

**TITLE 365. INSURANCE DEPARTMENT
CHAPTER 10. LIFE, ACCIDENT AND HEALTH**

INTENDED RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 5. Minimum Standards; Contract Guidelines

Part 5. Long-Term Care Insurance [NEW]

365:10-5-53. Contingent benefit upon lapse [NEW]

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

365:10-5-Appendix HH. Partnership Program Notice [NEW]

365:10-5-Appendix II. Partnership Status Disclosure Notice [NEW]

365:10-5-Appendix JJ. Issuer Certification Form [NEW]

365:10-5-Appendix KK. Approved Long Term Care Partnership Program Policy Summary [NEW]

Part 19. Oklahoma Health Care Freedom of Choice Regulation

365:10-5-181. Good faith estimate by insurer [AMENDED]

Part 21. Extension and Termination of Coverage Under Group Accident and Health Policy Contracts of Hospital and Medical Services or Indemnity [NEW]

365:10-5-190. Purpose. [NEW]

365:10-5-191. Applicability and scope [NEW]

365:10-5-192. Definitions [NEW]

365:10-5-193. Periods for which coverage is extended [NEW]

365:10-5-194. When Extension Period Begins [NEW]

365:10-5-195. Required Notification to Employee Whose Insurance is Terminated [NEW]

SUMMARY:

The purpose of the long term care rules is to set forth standards for approval of long-term care insurance policies pursuant to the Oklahoma Long-term Care Partnership Act, 63 O.S. § 1-1955.1, et seq. (the Act). The Act provides that the Oklahoma Health Care Authority shall provide for asset disregard for purposes of qualification for Medicaid benefits to the extent the payments are for covered services under the Oklahoma Long-term Care Partnership Program for purchasers of an Oklahoma Long-term Care Partnership Program approved policy the form of which has been approved by the Insurance Department pursuant to the Act and Section 1-1955.2(4) specifically. Section 1-1955.3 of the Act requires that the Oklahoma Health Care Authority (OHCA) administer the Act upon repeal of the restrictions to asset protection contained in the federal Omnibus Budget Reconciliation Act of 1933. Public Law 109-171, known as the Deficit Reduction Act of 2005, repealed the restrictions to asset protection and authorized states to implement long-term care partnership programs.

Rule 365:10-5-181 is amended. The proposed amendment revises an incorrect statutory citation.

The purpose of Part 21 is to implement Section 4509 of Title 36 of the Oklahoma Statutes, to promote the public interest, to promote the availability of extension of benefits, to protect individuals during a continuing course of medical treatment, to prevent unfair practices, and to facilitate public understanding in the availability of extension of benefits upon termination of coverage.

AUTHORITY:

Insurance Commissioner, 36 O.S. §§ 307.1, 36 O.S. § 4421, and 63 O.S. § 1955.5.

COMMENT PERIOD:

Written or oral comments regarding the proposed rule amendment shall be received on or before March 3, 2008. Comments shall be directed to Karl Kramer, First Assistant General Counsel, Oklahoma Insurance Department, P.O. Box 53408, Oklahoma City, Oklahoma 73152-3408.

PUBLIC HEARING:

A public hearing regarding the proposed rule amendment will be held March 4, 2008 at 9:30 a.m. at the Oklahoma Insurance Department, 2401 N.W. 23rd Street, Suite 28, Oklahoma City, Oklahoma 73107.

REQUEST FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities are requested to provide any increase in costs expected to be incurred due to compliance with the proposed rules. The comments shall be submitted to Karl Kramer, First Assistant General Counsel, Oklahoma Insurance Department, at the mailing address above on or before March 3, 2008.

COPIES OF PROPOSED RULES:

Copies of the proposed rule amendments may be inspected at the Oklahoma Insurance Department at the physical address listed above. Office hours are from 8:00 a.m. through 5:00 p.m., Monday through Friday. Additional copies of the rules may also be obtained at the Oklahoma Insurance Department.

RULE IMPACT STATEMENT:

A rule impact statement will be prepared prior to February 1, 2008 in accordance with 75 O.S. § 303(D). A copy of the statement may be obtained at the physical address above.

CONTACT PERSON:

Karl Kramer, First Assistant General Counsel, (405) 521-2746.

**TITLE 365. INSURANCE DEPARTMENT
CHAPTER 10. LIFE, ACCIDENT AND HEALTH**

**SUBCHAPTER 5. MINIMUM STANDARDS; CONTRACT GUIDELINES
PART 5. LONG-TERM CARE INSURANCE**

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 26(A), (D) (3), (E), (F), (G), and (J) of the Long-Term Care Insurance Model Regulation promulgated by the National Association of Insurance Commissioners, as adopted in October 2000, 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.

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 per cent compounded annually per year or a rate, compounded annually, that is based on the annual 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 per cent 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.

(5) The policy provides a nursing home benefit of at least seventy dollars (\$70) a day if issued in the year 2008 and five percent (5%) greater than the previous year's minimum rounded up to the nearest dollar for each year thereafter. No policy or certificate shall pay for care in excess of the actual charges. Policies that pay benefits based on a percentage of costs, and not a daily benefit amount, shall provide benefits which are equal to at least seventy percent (70%) of the actual charges incurred by the insured or at least seventy percent (70%) of the average private pay rate provided by the Oklahoma Health Care Authority.

(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. 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) Within one hundred eighty (180) days of the date that an insurer begins to advertise, market, offer or sell policies that qualify under the state long-term care partnership program, the insurer shall offer, on a one time basis, in writing, to all existing

policyholders and certificate holders that were issued long-term care coverage by the insurer on or after February 8, 2006, the option to exchange their existing long-term care coverage for coverage that is intended to qualify under the state's 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.

(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.

Appendix HH [NEW]

Partnership Program Notice

Important Consumer Information Regarding the Oklahoma Long-Term Care Insurance Partnership Program

Some long-term care insurance policies [certificates] sold in Oklahoma may qualify for the Oklahoma Long-Term Care Insurance Partnership Program (the Partnership Program). The Partnership Program is a partnership between state government and private insurance companies to assist individuals in planning their long-term care needs. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance policies [certificates] that qualify as Partnership Policies [Certificates] may protect the policyholder's [certificateholder's] assets through a feature known as "Asset Disregard" under Oklahoma's Medicaid program.

Asset Disregard means that an amount of the policyholder's [certificateholder's] assets equal to the amount of long-term care insurance benefits received under a qualified Partnership Policy [Certificate] will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership Policy [Certificate] without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply and special rules may apply to persons whose home equity exceeds \$500,000. Asset Disregard is not available under a long-term care insurance policy [certificate] that is not a Partnership Policy [Certificate]. Therefore, you should consider if Asset Disregard is important to you, and whether a Partnership Policy meets your needs. **The purchase of a Partnership Policy does not automatically qualify you for Medicaid.**

What are the Requirements for a Partnership Policy [Certificate]? In order for a policy [certificate] to qualify as a Partnership Policy [Certificate], it must, among other requirements:

- be issued to an individual after July 1, 2008;
- cover an individual who was an Oklahoma resident when coverage first becomes effective under the policy;
- be a tax-qualified policy under 5 7702(B)(b) of the Internal Revenue Code of 1986;
- meet stringent consumer protection standards and
- meet the following inflation requirements:
 - For ages 60 or younger - provides compound **annual** inflation protection
 - For ages 61 to 65 -provides some level of inflation protection
 - For ages 76 and older - no purchase of inflation protection is required

If you apply and are approved for long-term care insurance coverage, [carrier name] will provide you with written documentation as to whether or not your policy [certificate] qualifies as a Partnership Policy [Certificate].

What Could Disqualify a Policy [Certificate] as a Partnership Policy. Certain types of changes to a Partnership Policy [Certificate] could affect whether or not such policy [certificate] continues to be a Partnership Policy [Certificate]. If you purchase a Partnership Policy [Certificate] and later decide to make *any* changes, you should first consult with [carrier name] to determine the effect of a proposed change. In addition, if you move to a state that does not maintain a Partnership Program or does not recognize your policy [certificate] as a Partnership Policy [Certificate], you would not receive beneficial treatment of your policy [certificate] under the Medicaid program of that state. The information contained in this disclosure is based on current Oklahoma and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your policy [certificate] under Oklahoma's Medicaid program.

Additional Information. If you have questions regarding long-term care insurance policies [certificates] please contact [carrier name.] If you have questions regarding current laws governing Medicaid eligibility, you should contact the Oklahoma Health Care Authority.

Appendix II [NEW]

Partnership Status Disclosure Notice

Important Information Regarding Your [Policy's] [Certificate's] Long-Term Care Insurance Partnership Status

This disclosure notice is issued in conjunction with your long-term care policy:

Some long-term care insurance policies [certificates] sold in Oklahoma qualify for the Oklahoma Long-Term Care Insurance Partnership Program. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meet certain State and Federal requirements. Long-term care insurance policies [certificates] that qualify as Partnership Policies [Certificates] may be entitled to special treatment, and in particular an “Asset Disregard,” under Oklahoma’s Medicaid program.

Asset Disregard means that an amount of the policyholder’s [certificateholder’s] assets equal to the amount of long-term care insurance benefits received under a qualified Partnership Policy [Certificates] will be disregarded for the purpose of determining the insured’s eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership Policy [Certificate] without affecting the person’s eligibility for Medicaid. All other Medicaid eligibility criteria will apply and special rules may apply to persons whose home equity exceeds \$[500,000]. Asset Disregard is **not** available under a long-term care insurance policy [certificate] that is not a Partnership Policy [Certificate]

Partnership Policy [Certificate] Status. Your long-term care insurance policy [certificate] is intended to qualify as a Partnership Policy [Certificate] under the Oklahoma Long-Term Care Partnership Program as of your Policy's [Certificate's] effective date.

What Could Disqualify Your [Policy] [Certificate] as a Partnership Policy. If you make any changes to your [policy] [certificate], such changes could affect whether your [policy] [certificate] continues to be a Partnership Policy. ***Before you make any changes, you should consult with [insert name of carrier] to determine the effect of a proposed change.*** In addition, if you move to a State that does not maintain a Partnership Program or does not recognize your [policy] [certificate] as a Partnership Policy [Certificate], you would not receive beneficial treatment of your [policy] [certificate] under the Medicaid program of that State. The information contained in this Notice is based on current State and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your [policy] [certificate] under Oklahoma’s Medicaid program.

Additional Information. If you have questions regarding your insurance policy [certificate] please contact [insert name of carrier.] If you have questions regarding current laws governing Medicaid eligibility, you should contact the Oklahoma Health Care Authority.

Appendix JJ [NEW]

ISSUER CERTIFICATION FORM

(relating to Qualified State Long-Term Care Insurance Partnership)

Under section 1917(b)(5)(B)(iii) of the Social Security Act (42 U.S.C. 1396p(b)(5)(B)(iii)), the State insurance commissioner of a State implementing a qualified State long-term care insurance partnership (“Qualified Partnership”) may certify that long-term care insurance policies (including certificates issued under a group insurance contract) covered under the Qualified Partnership meet certain consumer protection requirements, and policies so certified are deemed to satisfy such requirements. These consumer protection requirements are set forth in section 1917(b)(5)(A) of the Social Security Act (42 U.S.C. 1396p(b)(5)(A)) and principally include certain specified provisions of the Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000) (referred to herein as the “2000 Model Regulation” and “2000 Model Act” respectively).

In order to provide each State insurance commissioner with information necessary to provide a certification for policies, this Issuer Certification Form requests information and a certification from issuers of long-term care insurance policies with respect to policy forms that may be covered under the Qualified Partnership of the State.

An insurance company may request certification of policies from time to time and, accordingly, may supplement this issuer certification form, *e.g.*, as it introduces new long-term care insurance policy forms for issuance.

I. GENERAL INFORMATION

A. Name, address and telephone number of issuer:

B. Name, address, telephone number, and email address (if available) of an employee of issuer who will be the contact person for information relating to this form:

C. Policy form number(s) (or other identifying information, such as certificate series) for policies covered by this Issuer Certification Form:

Specimen copies of each of the above policy forms, including any riders and endorsements, shall be provided upon request.

II. QUESTIONS REGARDING APPLICABLE PROVISIONS OF THE 2000 MODEL REGULATION AND 2000 MODEL ACT

Please answer each of the questions below with respect to the policy forms identified in section I.C above. For purposes of answering the questions below, any provision of the 2000 Model Regulation or 2000 Model Act listed below shall be treated as including any other provision of the 2000 Model Regulation or 2000 Model Act necessary to implement the provision.

Are the following requirements of the 2000 Model Regulation met with respect to all policies (including certificates issued under a group insurance contract) intended to be covered under the Qualified Partnership that are issued on each of the policy forms identified in section I.C above?

Yes ___ No ___ N/A ___ A. Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the 2000 Model Act relating to such section 6A.

Yes ___ No ___ N/A ___ B. Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.

Yes ___ No ___ N/A ___ C. Section 6C (relating to extension of benefits).

Yes ___ No ___ N/A ___ D. Section 6D (relating to continuation or conversion of coverage).

Yes ___ No ___ N/A ___ E. Section 6E (relating to discontinuance and replacement of policies).

Yes ___ No ___ N/A ___ F. Section 7 (relating to unintentional lapse).

Yes ___ No ___ N/A ___ G. Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.

Yes ___ No ___ N/A ___ H. Section 9 (relating to required disclosure of rating practices to consumer).

Yes ___ No ___ N/A ___ I. Section 11 (relating to prohibitions against post-claims underwriting).

Yes ___ No ___ N/A ___ J. Section 12 (relating to minimum standards).

Yes ___ No ___ N/A ___ K. Section 14 (relating to application forms and replacement coverage).

Yes ___ No ___ N/A ___ L. Section 15 (relating to reporting requirements).

Yes ___ No ___ N/A ___ M. Section 22 (relating to filing requirements for marketing).

Yes ___ No ___ N/A ___ N. Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.

Yes ___ No ___ N/A ___ O. Section 24 (relating to suitability).

Yes ___ No ___ N/A ___ P. Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

Yes ___ No ___ N/A ___ Q. The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in section 7702B(g)(4) of the Internal Revenue Code of 1986 (26 U.S.C. 7702B(g)(4)).

Yes ___ No ___ N/A ___ R. Section 29 (relating to standard format outline of coverage).

Yes ___ No ___ N/A ___ S. Section 30 (relating to requirement to deliver shopper's guide).

Are the following requirements of the 2000 Model Act met with respect to all policies (including certificates issued under a group insurance contract) intended to be covered under the Qualified Partnership that are issued on each of the policy forms identified in section I.C above?

Yes ___ No ___ N/A ___ A. Section 6C (relating to preexisting conditions).

Yes ___ No ___ N/A ___ B. Section 6D (relating to prior hospitalization).

- Yes ___ No ___ N/A ___ C. The provisions of section 8 relating to contingent nonforfeiture benefits.
- Yes ___ No ___ N/A ___ D. Section 6F (relating to right to return).
- Yes ___ No ___ N/A ___ E. Section 6G (relating to outline of coverage).
- Yes ___ No ___ N/A ___ F. Section 6H (relating to requirements for certificates under group plans).
- Yes ___ No ___ N/A ___ G. Section 6J (relating to policy summary).
- Yes ___ No ___ N/A ___ H. Section 6K (relating to monthly reports on accelerated death benefits).
- Yes ___ No ___ N/A ___ I. Section 7 (relating to incontestability period).

In order for a policy to be covered under the Qualified Partnership of the State, the answers to all questions above should be “yes” (or “N/A” where all requirements with respect to a provision above are not applicable). If answers differ between policy forms (*e.g.*, a requirement would be answered “Yes” for one form and “N/A” for another), you should use separate Issuer Certification Forms for such policies.

III. CERTIFICATION

I hereby certify that the answers, accompanying documents, and other information set forth herein are, to the best of my knowledge and belief, true, correct, and complete.

Date

Name and title of officer of the Issuer

Signature of officer of the Issuer

Appendix KK [NEW]

APPROVED LONG TERM CARE PARTNERSHIP PROGRAM POLICY SUMMARY

1. Name of insured _____
2. Policy/certificate number _____
3. Effective date of coverage _____
4. The policy/certificate was issued in the state of _____
5. Issue age of the insured at the time the coverage was issued _____
6. The policy/certificate was issued With Without inflation coverage
7. The inflation coverage is Simple Inflation Compound Inflation None
8. The inflation coverage is currently in effect on the coverage Yes No
if no, the date inflation coverage ceased _____
9. The policy is intended to meet the standards of a tax qualified long-term care policy Yes
 No
10. The cumulative dollar amount of insurance benefits paid \$_____
- (Note: The indicated amount does not include any payments for cash surrender, return of premium death benefits, or waiver of premium, and if joint coverage, the amount is for the indicated insured only)
11. The total dollar amount of insurance benefits remaining available under the policy
\$_____
12. As of date for which this form was completed _____
13. The name, phone number and email address of the person completing this form

Name

Phone Number

Email Address

I hereby certify that the above information is true and accurate and that the coverage meets partnership status in Oklahoma at the time of this certification.

Signature

Date: _____

**PART 19. OKLAHOMA HEALTH CARE FREEDOM
OF CHOICE REGULATION**

365:10-5-181. Good faith estimate by insurer

A good faith estimate of the allowable fee pursuant to Section ~~6055 (E)~~ 6055(F) of Title 36 must be provided upon request within seventy-two (72) hours of receipt of said request. Request may be made by telephone, fax or mail.

**PART 21 . EXTENSION AND TERMINATION OF COVERAGE UNDER GROUP
ACCIDENT AND HEALTH POLICY AND CONTRACTS OF HOSPITAL AND
MEDICAL SERVICES OR INDEMNITY**

365:10-5-190. Purpose

The purpose of this Part is to implement Section 4509 of Title 36 of the Oklahoma Statutes, to promote the public interest, to promote the availability of extension of benefits, to protect individuals during a continuing course of medical treatment, to prevent unfair practices, and to facilitate public understanding in the availability of extension of benefits upon termination of coverage.

365:10-5-191. Applicability and scope

(a) Except as otherwise specifically provided, this Part applies to all group accident and health insurance policies, contracts, or certificates issued or issued for delivery in this state on or after the effective date hereof, by the following insurance carriers:

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

365:10-5-192. Definitions

For the purpose of this Part, the term "terminated" or "termination" as used in 36 O.S. § 4509 shall mean an employee's loss of coverage, regardless of cause, including termination of the entire group.

365:10-5-193. Periods for which coverage is extended

(a) In the case of any employee whose group accident and health insurance policy, contract, or certificate is terminated, the coverage provided prior to the termination shall remain in effect for a period of at least thirty (30) days for the terminated employee and his or her dependents who were covered at the time coverage was terminated.

- (1) A period of 30 days will be granted for payment of premium due for the extension of coverage period, during which period the coverage shall remain in force.
- (2) Premiums for the extension of coverage may be withheld from any claim payment for

covered expenses payable under the policy, certificate, or contract where the expenses are incurred during the thirty (30) day period after the policy, certificate, or contract has terminated.

(3) All terminated employees are eligible for the thirty (30) day extension period provided for under 36 O.S. § 4509(A), regardless of whether they qualify for the additional extension period provided for by 36 O.S. § 4509(B).

(4) A conversion policy is not “similar insurance” as contemplated by 36 O.S. § 4509(A) unless the coverage available under the conversion policy is substantially similar to the group accident and health insurance policy, certificate, or contract that terminated. A policy containing a pre-existing condition limitation shall not be considered similar insurance.

(b) In the case of an employee who had coverage under a policy, certificate, or contract for at least six (6) months and whose insurance has terminated, the coverage provided prior to the termination shall remain in effect for any continuous loss that began while the insurance was in force for a period of not less than three (3) months in the case of basic coverage or six (6) months in the case of major medical coverage. This extension may be predicated upon the continuous total disability of the person insured or his or her dependents or the expenses incurred in connection with a plan of surgical treatment, which shall include maternity care and delivery expenses that commenced prior to the termination.

(1) Premiums may be charged for the extension of benefits provided in this subsection.

(2) Premium charged shall be the premium which would have been charged for the coverage provided under the group policy, certificate, or contract had termination not occurred.

(3) Billing of premiums charged shall be mailed directly to the insured at the last known address of the insured or an address provided by the insured.

(4) Premium billing shall be made based on the premium billing schedule that the group policy, certificate, or contract had in place prior to the termination of coverage.

(5) Extension of insurance coverage shall not be conditioned upon the payment or receipt of premiums before coverage is provided.

(6) Premiums for the extension of coverage may be withheld from any claim payment for covered expenses incurred and due during the extension of coverage period. Normal collection methods provided by law may be used for premiums due but not remitted by the terminated employee.

365:10-5-194. When Extension Period Begins

In the case of an employee electing an extension of coverage of a group policy, certificate, or contract pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub.L. 99-272, Apr. 7, 1986, 100 Stat. 82, the extension of coverage provided under 36 O.S. § 4509 begins upon termination or exhaustion of the COBRA coverage period, which ever comes first.

(1) Extension of coverage shall be available to an employee who does not elect extension of coverage under the provisions of COBRA.

(2) The extension of coverage begins at the termination or exhaustion of coverage provided by COBRA and is subject to the same extension of coverage requirement had COBRA not been chosen.

(3) Extension of coverage shall be available to an employee who elected the COBRA

extension of coverage option at the time such COBRA coverage is terminated, even if termination occurs prior to the exhaustion of the coverage that could be provided by COBRA.

365:10-5-195. Required Notification to Employee Whose Insurance is Terminated

(a) Upon termination of coverage, an employee shall be notified in writing of the extension of coverage option provided for under Section 4509 of Title 36 of the Oklahoma Statutes. The insurance carrier shall mail the notice to the employee at the employees last known address within ten (10) days after termination is first known to the insurance carrier writing the group accident and health insurance policies, contracts, or certificate.

(b) The notice required by this section shall provide:

(1) The dates of extension of coverage;

(2) The provisions for payment of premium, if any;

(3) The fact that premium is not required to be paid prior to coverage being provided but that premium can be withheld from claims incurred during the extension of coverage period; and

(4) Notice to the insured that coverage may be extended for up to six (6) months in the case of continuous total disability, or in connection with a plan of surgical treatment, maternity care and delivery expenses, which commenced prior to the termination of coverage.