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| **Maine Bureau of Insurance** |
| Form Filing Review Requirements Checklist |
| TOI - LTC03G and LTC03I  |
| Group & Individual Long Term Care/PartnershipThis checklist requires COMPANY DEMOGRAPHICS, CERTIFICATION, APPENDIX |
| Revised – 11/21/2019 |
| Carriers must confirm compliance and IDENTIFY the LOCATION (Form number, Page number, Section, Paragraph, etc.) of the standard in the form in the last column. Any response of N/A requires that a carrier explain why the requirement is not applicable. |
| This checklist is intended to provide a summary of State and Federal requirements for the TOI listed above. Please see the laws/rules referenced in the checklist below for the full requirement.**Company Name: ­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Policy Form(s) covered by this certification: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Will the form(s) be offered as Partnership coverage?** **Yes \_\_\_\_ No \_ \_\_\_\_****\* Requirements marked with an asterisk (\*) are required by federal law for Long-Term Care Partnership Policies** |

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| **REVIEW REQUIREMENTS** | **REFERENCES** |  | **COMPLIANCE** |
| **GENERAL SUBMISSION REQUIREMENTS** |  |  |  |
| Electronic (SERFF) Filing Requirements: | [Title 24-A § 2412](https://legislature.maine.gov/statutes/24-A/title24-Asec2412.html)(2) [Bulletin 360](https://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/360_0.pdf) | All filings must be filed electronically, using the NAIC System for Electronic Rate and Form Filing (SERFF). See <http://www.serff.com>  |  |
| FILING FEES | [Title 24-A § 601](https://legislature.maine.gov/statutes/24-A/title24-Asec601.html) (17) | $20.00 for Rate filings, rating rules filings, insurance policy, forms, riders, endorsements and certificates. See General Instructions page in SERFF for additional information on filing fee structure. Filing fees must be submitted by EFT in SERFF at the time of submission of the filing. All filings require a filing fee unless specifically excluded per 24-A M.R.S.A. §4222(1), and/or are a required annual report. |  |
| Grounds for disapproval | [Title 24-A § 2413](https://legislature.maine.gov/statutes/24-A/title24-Asec2413.html) | Seven categories of the grounds for disapproving a filing. |  |
| Readability | [Title 24-A § 2441](https://legislature.maine.gov/statutes/24-A/title24-Asec2441.html) | Minimum of 50.  Riders, endorsements, applications all must be scored. They may be scored either individually or in conjunction with the policy/certificate to which they will be attached. Exceptions: Federally mandated forms/language, Groups > 1000, Group Annuities as funding vehicles. Scores must be entered on form schedule tab in SERFF. |  |
| Variability of Language | [Title 24-A § 2412](https://legislature.maine.gov/statutes/24-A/title24-Asec2412.html)  [Title 24-A § 2413](https://legislature.maine.gov/statutes/24-A/title24-Asec2413.html) | Forms with variable bracketed information must include all the possible language that might be placed within the brackets. The use of too many variables will result in filing disapproval as Bureau staff may not be able to determine whether the filing is compliant with Maine laws and regulations. |  |
| **GENERAL POLICY PROVISIONS** |  |  |  |
| Certificate of Coverage – Group | [Title 24-A § 5074](https://legislature.maine.gov/statutes/24-A/title24-Asec5074.html)(5) | A certificate issued pursuant to a group long-term care insurance policy that is delivered or issued for delivery in this State must include: A. A description of the principal benefits and coverage provided in the policy; B. A statement of the principal exclusions, reductions and limitations contained in the policy; and C. A statement that the group master policy determines governing contractual provisions and that the policy is available for viewing in the offices of the policyholder and will be copied for the certificate holder upon request at no cost. |  |
| Continuation of Coverage or Conversion | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 6(D) | Mandatory continuation of coverage or conversion privilege to individual coverage must be disclosed in group policy/certificate of coverage. |  |
| Discontinuance and Replacement | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 6(E) | If a group policy is replaced by another group policy issued to the same policyholder, the successor insurer shall offer long-term care coverage to all persons insured, as of the termination date, under the previous policy. Coverage and premiums under the successor policy:(1) Shall not result in an exclusion for any preexisting condition for which there would be coverage under the replaced policy; and(2) Shall not vary or depend on the insured’s health or disability status, claim experience or prior use of long-term care services. |  |
| Extension of Benefits | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 6(C) | Requires disclosure that benefits may continue after policy terminates if insured was institutionalized before termination and remains institutionalized. |  |
| Free-look Period | [Title 24-A § 5075](https://legislature.maine.gov/statutes/24-A/title24-Asec5075.html)(4) | Requires disclosure on face page or attached to policy that insured has a 30-day free look period as of the policy delivery date. |  |
| Genetic Information Protections | [Title 24-A § 2159](https://legislature.maine.gov/statutes/24-A/title24-Asec2159-C.html)-C(3)[Title 24-A § 2159](https://legislature.maine.gov/statutes/24-A/title24-Asec2159.html)-C(4) | An insurer may not make or permit any unfair discrimination against an individual in the application of genetic information or the results of a genetic test in the issuance, withholding, extension or renewal of an insurance policy. An insurer may not request, require, purchase or use information obtained from an entity providing direct-to-consumer genetic testing without the informed written consent of the individual who has been tested. |  |
| Incontestability Period | [Title 24-A § 5076](https://legislature.maine.gov/statutes/24-A/title24-Asec5076.html) | Requires disclosure of phased incontestability periods leading, after two years, to no contestability unless the insured knowingly and intentionally misrepresented relevant facts. |  |
| Individual Certificates | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 6(H) | Discloses right of certificateholder to a copy of the group policy. Requires disclosure in every certificate that if there is inconsistency between certificate and policy, the policy controls. |  |
| Limitations and Exclusions | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 6(B) | A policy may not be issued as long-term care insurance if the policy excludes or limits coverage by the type of illness, medical condition or accident or the kind of treatment, except as provided by this rule. |  |
| Live Organ Donation Prohibition | [Title 24-A § 2159](https://legislature.maine.gov/statutes/24-A/title24-Asec2159-D.html)-D | Notwithstanding any other provision of law, an insurer authorized to do business in this State may not: A. Limit coverage or refuse to issue or renew coverage of an individual under any life insurance, disability insurance or long-term care insurance policy due to the status of that individual as a living organ donor; B. Preclude an individual from donating all or part of an organ as a condition of receiving coverage under a life insurance, disability insurance or long-term care insurance policy; C. Consider the status of an individual as a living organ donor in determining the premium rate for coverage of that individual under a life insurance, disability insurance or long-term care insurance policy; or D. Otherwise discriminate in the offering, issuance, cancellation, amount of coverage, price or any other condition of a life insurance, disability insurance or long-term care insurance policy based solely and without any additional actuarial justification upon the status of an individual as a living organ donor. |  |
| Minimum benefit level | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 12(B) & (C) | Mandates a minimum benefit level for home care and community care services to have a dollar equivalent of at least 50% of one year of covered nursing home benefits.Home health care coverage may be applied to the non-residential home health care benefits provided in the policy/certificate when determining maximum coverage under the policy or certificate. |  |
| Notice to Buyer | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 22(A)(2) | Insurer must display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following notice:“Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.” |  |
| Other Limitations or Conditions on Eligibility | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 8(E) | A policy or certificate containing any limitation or condition for eligibility, other than those prohibited by 24-A M.R.S.A. §5075, shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate labeled “Limitations or Conditions on Eligibility for Benefits.” |  |
| Outline of Coverage - Graphic Comparison | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 13(D) | The outline of coverage must contain a graphic comparison, covering at least 20 years into the future, showing the amount of benefits with the inflation protection contrasted with the amount of benefits without the inflation protection. |  |
| Outline of Coverage – Individualand Notice to Buyer | [Title 24-A § 5074](https://legislature.maine.gov/statutes/24-A/title24-Asec5074.html)(2)(A-G)[Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 29[Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 22(A)(2) | An outline of coverage must be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and its purpose. In the case of producer solicitations, an insurance producer shall deliver the outline of coverage prior to the presentation of an application or enrollment form. In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form. In the case of a policy issued to an employer group as described in section 2804, a labor union group as described in section 2805 or a trustee group as described in section 2806, an outline of coverage is not required to be provided if the information described in this subsection is contained in other materials relating to enrollment that have been filed with and approved by the superintendent. The outline of coverage must be in a standard format, including style, arrangement, overall appearance and content, prescribed by the superintendent and must include the following information: A. A description of the principal benefits and coverage provided in the policy or certificate; B. A statement of the principal exclusions, reductions and limitations contained in the policy or certificate; C. A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage must be specifically described; D. A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions; E. A description of the terms under which the policy or certificate may be returned and premium refunded; F. A statement as to whether the policy or certificate is intended to be qualified for purposes of federal and state individual income taxes; and G. A brief description of the relationship of cost of care and benefits.Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following notice:“Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.” |  |
| Policy Definitions | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 5 | No long-term care insurance policy shall use theterms set forth in this section unless the terms aredefined in the policy and are consistent with thefollowing definitions:A.“Activities of daily living” means, at a minimum, bathing, continence, dressing, eating, toileting and transferring.B.“Acute condition” means that the individual is medically unstable and requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.C.“Adult day care” means a program for six or more individuals of social and health-related services provided during the day in a community group setting, for the purpose of supporting frail, impaired, elderly or other disabled adults who can benefit from care in a group setting outside the home.D.“Bathing” means washing oneself by sponge bath, or in a tub or shower, including the task of getting into or out of the tub or shower.E.“Cognitive impairment” means a deficiency in a person’s short-term or long-term memory, orientation as to person, place or time, deductive or abstract reasoning, or judgment as it relates to safety awareness.F.“Continence” means the ability to maintain control of bowel or bladder functions, or, when unable to maintain such control, the ability to perform associated personal hygiene, including caring for a catheter or colostomy bag.G.“Dressing” means putting on and taking off all items of clothing and any necessary brace, fastener or artificial limb.H.“Eating” means feeding by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenous line.I.“Hands-on assistance” means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activity of daily living.J.“Home health care services” means medical and non-medical services rendered in their residences to ill, disabled or infirm persons, including homemaker services, assistance with activities of daily living and respite care.K.“Medicare” means “The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended,” or “Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof,” or words of similar import.L.“Mental or nervous disorder” means any one of the following: neurosis, psychoneurosis, psychopathy, psychosis, or other mental or emotional disease or disorder.M.“Personal care” means the rendering of hands-on services by another person to assist the individual in the activities of daily living.N.“Skilled nursing care,” “personal care,” “home care,” “specialized care,” “assisted living care” and other service described in the policy shall be defined in relation to the level of skill required, the nature of the care and the setting in which the services are provided.O.“Skilled nursing facility,” “extended care facility,” “convalescent nursing home,” “personal care facility,” “specialized care providers,” “assisted living facility,” and “home care agency” and all other service providers shall be defined in relation to the facilities and the required available services, together with the licensure, certification, registration or degree status of the persons who provide services and those who supervise the services. When the definition requires that the provider be appropriately licensed, certified or registered, it shall also state what requirements a provider must meet in lieu of licensure, certification or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified or registered, or when the state licenses, certifies or registers the provider of services under another name.P.“Toileting” means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.Q.“Transferring” means moving into or out of a bed, chair or wheelchair. |  |
| Preexisting Condition | [Title 24-A § 5075](https://legislature.maine.gov/statutes/24-A/title24-Asec5075.html)(2) | A long-term care insurance policy or certificate must provide coverage for preexisting conditions in accordance with the following. A. A policy or certificate may not define "preexisting condition" in a manner that is more restrictive than the following: "Preexisting condition" means a condition for which medical advice or treatment was recommended by or received from a provider of health care services within 6 months preceding the effective date of coverage of an insured person. B. A policy or certificate may not exclude coverage for a loss or confinement that is the result of a preexisting condition unless such loss or confinement begins within 6 months following the effective date of coverage of an insured person. C. The definition of "preexisting condition" in paragraph A does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in paragraph B expires. A long-term care insurance policy or certificate may not exclude, or use waivers or riders of any kind to exclude, limit or reduce, coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in paragraph B. D. The superintendent may extend the limitation periods set forth in paragraphs A and B with regard to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public. |  |
| Prior Hospitalization or Institutionalization | [Title 24-A § 5075](https://legislature.maine.gov/statutes/24-A/title24-Asec5075.html)(3) | Prohibits making eligibility for benefits conditional on a prior hospitalization requirement, on receipt of a higher level of care, or prior institutional care. |  |
| Rates - Initial | [Title 24-A § 2701](https://legislature.maine.gov/statutes/24-A/title24-Asec2701.html)(2)(A)[Title 24-A § 2736](https://legislature.maine.gov/statutes/24-A/title24-Asec2736.html)[Title 24-A § 2839](https://legislature.maine.gov/statutes/24-A/title24-Asec2839.html)[Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 10 | This applies to all initial rate filings for LTC policies issued on and after October 1, 2004, for new forms. Please use the appropriate rate filing review checklist for submission requirements.A Long Term Care insurance policy rate filing must be submitted whenever a new policy, rider, or endorsement form that affects benefits is submitted for approval. Rates must be filed with the form rather than separately. |  |
| Rates - Revised | [Title 24-A § 2701](https://legislature.maine.gov/statutes/24-A/title24-Asec2701.html)(2)(A)[Title 24-A § 2736](https://legislature.maine.gov/statutes/24-A/title24-Asec2736.html)[Title 24-A § 2839](https://legislature.maine.gov/statutes/24-A/title24-Asec2839.html)[Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) | This applies to all rate revision filings for in-force LTC policies issued on and after October 1, 2004. For policies issued before October 1, 2004, separate rate filing(s) must be submitted using the applicable [Rule 420](https://www.maine.gov/sos/cec/rules/02/031/031c420.doc) rate filing checklist. Please use the appropriate rate filing review checklist for submission requirements.A Long Term Care insurance policy rate filing must be submitted whenever there is a change in the rates applicable to a previously approved form.Rates must be filed with the form rather than separately. |  |
| Rebates | [Title 24-A § 2160](https://legislature.maine.gov/statutes/24-A/title24-Asec2160.html)[Title 24-A § 2163-A](https://legislature.maine.gov/statutes/24-A/title24-Asec2163-A.html)[Bulletin 426](https://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/426.pdf)[Bulletin 382](https://www.maine.gov/pfr/insurance/themes/insurance/pdf/382.pdf) | Are there any provisions that give the insured a benefit not associated with indemnification or loss? Yes \_\_\_No \_\_\_ |  |
| Renewability | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 6(A)[Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 8(A) | All long-term care insurance policies shall contain a renewability provision. The first page of the policy must contain the renewability provision, which must specify that the policy is ‘guaranteed renewable’ or that it is ‘noncancelable,’ and explain what the term means.This subsection shall not apply to policies that do not contain a renewability provision and under which the right to nonrenew is reserved solely to the policyholder. |  |
| Right to Reduce Coverage and Lower Premiums | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 25 | Policy or certificate must state that the insured is entitled to reduce coverage and lower the premium by either reducing the maximum benefit, or the daily, weekly or monthly benefit amount. Other reduction options may be offered. A description of how coverage may be reduced, and the process for requesting and implementing the reduction must be included. If the policy or certificate is about to lapse, the insurer must provide a written reminder of the right to reduce coverage and premiums. |  |
| Tax Qualification Disclosure | [Title 24-A § 5074](https://legislature.maine.gov/statutes/24-A/title24-Asec5074.html)(3)[Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 8(F) | The face page of the policy, certificate or rider shall state prominently whether the policy or certificate is intended to qualify for income tax benefits under federal law and/or state law.(Partnership policies are required to be tax qualified.) |  |
| Third Party 10 Day Notice of Cancellation Due to Cognitive Impairment or Functional Incapacity | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 7(A & B) | Notice Before Lapse or Termination Date No individual policy or certificate shall beissued until the insurer has received from theapplicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person’s full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: “Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice.” The insurer shall notify the insured of the right to change this written designation, no less often than once every two years.(2) When the policyholder or certificateholder pays the premium for a policy or certificate through a payroll or pension deduction plan, the requirements of Section (7)(A)(1) need not be met until 60 days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.Lapse or termination for nonpayment of premium. No individual policy or certificate shalllapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to Section 7(A)(1), at the address or addresses provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid. Notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of five days after the date of mailing.Reinstatement. In addition to therequirement in Section 7(A), a policy or certificate shall include a provision for reinstatement of coverage in the event of lapse if the insurer is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. Such reinstatement shall be available to the insured if requested within five months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate. |  |
| **CLAIMS** |  |  |  |
| Appeals of Claims Denials | [Title 24-A § 5083](https://legislature.maine.gov/statutes/24-A/title24-Asec5083.html)(5)[Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 31(C) | An insured who receives a claims denial in accordance with this section has the right to internal appeal and, after exhausting an insurer's internal appeals process, the right to request an external review.If the insurer denies a claim in whole or part, the insurer shall promptly issue a written notice to the insured explaining the specific reason or reasons for the denial. If the insurer cannot pay the claim within 30 days because it does not have sufficient information to make a decision, the insurer shall decide the claim and notify the insured in accordance with the following requirements.(1)An insurer may not extend the time for resolution of a claim beyond 30 days after receipt of documentation and information related to a technical issue. The insurer may not extend the time period beyond 30 days for documentation that the insurer already possesses.  (2)An insurer may not extend the time for resolution of a claim beyond 30 days after receipt of all documentation and information initially requested from the insured unless the insurer determines, as a result of its review of that information, that the insurer cannot reasonably decide the claim without additional information relating to a substantive issue.(a)The insurer may not delay the resolution of the claim any longer than is reasonably necessary and must act expeditiously to obtain all necessary information.(b)If the resolution of the claim is being delayed because a source other than the insured is failing to provide necessary information, the insurer shall notify the insured of the reason for the delay and the nature of the missing information, unless such notice might prejudice the insurer’s investigation of suspected fraud or other misconduct. |  |
| Calculation of health benefits based on actual cost | [Title 24-A § 2185](https://legislature.maine.gov/statutes/24-A/title24-Asec2185.html) | If the insurer has negotiated discounts with providers, the insurer must provide for the calculation of all covered health benefits, including without limitation all coinsurance, deductibles and lifetime maximum benefits, on the basis of the net negotiated cost and must fully reflect any discounts or differentials from charges otherwise applicable to the services provided. With respect to policies involving risk-sharing compensation arrangements, net negotiated costs may be calculated at the time services are rendered on the basis of reasonably anticipated compensation levels and are not subject to retrospective adjustment at the time a cost settlement between a provider and the insurer or organization is finalized. |  |
| Interest on Overdue Undisputed Claims | [Title 24-A § 5083](https://legislature.maine.gov/statutes/24-A/title24-Asec5083.html)(6) | An undisputed claim that is not paid within 30 days is overdue. If an insurer fails to pay an undisputed claim or any undisputed part of the claim when due, the amount of the overdue claim or part of the claim bears interest at the rate of 1 1/2% per month after the due date. |  |
| Notice of Claim; Response by Insured | [Title 24-A § 5083](https://legislature.maine.gov/statutes/24-A/title24-Asec5083.html) | Upon receipt of a notice of claim for benefits under a policy or certificate of long-term care insurance delivered or issued for delivery in this State, an insurer, whether actively marketing or renewing long-term care insurance in this State, shall provide the insured a written statement with sufficient detail to permit the insured to understand and respond with the documentation specified in subsection 2. The written statement must be provided by the insurer within 10 business days following receipt of the notice of claim. |  |
| Payment of claim | [Title 24-A § 5083](https://legislature.maine.gov/statutes/24-A/title24-Asec5083.html)[Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 31 | A claim for payment of benefits under a policy or certificate of long-term care insurance delivered or issued for delivery in this State is payable within 30 days. |  |
| Rule Definitions | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 4 | J. “Substantive issue” means a matter that isintegral to the determination of whether theinsured is eligible for benefits under a policy andthat involves information essential for the insurerto have prior to paying the claim. A substantiveissue includes the issues generated by the itemsdescribed in Sections 31(A)(1) through 31(A)(5).A substantive issue also includes informationnecessary to pay the claim that the insurer isunable to obtain because the provider refuses toprovide it or because it is not available fromsources other than the insured or the insured’sauthorized representative. K. “Technical issue” means a matter that isprocedural in nature or not integral to thedetermination of whether the insured is entitled tobenefits under the policy. Examples of a technicalissue are an insurer’s lack of receipt completedforms that duplicate information that the insureralready has or the license number for a long-termcare facility. |  |
| **APPLIES TO ONLY LONG-TERM CARE INSURANCE** |  |  |  |
| Notice to Applicant – Replacing Existing Insurance | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 14 | Application must include specific questions to determine whether the insured has another long-term care policy/certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. If the sale involves replacement of a current policy, Appendix A notice is required. |  |
| **ADDITIONAL REQUIREMENTS FOR LONG-TERM CARE** |  |  |  |
| Disclosing Rating Practices to Applicants: | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 9 | The insurer must disclose at the time of application that premiums may be increased, and a history of premium increases for the policy or similar policies for in the last 10 years in any state. Must obtain the applicant’s signed acknowledgement of receiving this information. Insurer must provide written notice of an upcoming rate increase to all policyholders and certificate holders at least 60 days before the effective date. |  |
| Post claims underwriting prohibition | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 11 | Requires two conspicuous cautionary notices to applicant regarding the truthfulness and completeness of answers to medical questions, and warns of remedies available to insurer when applicant fails to heed the notices. |  |
| Advertising Filing | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 21 | Every insurer, health care service plan or other entity providing long-term care insurance in this state shall file with the superintendent for prior approval a copy of any long-term care insurance advertisement intended for use in this state, whether through written, radio, television, internet or other medium. If the advertisement has not been affirmatively approved or disapproved within 30 days after filing, it will be deemed approved. |  |
| Annual Reports to Superintendent | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 16 | Reporting on lapses, replacements, and claim denials. |  |
| Benefit Payment Status Report | [Title 24-A § 5075](https://legislature.maine.gov/statutes/24-A/title24-Asec5075.html)(5) | Any time a long-term care benefit that is funded through a life insurance policy or certificate by the acceleration of the death benefit is in benefit payment status, a monthly report must be provided to the policyholder or certificate holder. The report must include: A. Any long-term care benefits paid out during the monthB. An explanation of any changes in the policy, including changes in death benefits or cash values, due to long-term care benefits being paid out; andC. The amount of long-term care benefits existing or remaining |  |
| Delivery of Shopper’s Guide | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 30 | A long-term care insurance shopper’s guide in the format developed by the National Association of Insurance Commissioners shall be provided to all prospective applicants of a long-term care insurance policy or certificate |  |
| Electronic Signatures | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 6(G) | Allows electronic signatures of individual insureds in employer, trade union and trustee group policies. |  |
| Marketing | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 22(A) | Every insurer, health care service plan or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall: Establish marketing procedures and producer training requirements to assure that:(a) Any marketing activity, including comparison of policies by its producers, will be fair and accurate; and(b) Excessive insurance is not sold or issued.(2) Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following notice:“Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.”(3) Provide to the applicant copies of the disclosure forms required in Section 9(B).(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance, except that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required.(5) Establish procedures, readily subject to audit by the superintendent, for verifying compliance with this section.(6) Provide written notice to prospective insureds at the time of solicitation of the availability of any public or private insurance counseling program for senior citizens, such notice to include the name, address and telephone number of each program.(7) Assure that any policy, certificate or rider conforms to the definitional requirements in Section 6(A) of “noncancelable,” “level premium” and any other word of similar import.(8) Explain the contingent nonforfeiture benefit upon lapse described in Section 26(C) and, if applicable for policies issued or renewed on or after January 1, 2008, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying periods in Section 26(C)(4). |  |
| Policy Summary | [Title 24-A § 5074](https://legislature.maine.gov/statutes/24-A/title24-Asec5074.html)(4) | At the time of policy or certificate delivery, a policy summary must be delivered for an individual life insurance policy that provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request but, regardless of a request, the insurer shall make such delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary also must include: A. An explanation of how the long-term care benefits interact with other components of the policy, including deductions from death benefits; B. An illustration of the amount of benefits, the length of benefits and the guaranteed lifetime benefits, if any, for each covered person; C. Any exclusions, reductions and limitations on benefits of long-term care; D. A statement indicating whether any long-term care inflation protection option required by law is available under this policy; and E. If applicable to the policy or certificate type, the summary must also include: (1) A disclosure of the effects of exercising other rights under the policy;(2) A disclosure of guarantees related to long-term care costs of insurance charges; and (3) Current and projected maximum lifetime benefits. |  |
| Suitability | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 23 | Every insurer, health care service plan or other entity marketing long-term care insurance shall develop and use suitability standards. |  |
| **APPEALS** |  |  |  |
| Second Level Review | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 32 (D) | (1) An insurer shall provide a second level appeal process to an insured who is dissatisfied with a first level review determination under Subsection C. The insured has the right to appear before authorized representatives of the insurer and shall be provided adequate notice of that option by the insurer. The insured may appeal the standard appeal decision by sending a written request to the insurer within 120 days after receipt of the standard appeal decision letter. (2) The insurer shall appoint a second level appeal review panel for each appeal subject to review under this subsection. A majority of the panel shall consist of employees or representatives of the insurer who were not previously involved in the appeal.(3) If an insured initiates a second level appeal without requesting to appear before authorized representatives of the insurer, the second level appeal shall be completed and written notice of the final internal appeal decision shall be sent to the insured within thirty (30) calendar days after the insurer’s receipt of all necessary information upon which a final determination can be made. Additional time is permitted when the insurer can establish that the 30-day time frame cannot reasonably be met due to the insurer’s inability to obtain necessary information from a person not affiliated with or under contract with the insurer. The insurer shall provide written notice of the delay to the insured. In such instances, decisions must be issued within 30 days after the insurer’s receipt of all necessary information. A decision adverse to the insured shall include the information specified in Subparagraph C(2).(4) Whenever an insured has requested the opportunity to appear before authorized representatives of the insurer, an insurer’s procedures for conducting a second level panel review shall include the following:(a) The review panel shall schedule and hold a review meeting within 45 days after receiving a request from the insured for a second level review. The review meeting shall be held at a time reasonably accessible to the insured. The insurer shall offer the insured the opportunity to appear before the review panel, at the insurer’s expense, by conference call, video conferencing, or other appropriate technology. The insured shall be notified in writing at least 15 days in advance of the review date. The insurer shall not unreasonably deny a request for postponement of the review made by the insured.(b) Upon the request of an insured, the insurer shall provide to the insured, free of charge, all relevant information that is not confidential and privileged from disclosure to the insured.(c) The insured has the right to:i) Attend the second level review by conference call, video conferencing, or other appropriate technology;ii) Present his or her case to the review panel;iii) Submit supporting material both before and at the review meeting;iv) Ask questions of any representative of the insurer who has provided information to the panel; andv) Be assisted or represented by a person of his or her choice.(d) If the insurer will have an attorney present to argue its case against the insured, the insurer shall so notify the insured at least 15 days in advance of the review and shall advise the insured of his or her right to obtain legal representation.(e) The insured’s right to a fair review shall not be made conditional on his or her appearance at the review.(f)The review panel shall issue a written decision to the insured within 5 working days after completing the review meeting. A decision adverse to the insured shall include the information specified in Subparagraph C(2). |  |
| Standard Appeal | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 32 | A. The insured may appeal the claims denial by sending a written request to the insurer within 120 days after receipt of the claims denial along with any additional supporting information. The internal appeal shall be considered by a panel of one or more qualified individuals, designated by the insurer, who did not participate in making the initial benefit determination.Timeline for Appeal. The internal appeal shall be completed and written notice of the internal appeal decision shall be sent to the insured within thirty (30) calendar days after the insurer’s receipt of all necessary information upon which a final determination can be made. Additional time is permitted when the insurer can establish the 30-day time frame cannot reasonably be met due to the insurer’s inability to obtain necessary information from a person not affiliated with or under contract with the insurer. The insurer shall provide written notice of the delay to the insured. In such instances, decisions must be issued within 30 days after the insurer’s receipt of all necessary information. Notice of Decision. If the claims denial appeal decision is adverse to the insured, the written decision shall contain:The qualifying credentials of the person or persons evaluating the appeal;A statement of the reviewers’ understanding of the reason for the insured’s request for an appeal;Reference to the specific policy provisions upon which the decision is based;The reviewers’ decision in clear terms and the rationale in sufficient detail for the insured to respond further to the insurer’s position;A reference to the evidence or documentation used as the basis for the decision, including any clinical review criteria used to make the determination. The decision shall include instructions for requesting copies, free of charge, of information relevant to the claim, including any referenced evidence, documentation, or clinical review criteria not previously provided to the insured. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the claims denial decision, either the specific rule, guideline, protocol or other similar criterion that was relied upon in making the claims denial decision or an explanation that a copy will be provided free of charge to the insured upon request;Notice of any subsequent appeal rights and the procedure and time limitation for exercising those rights. Notice of external review rights must be provided for decisions on claims denials eligible for external review. Notice of the insured’s right to contact the superintendent’s office. The notice shall contain the toll free telephone number, website address and mailing address of the bureau. |  |
| **DISCLOSURE STANDARDS & REQUIREMENTS** |  |  |  |
| Acceptance by Insured | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 8(B) | Riders/endorsements added to an individual policy after the date of issue require signed acceptance by insured. |  |
| Limitation Disclosures | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 8(D) | If a policy or certificate contains any limitations with respect to preexisting conditions defined in accordance with Title 24-A §5075(2), the limitations shall appear as a separate paragraph in the policy or certificate and shall be labeled as “Preexisting Condition Limitations.” |  |
| Payment of Benefits Disclosure | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 8(C) | A policy that provides for the payment of benefits based on standards described as “usual and customary,” “reasonable and customary,” or words of similar import, shall comply with the following requirements:(1)It must include a definition of these terms and an explanation of the terms in its accompanying outline of coverage.(2)It must clearly disclose that the insured or enrollee may be subject to balance billing as a result of claims adjustment(3)It must provide a toll-free number that an insured or enrollee may call prior to receiving services to determine the maximum allowable charge permitted by the carrier for a specified service.(4)The carrier must provide to the superintendent on request complete information on the methodology and specific data used by the carrier or any 3rd party on behalf of the carrier in adjusting any claim submitted by or on behalf of the insured or enrollee. In considering the reasonableness of the methodology for calculating maximum allowable charges, the superintendent shall consider whether the methodology takes into account relevant data specific to this State if there is sufficient data to constitute a representative sample of charge data for the same or comparable service. |  |
| **EXTERNAL REVIEW** |  |  |  |
| External Review | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 33 | A. Notice of External Review. If the insurer’s claims denial eligible for external review is upheld after completion of the insurer’s internal appeal process outlined in section 32, the insurer shall provide a written description of the insured’s right to request an external review. The notice must include:(1) A description of the external review procedure and the requirements for making a request for external review;(2) A statement informing the insured how to request assistance from the insurer in filing a request for external review;(3) A statement informing the insured of the right to participate in the external review proceeding by teleconference or other reasonable means, to obtain and submit material in support of the claim, to ask questions of the insurer, and to have outside assistance; and (4) A statement informing the insured of the right to seek assistance or file a complaint with the bureau and the toll-free number for the bureau.B. Request. The insured may request an external review of the claims denial eligible for external review after completion of both levels of the insurer’s internal appeal process outlined in Section 32. A written request for external review may be made by the insured to the bureau within 120 days after the insurer’s written notice of the final internal appeal decision is received by the insured. The insured may not be required to pay any filing fee as a condition of processing a request for external review.C. Cost. The cost of the external review shall be borne by the insurer.D. Insured’s Right to Alternative Formats. The insurer shall provide auxiliary telecommunications devices or qualified interpreter services by a person proficient in American Sign Language, when requested by an insured who is deaf or hard-of-hearing; shall provide printed materials in an accessible format, including Braille, large-print materials, computer diskette, audio cassette or a reader, when requested by an insured who is visually impaired; and shall make such other reasonable accommodations as may be necessary to allow an insured to exercise the right to external review under this section.E. Bureau Oversight. The bureau shall oversee the external review process and shall contract with approved independent review organizations to conduct external reviews and render external review decisions. At a minimum, an independent review organization approved by the bureau shall ensure the selection of qualified and impartial reviewers who have no professional, familial, or financial conflict of interest relating to the insurer, the insured, or the insured’s authorized representative or long-term care provider involved in the external review.F. Independent External Review Decision; Timelines. An external review decision must be made in accordance with the following requirements.(1) In rendering an external review decision, the independent review organization must give consideration to the following:(a) All relevant clinical information relating to the insured’s physical and mental condition, including any competing clinical information;(b) All relevant clinical standards and guidelines, including, but not limited to, those standards and guidelines relied upon by the insurer.(2) If the independent review organization rules in favor of the claimant in a dispute arising out of a federally tax-qualified contract, it shall provide a certification by a licensed health care practitioner (as defined in Section 7702B(c)(4) of the Internal Revenue Code) that the insured is chronically ill.(3) An external review decision must be rendered by an independent review organization within 30 days of receipt of a completed request for external review from the bureau.(4) Binding nature of decision. An external review decision is binding on the insurer. An insured may not file a request for a subsequent external review involving the same claims denial for which the insured has already received an external review decision pursuant to this section. An external review decision made under this section is not considered final agency action pursuant to Title 5, chapter 375, subchapter II.G. Additional Rights. Nothing contained in this section shall limit the ability of an insurer to assert any rights an insurer may have under the policy related to:(1) An insured’s misrepresentation;(2) Changes in the insured’s benefit eligibility; and(3) Terms, conditions, and exclusions of the policy, other than the failure to meet the requirements to pay the claim. |  |
| **INFLATION PROTECTION** |  |  |  |
| Optional Inflation Protection | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 13(A) | Certification that all policyholders or certificate holders are offered a 5% compound inflation benefit or alternative inflation protection complying with Section 13.Requirements for optional inflation protection benefit at compounded annual rate of at least 5%, or specified alternative provisions. |  |
| Partnership Policies Only | [Bulletin 418](https://www.maine.gov/pfr/insurance/themes/insurance/pdf/418.pdf) [Bulletin 419](https://www.maine.gov/pfr/insurance/themes/insurance/pdf/419.pdf) | Indicate which level of inflation protection is provided by the form(s). If different forms or riders in this filing provide different levels of inflation protection, specify which form numbers fall within each category. |  |
| **NONFORFEITURE STANDARDS & REQUIREMENTS** |  |  |  |
| Nonforfeiture Benefit Offer Required and Contingent Nonforfeiture Benefit Upon Lapse | [Title 24-A § 5077](https://legislature.maine.gov/statutes/24-A/title24-Asec5077.html)[Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 26(B, C, D, & E) | Except as provided in subsection 2, a long-term care insurance policy or certificate may not be delivered or issued for delivery in this State unless the policyholder or certificate holder has been offered the option of purchasing a policy or certificate that includes a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy.If the policyholder or certificate holder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that must be made available for a specified period of time following a substantial increase in premium rates. 2. Group policyholders.  When a group long-term care insurance policy is issued, the offer required in subsection 1 must be made to the group policyholder. If the group long-term care insurance policy is issued to a group described in section 2808 other than to a continuing care retirement community or other similar entity, the offer must be made to each proposed certificate holder. |  |
| **PROHIBITIONS** |  |  |  |
| Cancellation, Nonrenewal or Termination | [Title 24-A § 5075](https://legislature.maine.gov/statutes/24-A/title24-Asec5075.html)(1)(A) | An insurer may not cancel, non-renew or otherwise terminate a long-term care insurance policy or certificate on the grounds of the age or the deterioration of the mental or physical health of the insured individual. |  |
| Establishing New Waiting Periods on Replacement | [Title 24-A § 5075](https://legislature.maine.gov/statutes/24-A/title24-Asec5075.html)(1)(B) | An insurer may not establish a new waiting period in the event that existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder. |  |
| Home care or community care prohibitions | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 12(A) | Insurer may not exclude or limit home care or community care benefits by imposing any of nine unlawful burdens on insured as condition to such benefits: insured would need care in skilled nursing facility if home care services were not provided; insured must first or concurrently receive nursing or therapeutic services, or both, in a home, community or institutional services; limiting eligible services to those rendered by registered or licensed practical nurses; requiring a nurse or therapist to provide services that a licensed home care worker is competent to provide within his or her licensure; excluding benefits for personal care services provided by a home health aide; requiring that home care be at a licensure level greater than necessitated by the eligible service; requiring the presence of an acute condition before home care benefits will be paid; limiting benefits to only those services a Medicare-certified provider or agency renders; excluding all benefits for adult day care services. |  |
| Limiting Coverage to Skilled Nursing care | [Title 24-A § 5075](https://legislature.maine.gov/statutes/24-A/title24-Asec5075.html)(1)(C) | Insurer may not limit coverage to skilled nursing care or providing more coverage for skilled nursing than for other levels of care rendered in a skilled care facility. |  |
| New Waiting or Pre-existing Condition Exclusion Period Prohibition for Replacement Plans | [Rule 425](https://www.maine.gov/sos/cec/rules/02/031/031c425.docx) § 15 | Pre-existing condition exclusions and probationary periods must be waived in replacement plans to the extent that they exceed the provisions of the prior plan. |  |

**Certification**

All Long-Term Care Policies in Maine are required to comply with the above provisions of the Maine Insurance Code and Rule 425. Policies offered as Long-Term Care Partnership policies must also provide inflation protection benefits to the extent required by federal law. Please complete the following:

I hereby certify that the answers, accompanying documents, and other information set forth herein for certification of the listed policy form or forms are to the best of my knowledge and belief, true, correct, and complete. I understand that false, inaccurate or incomplete information on this form or accompanying documents may result in disapproval of listed policies for use in Maine and other administrative sanctions.

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Date Signature

**Contact Information:**

Name of Certifying Officer: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title of Certifying Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Company Contact

(If other than certifying officer): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**APPENDIX**

[Company Letterhead]

**IMPORTANT NOTICE REGARDING YOUR POLICY’S**

**LONG-TERM CARE INSURANCE PARTNERSHIP STATUS**

(Please Keep This Notice with Your Policy or Certificate)

**Policy Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insured’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**The Maine Long-Term Care Partnership Program** is a partnership between Maine and private insurers offering long-term care insurance policies. The **Maine Long-Term Care Partnership Program** became effective on July 1, 2009, and is provided in accordance with the federal Deficit Reduction Act of 2005 (P.L. 109-171).

**Notice of Partnership Policy Status.** This Notice verifies that the long-term care insurance policy or certificate that you have purchased is intended to qualify under the Maine Long-Term Care Partnership Program as of the policy’s or certificate’s effective date. This Notice explains the valuable MaineCare (Medicaid) asset protection that you may receive from purchasing a Partnership Policy. The purchase of a Partnership Policy does not automatically qualify you for MaineCare.

**MaineCare Asset Protection.** Long-term care insurance is an important tool that helps individuals prepare for future long-term care needs. Partnership Policies provide an additional level of protection. In particular, such policies permit individuals to protect additional assets from spend-down requirements under the MaineCare program if assistance under this program is ever needed and you otherwise qualify for MaineCare.

Specifically, when your assets are calculated for purposes of the eligibility and recovery provisions of the MaineCare program, MaineCare will disregard an additional amount of assets that is equal to the amount of insurance benefits you have received from your Partnership Policy.

For example, if you receive $200,000 of insurance benefits from your Partnership Policy, you generally would be able to retain $200,000 of assets above and beyond the amount of assets normally permitted for MaineCare eligibility. Other MaineCare eligibility requirements regarding assets and income must still be met. Medicaid eligibility requirements may vary from one state to another and may change over time.

**Additional Consumer Protections**. In addition to providing MaineCare asset protection, your Partnership Policy has other important features. Under the rules governing the Maine Long-Term Care Partnership Program, your Partnership Policy must be a qualified long-term care insurance contract under federal tax law, and as such, the insurance benefits you receive from the policy generally will be subject to beneficial income tax treatment. (Please note that these tax benefits are not exclusive to Partnership Policies. A policy can be a qualified long-term care insurance contract under federal tax law even if it is not a Partnership Policy.) In order to qualify for the Partnership Program, your policy must also contain certain inflation protections if sold to you under age 76, with stronger protections required if you are under age 61.

**What Could Disqualify Your Policy as a Partnership Policy.** If you make any changes to your policy or certificate, such changes could affect whether your policy or certificate continues to qualify as a Partnership Policy. Before you make any changes, you should consult with the issuer of your policy to determine the effect of a proposed change. In addition, if you move to a state that does not maintain a Partnership program or does not recognize your policy as a Partnership Policy, you would not receive Medicaid asset protection in that state. Also, changes in federal or state law could affect the Medicaid asset protection available with respect to your Partnership Policy.

**Additional Information.** If you would like further information about the MaineCare asset protection provided by your Partnership Policy, please contact the Maine Department of Health and Human Services at (207) 287-3707 or visit their website at <http://www.maine.gov/dhhs>. If you would like further information about the Maine Long-Term Care Partnership Program, please call the Maine Bureau of Insurance at (800) 300-5000 (in state) or (207) 624- 8458 or visit their website at <http://www.maine.gov/pfr/insurance>.