TITLE 760 DEPARTMENT OF INSURANCE

Proposed Rule
LSA Document #09-211

DIGEST

Amends 760 IAC 3-4-1, 760 IAC 3-6-1, and 760 IAC 3-14-1 concerning policy provisions, benefit standards, and required disclosure provisions. Adds 760 IAC 3-2-1.2, 760 IAC 3-2-1.4, 760 IAC 3-2-6.3, and 760 IAC 3-2-8.5 concerning definitions. Adds 760 IAC 3-6.1 and 760 IAC 3-7.1 concerning benefit standards for standardized Medicare supplement benefit plans. Adds 760 IAC 3-19.1 concerning the prohibition against use of genetic information and requests for genetic testing. Effective 30 days after filing with the Publisher.

IC 4-22-2.1-5 Statement Concerning Rules Affecting Small Businesses

760 IAC 3-2-1.2; 760 IAC 3-2-1.4; 760 IAC 3-2-6.3; 760 IAC 3-2-8.5; 760 IAC 3-4-1; 760 IAC 3-6-1; 760 IAC 3-6.1; 760 IAC 3-7.1; 760 IAC 3-14-1; 760 IAC 3-19.1

SECTION 1. 760 IAC 3-2-1.2 IS ADDED TO READ AS FOLLOWS:

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)

SECTION 2. 760 IAC 3-2-1.4 IS ADDED TO READ AS FOLLOWS:

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)

SECTION 3. 760 IAC 3-2-6.3 IS ADDED TO READ AS FOLLOWS:

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)

SECTION 4. 760 IAC 3-2-8.5 IS ADDED TO READ AS FOLLOWS:

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)

SECTION 5. 760 IAC 3-4-1 IS AMENDED TO READ AS FOLLOWS:

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)

SECTION 6. 760 IAC 3-6-1 IS AMENDED TO READ AS FOLLOWS:

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

760 IAC 3-6-1 Benefit standards for policies or certificates issued or delivered after December 31, 1991, and prior to 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 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:

(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 reinstituted 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) 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. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution 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.

(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.

(6) Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses, to the extent not covered by Medicare.

(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:

(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.

(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).

(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; 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)

SECTION 7. 760 IAC 3-6.1 IS ADDED TO READ AS FOLLOWS:

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 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:

(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 reinstituted 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) 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. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution 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.

(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.

(6) Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

(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:

(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) 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.

(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.

(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.

(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)

SECTION 8. 760 IAC 3-7.1 IS ADDED TO READ AS FOLLOWS:

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) 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) If an issuer offers any benefit plan in addition to Plan A, then the issuer must also offer either Plan C or Plan F. Therefore, if any benefit plan is authorized by the state other than Plan A, then either Plan C or Plan F must be among the authorized benefit plans adopted by the state.

(f) 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; 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:
(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 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.

(9) 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; and

(E) medically necessary emergency care in a foreign country.

(10) 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; and

(G) preventive medical care.

(11) 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; and

(G) preventive medical care benefit.

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.

(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.

(i) Insurers are permitted to continue to use approved forms through December 31, 2005. Insurers may offer any authorized plan upon approval of the commissioner.

(j) 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)

SECTION 9. 760 IAC 3-14-1 IS AMENDED TO READ AS FOLLOWS:

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:
(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:

"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.

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.

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[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.

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[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.

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

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.

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[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.

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[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.

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.

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[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.

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[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
- 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.

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[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.

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[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.

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[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.

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[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.

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[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

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.

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[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.

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[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
- 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.

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(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.

Basic Benefits: For Plans A – J.

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).

Blood: First three pints of blood each year.

A	B	C	D	~~E~~	F / F*	G	~~H~~	I	J / J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	~~Basic Benefits~~	Basic Benefits	Basic Benefits	~~Basic Benefits~~	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	~~Skilled Nursing Facility Coinsurance~~	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	~~Skilled Nursing Facility Coinsurance~~	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	~~Part A Deductible~~	Part A Deductible	Part A Deductible	~~Part A Deductible~~	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess ~~(80%)~~ **(100%)**		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	~~Foreign Travel Emergency~~	Foreign Travel Emergency	Foreign Travel ~~Emergency~~	~~Foreign Travel Emergency~~	Foreign Travel Emergency	Foreign Travel Emergency
			~~At-Home Recovery~~			~~At-Home Recovery~~		At-Home Recovery	At-Home Recovery
				~~Preventive Care NOT covered by Medicare~~					Preventive Care NOT covered by Medicare

*Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year [$1,500] deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are [$1,500]. 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 similar services as Plans A-J, but cost-sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	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
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	100% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess ~~(100%)~~ **(50%)**		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	$[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 Plans A-J.

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 651-54 through 651-87. Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act ~~(September 2004)~~ **(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)

SECTION 10. 760 IAC 3-19.1 IS ADDED TO READ AS FOLLOWS:

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:

(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)

Notice of Public Hearing

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An html version of this document.