

TITLE 365. INSURANCE DEPARTMENT
CHAPTER 10. LIFE, ACCIDENT AND HEALTH
SUCHAPTER 5. MINIMUM STANDARDS; CONTRACT GUIDELINES
PART 5. LONG-TERM CARE INSURANCE

365:10-5-40. Purpose

The purpose of this Part is to implement 36 O.S. §4421 et seq., to promote the public interest, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term insurance coverages, and to facilitate flexibility and innovation in the development of long-term care insurance.

[Source: Amended at 10 Ok reg 397, eff 11-12-92 (emergency); Amended at 10 Ok Reg 3033, eff 7-15-93]

365:10-5-41. Definitions

For the purpose of this Part, the terms "long-term care insurance", "applicant", "certificate", "group long-term care insurance", and "policy" shall have the meanings set forth in section 4424 of the Long-term Care Insurance Act.

[Source: Amended at 10 Ok Reg 397, eff 11-12-92 (emergency); Amended at 10 Ok Reg 3033, eff 7-15-93]

365:10-5-41.1. Terms under which the policy [certificate] may be continued in force or discontinued [REVOKED]

[Source: Added at 10 Ok Reg 397, eff 11-12-92 (emergency); Added at 10 Ok Reg 3033, eff 7-15-93; Revoked at 1-0 Ok Reg 4231, eff 7-15-93 (emergency); Revoked at 10 Ok Reg 1843, eff 5-15-94]

365:10-5-41.2. Applicability and scope

(a) Except as otherwise specifically provided, this Part applies to all long-term care insurance policies delivered or issued for delivery in this state on or after the effective date hereof, by:

- (1) insurers;
- (2) fraternal benefit societies;
- (3) nonprofit health, hospital and medical service corporations;
- (4) prepaid health plans;
- (5) health maintenance organizations; and
- (6) all similar organizations.

(b) Certain provisions of this regulation apply only to qualified long-term care insurance contracts as noted.

(c) Additionally, this regulation is intended to apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if:

- (1) The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services;
- (2) The disability income policy is advertised, marketed or offered as insurance for long-term care services; or
- (3) Benefits under the policy may commence after the policyholder has reached Social Security's normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

[Source: Added at 10 Ok Reg 397, eff 11-12-92 (emergency); Added at 10 Ok Reg 3033, eff 7-15-93; Amended at 18 Ok Reg 1277, eff 7-14-01]

365:10-5-42. Policy definitions

(a) No long-term care insurance policy delivered or issued for delivery in the State of Oklahoma shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

- (1) "**Activities of daily living**" means at least bathing, continence, dressing, eating, toileting and transferring.
- (2) "**Acute condition**" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.
- (3) "**Adult day care**" means a program for four (4) 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.
- (4) "**Bathing**" means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- (5) "**Cognitive impairment**" means a deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.
- (6) "**Continence**" means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- (7) "**Dressing**" means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- (8) "**Eating**" means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
- (9) "**Exceptional increase**" means only those increases filed by an insurer as exceptional for which the Commissioner determines the need for the premium rate increase is justified:
 - (A) Due to changes in laws or regulations applicable to long-term care coverage in this state; or
 - (B) Due to increased and unexpected utilization that affects the majority of insurers of similar products.

Except as provided in OAC 365:10-5-47, exceptional increases are subject to the same requirements as other premium rate schedule increases. The

Commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase. The Commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

(10) "**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.

(11) "**Home health care services**" means medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance and activities of daily living and respite care services.

(12) "**Incidental**," as used in O.A.C. 365:10-5-47.1(j), means that the value of the long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

(13) "**Medicare**" shall be defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended", or "Title I, Part I of Public Laws 89-97, As Enacted by the Eighty-Ninth Congress of the United States of American 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.

(14) "**Mental or Nervous Disorder**" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

(15) "**Personal care**" means the provision of hands-on services to assist an individual with activities of daily living.

(16) "**Qualified Actuary**" means a member in good standing of the American Academy of Actuaries.

(17) "**Similar policy forms**" means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in 36 O.S. § 4424(4)(a) and are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

(18) "**Skilled nursing care**", "**intermediate care**", "**personal care**", "**home care**", and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

(19) "**Toileting**" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

(20) "**Transferring**" means moving into or out of a bed, chair or wheelchair.

(b) All providers of services, including but not limited to "skilled nursing facility", "extended care facility," "convalescent nursing home," "personal care facility," "specialized care providers," "assisted living facility," and "home care agency," shall be defined in relation to the services and facilities required to be available and the licensure, certification, registration or degree status of those providing or supervising the services. The definition may require When the definition requires that the provider be appropriately licensed or, 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.

[**Source:** Amended at 10 Ok Reg 397, eff 11-12-92 (emergency); Amended at 10 Ok Reg 3033, eff 7-15-93; Amended at 15 Ok Reg 3207, eff 7-13-98; Amended at 18 Ok Reg 1277, eff 7-14-01; 26 Ok Reg 1529, eff 7-14-2009]

365:10-5-43. Policy practices and provisions

(a) **Renewability.** The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of O.A.C. 365:10-5-44.

(1) No such policy issued to an individual shall contain renewal provisions other than "guaranteed renewable" or "noncancellable".

(2) The term "guaranteed renewable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(3) The term "noncancellable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

(4) The term "level premium" may only be used when the insurer does not have the right to change the premium.

(5) In addition to the other requirements of this subsection, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.

(b) **Limitations and exclusions.**

(1) No policy may be delivered or issued for delivery in this state as long-term care insurance if such policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

(A) Pre-existing conditions or diseases;

(B) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;

(C) Alcoholism and drug addiction;

(D) Illness, treatment or medical condition arising out of:

- (i) war or act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to a military unit, or working in an area of war whether voluntarily or as required by an employer;
- (ii) participation in a felony, riot or insurrection;
- (iii) service in the armed forces or units auxiliary thereto;
- (iv) suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or
- (v) aviation (this exclusion applies only to non-fare-paying passengers);

(E) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental programs (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.

(F) Expenses for services or items available or paid under another long-term care insurance or health insurance policy;

(G) In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.

(H) This subsection is not intended to prohibit exclusions and limitations by type of provider. However, no long-term care issuer may deny a claim because services are provided in a state other than the state of policy issue under the following conditions:

- (i) When the state other than the state of policy issue does not have the provider licensing, certification or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification or registration; or
- (ii) When the state other than the state of policy issue licenses, certifies or registers the provider under another name.
- (iii) For purposes of this paragraph 365:10-5-43(b)(1)(H), "state of policy issue" means the state in which the individual policy or certificate was originally issued.

(2) Subsection (b) of this section is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

(c) **Extension of benefits.** Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

(d) Continuation or conversion.

(1) Group long-term care insurance issued in this state on or after the effective date of this subsection shall provide covered individuals with a basis for continuation or conversion of coverage.

(2) For the purposes of this section, "a basis for continuation of coverage" means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies which restrict provision of benefits and services to, or contain incentives to use certain providers and/or facilities may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy. The Commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(3) For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

(4) For the purposes of this section, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers and/or facilities, the Commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(5) Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

(6) Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

(7) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

(A) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

(B) The terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage:

(i) Providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and

(ii) The premium for which is calculated in a manner consistent with the requirements of paragraph (6) of this subsection.

(8) Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

(9) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

(10) Notwithstanding any other provision of this section, any insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person, shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

(11) For the purposes of this section a "Managed-Care Plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

(e) **Discontinuance and replacement.** If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

(1) Shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

(2) Shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services.

(f) **Premium increase prohibitions.**

(1) The premiums charged to an insured for long-term care insurance shall not increase due to either:

(A) The increasing age of the insured at ages beyond sixty-five (65); or

(B) The duration the insured has been covered under the policy.

(2) The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under O.A.C. 365:10-5-48.6, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

(3) A reduction in benefits shall not be considered a premium change, but for purpose of the calculation required under O.A.C. 365:10-5-48.6, the initial annual premium shall be based on the reduced benefits.

(g) Electronic Enrollment for Group Policies.

(1) In the case of a group defined in Section 4424(4)(a) of Title 36 of this states statutes any requirement that a signature of an insured be obtained by an agent or insurer shall be deemed satisfied if:

(a) The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;

(b) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records; and

(c) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information and "privileged information." is maintained. "For purposes of this subparagraph 365:10-5-43(g)(1)(c), "privileged information" means any individually identifiable information that relates to a claim for insurance benefits or a civil or criminal proceeding involving an individual and is collected in connection with or in reasonable anticipation of a claim for insurance benefits or civil or criminal proceeding involving an individual.

(2) The insurer shall make available, upon request of the commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

[Source: Amended at 10 Ok Reg 397, eff 11-12-92 (emergency); Amended at 10 Ok Reg 3033, eff 7-15-93; Amended at 18 Ok Reg 1277, eff 7-14-01; Amended at 22 Ok Reg 1954, eff 7-14-05; 26 Ok Reg 1529, eff 7-14-2009]

365:10-5-43.1. Unintentional lapse

Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

(1) **Notice requirements.**

(A) **Notice before lapse or termination.** No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant 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 thirty (30) days after a premium is due and unpaid. I elect NOT to designate any person to receive such notice." The insurer shall notify the insured of the right to change this written designation, no less often than once every two (2) years.

(B) Payroll or pension deduction plan notice requirements. When the policyholder or certificateholder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in (A) of this paragraph need not be met until sixty (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.

(C) Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to this Section, at the address 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; and notice may not be given until thirty (30) days after a premium is due and unpaid. Notice shall be deemed to have been given as of five (5) days after the date of mailing.

(2) Reinstatement. In addition to the requirement in paragraph (1) of this section, a long-term care insurance policy or certificate shall include a provision which provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five (5) 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, if any, contained in the policy and certificate.

[Source: Added at 10 Ok Reg 3033, eff 7-15-93; Amended at 26 Ok Reg 1529, eff 7-14-2009]

365:10-5-44. Required disclosure provisions

(a) **Renewability.** Individual long-term care insurance policies shall contain a renewability provision. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. This provision shall not apply to policies which do not contain a renewability provision, and under which the right to non-renew is reserved solely to the policyholder.

(b) **Premium rate change.** A long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that premium rates may change. Such provision shall be appropriately captioned, and shall appear on the first page of the policy.

(c) **Riders and endorsements.** Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.

(d) **Payment of benefits.** A long-term insurance policy which provides for the payment of benefits based on standards described as "usual and customary", "reasonable and customary" or words of similar import shall include definitions of such terms and an explanation of such terms in its accompanying outline of coverage.

(e) **Limitations.** If a long-term care insurance policy or certificate contains any limitations with respect to pre-existing conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Pre-existing Condition Limitations."

(f) **Other limitations or conditions on eligibility for benefits.** A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those listed in paragraphs (1) and (2) of this subsection shall set forth a description of such limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

(1) A long-term care insurance policy containing post-confinement, post-acute care or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits" such limitations or conditions, including any required number of days of confinement.

(2) A long-term care insurance policy or rider which conditions eligibility of non-institutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty (30) days.

(g) **Disclosure of tax consequences.** With regard to life insurance policies which provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This subsection shall not apply to qualified long-term care insurance contracts.

(h) **Benefit triggers.** Activities of daily living and cognitive impairment shall be used to measure an insured's need for long term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained in this section. If these triggers differ for different benefits, explanations of the trigger shall accompany each benefit description. If an attending physical or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

(i) **Qualified long-term care insurance contract.** A qualified long-term care insurance contract must include a disclosure statement in the policy and in the outline of coverage that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. [Policies that are not intended to be a qualified long-term care insurance contract must include a disclosure statement in the policy and in the outline of coverage that the policy is not intended to be a qualified long-term care insurance contract. The disclosure shall be prominently displayed, and shall read as follows: **This long-term care insurance policy (certificate) is not intended to be a qualified long-term care insurance contract. You need to be aware that benefits received under this policy may create unintended, adverse income tax consequences to you. You may want to consult with a knowledgeable individual about these potential income tax consequences.**]

[Source: Amended at 10 Ok Reg 397, eff 11-12-92 (emergency); Amended at 10 Ok Reg 3033, eff 7-15-93; Amended at 15 Ok Reg 3207, eff 7-13-98; Amended at 18 Ok Reg 1277, eff 7-14-01; Amended at 26 Ok Reg 1529, eff 07-14-2009]

365:10-5-44.1. Prohibition against post-claims underwriting

(a) **Application question regarding health condition.** All applications for long-term care insurance policies or certificates except those which are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

(b) **Application question regarding prescriptions.**

(1) If an application for long-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

(2) If the medications listed in such application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

(c) **Except guaranteed issue.** Except for policies or certificates which are guaranteed issue:

(1) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate:

Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy.

(2) The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:

Caution: The issuance of this long-term care insurance [policy][certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

(3) Prior to issuance of long-term care policy or certificate to an applicant age seventy-five (75) or older, the insurer shall obtain one of the following:

- (A) A report of a physical examination;
- (B) An assessment of functional capacity;
- (C) An attending physician's statement; or
- (D) Copies of medical records.

(d) **Copy of application attached to delivered policy.** A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of the delivery of the policy or certificate unless it was retained by the applicant at the time of application.

(e) **Maintain record of rescissions.** Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those which the insured voluntarily effectuated and shall annually furnish this information to the Insurance Commissioner in the format prescribed by the National Association of Insurance Commissioners (see Appendix C of this Chapter).

[Source: Added at 10 Ok Reg 397, eff 11-12-92 (emergency); Added at 10 Ok Reg 3033, eff 7-15-93]

365:10-5-44.2. Minimum standards for home health and community care benefits in long-term care insurance policies

(a) **Home health care benefit standards.** A long-term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services, limit or exclude benefits:

- (1) By requiring that the insured/claimant would need care in a skilled nursing facility if home health care services were not provided;
- (2) By requiring that the insured/claimant first or simultaneously receive nursing and/or therapeutic services in a home, community, or institutional setting before home health care services are covered;
- (3) By limiting eligible services to services provided by registered nurses or licensed practical nurses;
- (4) By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification.
- (5) By excluding coverage for personal care services provided by a home health aide.
- (6) By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service.
- (7) By requiring that the insured/claimant have an acute condition before home health care services are covered;
- (8) By limiting benefits to services provided by Medicare-certified agencies or providers.
- (9) By excluding coverage for adult day care services.

(b) **Home health care dollar amount requirement.** A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

(c) **Determination of maximum coverage.** Home health care coverage may be applied to the non-home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

[Source: Added at 10 Ok Reg 397, eff 11-12-92 (emergency); Added at 10 Ok Reg 3033, eff 7-15-93]

365:10-5-44.3. Requirement to offer inflation protection

(a) **Inflation protection option.** No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

(1) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent (5%);

(2) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent (5%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

(3) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(b) **Offer to group policyholder.** Where the policy is issued to a group, the required offer in subsection (a) of this section shall be made to the group policyholder; except, if the policy is issued to a group defined in 36 O.S. §4424(4)(d) of the Long-term Care Insurance Act other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.

(c) **Exceptions.** The offer in subsection (a) of this section shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

(d) **Information included in outline of coverage.** Insurers shall include the following information in or with the outline of coverage (An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure):

(1) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty (20) year period.

(2) Any expected premium increases or additional premium to pay for automatic or optional benefits increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at ages 75 and 85 for benefit increases.

(e) **Continuation of inflation protection benefit increases.** Inflation protection benefit increases under a policy which contains such benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

(f) **Constant premium offer.** An offer of inflation protection which provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. Such

offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

(g) **Inflation protection rejection requirements.**

(1) Inflation protection as provided in (a)(1) of this section shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this subsection.

(2) The rejection shall be considered a part of the application and shall state:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and

without inflation protection. Specifically, I have reviewed Plans [numbers of Plans], and I reject inflation protection.

[Source: Added at 10 Ok Reg 397, eff 11-12-92 (emergency); Added at 10 Ok Reg 3033, eff 7-15-93]

365:10-5-44.4. Required disclosure of rating practices to consumers

(a) This section shall apply as follows:

(1) Except as provided in Paragraph (2), this section applies to any long-term care policy or certificate issued in this state on or after November 1, 2001.

(2) For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in 36 O.S. § 4424(4)(a), which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following November 1, 2002.

(b) Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subsection to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the information listed in this section to the applicant no later than at the time of delivery of the policy or certificate.

(1) A statement that the policy may be subject to rate increases in the future;

(2) An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision;

(3) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

(4) A general explanation for applying premium rate or rate schedule adjustments that shall include:

(A) A description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and

(B) The right to a revised premium rate or rate schedule as provided in Paragraph (2) if the premium rate or rate schedule is changed;

(5) Premium rate increase information.

(A) Information regarding each premium rate increase on this policy form or similar policy forms over the past ten (10) years for this state or any other state that, at a minimum, identifies:

(i) The policy forms for which premium rates have been increased;

(ii) The calendar years when the form was available for purchase; and

(iii) The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

(B) The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.

(C) An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.

(D) If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of this section or the end of a twenty-four-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with Subparagraph (A) of this paragraph.

(E) If the acquiring insurer in Subparagraph (D) above files for a subsequent rate increase, even within the twenty-four-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in Subparagraph (D), the acquiring insurer shall make all disclosures required by Paragraph (5), including disclosure of the earlier rate increase referenced in Subparagraph (D).

(c) An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under paragraphs (b)(1) and (5). If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

(d) An insurer shall use the forms in Appendices W and DD to comply with the requirements of Subsections (a) and (b) of this section.

(e) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least sixty (60) days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by Subsection B when the rate increase is implemented.

[Added at 18 Ok Reg 1277, eff 7-14-01]

365:10-5-44.5. Initial filing requirements

(a) This section applies to any long-term care policy issued in this state on or after November 1, 2001.

(b) An insurer shall provide the information listed in this subsection to the commissioner 60 days prior to making a long-term care insurance form available for sale.

(1) A copy of the disclosure documents required in OAC 365:10-5-44.4; and

(2) An actuarial certification consisting of at least the following:

(A) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

(B) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

(C) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

(D) A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

(i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(ii) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(iii) A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); and

(iv) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur;

(I) An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;

(II) If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under Subsection (c) based on a standard age distribution; and

(E) Premium rate schedule.

(i) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or

(ii) A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

(c) Actuarial demonstration.

(1) The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

(2) In the event the commissioner asks for additional information under this provision, the period in Subsection A does not include the period during which the insurer is preparing the requested information.

(3) The commissioner may have the actuarial demonstration reviewed by an independent actuary in those instances where the demonstration does not address fully the questions that triggered the request for the actuarial demonstration.

365:10-5-45. Requirements for application forms and for replacement coverage

(a) **Application form requirements.** Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or 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. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing such questions may be used. With regard to a replacement policy issued to a group defined by 36 O.S. §4424(4)(a), the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced; provided, however, that the certificateholder has been notified of the replacement.

(1) Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?

(2) Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months?

(A) If so, with which company?

(B) If that policy lapsed, when did it lapse?

(3) Are you covered by Medicaid?

(4) Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

(b) **Other policies required to be listed on the application form.** Agents shall list any other health insurance policies they have sold to the applicant.

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

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

(c) **Solicitations other than direct response.** Upon determining that a sale will involve replacement, an insurer; other than an insurer using direct response solicitation methods, or its agent; shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner as set out in Appendix LL of this chapter.

(d) **Direct response solicitations.** Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner as set out in Appendix MM.

(e) **Notification of replacement intent.** Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Such notice shall be made within five (5) working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

(f) **Life insurance policies that accelerate benefits.** Life Insurance policies that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of the Life Insurance and Annuity Policyholders Protection Act, 36 O.S. § 4031 et seq. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

[Source: Amended at 10 Ok Reg 397, eff 11-12-92 (emergency); Amended at 10 Ok Reg 3033, eff 7-15-93; Amended at 26 Ok Reg 1529, eff 07-14-2009]

365:10-5-45.1.Reporting requirements

(a) Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.

(b) Each insurer shall report annually by June 30 the ten percent (10%) of its agents with the greatest percentages of lapses and replacements as measured by (a) of this section.

(c) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

(d) Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.

(e) Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year.

(f) Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied. An insurer shall use the form in Appendix CC to comply with this provision.

(g) For purposes of this section:

(1) "Policy" means only long-term care insurance;

(2) Subject to paragraph 3 of this subsection, "claim" means a request for payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

(3) "Denied" means the insurer refused to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

(4) "Report" means on a statewide basis.

(h) Reports required under this section shall be filed with the commissioner.

[Source: Added at 10 Ok Reg 397, eff 11-12-92 (emergency); Added at 10 Ok Reg 3033, eff 7-15-93; Amended at 18 Ok Reg 1277, eff 7-14-01; Amended at 26 Ok Reg 1529, eff 07-14-2009; Amended at 27 Ok Reg 1531, eff 7-14-10]

365:10-5-45.2. Licensing

No agent is authorized to market, sell, solicit or otherwise contact any person for the purpose of marketing long-term care insurance except as authorized by the Oklahoma Producer Licensing Act, 36 O.S. § 1435.1, et seq.

[Source: Added at 10 Ok Reg 397, eff 11-12-92 (emergency); Added at 10 Ok Reg 3033, eff 7-15-93; Amended at 26 Ok Reg 1529, eff 07-14-2009]

365:10-5-45.3. Discretionary powers of Commissioner

The Commissioner may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this Part with respect to a specific long-term care insurance policy or certificate upon a written finding that:

- (1) The modification or suspension would be in the best interest of the insureds; and
- (2) The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and
- (3) At least one of the following applies:
 - (A) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or
 - (B) The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or
 - (C) The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

[Source: Added at 10 Ok Reg 397, eff 11-12-92 (emergency); Added at 10 Ok Reg 3033, eff 7-15-93]

365:10-5-46. Reserve standards

(a) Benefits provided through acceleration of benefits.

- (1) When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such, policy reserves for such benefits shall be determined in accordance with such tables as may be approved by the Commissioner. Claim reserves must also be established in the case when such policy or rider is in claim status.
- (2) Reserves for policies and riders subject to this subsection should be based on the multiple decrement model utilizing all relevant decrement except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into

account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

(3) In the development and calculation of reserves for policies and riders subject to this subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

- (A) Definition of insured events;
- (B) Covered long-term care facilities;
- (C) Existence of home convalescence care coverage;
- (D) Definition of facilities;
- (E) Existence or absence of barriers to eligibility;
- (F) Premium waiver provision;
- (G) Renewability;
- (H) Ability to raise premiums;
- (I) Marketing method;
- (J) Underwriting procedures;
- (K) Claims adjustment procedures;
- (L) Waiting period;
- (M) Maximum benefit;
- (N) Availability of eligible facilities;
- (O) Margins in claim costs;
- (P) Optional nature of benefit;
- (Q) Delay in eligibility for benefit;
- (R) Inflation protection provisions; and
- (S) Guaranteed insurability option.

(4) Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

(b) **Other.** When long-term care benefits are provided other than as in (a) of this section, reserves shall be determined by using tables established for reserve purposes by a qualified actuary and acceptable to the Commissioner.

[Source: Amended at 10 Ok Reg 397, eff 11-12-92 (emergency); Amended at 10 Ok Reg 3033, eff 7-15-93]

365:10-5-47. Loss ratio

(a) This section shall apply to all long-term care insurance policies and certificates except those covered under OAC 365:10-5-44.5 and 365:10-5-47.1.

(b) Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

- (1) Statistical credibility of incurred claims experience and earned premiums;

- (2) The period for which rates are computed to provide coverage;
- (3) Experienced and projected trends;
- (4) Concentration of experience within early policy duration;
- (5) Expected claim fluctuation;
- (6) Experience refunds, adjustments or dividends;
- (7) Renewability features;
- (8) All appropriate expense factors;
- (9) Interest;
- (10) Experimental nature of the coverage;
- (11) Policy reserves;
- (12) Mix of business by risk classifications; and
- (13) Product features such as long elimination periods, high deductibles and high maximum limits.

(c) Subsection (b) shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

- (1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
- (2) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of §4029 of title 36 of the Oklahoma Code.
- (3) The policy meets the following disclosure requirements:
 - (A) If an application for a long-term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than thirty (30) days after the date of approval.
 - (B) At the time of delivery, a policy summary shall 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 request shall make delivery no later than at the time of policy delivery. IN addition to complying with all applicable requirements, the summary shall also include:
 - (i) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;
 - (ii) An illustration of the amount of benefits, the length of benefit, and the guaranteed life time benefits if any, for each covered person;
 - (iii) Any exclusions, reductions and limitations on benefits of long-term care;
 - (iv) A statement that any long-term care inflation protection option required by OAC 365:10-5-44.3 is not available under this policy;

(v) If applicable to the policy type, the summary shall also include:

(I) A disclosure of the effects of exercising other rights under the policy;

(II) A disclosure of guarantees related to long-term care costs of insurance charges; and

(III) Current and projected maximum lifetime benefits; and

(vi) The provisions of the policy summary listed above may be incorporated into a basic illustration required to be delivered in accordance with OAC 365:10-3-54 and 365:10-3-55.

(C) Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. The report shall include:

(i) Any long-term care benefits paid out during the month;

(ii) An explanation of any changes in the policy, e.g. death benefits or cash values, due to long-term care benefits being paid out; and

(iii) The amount of long-term care benefits existing or remaining.

(4) Any policy illustration that meets the applicable requirements of the Oklahoma Life Insurance Illustrations Regulation, OAC 365:10-5-50, et seq; and

(5) An actuarial memorandum is filed with the insurance department that includes:

(A) A description of the basis on which the long-term care rates were determined;

(B) A description of the basis for the reserves;

(C) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(D) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(E) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(F) The estimated average annual premium per policy and the average issue age;

(G) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(H) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

[Source: Amended at 10 Ok Reg 397, eff 11-12-92 (emergency); Amended at 10 Ok Reg 3033, eff 7-15-93; Amended at 18 Ok Reg 1277, eff 7-14-01]

365:10-5-47.1. Premium rate schedule increases

(a) This section shall apply as follows:

(1) Except as provided in Paragraph (2), this section applies to any long-term care policy or certificate issued in this state on or after November 1, 2001.

(2) For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in 36 O.S. § 4424(4)(a), which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following November 1, 2002.

(b) An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least 60 days prior to the notice to the policyholders and shall include:

(1) Information required by OAC 365:10-5-44.4;

(2) Certification by a qualified actuary that:

(A) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;

(B) The premium rate filing is in compliance with the provisions of this section;

(3) An actuarial memorandum justifying the rate schedule change request that includes:

(A) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

(i) Annual values for the five (5) years preceding and the three (3) years following the valuation date shall be provided separately;

(ii) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(iii) The projections shall demonstrate compliance with Subsection C; and

(iv) For exceptional increases,

(I) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(II) In the event the commissioner determines as provided in OAC 365:10-5-42(a)(9) that offsets may exist, the insurer shall use appropriate net projected experience;

(B) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(C) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

(D) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

(E) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates;

(4) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

(5) Sufficient information for review and approval of the premium rate schedule increase by the commissioner.

(c) All premium rate schedule increases shall be determined in accordance with the following requirements:

(1) Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(2) Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(A) The accumulated value of the initial earned premium times fifty-eight percent (58%);

(B) Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis;

(C) The present value of future projected initial earned premiums times fifty-eight percent (58%); and

(D) Eighty-five percent (85%) of the present value of future projected premiums not in Subparagraph (c) on an earned basis;

(3) In the event that a policy form has both exceptional and other increases, the values in Subparagraphs (2)(B) and (2)(D) will also include seventy percent (70%) for exceptional rate increase amounts; and

(4) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in the NAIC Health Reserves Model Regulation Appendix A, Section IIA. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

(d) For each rate increase that is implemented, the insurer shall file for approval by the commissioner updated projections, as defined in Subsection (b)(3)(A), annually for the next three (3) years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three (3) years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in Subsection (k), the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

(e) If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in Subsection (b)(3)(A), shall be filed for approval by the commissioner every five (5) years following the end of the required period in Subsection (d). For group insurance policies that meet the conditions in Subsection (k), the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

(f) Actual experience match with projected experience

(1) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in Subsection (c), the commissioner may require the insurer to implement any of the following:

(A) Premium rate schedule adjustments; or

(B) Other measures to reduce the difference between the projected and actual experience.

(2) In determining whether the actual experience adequately matches the projected experience, consideration should be given to Subsection (b)(3)(E), if applicable.

(g) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

(1) A plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in Subsection (h) of this section; and

(2) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to Subsection (c) had the greater of the original anticipated lifetime loss ratio or fifty-eight percent (58%) been used in the calculations described in Subsection (c)(2)(A) and (C).

(h) Adverse lapsation.

(1) For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

(A) The rate increase is not the first rate increase requested for the specific policy form or forms;

(B) The rate increase is not an exceptional increase; and

(C) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse

(2) In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to

replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

(A) The offer shall:

- (i) Be subject to the approval of the commissioner;
- (ii) Be based on actuarially sound principles, but not be based on attained age; and
- (iii) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

(B) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

- (i) The maximum rate increase determined based on the combined experience; and
- (ii) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent (10%).

(i) If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of Subsection (h) of this section, prohibit the insurer from either of the following:

- (1) Filing and marketing comparable coverage for a period of up to five (5) years; or
- (2) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

(j) Subsections (a) through (I) shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in 365:10-5-42(12), if the policy complies with all of the following provisions:

- (1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
- (2) The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:
 - (A) OAC 365:10-3-50 et al - Life Insurance Illustrations ;
 - (B) §4030.2 et seq of title 36 of the Oklahoma Code - Nonforfeiture Law for Individual Deferred Annuities, and
 - (C) 365:10-9-10 et seq - Variable Annuity Regulation;
- (3) The policy meets the disclosure requirements of Section 4426(G), (H), and (I) of Title 36 – Long-Term Care Insurance;
- (4) The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:
 - (A) Policy illustrations as required by OAC 365:10-3-50 et seq - Life Insurance Illustrations;

- (B) Disclosure requirements in Annuity Disclosure Model Regulation];
 - and
 - (C) Disclosure requirements in OAC 365:10-9-10 et seq - Variable Annuity Regulation.
- (5) An actuarial memorandum is filed with the insurance department that includes:
- (A) A description of the basis on which the long-term care rates were determined;
 - (B) A description of the basis for the reserves;
 - (C) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
 - (D) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;
 - (E) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
 - (F) The estimated average annual premium per policy and the average issue age;
 - (G) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
 - (H) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.
- (k) Subsections (f) and (h) shall not apply to group insurance policies as defined in Section 4424(4)(a) of Title 36 where:
- (1) The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or
 - (2) The policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than twenty percent (20%) of the total premium for the group in the calendar year prior to the year a rate increase is filed.

[Added at 18 Ok Reg 1277, eff 7-14-01]

365:10-5-48. Filing requirement

Prior to an insurer or similar organization offering group or individual long-term care insurance to a resident of this state pursuant to 36 O.S. §4425 to the Long-term Care Insurance Act, it shall receive prior approval by the Commissioner of all group and individual policies or certificates intended to be sold or issued to residents of this state.

[Source: Amended at 10 Ok Reg 397, eff 11-12-92 (emergency); Amended at 10 Ok Reg 3033, eff 7-15-93]

365:10-5-48.1. Filing requirements for advertising

(a) Every insurer, health care service plan or other entity providing long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio or television medium to the Insurance Commissioner of this state. In addition, all advertisements shall be retained by the insurer, health care service plan or other entity for at least three (3) years from the date the advertisement was first used.

(b) The Commissioner may exempt from the requirements in (a) of this section any advertising form or material when in the Commissioner's opinion, the requirement may not be reasonably applied.

[Source: Added at 10 Ok Reg 397, eff 11-12-92 (emergency); Added at 10 Ok Reg 3033, eff 7-15-93]

365:10-5-48.2. Standards for marketing

(a) **Marketing requirements.** Every insurer, health care service plan or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

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

(2) Establish marketing procedures to assure excessive insurance is not sold or issued.

(3) Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following: **Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.**

(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.

(5) Establish audible procedures for verifying compliance with this subsection (a).

(6) If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by the Commissioner, provide written notice to the prospective policyholder and certificateholder, at solicitation, that such a program is available and the name, address and telephone number of the program.

(7) For long-term care health insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to 365:10-5-43(a)(3).

(b) **Prohibited marketing practices.** In addition to the practices prohibited in 36 O.S. §1201 et seq., the Unfair Practices and Frauds Act, the following acts and practices are prohibited:

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

(2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

(4) Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

(c) Endorsement, filing and disclosure requirements.

(1) With respect to the obligations set forth in this subsection, the primary responsibility of an association, as defined in 36 O.S. §4424(4)(b), when endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Association shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

(2) The insurer shall file with the insurance department the following material:

- (A) The policy and certificate,
- (B) A corresponding outline of coverage, and
- (C) All advertisements requested by the insurance department.

(3) The association shall disclose in any long-term care insurance solicitation:

- (A) The specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members, and
- (B) A brief description of the process under which such policies and the insurer issuing such policies were selected.

(4) If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose such fact to its members.

(5) The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve such insurance policies as well as the compensation arrangements made with the insurer.

(6) The association shall also:

- (A) At the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the policies,

including its benefits, features, and rates and update such examination thereafter in the event of material change;

(B) Actively monitor the marketing efforts of the insurer and its agents;

(C) Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding such policies or certificates.

(7) No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the State Insurance Department the information required in this subsection (c).

(8) The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in this subsection (c).

(9) Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice in violation of 36 O.S. §1201 et seq.

[Source: Added at 10 Ok Reg 397, eff 11-12-93 (emergency); Added at 10 Ok Reg 3033, eff 7-15-93; Amended at 11 Ok Reg 1843, eff 5-15-94; Amended at 18 Ok Reg 1277, eff 7-14-01]

365:10-5-48.3. Appropriateness of recommended purchase

In recommending the purchase or replacement of any long-term care insurance policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

[Source: Added at 10 Ok Reg 397, eff 11-12-92 (emergency); Added at 10 Ok Reg 3033, eff 7-15-93]

365:10-5-48.4. Prohibition against preexisting conditions and probationary periods in replacement policies or certificates

If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

[Source: Added at 10 Ok Reg 397, eff 11-12-92 (emergency); Added at 10 Ok Reg 3033, eff 7-15-93]

365:10-5-48.5. Suitability

(a) This section shall not apply to life insurance policies that accelerate benefits for long-term care.

(b) Every insurer, health care service plan or other entity marketing long-term care insurance (the "issuer") shall:

(1) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

- (2) Train its agents in the use of its suitability standards; and
 - (3) Maintain a copy of its suitability standards and make them available for inspection upon request by the commission.
- (c) The guidelines contained herein must be followed to insure that the coverage in question is suitable for the candidate and in order to protect the privacy of a proposed insured.
 - (1) To determine whether the applicant meets the standards developed by the issuer, the agent and issuer shall develop procedures that take the following into consideration:
 - (A) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;
 - (B) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and
 - (C) The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.
 - (2) The issuer, and where an agent is involved, the agent shall make reasonable efforts to obtain the information set out in Paragraph (1) of this subsection. The efforts shall include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Appendix W of this chapter, in not less than twelve (12) point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the commissioner.
 - (3) A completed personal worksheet shall be returned to the issuer prior to the issuer's issuing coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.
 - (4) The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet in Appendix W of this chapter is prohibited.
- (d) The issuer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.
- (e) Agents shall use the suitability standards developed by the issuer in marketing long-term care insurance.
- (f) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in Appendix X of this chapter, in not less than twelve (12) point type.
- (g) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to Appendix Y of this chapter. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either

the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

(h) The issuer shall report annually to the Commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

[Source: Added at 13 Ok Reg 3281, eff 8-1-96]

365:10-5-48.6. Nonforfeiture benefit requirement

(a) No insurer may offer a long-term care insurance policy unless the insurer also offers to the applicant the option to purchase a policy that provides for nonforfeiture benefits. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(1) For purposes of this section, attained age rating is defined as a schedule of premiums starting from the issue date which increases with increasing age at least one percent per year prior to age fifty (50), and at least three percent (3%) per year beyond age fifty (50).

(2) For purposes of this section, the nonforfeiture benefit shall be a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in Paragraph (3) of this subsection.

(3) The standard nonforfeiture credit will be equal to 100 percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of paragraph (b) of this subsection.

(4) No policy or certificate shall begin a nonforfeiture benefit later than the end of the third year following the policy or certificate issue date except that for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

(A) The end of the tenth year following the policy or certificate issue date;
or

(B) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(5) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

(b) All benefits paid by the insurer while the policy or certificate is in premium paying status and in the "paid up status" will not exceed the maximum benefits which would have been payable if the policy or certificate had remained in premium paying status.

(c) There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

(d) The requirements set forth in this section shall become effective July 1, 1996, and shall apply as follows:

(1) Except as provided in paragraph (2) of this subsection, the provisions of this section apply to any long-term care policy issued in this state on or after the effective date of this amended regulation.

(2) For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in 36 O.S. §4424(4), which policy was in force at the time this amended regulation became effective, the provisions of this section shall not apply.

(e) Premiums charged for a policy or certificate containing nonforfeiture benefits shall be subject to the loss ratio requirements of O.A.C. 365:10-5-47 treating the policy as a whole.

(f) To comply with the requirement to offer a nonforfeiture benefit pursuant to Section 4426.2 of Title 36 of the Oklahoma Code – Nonforfeiture benefits:

(1) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits.

(2) The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder.

(g) If the offer required to be made under Section 4426.2 of Title 36 of Oklahoma Code – Nonforfeiture benefits is rejected, the insurer shall provide the contingent benefit upon lapse described in this section.

(1) After rejection of the offer required under Section 4426.2 of Title 36, for individual and group policies without nonforfeiture benefits issued after the effective date of this section, the insurer shall provide a contingent benefit upon lapse.

(2) In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(3) The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in Table 1 of Appendix EE of this chapter based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least sixty (60) days prior to the due date of the premium reflecting the rate increase.

(4) A contingent benefit on lapse shall also be triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal

to or exceeding the percentage of the insured's initial annual premium set forth in Table 2 of Appendix EE of this chapter based on the insured's issue age, the policy or certificate lapses within 120 days of the due date of the premium so increased, and the ratio in Paragraph (6)(b) of this section is forty percent (40%) or more. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase. This provision shall be in addition to the contingent benefit provided by Paragraph (3) above and where both are triggered, the benefit provided shall be at the option of the insured.

(5) On or before the effective date of a substantial premium increase as defined in Paragraph (3) above, the insurer shall:

(A) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased; (The insured's right to reduce policy benefits in the event of the premium increase does not affect any other right to elect a reduction in benefits provided under the policy.)

(B) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of Subsection (A) of this section. This option may be elected at any time during the 120-day period referenced in Paragraph (3) of this subsection.

(C) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in Subsection (g)(3) of this section shall be deemed to be the election of the offer to convert in Subparagraph (B) of this paragraph above.

(6) On or before the effective date of a substantial premium increase as defined in Paragraph (4) of this subsection above, the insurer shall:

(A) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(B) Offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety percent (90%) of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120-day period referenced in Paragraph (4); and

(C) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in paragraph (4) shall be deemed to be the election of the offer to convert in Subparagraph (B) of this subsection above if the ratio is forty percent (40%) or more.

(h) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are described in this subsection:

(1) For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least one percent per year prior to age fifty (50), and at least three percent (3%) per year beyond age fifty (50).

(2) For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in Paragraph (3).

(3) The standard nonforfeiture credit will be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of Subsection (i).

(4) Benefit date.

(A) The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three (3) years as well as thereafter.

(B) Notwithstanding Subparagraph (A), for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

(i) The end of the tenth year following the policy or certificate issue date; or

(ii) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(5) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

(i) All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status.

(j) There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

(k) The requirements set forth in this section shall become effective twelve (12) months after adoption of this provision and shall apply as follows:

(1) Except as provided in Paragraph (2), the provisions of this section apply to any long-term care policy issued in this state on or after the effective date of this amended regulation.

(2) For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in 36 O.S. § 4424(4)(a), which policy was in force at the time this amended regulation became effective, the provisions of this section shall not apply.

(l) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of O.A.C. 365:10-5-47 treating the policy as a whole.

(m) To determine whether contingent nonforfeiture upon lapse provisions are triggered under Subsection (g) of this section, a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

(n) A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

- (1) The nonforfeiture provision shall be appropriately captioned;
- (2) The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in the changes in rates for premium payment contracts approved by the commissioner for the same contract form; and
- (3) The nonforfeiture provision shall provide at least one of the following:
 - (A) Reduced paid-up insurance;
 - (B) Extended term insurance;
 - (C) Shortened benefit period; or
 - (D) Other similar offerings approved by the commissioner.

[Source: Added at 13 Ok Reg 3281, eff 8-1-96; Amended at 18 Ok Reg 1277, eff 7-14-01; Amended 26 Ok Reg 1529, eff 07-14-2009]

365:10-5-48.7. Standards for benefit triggers

(a) A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment.

(b) Activities of daily living

(1) Activities of daily living shall include at least the following as defined in Rule 365:10-5-42(a) and in the policy:

- (A) Bathing;
- (B) Continence;
- (C) Dressing;
- (D) Eating;
- (E) Toileting; and
- (F) Transferring;

(2) Insurers may use activities of daily living to trigger covered benefits in addition to those contained in Paragraph (1) as long as they are defined in the policy.

(c) An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in Subsections a and b.

(d) For purposes of this section the determination of a deficiency shall not be more restrictive than:

- (1) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or
 - (2) If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.
- (e) Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.
- (f) Long term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.
- (g) The requirements set forth in this section shall be effective November 1, 1998, and shall apply as follows:
- (1) Except as provided in Paragraph (2), the provisions of this section apply to a long-term care policy issued in this state on or after the effective date of this section.
 - (2) For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in 36 O.S. Section 4424(4)(a) of the Long-term Care Insurance Act that was in force at the time this section became effective, the provisions of this section shall not apply.

[Source: Added at 15 Ok Reg 3207, eff 7-13-98]

365:10-5-49. Policy summary [REVOKED]

[Source: Revoked at 10 Ok Reg 397, eff 11-12-92 (emergency); Revoked at 10 Ok Reg 3033, eff 7-15-93]

365:10-5-50. Standard format outline of coverage

This section implements, interprets and makes specific, the provisions of 36 O.S. Section 4426(F) in prescribing a standard format and the content of an outline of coverage.

- (1) **Free-standing document.** The outline of coverage shall be a free-standing document, using no smaller than ten point type.
- (2) **Contain no advertising.** The outline of coverage shall contain no material of an advertising nature.
- (3) **Emphasizing text.** Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.
- (4) **Sequence of text.** Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.
- (5) **Format for outline of coverage.** Format for outline of coverage shall be as described in Appendix AA of this chapter.

[Source: Amended at 10 Ok Reg 397, eff 11-12-92 (emergency); Amended at 10 Ok Reg 3033, eff 7-15-93; Amended at 10 Ok Reg 4231, eff 7-15-93 (emergency); Amended at 11 Ok Reg 1843, eff 5-15-94; Amended at 15 Ok Reg 3207, eff 7-13-98]

365:10-5-50.1. Requirement to deliver shopper's guide

(a) A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the Commissioner, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

(1) In the case of agent solicitations, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form.

(2) In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.

(b) Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the guide referenced in (a) of this section, but shall furnish the policy summary required under 36 O.S. § 4426.

[Source: Added at 10 Ok Reg 397, eff 11-12-92 (emergency); Added at 10 Ok Reg 3033, eff 7-15-93]

365:10-5-51. Prohibition against post-claims underwriting [REVOKED]

[Source: Revoked at 10 Ok Reg 397, eff 11-12-92 (emergency); Revoked at 10 Ok Reg 3033, eff 7-15-93]

365:10-5-52. Requirement to offer inflation protection [REVOKED]

[Source: Revoked at 10 Ok Reg 397, eff 11-12-92 (emergency); Revoked at 10 Ok Reg 3033, eff 7-15-93]

365:10-5-53. Contingent benefit upon lapse

(a) Notwithstanding any other rule, the Commissioner may require the administration by an insurer of the contingent benefit upon lapse, as described in Section 365:10-5-48.6(g), as a condition of approval or acknowledgment of a rate adjustment for a block of business for which the contingent benefit upon lapse is not otherwise available.

(b) The insurer shall notify policyholders and certificate holders of the contingent benefit upon lapse when required by the commissioner in conjunction with the implementation of a rate adjustment. The commissioner may require an insurer who files for such a rate adjustment to allow policyholders and certificate holders to reduce coverage to avoid an increase in the policy's premium amount.

(c) The Insurance Commissioner may also approve any other alternative mechanism filed by the insurer in lieu of the contingent benefit upon lapse.

[Source: Added at 25 Ok Reg 1643, eff 07-14-2008; Amended 26 Ok Reg 1529, eff 07-14-2009]

365:10-5-54. State long-term care insurance partnership program

(a) **Purpose.** In accordance with Section 6021 of the Deficit Reduction Act of 2005 (Pub.L. 109-171) and in addition to the applicable provisions of this chapter, the provisions of this section shall apply to any qualified state long-term care insurance partnership policy.

(b) **Requirements for partnership policies.** "Qualified state long-term care insurance partnership policy" or "partnership policy" means an insurance policy that meets the following requirements:

(1) The policy covers an insured who was a resident of Oklahoma (or a Partnership State) when coverage first became effective under the policy.

(2) The policy is a qualified long-term care insurance policy as defined in Section 7702B(b) of the Internal Revenue Code of 1986 and was issued no earlier than July 1, 2008.

(3) The policy meets all the applicable requirements of this Part and the requirements of the National Association of Insurance Commissioners long-term care insurance model act and model regulation as those requirements are set forth in Section 1917(b)(5)(A) of the Social Security Act (42 USC Section 1396p(b)(5)(A)).

(4) The policy provides the following inflation protections:

(A) For a person who is less than sixty-one years of age as of the date of purchase of the policy, the policy provides annual inflation protection of at least three percent (3%) per year compounded annually or a rate, compounded annually, that is based upon changes in the consumer price index.

(B) For a person who is at least sixty-one years of age but less than seventy-six years of age as of the date of purchase of the policy, the policy provides annual inflation protection of at least three percent (3%) simple or a rate that is based on the annual consumer price index.

(C) For a person who is at least seventy-six years of age as of the date of purchase of the policy, the policy may provide inflation protection.

(c) **Meaning of consumer price index.** As used in this section, "consumer price index" means consumer price index for all urban consumers, U.S. city average, all items, as determined by the bureau of labor statistics of the United States department of labor. The Commissioner may approve an alternative index to be used in place of the consumer price index or alternative inflation protection programs developed by the insurer if the Commissioner deems that such programs would meet the intent of this section.

(d) **Notice from insurer or agent.**

(1) An insurer or its agent, soliciting, negotiating or offering to sell a policy that is intended to qualify as a partnership policy, shall provide to each prospective applicant a Partnership Program Notice (Appendix HH), outlining the requirements and benefits of a partnership policy. A similar notice may be used for this purpose if filed and approved by the Commissioner. The Partnership Program Notice shall be provided with the required Outline of Coverage.

(2) A partnership policy issued or issued for delivery in Oklahoma shall be accompanied by a Partnership Disclosure Notice (Appendix II) explaining the benefits associated with a partnership policy and indicating that at the time issued, the policy is a qualified state long-term care insurance partnership policy. A similar notice may be used if filed and approved by the Commissioner. The Partnership Disclosure Notice shall also include a statement indicating that by purchasing this partnership policy, the insured does not automatically qualify for Medicaid.

(e) Partnership policy filings.

(1) A partnership policy shall not be issued or issued for delivery in Oklahoma unless filed with and approved by the Commissioner. Any policy submitted for certification as a partnership policy shall be accompanied by a Partnership Certification Form (Appendix JJ), or a similar form filed and approved by the commissioner.

(2) Insurers requesting to make use of a previously approved policy form as a qualified state long-term care partnership policy shall submit to the commissioner a Partnership Certification Form signed by an officer of the company. Upon request of the Commissioner, the Partnership Certification Form shall be accompanied by a copy of the policy or certificate form listed, the approval date, and a bookmark for each of the requirements listed in sections II and III of the form. A Partnership Certification Form shall be required for each policy form submitted for partnership qualification.

(f) Offers of exchange.

(1) Once an insurer begins to advertise, market, offer, or sell policies that qualify under the state long-term care partnership program, the insurer shall offer to policyholders and certificate holders the opportunity to exchange their existing long-term coverage for coverage that is intended to qualify under the state's long-term care partnership program provided that:

(A) The insurer is required to make the offer only for existing long-term care coverage that was issued on or after February 8, 2006;

(B) The insurer is required to make the offer only for existing long-term care coverage that is the type certified by the insurer for purposes of the state long-term care partnership program;

(C) The insurer is required to make the offer on at least a one time basis, in writing, to the existing policyholder or certificate holder at the time of the policy's first renewal following the date that the insurer begins to advertise, market, offer, or sell policies that qualify under the state's long-term care partnership program; and

(D) All of an insurer's existing long-term care policyholders or certificate holders possessing coverage of the type certified by the insurer shall be given the opportunity to exchange their existing coverage within one year of the date that the insurer began to advertise, market, offer, or sell policies that qualify under the state long-term care partnership program.

(2) An exchange occurs when an insurer offers a policyholder or certificate holder (hereinafter "insured") the option to replace an existing long-term care insurance policy with a policy that qualifies as a partnership plan, and the insured accepts the offer to terminate the existing policy and accepts the new policy. In making an offer to exchange, an insurer shall comply with all of the following requirements:

(A) The offer shall be made on a nondiscriminatory basis without regard to the age or health status of the insured;

(B) The offer shall remain open for a minimum of ninety (90) days from the date of mailing by the insurer.

(3) Notwithstanding subsections (f)(1) and (2) of this section,

(A) An offer to exchange may be deferred for any insured who is currently eligible for benefits under an existing policy or who is subject to an elimination period on a claim, but such deferral shall continue only as long as such eligibility or elimination period exists; and

(B) An offer to exchange does not have to be made if the insured would be required to purchase additional benefits to qualify for the state long-term care partnership program and the insured is not eligible to purchase the additional benefits under the insurer's new business, long-term care and underwriting guidelines.

(4) If the new policy has an actuarial value of benefits equal to or lesser than the actuarial value of benefits of the existing policy, then all of the following apply:

(A) The new policy shall not be underwritten; and

(B) The rate charged for the new policy shall be determined using the original issue age and risk class of the insured that was used to determine the rate of the existing policy.

(5) If the new policy has an actuarial value of benefits exceeding the actuarial value of the benefits of the existing policy, then all of the following apply:

(A) The insurer shall apply its new business, long-term care, underwriting guidelines to the increased benefits only; and

(B) The rate charged for the new policy shall be determined using the method set forth in paragraph (4)(B) of this subsection for the existing benefits, increased by the rate for the increased benefits using the then current attained age and risk class of the insured for the increased benefits only.

(6) The new policy offered in an exchange shall be on a form that is currently offered for sale by the insurer in the general market and the effective date of the partnership plan policy shall be the same as the new policy.

(7) In the event of an exchange, the insured shall not lose any rights, benefits or built-up value that has accrued under the original policy with respect to the benefits provided under the original policy, including, but not limited to, rights established because of the lapse of time related to pre-existing condition exclusions, elimination periods, or incontestability clauses.

(8) Insurers may complete an exchange by either issuing a new policy or by amending an existing policy with an endorsement or rider.

(9) For those insureds with long-term care policies issued before February 8, 2006, any insurer may offer any insured an option to exchange an existing policy for a policy that qualifies as a state long-term partnership plan. The requirements set forth in subsections (f)(2) through (8) of this section shall apply to any such exchange.

(g) **Report to HHS.** All insurers shall report to the Health and Human Services Secretary such information as required by Centers for Medicare & Medicaid Services (CMS), including but not limited to:

(1) Notification regarding when insurance benefits provided under partnership plans have been paid and the amount of such benefits paid, and

(2) Notification regarding when such policies otherwise terminate.

(h) **Requests for information by insured.** All insurers shall provide to any insured requesting such information a copy of the Approved Long-Term Care Partnership Program Policy Summary, which is hereby adopted and incorporated into this rule by reference. An insurer may use its own form as long as the information and content is consistent with the information contained in Appendix KK to this chapter.

(i) **Closed blocks.** The Insurance Commissioner may prohibit an insurer from offering a partnership policy, through an order issued after opportunity for hearing, when an insurer has previously closed or intends to close a block of long-term care insurance coverage or long-term care partnership insurance coverage.

[Source: Added at 25 Ok Reg 1643, eff 07-14-2008; Amended 26 Ok Reg 1529, eff 07-14-2009]

365:10-5-55. Availability of New Services or Providers

(a) An insurer shall notify policyholders of the availability of a new long-term policy series that provides coverage for new long-term care services or providers material in nature and not previously available through the insurer to the general public. The notice shall be provided within twelve (12) months of the date of the new policy series is made available for sale in this state.

(b) Notwithstanding Subsection (a) of this section, notification is not required for any policy issued prior to the effective date of this Section or to any policyholder or certificateholder who is currently eligible for benefits, within an elimination period or on a claim, or who previously had been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

(c) The insurer shall make the new coverage available in one of the following ways:

(1) By adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age;

(2) By exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The premium credits shall be based on premiums paid or reserves held for the prior policy or certificate;

(3) By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status shall be recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost for the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or

(4) By an alternative program developed by the insurer that meets the intent of this Section if the program is filed with and approved by the commissioner.

(d) An insurer is not required to notify policyholders of a new proprietary policy series created and filed for use in a limited distribution channel. For purposes of this Subsection, "limited distribution channel" means through a discrete entity, such as a financial institution or brokerage, for which specialized products are available that are not

available for sale to the general public. Policyholders that purchased such a new proprietary policy shall be notified when a new long-term care policy series that provides coverage for new long-term care services or providers material in nature is made available to that limited distribution channel.

(e) Policies issued pursuant to this Section shall be considered exchanges and not replacements. These exchanges shall not be subject to O.A.C. 365:10-5-45 and 365:10-5-48.5, and the reporting requirements of O.A.C. 365:10-5-45.1(a)-(e).

(f) Where the policy is offered through an employer, labor organization, professional, trade or occupational association, the required notification in Subsection (a) of this section shall be made to the offering entity. However, if the policy is issued to a group defined at Section 4424(4)(a) of Title 36, the notification shall be made to each certificateholder.

(g) Nothing in this section shall prohibit an insurer from offering any policy, rider, certificate or coverage change to any policyholder or certificateholder. However, upon request any policyholder may apply for currently available coverage that includes the new services or providers. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

(h) This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(i) This section shall become effective on or after July 14, 2009.

[Source: Added at 26 Ok Reg 1529, eff 7-14-2009; Amended at 27 Ok Reg 1531, eff 7-14-10]

365:10-5-56. Right to Reduce Coverage and Lower Premiums

(a) Every long-term care insurance policy and certificate shall include a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:

(1) Reducing the maximum benefit; or

(2) Reducing the daily, weekly or monthly benefit amount.

(3) The insurer may also offer other reduction options that are consistent with the policy or certificate design or the carrier's administrative processes.

(b) The provision shall include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.

(c) The age to determine the premium for the reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force.

(d) The insurer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.

(e) If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificateholder of his or her right to reduce coverage and premiums in the notice required by O.A.C. 365:10-5-43.1(1).

(f) This Section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(g) The requirements of this Section shall apply to any long-term care policy issued in this state on or after July 14, 2010.

[**Source:** Added at 26 Ok Reg 1529, eff 7-14-2009]