Indiana Department of Insurance
Filing Company Checklist
Group Long Term Care Policy Review Standards

Association policies/certificates should be filed as GROUP, not individual

(This Checklist must be submitted with any LTC filing – attach as PDF Document if filing electronically)

Company Name_____ **NAIC #** _____

Form number(s)_____ **Filing date**_____

Traditional ☐ **Tax Qualified** ☐ **Non TQ** ☐ **Partnership** ☐

Statute/ Regulation	***Requirement***	***N/A*** ***(If asking for special consideration on any item please address in Cover Letter)***	***Location in Submitted Documents***	***For DOI USE ONLY*** ***Yes/No Comments***
General Filing Requirements				
IC 27-1-3-15	***Filing Fees***—We will bill you quarterly. The fees are $35 per form plus $35 for rates or the retaliatory fees based on your state of domicile. **PLEASE DO NOT** submit any filing fees with your filing.			
Bulletin 125	**All rate filings that involve either an aggregate rate change or a change in the underlying factors utilized to calculate premium must be filed electronically. All information required by the Indiana Department of Insurance is on the website under the Accident and Health Instructions page must be included in the electronic filing.**			
Bulletin 125	NAIC Standard A&H Transmittal Sheet—Use coding from NAIC Uniform Product Coding Matrix—Links to these items on the IDOI website or www.naic.org			
Bulletin 125	A cover document, either the General Information tab within SERFF or an NAIC Transmittal form or a cover letter in duplicate if filed via paper, and one copy of all forms and rates to be filed. The cover document should include:			
	a) A reference "Re:" line identifying the insurance company's name and NAIC number, and the form number of **each** form to be filed.			
	b) If there are numerous forms in one filing, please list them on a separate document and indicate via reference "see additional listing." Please list the most important form first and keep the same order in related correspondence			
	c) The name of a contact person, w/ e-mail address, telephone and fax numbers. **All correspondence relative to paper filings will be done via e-mail when possible.** On all e-mails and other correspondence, please include NAIC number, Company Name and lead form number. Any submission of			

	additional forms or materials should include a separate response, in duplicate (if paper), for each filing being addressed.			
	d) The nature of the insurance product (e.g. Medicare Supplement, individual, small group, association group, employer group health, etc.)			
Bulletin 125	For paper filings, a postage-paid, self-addressed envelope of adequate size to hold the "approved" or "filed" stamped duplicate correspondence and any extra copies of forms that you wish to have returned. (There is no need to send more than one copy of the forms.)			
Bulletin 125	If the filing is submitted by an outside consulting firm, a letter giving authorization to file on behalf of the company. If you are filing for multiple companies, you must submit an authorization from each Company, list each company separately on the cover letter by NAIC #, Company Name and form #. Separate filing/retaliatory fees for each company will be applicable.			
GENERAL*:*				
Required Provisions for Group A&H Policies IC 27-8-5-19	The following rights of insurers and insureds must be disclosed in group accident and sickness policies issued in Indiana. Exact wording is not required, as long as the substance matches the statutory language, or is more favorable to the insured or policyholder.			
IC 27-8-5-19(c)(1)	**GRACE PERIOD**: The policyholder has a grace period of 31 days for payment of premium due, except the first premium. Policy remains in force during the grace period, but insurer may hold claims incurred during grace period until premium is received.			
IC 27-8-5-19(c)(2)	**INCONTESTABILITY**: Validity of policy may not be contested after 2 years except for a) nonpayment of premiums, or if b) the disputed statement is in a written instrument signed by insured. Ineligibility of insured or enrollee under the policy may be disputed any time.			
IC 27-8-5-19(c)(3)	**COPY OF APPLICATION**: If there is an application, a copy must be attached to the policy at issue. Statements made by persons insured are representations, not warranties, and must be provided to insured persons in case of a dispute.			
IC 27-8-5-19(c)(4)	**EVIDENCE OF INSURABILITY**: Insurers may reserve the right to require individual evidence of insurability as a condition of coverage.			
IC 27-8-5-19(c)(7)	**MISSTATEMENT OF AGE**: Clear statement of how premiums, benefits or both will be fairly adjusted if covered person's age is misstated and if premiums and benefits vary by age.			
IC 27-8-5-19(c)(8)	**CERTIFICATE**: Insurer must issue to policyholder, for delivery to each insured person, a certificate of coverage explaining the protection to whom benefits are payable.			
IC 27-8-5-19(c)(9)	**TIMELY NOTICE OF CLAIM**: Insured must provide written notice of claim within 20 days after occurrence or commencement of loss, or as soon as reasonably possible.			

IC 27-8-5-19(c)(10)	**CLAIM FORMS**: Insurer must provide forms for filing proof of loss within 15 days of notice of claim, or claimants can submit their own.			
IC 27-8-5-19(c)(11)	**PROOF OF LOSS**: a) For disability claim, written proof of loss must be provided within 90 days of commencement of insurer's liability and at reasonable intervals thereafter if required. b) For other loss, written proof must be furnished within 90 days of loss. c) Claim will not be reduced if (a) or (b) was not reasonably possible but no later than 1 year after requirement.			
IC 27-8-5-3(a)(8) IC 27-8-5.7	**CLEAN CLAIMS:** An insurer shall pay or deny each clean claim as follows: (1) If the claim is filed electronically, within thirty (30) days after the date the claim is received by the insurer. (2) If the claim is filed on paper, within forty-five (45) days after the date the claim is received by the insurer. If an insurer fails to pay or deny a clean claim in the time required under subsection (a); and the insurer subsequently pays the claim; the insurer shall pay the provider that submitted the claim interest on the accident and sickness insurance policy allowable amount of the claim paid under this section.			
IC 27-8-5-19(c)(12)	**TIMELY PAYMENT OF CLAIMS**: all benefits payable under the policy (other than benefits for loss of time) will be paid in accordance with IC 27-8-5.7; and subject to due proof of loss, all accrued benefits under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and any balance remaining unpaid at the termination of the period for which the insurer is liable will be paid as soon as possible after receipt of the proof of loss.			
IC 27-8-5-19(c)(13)	**BENEFICIARIES**: Loss of life benefits are paid to the beneficiary designated by the insured. If the policy contains conditions pertaining to family status the policy terms apply. All other benefits payable to the person insured. Insurer may also choose to pay up to $5000 to a relative by blood or marriage if beneficiary is an estate or a minor. (Does not apply to policies insuring lives of debtors.)			
IC 27-8-5-19(c)(14)	**PHYSICAL EXAMINATION AND AUTOPSY**: Insurer has the right to examine the person during the pendency of a claim or to conduct an autopsy in case of death, unless prohibited by law.			
IC 27-8-5-19(c)(15)	**LEGAL ACTIONS**: No lawsuit may be filed to recover under the policy before 60 days after proof of loss is filed, and not later than 3 years after proof of loss is required to be filed.			
Bulletin 128	Notice to policyholders regarding filing complaints with the Department of Insurance			
Return of Policy Notice IC 27-8-12-13	A certificate holder solicited by direct response can return the certificate within 30 days. The first page of the certificate must have a notice outlining this right.			
Group Certificate Contents IC 27-8-12-15	A certificate delivered or issued in Indiana must include a description of benefits, exclusions, limitations, and reductions. The master policy should be consulted for exact terms.			

Group Policy Issued in Another State IC 27-8-12-17	Group long term insurance under a group policy issued in another state cannot be offered to an Indiana resident unless the benefits are substantially similar to Indiana's requirements as determined by the Indiana commissioner.			
Group Policy Issued In Another State IAC 2-14-1	Notice of approval to be filed for a group policy filed in another state. Certificates delivered to Indiana residents shall be reviewed.			
Pre-Existing Limitations IC 27-8-12-10 ; IC 27-8-12-10.5; IC 27-8-12-10.6	Refer to citation.			
Federal Tax Qualified Definition (TQ) 760 IAC 2-2-3.7	Refer to Citation for TQ Requirements			
Continuation or Conversion 760 IAC 2-3-4	Requirements and qualification for continuation or offering conversion policy detailed.			
Replacement 760 IAC 2-3-5	Replacement of a group LTC policy with another group LTC policy shall not exclude previously covered pre-existing conditions and premiums will not be affected by previous health status or claims.			
Premiums 760 IAC 2-3-6	Premium increases cannot be based on the increasing age of insured at ages beyond 65 OR the duration that the insured has been covered by such policy.			
Electronic Enrollment 760 IAC 2-3-7	Electronic enrollment is permitted if enrollment is verified and safeguards are in place.			
Policy Provisions				
Unintentional Lapse 760 IAC 2-3-8	Provides for notification of additional person if policy lapses due to non-payment; time frame for notification and reinstatement; provides for reinstatement if lapse due to cognitive impairment.			
Non Partnership Policy 760 IAC 2-20-34(10)	**LTC Policies that are not Partnership compliant must state so, in accordance with Rule 34(10).**			
Home Health & CC Care Benefits 760 IAC 2-6-1	Lists minimum benefit standards, limitations, and allowable exclusions for these services.			
Inflation Protection Offer 760 IAC 2-7-1(a)	Offer no less favorable than (1)one of the following: 1) Annual Compound 5% inflation 2) GPO at least 5% annual compound 3) Cover a specified % of actual or reasonable charges without maximum limit. (Additional inflation offers not less than 3%.)			
760 IAC 2-7-1-3(b)	Inflation protection continues at same level for policy benefit.			
760 IAC 2-7-1-3(d)	Requires signature to reject inflation protection.			
760 IAC 2-7-2	Required inflation offer shall be made to the group policyholder.			
Non-Forfeiture Benefit 760 IAC 2-16.1-1	Non-forfeiture offer to be included, if rejected, contingent benefit offer.			
Benefit Triggers 760 IAC 2-16.1-2 760 IAC 2-16.1-3	Benefit payments triggered by deficiency in not more than 3 ADLs or cognitive impairment. Triggers defined for TQ policy.			
Policy Termination IC 27-8-12-9	Insurer may not cancel, decline to renew or otherwise terminate a policy based solely on the age or deterioration in mental or physical health of the insured individual or certificate holder.			
DISCLOSURES				
Renewability 760 IAC 2-4-1(a)	Individual policies must contain a renewability provision, which should be displayed on the first page of policy, and clearly state the terms and any limitations.			
760 IAC 2-4-1(b)	Applicant signature required for changes to policy that reduce or eliminate benefits.			
760 IAC 2-4-1(c)	Terms such as "reasonable and customary", "usual and customary" or similar must be defined in the accompanying outline of			

	coverage.			
760 IAC 2-4-1(d)	Pre-existing limitations must be listed separately and labeled.			
760 IAC 2-4-1(e)	Eligibility conditions or limitations shall be fully described in a separate paragraph and labeled.			
760 IAC 2-4-1(g)	ADLs and Cognitive Impairment shall be used as benefit triggers, described, and labeled.			
760 IAC 2-4-1(h) & (i)	Tax status of policy shall be disclosed in policy and outline of coverage.			
Notice To Buyer 760 IAC 2-15-1(a)(3)	"Notice to Buyer" verbatim statement required on 1st page of outline and policy.			
Rating Practices 760 IAC 2-4-2(e)	Disclose rating practices to applicant (Refer to 2-19.5-1 and 2-19.5-2 for format).			
Marketing Standards 760 IAC 2-15-1(a)(6)	Information page about the SHIP/Partnership Program to be included as a separate page or listed as additional item on outline. (download www.longtermcareinsurance.in.gov)			
APPLICATION				
Medication 760 IAC 2-5-1	Medications prescribed to be listed if queried.			
Supplemental Information 760 IAC 2-5-2	Caution statements prominently displayed and verbatim on application and policy except for guaranteed issue.			
Questions 760 IAC 2-8-1	Application questions to use regarding existing coverage and replacement.			
Replacement 760 IAC 2-8-3 760 IAC 2-8-4	Required notice for replacement of existing policy. (Refer to citation for format.)			
OUTLINE OF COVERAGE IC 27-8-12-14(E) 760 IAC 2-7-4 760 IAC 2-17-1	Refer to citations for Outline of Coverage requirements and contents.			
SUITABILITY 760 2-15.5-1(d)	Submit "Long Term Care Personal Worksheet" to be reviewed. Refer to 760 2-19.5 for format.			
STANDARD FORMS 760 IAC 2-19.5	Required Forms to Be Given To Applicant			
760 IAC 2-19.5-1	Long Term Care Personal Worksheet (Refer to citation for format)			
760 IAC 2-19.5-2	Potential Rate Increase Disclosure Form (Refer to citation for format)			
Disclosure Form 760 IAC 2-19.5-3	Things You Should Know Before You Buy Long Term Care Insurance (Refer to citation for format)			
Indiana Long Term Care Partnership Policies (ILTCIP) 760 IAC 2-20				
Policy Requirements	**Requirements below apply specifically to Indiana Partnership ("qualified") Filings**			
Qualification 760 IAC 2-20-33	Partnership policies, riders, and certificates must comply with specific requirements to be Partnership compliant.			
Marketing Standards 760 IAC 2-20-34(1)(A-E)	Standards and provisions for policies, certificates, and riders. Refer to citation for format.			
760 IAC 2-20-34(2)	To offer a facility only Partnership qualified policy, an insurer must also offer an integrated Partnership qualified policy.			
760 IAC 2-20-34(3)	Must offer option to have application date as the policy effective date.			
760 IAC 2-20-34(4)	"Important Message" document describing asset protection to be delivered to applicant.			
760 IAC 2-20-34(5)	Applicants must sign confirming the policy is dollar for dollar not total asset protection and that is their intention.			
760 IAC 2-20-34(6)	State compliance with agent continuing education requirements.			
760 IAC 2-20-34(7)	Front page of policy, application, and outline of coverage must contain verbatim in bold/boxed language regarding asset protection qualification.			

760 IAC 2-20-34(8)	For all LTC facility policies or certificates, must state, on outline and front page, "Long Term Care Facility Policy (Certificate)". Also must include statement as set out in Rule Sec (9).			
760 IAC 2-20-34(9)	Rider must include language verbatim in bold/boxed regarding asset protection qualification.			
760 IAC 2-20-33	Partnership policies, riders, and certificates must comply with specific requirements to be Partnership compliant.			
760 IAC 2-20-35	Minimum benefit standards for qualifying policies, certificates, and riders. Refer to regulation.			
Required Provisions 760 IAC 2-20-36	Refer to citation for provisions.			
Minimum Benefit and Provisions 760 IAC 2-20-36.1	To be a qualified **Integrated** Partnership policy or certificate, it must: 1) Have maximum benefit amount = to at least 365 x the minimum daily nursing facility benefit, and; 2) Offer maximum benefit amount option equivalent to 365 x minimum daily nursing facility benefit, and; 3A) Offer daily nursing benefit at least 75% of average daily rate of private pay rate in nursing facilities rounded to the next highest $5 or $10 increment, but no policy shall pay in excess of actual charges, and; 3B) Daily home and community based benefit of at least 50% of daily nursing facility benefit contained in the policy, but may not pay in excess of actual charges, and; 3C) Daily home and community based benefits may not exceed daily nursing facility benefit, and; 4) Provide benefits equal to at least 75% of the per diem cost incurred by insured on expense incurred basis policy. 5) Provide that benefits can be used to purchase nursing facility care or community and home based care (which includes home health nursing, aide services, attendant care, respite care and adult day care), and; 6) All home and community based services shall include case management services delivered by a case management agency, which may be limited, but shall not be less than 13 x daily nursing home benefit a year. 7) Benefits for Residential Care Facilities must: (A) Provide a daily RCF benefit of at least 75% and no more than NF benefit (B) On expense incurred basis, RCF not to exceed 75% of per diem cost. (C) Provide provision to purchase care in NF or RCF.			
Minimum Standards & Provisions for Facility Policy or Certificate 760 IAC 2-20-36.2	1) Offer max benefit option equivalent to 365 x the minimum daily nursing facility benefit. 2) Max benefit must be at least 365 x minimum daily nursing facility benefit. 3) Daily nursing facility benefit of at least 75% of the average daily private pay rate in nursing facilities rounded to the nearest $5 or $10 increment. May not pay benefits in excess of actual charges. 4) If issued on expense incurred basis, provide daily nursing facility benefits which are equal to at least 75% of the per diem cost incurred by the insured. 5) May include benefits for residential care facilities, in a LTC facility policy			
760 IAC 2-20-36.2	Insurers may include benefits for residential care facilities in a LTC facility policy or certificate, BUT, then they must: 5A) Provide daily residential care benefit of at least 50% of (and no more than) the daily			

	nursing facility benefit, and; 5B) If issued on expense incurred basis, must provide daily benefit which does not exceed 50% of the per diem cost insured, and; 5C) Include a provision that policy or certificate benefits can be used to purchase care in a nursing facility or residential care facility.			
Minimum Standards for Riders 760 IAC 2-20-36.3(c)	Minimum standards for LTC Partnership <u>RIDERS:</u> Partnership Riders that provide home and community based services must provide, at minimum: home health nursing, home health aide services, attendant care, respite care and adult day care.			
760 IAC 2-20-36.3(d)	Home and community based services covered through such Rider must include case management services delivered by a case management agency. Rider may limit such benefits, but not less than 13 x daily nursing home benefit per year, and case management benefits cannot count towards the maximum policy/certificate benefit.			
760 IAC 2-20-36.3(e)	Such Riders must also (as of effective date): (1) Include a minimum daily home and community based benefit of 50% of the current daily nursing facility benefit of the LTC facility policy/certificate. (2) Provide that the daily home & community based benefit not exceed the current daily nursing facility benefit. (3) If issued on an expense incurred basis, provide benefits = to at least 75% of the per diem cost incurred.			
760 IAC 2-20-36.3(f)(1) & (2)	Provide a max benefit of at least 50% of the then current max total benefit amount of the LTC policy/certificate, but not exceeding such max benefit.			
General Regulatory Issues	Under the authority provided by IC 27-4-1-4 the Department monitors various issues that have been determined to be unfair, misleading or potentially constitute unfair trade practices. The following issues will also be reviewed.			
Application questions 27-8-5-1.5(I)	1. Questions regarding an applicant's health cannot inquire about non-specific conditions prior to the most recent five years. 2. Questions inquiring if an applicant has had signs or symptoms of a condition are not permitted. 3. Small employer applications may not require applicants declining coverage to complete health questions.			
Arbitration 27-8-5-1(i)	Mandatory and/or binding arbitration provisions are prohibited.			
First manifest language 27-8-5-19(c)(6) 27-8-5-2.5 27-8-15-27	Typically first manifest type language creates a permanent exclusion of coverage related to a condition present any time prior to the effective date of coverage contrary to any pre-existing condition provisions included in the form. Such inconsistencies are not permitted.			
Foreign language forms Bulletin 106	Foreign language forms must comply with Bulletin 106.			
Large endorsements 27-8-5-1.5(I)	The Department does not allow use of large or confusing endorsements to bring contracts into compliance. In such cases the entire contract should be refiled to incorporate the multiple changes. On a similar note, Indiana specific certificates should be filed rather than file an endorsement to revise another state's certificate.			
Open endorsements 27-8-5-1(I)	Highly flexible or "blank check" type endorsement forms that provide unlimited ability to revise forms without regulatory review are not allowed.			
Privacy of health information 27-8-5-1(I)	Employers cannot be asked to reveal or certify the accuracy of any knowledge they may have			

	regarding an individual's health condition.			
Various fees 27-8-5-1(I)	Fees charged to accept or process an application are not allowed. One-time fees such as may be charged to issue a policy are acceptable providing they are clearly labeled and accompanied by a disclosure that the fee is fully refundable if the policy is not issued, not taken or returned during the "free look" period.			
Bulletin 103	No full and final discretion clauses except where policy is governed by ERISA			
760 IAC 1-8	Use of terms "Noncancellable" and "Guaranteed Renewable" must not be misleading			
27-8-5-1(I)	The policy form cannot contain provisions that are unjust, unfair, inequitable, misleading, or deceptive, or that encourage misrepresentation of the policy.			

I hereby certify, pursuant to IC 27-8-5-1.5(i)(1)(C), that the policy form submitted with this checklist meets all requirements of Indiana law.

Filer: _____

Printed: _____

Company: _____

Title: _____

Date: _____