all of your medical costs.

[for agents:]

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

[for direct response:]

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

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "The Medicare Handbook" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.] Review the application carefully before you sign it. Be certain that all information has been properly recorded.

(h) The NAIC Model Laws, Regulations and Guidelines, Vol. IV, pages 651-56 through 651-97. Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (October 2008) are hereby incorporated by reference as if fully set out herein as the format for the charts described in subsection (d). (*Department of Insurance; 760 IAC 3-14-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2581; errata filed Sep 20, 1993, 5:00 p.m.: 17 IR 200; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3431; errata filed Sep 24, 1996, 10:30 a.m.: 20 IR 332; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1978; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 14, 2005, 3:00 p.m.: 29 IR 535; filed Jul 27, 2009, 10:36 a.m.: 20090826-IR-760090211FRA*)

Rule 15. Requirements for Application Forms and Replacement Coverage

760 IAC 3-15-1 Application forms and replacement coverage

Authority: IC 27-8-13-10; IC 27-8-13-16

Affected: IC 27-8-13-1

Sec. 1. (a) Application forms shall include statements and questions as established in this subsection designed to elicit information as to whether, as of the date of the application, the applicant currently has another Medicare supplement, Medicare Advantage, or Medicaid coverage or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing questions and statements may be used, such as the following:

(1) The following statements:

(A) You do not need more than one (1) Medicare supplement policy.

(B) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(C) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(D) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for twenty-four (24) months. You must request this suspension within ninety (90) days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within ninety (90) days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(E) If you are eligible for and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within ninety (90) days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(F) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as

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Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

(2) If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one (1) or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. Please answer all questions:

To the best of your knowledge,

(A) Did you turn age sixty-five (65) in the last six (6) months?

Yes _____ No _____

(B) Did you enroll in Medicare Part B in the last six (6) months?

Yes _____ No _____

(C) If yes, what is the effective date? _____

(D) Are you covered for medical assistance through the state Medicaid program?

[NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.]

Yes _____ No _____

(i) If yes, will Medicaid pay your premiums for this Medicare supplement policy?

Yes _____ No _____

(ii) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

Yes _____ No _____

(E) If you had coverage from any Medicare plan other than original Medicare within the past sixty-three (63) days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

Start ___/___/___ END ___/___/___

(F) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

Yes _____ No _____

(G) Was this your first time in this type of Medicare plan?

Yes _____ No _____

(H) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

Yes _____ No _____

(I) Do you have another Medicare supplement policy in force?

Yes _____ No _____

(i) If so, with what company, and what plan do you have [optional for Direct Mailers]?

(ii) If so, do you intend to replace your current Medicare supplement policy with this policy?

Yes _____ No _____

(J) Have you had coverage under any other health insurance within the past sixty-three (63) days? (For example, an employer, union, or individual plan)

Yes _____ No _____

(i) If so, with what company and what kind of policy?

(ii) What are your dates of coverage under the other policy?

START ___/___/___ END ___/___/___

If you are still covered under the other policy, leave "END" blank.

(b) Agents shall list any other health insurance policies they have sold to the applicant. List policies sold that:

(1) are still in force; and

(2) in the past five (5) years, are no longer in force.

(c) In the case of a direct response issuer, a copy of the application or supplemental form:

(1) signed by the applicant; and

(2) acknowledged by the insurer;

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shall be returned to the applicant by the insurer upon delivery of the policy.

(d) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer or its agent, shall furnish the applicant, before issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One (1) copy of the notice signed by the applicant and 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. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

(e) The notice required by subsection (d) for an issuer shall be provided in substantially the following form in not smaller than 12-point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

[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 terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement coverage or, if applicable, Medicare Advantage because you intend to terminate your existing Medicare supplemental coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reasons (check one):

- Additional benefits.
No change in benefits, but lower premiums.
Fewer benefits and lower premiums.
My plan has outpatient prescription drug coverage and I am enrolling in Part D.
Disenrollment from a Medicare Advantage plan. Please explain the reason for disenrollment [optional only for Direct Mailers]
Other (please specify).

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

(2) If 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 and 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, review it carefully to be certain that all information has been properly recorded. (If the policy or certificate is guaranteed issue, this paragraph need not appear.)

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it. (Signature of Agent, Broker or Other Representative)*

[Typed Name and Address of Issuer, Agent or Broker]

(Applicant's Signature)

(Date)

*Signature not required for direct response sales.

(f) Subsection (e)(1) and (e)(2) of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation. (*Department of Insurance; 760 IAC 3-15-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2615; filed Jul 18, 1996, 1:00 p.m.: 19 IR 3464; errata filed Sep 24, 1996, 10:30 a.m.: 20 IR 332; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 14, 2005, 3:00 p.m.: 29 IR 544; readopted filed Nov 29, 2011, 9:14 a.m.: 20111228-IR-760110553RFA*)

Rule 16. Filing Requirements for Advertising

760 IAC 3-16-1 Filing requirements for advertising

Authority: IC 27-8-13-10

Affected: IC 27-8-13-18

Sec. 1. An issuer shall file a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio, or television media to the commissioner of the department of insurance of this state. (*Department of Insurance; 760 IAC 3-16-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2616; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA*)

Rule 17. Standards for Marketing

760 IAC 3-17-1 Marketing

Authority: IC 27-8-13-10; IC 27-8-13-16

Affected: IC 27-4-1-4; IC 27-8-13-1

Sec. 1. (a) An issuer, directly or through its producers, shall do the following:

- (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 excessive insurance is not sold or issued.
 - (3) Establish marketing procedures which set forth a mechanism or formula for determining whether a replacement policy or certificate is truly in the best interest of the applicant.
 - (4) Display prominently by type, stamp, or other appropriate means, on the first page of the policy, the following:
"Notice to buyer: This policy may not cover all of your medical expenses."
 - (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.
 - (6) Establish auditable procedures for verifying compliance with this subsection.
- (b) In addition to the practices prohibited in IC 27-4-1-4, 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.
- (c) The terms "Medicare supplement", "Medigap", "Medicare wrap-around", and words of similar import shall not be used

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unless the policy is issued in compliance with this article. (Department of Insurance; 760 IAC 3-17-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2616; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA)

Rule 18. Recommended Purchase and Excessive Insurance

760 IAC 3-18-1 Appropriateness of recommended purchase and excessive insurance; reporting of multiple policies

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1; IC 27-8-13-12
Affected: IC 27-8-13

Sec. 1. (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 a Medicare supplement policy or certificate that will provide an individual more than one (1) Medicare supplement policy or certificate is prohibited, except that an agent may sell a replacement policy or certificate in accordance with 760 IAC 3-15-1 provided that the replacement policy or certificate is not made effective any sooner than is necessary to provide continuous benefits for preexisting conditions.

(c) An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

(d) An insurer that issues a Medicare supplement policy or certificate to any individual who has one (1) policy or certificate then in effect, except as permitted by subsection (b), shall, at the request of the insured, either:

- (1) refund the premiums; or
(2) pay any claims on the policy or certificate;

whichever is greater.

(e) Before March 2 of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one (1) Medicare supplement policy or certificate:

- (1) The policy and certificate number.
(2) The date of issuance.
(f) The items set forth in subsection (e) must be grouped by individual policyholder.
(g) The form for reporting the information required by subsection (e) is as follows:

FORM FOR REPORTING
MEDICARE SUPPLEMENT MULTIPLE POLICIES

Company Name: _____

Address: _____

Phone Number: _____

Due March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one (1) Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Table with 2 columns: Policy and Certificate #, Date of Issuance. Contains 3 empty rows.

Signature

Name and Title (please type)

Date

(Department of Insurance; 760 IAC 3-18-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2617; errata filed Sep 20, 1993, 5:00 p.m.: 17 IR 200; filed Feb 1, 1999, 10:45 a.m.: 22 IR 1987; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Sep 14, 2005, 3:00 p.m.: 29 IR 546; errata filed Oct 5, 2005, 2:25 p.m.: 29 IR 548; readopted filed Nov 29, 2011, 9:14 a.m.: 20111228-IR-760110553RFA)

Rule 19. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods, and Probation Periods

760 IAC 3-19-1 Prohibition against preexisting conditions, waiting periods, elimination periods, and probationary periods in replacement policies or certificates

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 1. (a) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.

(b) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods. (Department of Insurance; 760 IAC 3-19-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2618; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA)

Rule 19.1. Prohibition Against Use of Genetic Information and Requests for Genetic Testing

760 IAC 3-19.1-1 Prohibition against discrimination, use of genetic information, and requests for genetic testing

Authority: IC 27-8-13

Affected: IC 27-8-13-1

Sec. 1. (a) This section applies to all policies with policy years beginning on or after May 21, 2009.

(b) The following definitions apply for purposes of this section only:

(1) "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of the individual.

(2) "Genetic information" means, with respect to any individual, information about the following:

(A) The individual's genetic tests.

(B) The genetic tests of family members of the individual.

(C) The manifestation of a disease or disorder in family members of the individual.

(D) Any request for, or receipt of, genetic services.

(E) Any participation in clinical research that includes genetic services by the individual or any family member of the individual.

Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by the pregnant woman, or with respect to an individual or family member utilizing an assisted reproductive technology, includes genetic information of any embryo legally held by the individual or family member. The term shall not include information about the sex or age of any individual.

(3) "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

(4) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. The term does not include an analysis of proteins or metabolites that:

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- (A) does not detect genotypes, mutations, or chromosomal changes; or
 - (B) is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.
- (5) "Issuer of a Medicare supplement policy" includes a third party administrator or other person acting for or on behalf of the issuer.
- (6) "Underwriting purposes" includes the following:
- (A) Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy.
 - (B) The computation of premium or contribution amounts under the policy.
 - (C) The application of any preexisting condition exclusion under the policy.
 - (D) Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.
- (c) An issuer of a Medicare supplement policy shall not:
- (1) deny or condition the issuance or effectiveness of the policy, including the imposition of any exclusion of benefits under the policy based on a preexisting condition; or
 - (2) discriminate in the pricing of the policy, including the adjustment of premium rates, of an individual on the basis of the genetic information with respect to the individual.
- (d) Nothing in subsection (c) shall be construed to limit the ability of an issuer of a Medicare supplement policy, to the extent otherwise permitted by law, from either of the following:
- (1) Denying or conditioning the issuance or effectiveness of the policy or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant.
 - (2) Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy. In such case, the manifestation of a disease or disorder in one (1) individual cannot also be used as genetic information about other group members and to further increase the premium for the employer.
- (e) An issuer of a Medicare supplement policy shall not request or require an individual or a family member of the individual to undergo a genetic test.
- (f) Subsection (e) shall not be construed to preclude an issuer of a Medicare supplement policy from obtaining and using the results of a genetic test in making a determination regarding payment, as defined for the purposes of applying the regulations promulgated by the Secretary under Part C of Title XI and Section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time, and consistent with subsection (c).
- (g) For purposes of subsection (f), an issuer of a Medicare supplement policy may request only the minimum amount of information necessary to accomplish the intended purpose.
- (h) Notwithstanding subsection (e), an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of the individual undergo a genetic test if each of the following conditions is met:
- (1) The request is made pursuant to research that complies with Part 46 of Title 45, Code of Federal Regulations, or equivalent federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research.
 - (2) The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of the child, to whom the request is made that:
 - (A) compliance with the request is voluntary; and
 - (B) noncompliance will have no effect on:
 - (i) enrollment status;
 - (ii) premium amounts; or
 - (iii) contribution amounts.
- (3) No genetic information collected or acquired under this subsection shall be used for any of the following:
- (A) Underwriting.
 - (B) Determination of eligibility to enroll or maintain enrollment status.
 - (C) Premium rating.
 - (D) The issuance, renewal, or replacement of a policy.
- (4) The issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided for

under this subsection, including a description of the activities conducted.

(5) The issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this subsection.

(i) An issuer of a Medicare supplement policy shall not request, require, or purchase genetic information for underwriting purposes.

(j) An issuer of a Medicare supplement policy shall not request, require, or purchase genetic information with respect to any individual prior to the individual's enrollment under the policy in connection with the enrollment.

(k) If an issuer of a Medicare supplement policy obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, the request, requirement, or purchase shall not be considered a violation of subsection (j) if the request, requirement, or purchase is not in violation of subsection (i). (*Department of Insurance; 760 IAC 3-19.1-1; filed Jul 27, 2009, 10:36 a.m.: 20090826-IR-760090211FRA*)

Rule 20. Separability

760 IAC 3-20-1 Separability

Authority: IC 27-8-13-9; IC 27-8-13-10; IC 27-8-13-10.1

Affected: IC 27-8-13-1

Sec. 1. If any provision of this article or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the article and the application of such provision to other persons or circumstances shall not be affected thereby. (*Department of Insurance; 760 IAC 3-20-1; filed Jul 8, 1993, 10:00 a.m.: 16 IR 2618; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; readopted filed Nov 27, 2007, 4:01 p.m.: 20071226-IR-760070717RFA; readopted filed Nov 26, 2013, 3:43 p.m.: 20131225-IR-760130479RFA*)

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