

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

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 1. General Provisions

Part 1. General Provisions

365:10-1-13. Notification required upon rejection

Subchapter 5. Minimum Standards; Contract Guidelines

Part 5. Long-term Care Insurance

365:10-5-42. Policy definitions [AMENDED]

365:10-5-43. Policy practices and provisions [AMENDED]

365:10-5-43.1. Unintentional lapse [AMENDED]

365:10-5-44. Required disclosure provisions [AMENDED]

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

365:10-5-45.1. Reporting requirements [AMENDED]

365:10-5-45.2. Licensing [AMENDED]

365:10-5-48.6. Nonforfeiture benefit requirement [AMENDED]

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

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

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

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

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

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

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

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

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

365:10-5-194. When extension period begins [REVOKED]

365:10-5-195. Required notification to employee whose insurance is terminated
[REVOKED]

Subchapter 27. Preneed Life Insurance Minimum Standards for Determining Reserve
Liabilities and Nonforfeiture Values Regulation [NEW]

365:10-27-1. Authority [NEW]

365:10-27-2. Scope [NEW]

365:10-27-3. Purpose [NEW]

365:10-27-4. Definitions [NEW]

365:10-27-5. Minimum Valuation Mortality Standards [NEW]

365:10-27-6. Transition Rules [NEW]

Appendix EE. Triggers For A Substantial Premium Increase [REVOKED AND
REENACTED]

Appendix LL. Notice To Applicant Regarding Replacement Of Individual Accident And
Sickness or Long-Term Care Insurance For Solicitations Other Than Direct Response [NEW]

Appendix MM. Notice To Applicant Regarding Replacement Of Accident And Sickness

or Long-Term Care Insurance For Direct Response Solicitations [NEW]

AUTHORITY:

Insurance Commissioner, 36 O.S. §§ 307.1, 1510(A)(4)(iii), 4029(H)(4)(h)(vi), 4427 and 4509

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SUPERSEDED EMERGENCY ACTIONS:

Subchapter 27. Preneed Life Insurance Minimum Standards for Determining Reserve Liabilities and Nonforfeiture Values Regulation [NEW]

365:10-27-1. Authority [NEW]

365:10-27-2. Scope [NEW]

365:10-27-3. Purpose [NEW]

365:10-27-4. Definitions [NEW]

365:10-27-5. Minimum Valuation Mortality Standards [NEW]

365:10-27-6. Transition Rules [NEW]

365:10-27-7. Effective Date [NEW]

INCORPORATION BY REFERENCE:

n/a

ANALYSIS:

The proposed amendments to Section 365:10-1-13, Notification Required Upon Rejection, updates the toll free number of the Oklahoma Health Insurance High Risk Pool and adds the web address to this rule which requires notification of contact information for the High Risk Pool when an insurer rejects an application for health insurance.

The proposed amendments to Part 5 of Subchapter 5, Long-term Care Insurance, 365:10-5-42 through 56, Appendix EE and new Appendices LL and MM, update the regulation to the most recent National Association of Insurance Commissioners' model regulation and implement federal mandates.

The proposed revocation of Part 21 of Subchapter 5, Extension and Termination of Coverage Under Group Accident and Health Policy Contracts of Hospital and Medical Services or Indemnity, Sections 365:10-5-190 through 195, is to allow the Insurance Department to seek legislative amendments that address the issues in a cleaner way. New rules will be adopted if statutory amendments are enacted or not, allowing more input/comment from the individuals and entities affected by the rules.

The purpose of the proposed new Subchapter 27, Preneed Life Insurance Minimum Standards For Determining Reserve Liabilities And Nonforfeiture Values Regulation, 365:10-27-1 through 6, is to establish for preneed insurance products minimum mortality standards for reserves and nonforfeiture values, and to require the use of the 1980 Commissioners Standard Ordinary (CSO) Mortality Table for use in determining the minimum standard of valuation of reserves and the minimum standard nonforfeiture values for preneed insurance products. Research completed by the Deloitte University of Connecticut Actuarial Center and commissioned by the Society of Actuaries as a part of a study of preneed mortality determined that the 2001 CSO Mortality Table, currently recognized as the prevailing table for the purposes of calculating reserves and nonforfeiture values both on a statutory basis and on a tax basis, produced inadequate reserves for insurance policies issued in support of a prearrangement agreement which provides goods and services at the time of an insured's death. This regulation became effective as emergency rules on September 11, 2008, with compliance required for policies issued on or after January 1, 2009.

CONTACT PERSON:

Karl F. Kramer, Deputy Insurance Commissioner, (405) 521-2668

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 14, 2009

SUBCHAPTER 1. GENERAL PROVISIONS

PART 1. GENERAL PROVISIONS

365:10-1-13. Notification required upon rejection

In the event an insurer rejects an applicant seeking health insurance coverage, such rejection shall be in writing and shall state with specificity the reason(s) for the denial. The rejection notification shall further advise the applicant of the availability of the Oklahoma Health Insurance High Risk Pool and its toll free telephone number in the following format: You may be qualified for health insurance coverage under the Oklahoma Health Insurance High Risk Pool. For more information regarding this alternative please call ~~1-800-933-7624~~ 1-877-793-6477. You may also want to visit the website of the Oklahoma Health Insurance High Risk Pool at www.okhrp.org.

SUBCHAPTER 5. MINIMUM STANDARDS; CONTRACT GUIDELINES

PART 5. LONG-TERM CARE INSURANCE

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 O.A.C. 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(j)~~ 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", "~~intermediate 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.

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.

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 ~~of cognitive impairment~~ or the 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.

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.**]

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.:

~~————NOTICE TO APPLICANT REGARDING REPLACEMENT OF
 ————INDIVIDUAL ACCIDENT AND SICKNESS OR LONG TERM CARE INSURANCE~~

~~————[Insurance company's name and address]~~

~~————SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.~~

~~According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long term care insurance and replace it with an individual long term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to~~

~~keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.~~

~~You should review this new coverage carefully, comparing it with all accident and sickness or long term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long term care coverage is a wise decision.~~

~~STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]:
 (Use additional sheets, as necessary.)~~

~~I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:~~

- 1. ~~Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in~~

~~denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.~~

- ~~2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.~~
- ~~3. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.~~
- ~~4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.~~

~~(Signature of Agent, Broker or Other Representative)
[Typed Name and Address of Agent or Broker]~~

The above "Notice to Applicant" was delivered to me on:

~~(Date)~~

~~(Applicant's Signature)~~

(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.:

~~NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS OR LONG TERM CARE INSURANCE~~

~~[Insurance company's name and address]~~

~~SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.~~

~~According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long term care insurance and replace it with the long term care insurance policy delivered herewith issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide,~~

~~without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.~~

~~You should review this new coverage carefully, comparing it with all accident and sickness or long term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long term care coverage is a wise decision.~~

- ~~1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.~~
- ~~2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.~~
- ~~3. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.~~
- ~~4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.~~

~~(Company Name)~~

(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.

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, "policy" shall mean only long-term care insurance and "report" means on a statewide basis.
- (h) Reports required under this section shall be filed with the commissioner.

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 ~~unless the agent has demonstrated his or her knowledge of long-term care insurance and the appropriateness of such insurance by passing a test required by this state and maintaining appropriate licenses~~ except as authorized by the Oklahoma Producer Licensing Act, 36 O.S. § 1435.1, et seq.

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 ~~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 ~~O.A.C. 365:10 Appendix 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. On or before the effective date of a substantial premium increase as defined in (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). This option may be elected at any time during the 120-day period referenced in Subsection (g)(3).~~

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

(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.

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~~ 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.

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 made 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.

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, 2008.

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.

PART 13. MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

365:10-5-123. Definitions

The following words or terms, when used in this Part, shall have the following meaning, unless the context clearly indicates otherwise:

"Applicant" means:

(A) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and

(B) In the case of a group Medicare supplement policy, the proposed certificateholder.

"Bankruptcy" means when a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in

the state.

"Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

"Certificate Form" means the form on which the certificate is delivered or issued for delivery by the issuer.

"Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days.

"Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

- (A) A group health plan;
- (B) Health insurance coverage;
- (C) Part A or Part B of title XVIII of the Social Security Act (Medicare);
- (D) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;
- (E) Chapter 55 of Title 10 United States Code (CHAMPUS);
- (F) A medical care program of the Indian Health Service or of a tribal organization; ~~A states health benefits risk pool;~~
- (G) A state health benefits risk pool;
- ~~(GH) A state health benefits program;~~
- ~~(HI) A health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);~~
- ~~(IJ) A public health plan as defined in federal regulation; and~~
- ~~(JK) A health benefit plan under section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).~~

"Creditable coverage" shall not include one or more, or any combination of the following:

- (A) Coverage only for accident or disability income insurance, or any combination thereof;
- (B) Coverage issued as a supplement to liability insurance;
- (C) Liability insurance, including general liability insurance and automobile liability insurance;
- (D) Workers' compensation or similar insurance;
- (E) Automobile medical payment insurance;
- (F) Credit-only insurance;
- (G) Coverage for on-site medical clinics; and
- (H) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

"Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

- (A) Limited scope dental or vision benefits;
- (B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and
- (C) Such other similar, limited benefits as are specified in federal regulations.

"Creditable coverage" shall not include the following benefits if offered as independent, noncoordinated benefits:

- (A) Coverage only for a specified disease or illness; and
- (B) Hospital indemnity or other fixed indemnity insurance.

"Creditable coverage" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

- (A) Medicare supplemental health insurance as defined under Section 1822(g)(1) of the Social Security Act;
- (B) Coverage supplemental to the coverage provided under Chapter 55 of the Title 10, United States Code; and
- (C) Similar supplemental coverage provided to coverage under a group health plan.

"Employee welfare benefit plan" means a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

"Insolvency" means an issuer is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

"Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

"Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

"Medicare Advantage " means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes:

- (A) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;
- (B) Medicare medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account; and
- (C) Medicare Advantage private fee-for-service plans.

"Medicare Supplement Policy" means a group or individual policy of accident and health insurance or a subscriber contract of a non-profit hospital service and medical indemnity corporation or health maintenance organization, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.) or an issued policy under a demonstration project specified in 42 U.S.C. Section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. "Medicare Supplement Policy" does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under §1833(a)(1)(A) of the Social Security Act.

"Pre-Standardized Medicare supplement benefit plan," "Pre-Standardized benefit plan" or "Pre-Standardized plan" means a group or individual policy of Medicare supplement insurance issued prior to July 1, 1992.

"1990 Standardized Medicare supplement benefit plan," "1990 Standardized benefit plan" or "1990 plan" means a group or individual policy of Medicare supplement insurance issued on or after July 1, 1992 and prior to June 1, 2010 and includes Medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.

"2010 Standardized Medicare supplement benefit plan," "2010 Standardized benefit plan" or "2010 plan" means a group or individual policy of Medicare supplement insurance issued on or after June 1, 2010.

"Policy Form" means the form on which the policy is delivered or issued for delivery by the issuer.

"Secretary" means the Secretary of the United States Department of Health and Human Services.

365:10-5-127. Benefit standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates issued or delivered on or after July 1, 1992 and Prior to June 1, 2010

(a) **Benefit standards.** The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after July 1, 1992 and prior to June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

(b) **General standards.** The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this Part.

(1) **Preexisting conditions.** A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

(2) **Sickness and accidents.** A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) **Benefits designed to cover cost sharing amounts under Medicare.** A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

(4) **Termination of coverage of a spouse.** No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(5) **Guaranteed renewable.** Each Medicare supplement policy shall be guaranteed renewable and

(A) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(B) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(C) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under (b)(5)(E) of this section, the issuer shall offer certificateholders an individual Medicare supplement policy which at the option of the certificateholder:

- (i) provides for continuation of the benefits contained in the group policy, or
 - (ii) provides for such benefits as otherwise meets the requirements of this subsection.
 - (D) If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:
 - (i) offer the certificateholder the conversion opportunity described in (b)(5)(C) of this section, or
 - (ii) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.
 - (E) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.
 - (F) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.
- (6) **Continuous loss.** Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.
- (7) ~~**Suspension.** A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period, not to exceed twenty four (24) months, in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of such policy or certificate within ninety (90) days after the date the individual becomes entitled to such assistance.~~
- (A) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period, not to exceed twenty-four (24) months, in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of such policy or certificate within ninety (90) days after the date the individual becomes entitled to such assistance.
- (B) If such suspension occurs and if the policyholder or certificateholder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstated effective as of the date of termination of such entitlement if the policyholder or certificateholder provides notice of loss of such

entitlement within ninety (90) days after the date of such loss and pays the premium attributable to the period.

~~(B)~~(C) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstated (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss.

~~(C)~~ (D) Reinstatement of such coverages:

(i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of such suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstatement of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

(iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

(8) If an issuer makes a written offer to the Medicare Supplement policyholders or certificateholders of one or more of its plans, to exchange during a specified period from his or her 1990 Standardized plan as described in O.A.C. 365:10-5-127 to a 2010 Standardized plan as described in O.A.C. 365:10-5-127.1, the offer and subsequent exchange shall comply with the following requirements:

(A) An issuer need not provide justification to the Commissioner if the insured replaces a 1990 Standardized policy or certificate with an issue age rated 2010 Standardized policy or certificate at the insured's original issue age and duration. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the commissioner according to the state's rate filing procedure.

(B) The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage.

(C) An issuer may not apply new pre-existing condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 Standardized policy or certificate of the insured, but may apply pre-existing condition limitations of no more than six (6) months to any added

benefits contained in the new 2010 Standardized policy or certificate not contained in the exchanged policy.

(D) The new policy or certificate shall be offered to all policyholders or certificateholders within a given plan, except where the offer or issue would be in violation of state or federal law.

(c) **Standards for basic ("Core") benefits common to Benefit Plans A-J.** Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic "core" package, but not in lieu thereof.

(1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balances;

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

(5) Coverage for the coinsurance amount (or in the case of hospital outpatient department services under a prospective payment system, the copayment amount) of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(d) **Standards for additional benefits.** The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by O.A.C. 365:10-5-128.

(1) Medicare Part A Deductible. Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) Skilled Nursing Facility Care. Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

(3) Medicare Part B Deductible. Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(4) Eighty Percent (80%) of the Medicare Part B Excess Charges. Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(5) One Hundred Percent (100%) of the Medicare Part B Excess Charges. Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(6) Basic Outpatient Prescription Drug Benefit. Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar (\$250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars (\$1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

(7) Extended Outpatient Prescription Drug Benefit. Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar (\$250) calendar year deductible to a maximum of three thousand dollars (\$3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

(8) Medically Necessary Emergency Care in a Foreign Country. Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars (\$250), and a lifetime maximum benefit of fifty thousand dollars (\$50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(9) Preventive Medical Care Benefit. Coverage for the following preventive health services not covered by Medicare:

(A) An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph (B) of this paragraph and patient education to address preventive health care measures.

(B) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician. Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of one hundred twenty dollars (\$120) annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

(10) At-Home Recovery Benefit. Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(A) For purposes of this benefit, the following definitions shall apply:

(i) "Activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(ii) "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or

licensed nurses registry.

(iii) "Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

(iv) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive 4 hours in a 24-hour period of services provided by a care provider is one visit.

(B) Coverage requirements and limitations are as follows:

(i) At-home recovery services provided must be primarily services which assist in activities of daily living.

(ii) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(iii) Coverage is limited to:

(I) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;

(II) The actual charges for each visit up to a maximum reimbursement of forty dollars (\$40) per visit;

(III) One thousand six hundred dollars (\$1,600) per calendar year;

(IV) Seven (7) visits in any one week;

(V) Care furnished on a visiting basis in the insured's home;

(VI) Services provided by a care provider as defined in this section;

(VII) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(VIII) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight (8) weeks after the service date of the last Medicare approved home health care visit.

(C) Coverage is excluded for:

(i) Home care visits paid for by Medicare or other government programs; and

(ii) Care provided by family members, unpaid volunteers or providers who are not care providers.

(e) **Standards for Plans K and L**

(1) Standardized Medicare supplement benefit plan "K" shall consist of the following:

(A) Coverage of One Hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any

Medicare benefit period;

(B) Coverage of One Hundred percent (100%) of the Part a Hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

(C) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expense for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit an an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(D) Medicare Part A Deductible: Coverage for Fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph (J);

(E) Skilled Nursing Facility Care: Coverage for Fifty percent (50%) of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare part A until the out-of-pocket limitation is met as described in Subparagraph (J);

(F) Hospice Care: Coverage for Fifty percent (50%) of the cost sharing for all part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in Subparagraph (J);

(G) Coverage for Fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Subparagraph (J);

(H) Except for coverage provided in Subparagraph (I) below, coverage for Fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in subparagraph (J) below;

(I) Coverage of One Hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(J) Coverage of One Hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance fo the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of Four Thousand dollars (\$4,000.00) in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(2) Standardized Medicare supplement benefit plan "L" shall consist of the following:

(A) The benefits described in Paragraphs (1) (A), (B), (C) and (I);

(B) The benefits described in Paragraphs (1) (D), (E), (F), (G) and (H), but substituting Seventy Five percent (75%) for Fifty percent (50%); and

(C) The benefit described in Paragraph (1) (J), but substituting Two Thousand dollars (\$2,000.00) for Four Thousand dollars (\$4,000.00).

365:10-5-127.1. Benefit standards for 2010 Standardized Medicare Supplement Benefit Plan policies or certificates issued for delivery on or after June 1, 2010

(a) Benefit Standards. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any 1990 Standardized Medicare supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of O.A.C. 365:10-5-126 and 365:10-5-127.

(b) General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(1) Preexisting conditions. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

(2) Sickness and accidents. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) Benefits designed to cover cost sharing amounts under Medicare. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment factors. Premiums may be modified to correspond with such changes.

(4) Termination of coverage of a spouse. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(5) Guaranteed renewable. Each Medicare supplement policy shall be guaranteed renewable.

(A) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.

(B) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(C) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under O.A.C. 365:10-5-127.1(b)(5)(E) of this regulation, the issuer shall offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder):

(i) Provides for continuation of the benefits contained in the group policy; or

(ii) Provides for benefits that otherwise meet the requirements of this Subsection.

(D) If an individual is a certificateholder in a group Medicare supplement

policy and the individual terminates membership in the group, the issuer shall

(i) Offer the certificateholder the conversion opportunity described in Section 8.1A(5)(c) of this regulation; or

(ii) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(E) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(6) **Continuous loss.** Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(7) **Suspension.**

(A) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

(B) If suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstated (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificateholder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(C) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstated (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss.

(D) Reinstitution of coverages as described in Subparagraphs (B) and (C):

(i) Shall not provide for any waiting period with respect to treatment

of preexisting conditions;

(ii) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and

(iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

(c) Standards for Basic (Core) Benefits Common to Medicare Supplement Insurance Benefit Plans A, B, C, D, F, F with High Deductible, G, M and N. Every issuer of Medicare supplement insurance benefit plans shall make available a policy or certificate including only the following basic “core” package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer’s payment as payment in full and may not bill the insured for any balance;

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

(5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

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

(d) Standards for additional benefits. The following additional benefits shall be included in Medicare supplement benefit Plans B, C, D, F, F with High Deductible, G, M, and N as provided by O.A.C. 365:10-5-128.2.

(1) Medicare Part A Deductible: Coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period.

(3) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

(4) Medicare Part B Deductible: Coverage for one hundred percent (100%) of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(5) One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage

for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(6) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

365:10-5-128. Standard Medicare Supplement ~~Benefit~~ Plans ~~plans~~ for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates issued for delivery on or after July 1, 1992, and prior to June 1, 2010

(a) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic "core" benefits, as defined in O.A.C. 365:10-5-127(c).

(b) No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in Sections 365:10-5-128(g) and ~~365:10-5-128.1~~ 365:10-5-128.3 of this regulation.

(c) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "L" listed in this subsection and conform to the definitions in O.A.C. 365:10-5-123. Each benefit shall be structured in accordance with the format provided in O.A.C. 365:10-5-127(c) and (d) or O.A.C. ~~Section~~ 365:10-5-127(e) and list the benefits in the order shown in this subsection. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of a benefit.

(d) An issuer may use, in addition to the benefit plan designations required in (c) of this section, other designations to the extent permitted by law.

(e) Make-up of benefit plans are as follows:

(1) Standardized Medicare supplement benefit plan "A" shall be limited to the Basic ("Core") Benefits Common to All Benefit Plans, as defined in 365:10-5-127(c).

(2) Standardized Medicare supplement benefit plan "B" shall include only the following: The Core Benefit as defined in 365:10-5-127(c), plus the Medicare Part A Deductible as defined in 365:10-5-127(d)(1).

(3) Standardized Medicare supplement benefit plan "C" shall include only the following: The Core Benefit as defined in 365:10-5-127(c), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible and Medically Necessary Emergency Care in a Foreign Country as defined in 365:10-5-127(d)(1), (2), (3) & (8) respectively.

(4) Standardized Medicare supplement benefit plan "D" shall include only the following: The Core Benefit as defined in 365:10-5-127(c), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in an Foreign Country and the At-Home Recovery Benefit as defined in 365:10-5-127(d) (1), (2), (8) & (10) respectively.

(5) Standardized Medicare supplement benefit plan "E" shall include only the following: The Core Benefit as defined in 365:10-5-127(c), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and Preventive Medical Care as defined in 365:10-5-127(d) (1), (2), (8) & (9) respectively.

(6) Standardized Medicare supplement benefit plan "F" shall include only the following: The Core Benefit as defined in 365:10-5-127(c), plus the Medicare Part A Deductible, the Skilled Nursing Facility Care, the Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in 365:10-5-127(d) (1), (2), (3), (5) & (8) respectively.

(7) Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: 100% of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in Section 365:10-5-127(c) of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Section 365:10-5-127(d)(1), (2), (3), (5) and (8) respectively. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "F" deductible shall be \$1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.

(8) Standardized Medicare supplement benefit plan "G" shall include only the following: The Core Benefit as defined in 365:10-5-127(c), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Eighty Percent (80%) of the Medicare Part B Excess Charges, Medically Necessary Emergency Care in a Foreign Country, and the At-Home Recovery Benefit as defined in 365:10-5-127(d) (1), (2), (4), (8) & (10) respectively.

(9) Standardized Medicare supplement benefit plan "H" shall consist of only the following: The Core Benefit as defined in 365:10-5-127(c), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Basic Prescription Drug Benefit and Medically Necessary Emergency Care in a Foreign Country as defined in 365:10-5-127(d) (1), (2), (6) & (8) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(10) Standardized Medicare supplement benefit plan "I" shall consist of only the following: The Core Benefit as defined in 365:10-5-127(c), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Basic Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country and At-Home Recovery Benefit as defined in 365:10-5-127(d) (1), (2), (5), (6), (8) & (10) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(11) Standardized Medicare supplement benefit plan "J" shall consist of only the following: The Core Benefit as defined in 365:10-5-127(c), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, One Hundred

Percent (100%) of the Medicare Part B Excess Charges, Extended Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care and At-Home Recovery Benefit as defined in 365:10-5-127(d) (1), (2), (3), (5), (7), (8), (9) & (10) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(12) Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in Section 365:10-5-127(c) of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign county, preventive medical care benefit and at-home recovery benefit as defined in Sections 365:10-5-127(d)(1), (2), (3), (5), (7), (8), (9) and (10) respectively. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be \$1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(ef) Make up of two Medicare supplement plans mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA);

(1) Standardized Medicare supplement benefit plan "K" shall consist of only those benefits described in Section 365:10-5-127(e)(1).

(2) Standardized Medicare supplement benefit plan "L" shall consist of only those benefits described in Section 365:10-5-127(e)(2).

(g) New or Innovative Benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefits.

365:10-5-128.1. Medicare Select Policies and Certificates [AMENDED AND RENUMBERED TO 365:10-5-128.3]

~~(a) Application. This section shall apply to Medicare Select policies and certificates, as defined in this section. No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.~~

~~(b) Definitions. For the purposes of this section:~~

~~(1) "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.~~

~~(2) "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or~~

provision of services concerning a Medicare Select issuer or its network providers.

(3) — ~~"Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.~~

(4) — ~~"Medicare Select policy" or "Medicare Select certificate" mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.~~

(5) — ~~"Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.~~

(6) — ~~"Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.~~

(7) — ~~"Service area" means the geographic area approved by the Commissioner within which an issuer is authorized to offer a Medicare Select policy.~~

(c) — ~~Authorization. The Commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the Commissioner finds that the issuer has satisfied all of the requirements of this regulation.~~

(d) — ~~Plan of operation approval. A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the Commissioner.~~

(e) — ~~Plan of operation requirements. A Medicare Select issuer shall file a proposed plan of operation with the Commissioner in a format prescribed by the Commissioner. The plan of operation shall contain at least the following information:~~

(1) — ~~Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:~~

(A) — ~~Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after hour care. The hours of operation and availability of after hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.~~

(B) — ~~The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:~~

(i) ~~To deliver adequately all services that are subject to a restricted network provision; or~~

(ii) ~~To make appropriate referrals.~~

(C) — ~~There are written agreements with network providers describing specific responsibilities.~~

(D) — ~~Emergency care is available twenty four (24) hours per day and seven (7) days per week.~~

(E) — ~~In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.~~

(2) — ~~A statement or map providing a clear description of the service area.~~

(3) — ~~A description of the grievance procedure to be utilized.~~

- (4) ~~— A description of the quality assurance program, including:

 - (A) ~~— The formal organizational structure;~~
 - (B) ~~— The written criteria for selection, retention and removal of network providers; and~~
 - (C) ~~— The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.~~~~
- (5) ~~— A list and description, by specialty, of the network providers.~~
- (6) ~~— Copies of the written information proposed to be used by the issuer to comply with Subsection (i).~~
- (7) ~~— Any other information requested by the Commissioner.~~
- (f) ~~— Plan of operation amendments. A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the Commissioner prior to implementing the changes. Changes shall be considered approved by the Commissioner after thirty (30) days unless specifically disapproved. An updated list of network providers shall be filed with the Commissioner at least quarterly.~~
- (g) ~~— Non-network providers. A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

 - (1) ~~— The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and~~
 - (2) ~~— It is not reasonable to obtain services through a network provider.~~~~
- (h) ~~— Unavailable services. A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.~~
- (i) ~~— Full disclosure. A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

 - (1) ~~— An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

 - (A) ~~— Other Medicare supplement policies or certificates offered by the issuer; and~~
 - (B) ~~— Other Medicare Select policies or certificates.~~~~
 - (2) ~~— A description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.~~
 - (3) ~~— A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans K and L.~~
 - (4) ~~— A description of coverage for emergency and urgently needed care and other out-of-service area coverage.~~
 - (5) ~~— A description of limitations on referrals to restricted network providers and to other providers.~~
 - (6) ~~— A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.~~
 - (7) ~~— A description of the Medicare Select issuer's quality assurance program and~~~~

~~grievance procedure.~~

~~(j) — Proof of full disclosure. Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Subsection (i) of Section 365:10-5-128.1 and that the applicant understands the restrictions of the Medicare Select policy or certificate.~~

~~(k) — Grievance procedures. A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement.~~

~~(1) — The grievance procedure shall be described in the policy and certificates and in the outline of coverage.~~

~~(2) — At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.~~

~~(3) — Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision makers who have authority to fully investigate the issue and take corrective action.~~

~~(4) — If a grievance is found to be valid, corrective action shall be taken promptly.~~

~~(5) — All concerned parties shall be notified about the results of a grievance.~~

~~(6) — The issuer shall report no later than each March 31st to the Commissioner regarding its grievance procedure. The report shall be in a format prescribed by the Commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.~~

~~(l) — Opportunity to purchase Medicare supplement.~~

~~(1) — At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.~~

~~(2) — At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six (6) months.~~

~~(3) — For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at home recovery services or coverage for Part B excess charges.~~

~~(m) — Coverage upon termination of program. Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.~~

~~(1) — Each Medicare Select issuer shall make available to each individual insured under~~

~~a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.~~

~~(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at home recovery services or coverage for Part B excess charges.~~

~~(n) Cooperation with state and federal agencies. A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.~~

365:10-5-128.2 Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates issued for delivery on or after June 1, 2010

(a) The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of O.A.C. 365:10-5-126 and 365:10-5-127.

(b) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic (core) benefits, as defined in O.A.C. 365:10-5-127.1. If an issuer makes available any of the additional benefits described in O.A.C. 365:10-5-127.1(d), or offers standardized benefit Plans K or L (as described in O.A.C 365:10-5-128.3(f)(8) and (9)), then the issuer shall make available to each prospective policyholder and certificateholder, in addition to a policy form or certificate form with only the basic (core) benefits as described above, a policy form or certificate form containing either standardized benefit Plan C (as described in O.A.C. 365:10-5-128.2(f)(3)) or standardized benefit Plan F (as described in O.A.C. 365:10-5-128.2(f)(5)).

(c) No groups, packages or combinations of Medicare supplement benefits other than those listed in this Section shall be offered for sale in this state, except as may be permitted in O.A.C. 365:10-5-128.2(g) and in O.A.C. 365:10-5-128.3.

(d) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in this Subsection and conform to the definitions in O.A.C. 365:10-5-123. Each benefit shall be structured in accordance with the format provided in O.A.C. 365:10-5-127.1(c) and (d); or, in the case of plans K or L, in O.A.C. 365:10-5-128.2(f)(8) or (9) of this regulation and list the benefits in the order shown. For purposes of this Section, “structure, language, and format” means style, arrangement and overall content of a benefit.

(e) In addition to the benefit plan designations required in Subsection (d) of this section, an issuer may use other designations to the extent permitted by law.

(f) Make-up of 2010 Standardized Benefit Plans:

(1) Standardized Medicare supplement benefit Plan A shall include only the

following: The basic (core) benefits as defined in O.A.C. 365:10-5-127.1(c).

(2) Standardized Medicare supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in Section of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible as defined in 365:10-5-127.1(d)(1).

(3) Standardized Medicare supplement benefit Plan C shall include only the following: The basic (core) benefit as defined in O.A.C. 365:10-5-127.1(c), plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in O.A.C. 365:10-5-127.1(d)(1), (3), (4), and (6), respectively.

(4) Standardized Medicare supplement benefit Plan D shall include only the following: The basic (core) benefit (as defined in O.A.C. 365:10-5-127.1(c), plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in an foreign country as defined in O.A.C. 365:10-5-127.1(d) (1), (3), and (6), respectively.

(5) Standardized Medicare supplement [regular] Plan F shall include only the following: The basic (core) benefit as defined in O.A.C. 365:10-5-127.1(c), plus one hundred percent (100%) of the Medicare Part A deductible, the skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in O.A.C. 365:10-5-127.1(d) (1), (3), (4), (5), and (6).

(6) Standardized Medicare supplement Plan F With High Deductible shall include only the following: one hundred percent (100%) of covered expenses following the payment of the annual deductible set forth in Subparagraph (b).

(A) The basic (core) benefit as defined in 365:10-5-127.1(c), plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in 365:10-5-127.1(d) (1), (3), (4), (5), and (6).

(B) The annual deductible in Plan F With High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by regular Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be \$1,500 and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars (\$10).

(7) Standardized Medicare supplement benefit Plan G shall include only the following: The basic (core) benefit as defined in 365:10-5-127.1(c), plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in 365:10-5-127.1(d) (1), (3), (5), and (6), respectively.

(8) Standardized Medicare supplement Plan K is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(A) Part A Hospital Coinsurance 61st through 90th days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

(B) Part A Hospital Coinsurance, 91st through 150th days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

(C) Part A Hospitalization After 150 Days: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(D) Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subparagraph (x);

(E) Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Subparagraph (x);

(F) Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in Subparagraph (x);

(G) Blood: Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Subparagraph (x);

(H) Part B Cost Sharing: Except for coverage provided in Subparagraph (ix), coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in Subparagraph (x);

(I) Part B Preventive Services: Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(J) Cost Sharing After Out-of-Pocket Limits: Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of \$4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(9) Standardized Medicare supplement Plan L is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

- (A) The benefits described in 365:10-5-128.2(f)(8)(A), (B), (C) and (I);
- (B) The benefit described in 365:10-5-128.2(f)(8)(D), (E), (F), (G) and (H), but substituting seventy-five percent (75%) for fifty percent (50%); and
- (C) The benefit described in 365:10-5-128.2(f)(8)(J), but substituting \$2000 for \$4000.

(10) Standardized Medicare supplement Plan M shall include only the following: The basic (core) benefit as defined in 365:10-5-127.1(c), plus fifty percent (50%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in 365:10-5-127.1(d)(2), (3) and (6).

(11) Standardized Medicare supplement Plan N shall include only the following: The basic (core) benefit as defined in 365:10-5-127.1(c), plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in 365:10-5-127.1(cd)(1), (3) and (6), with copayments in the following amounts:

- (A) the lesser of twenty dollars (\$20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and
- (B) the lesser of fifty dollars (\$50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

(g) New or Innovative Benefits: An issuer may, with the prior approval of the Commissioner, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

365:10-5-128.3. Medicare Select Policies and Certificates [AMENDED AND RENUMBERED FROM 365:10-5-128.1]

(a) **Application.** This section shall apply to Medicare Select policies and certificates, as defined in this section. No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

(b) **Definitions.** For the purposes of this section:

- (1) "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.
- (2) "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.
- (3) "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare

Select policy or certificate.

(4) "Medicare Select policy" or "Medicare Select certificate" mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.

(5) "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

(6) "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

(7) "Service area" means the geographic area approved by the Commissioner within which an issuer is authorized to offer a Medicare Select policy.

(c) **Authorization.** The Commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the Commissioner finds that the issuer has satisfied all of the requirements of this regulation.

(d) **Plan of operation approval.** A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the Commissioner.

(e) **Plan of operation requirements.** A Medicare Select issuer shall file a proposed plan of operation with the Commissioner in a format prescribed by the Commissioner. The plan of operation shall contain at least the following information:

(1) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(A) Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(B) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(i) To deliver adequately all services that are subject to a restricted network provision; or

(ii) To make appropriate referrals.

(C) There are written agreements with network providers describing specific responsibilities.

(D) Emergency care is available twenty-four (24) hours per day and seven (7) days per week.

(E) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

(2) A statement or map providing a clear description of the service area.

(3) A description of the grievance procedure to be utilized.

(4) A description of the quality assurance program, including:

(A) The formal organizational structure;

- (B) The written criteria for selection, retention and removal of network providers; and
- (C) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.
- (5) A list and description, by specialty, of the network providers.
- (6) Copies of the written information proposed to be used by the issuer to comply with Subsection (i).
- (7) Any other information requested by the Commissioner.
- (f) **Plan of operation amendments.** A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the Commissioner prior to implementing the changes. Changes shall be considered approved by the Commissioner after thirty (30) days unless specifically disapproved. An updated list of network providers shall be filed with the Commissioner at least quarterly.
- (g) **Non-network providers.** A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:
 - (1) The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and
 - (2) It is not reasonable to obtain services through a network provider.
- (h) **Unavailable services.** A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.
- (i) **Full disclosure.** A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:
 - (1) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:
 - (A) Other Medicare supplement policies or certificates offered by the issuer; and
 - (B) Other Medicare Select policies or certificates.
 - (2) A description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.
 - (3) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans K and L.
 - (4) A description of coverage for emergency and urgently needed care and other out-of-service area coverage.
 - (5) A description of limitations on referrals to restricted network providers and to other providers.
 - (6) A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.
 - (7) A description of the Medicare Select issuer's quality assurance program and grievance procedure.
- (j) **Proof of full disclosure.** Prior to the sale of a Medicare Select policy or certificate, a

Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Subsection (i) of this Section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

(k) **Grievance procedures.** A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement.

(1) The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

(2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

(3) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

(4) If a grievance is found to be valid, corrective action shall be taken promptly.

(5) All concerned parties shall be notified about the results of a grievance.

(6) The issuer shall report no later than each March 31st to the Commissioner regarding its grievance procedure. The report shall be in a format prescribed by the Commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

(l) **Opportunity to purchase Medicare supplement.**

(1) At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

(2) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six (6) months.

(3) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

(m) **Coverage upon termination of program.** Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

(1) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make

the policies and certificates available without requiring evidence of insurability.

(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

(n) **Cooperation with state and federal agencies.** A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

365:10-5-129. Open enrollment

(a) An ~~No~~ issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this State, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6) month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under this subsection without regard to age.

(b) If an applicant qualifies under subsection (a) or subsection (d) of this Section and submits an application during the time period referenced in said subsection (a) or subsection (d)), and

(1) as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition; or

(2) as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this subsection.

(c) Except as provided in Subsection (b) and Section 365:10-5-140, subsection (a) and subsection (d) of this Section shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective.

(d) At least one of the ten standardized Medicare supplement plans currently available from an issuer shall be made available to all applicants who qualify under this subsection by reason of disability. The issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this State because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for such policy or certificate is submitted during the six (6) month period beginning with the first month in which an individual first enrolled for benefits under Medicare Part B.

(e) In the event Social Security backdates the Medicare enrollment date, the six-month enrollment period shall be calculated from the date the individual first receives notification of

approval of Medicare coverage.

365:10-5-129.1. Guaranteed Issue for Eligible Persons

(a) **Guaranteed Issue.**

(1) Eligible persons are those individuals described in subsection (b) who apply to enroll under the policy not later than sixty-three (63) days after the date of the termination of enrollment described in subsection (b), and who submit evidence of the date of termination, disenrollment or Medicare Part D enrollment with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection (c) that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

(b) **Eligible Persons.** An eligible person is an individual described in any of the following paragraphs:

(1) **Employee welfare benefit plan.** The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all or substantially all supplemental health benefits to the individual.

(2) **Medicare Advantage.** The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

(A) The certification of the organization's organization or plan's plan certification [under this part] has been terminated;

~~(B)~~ (B) ~~or the~~ The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

~~(BC)~~ (C) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;

~~(CD)~~ (D) The individual demonstrates, in accordance with guidelines established by the Secretary, that:

(i) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or

- the failure to provide such covered care in accordance with applicable quality standards; or
- (ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or
- (DE) The individual meets such other exceptional conditions as the Secretary may provide.
- (3) **Organizations.**
- (A) The individual is enrolled with:
- (i) An eligible organization under a contract under Section 1876 (Medicare risk or cost);
- (ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;
- (iii) An organization under an agreement under Section 1833(a)(1)(A) (health care prepayment plan); or
- (iv) An organization under a Medicare Select Policy; and
- (B) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Section 365:10-5-129.1(b)(2).
- (4) **Medicare supplement.** The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:
- (A) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or because of other involuntary termination of coverage or enrollment under the policy;
- (B) The issuer of the policy substantially violated a material provision of the policy; or
- (C) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;
- (5) **Termination of enrollment and subsequent enrollment.** The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare risk or cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act or a Medicare Select Policy; and an organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan), or a Medicare Select policy; and the subsequent enrollment under this subparagraph is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act); or
- (6) **Medicare Advantage disenrollment.**
- (A) The individual, upon first becoming ~~both enrolled in~~ eligible for benefit under Medicare Part A of Medicare and at age 65 years of age or older, enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan by not

later than twelve (12) months after the effective date of enrollment.

~~(B) The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in Subsection 365:10-5-129.1(e)(4).~~

~~(C) An individual, under age 65, who first becomes eligible for Medicare Part B and enrolls in a Medicare Advantage plan under part C of Medicare, and disenrolls from the plan by not later than twelve (12) months after the effective date of enrollment.~~

(7) **Part D Benefit Enrollment.** The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in Subsection 365:10-5-129.1(e)(4).

(c) **Guaranteed issue time periods.**

(1) In the case of an individual described in Section 365:10-5-129.1(b)(1), the guaranteed issue period begins on the later of the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of such a termination or cessation); or the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter;

(2) In the case of an individual described in Section 365:10-5-129.1(b)(2), (b)(3), (b)(5) or (b)(6) whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated;

(3) In the case of an individual described in Section 365:10-5-129.1(b)(4)(A), the guaranteed issue period begins on the earlier of the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and the date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage is terminated.

(4) In the case of an individual described in Section 365:10-5-129.1(b)(2), (b)(4)(B), (b)(4)(C), (b)(5) or (b)(6) who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date;

(5) In the case of an individual described in Subsection 365:10-5-129.1(b)(6), the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty-day (60) period immediately preceding the initial Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and

(6) In the case of an individual described in Section 365:10-5-129.1(b) but not described in the preceding provisions of this Subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three (63)

days after the effective date.

(d) **Extended Medigap access for interrupted trial periods.**

(1) In the case of an individual described in Section 365:10-5-129.1(b)(5) (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in Section 365:10-5-129.1(b)(5)(A) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in Section 365:10-5-129.1(b)(5);

(2) In the case of an individual described in Section 365:10-5-129.1(b)(6) (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in Section 365:10-5-129.1(b)(6) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in Section 365:10-5-129.1(b)(6); and

(3) For purposes of Sections 365:10-5-129.1(b)(5) and (b)(6), no enrollment of an individual with an organization or provider described in Section 365:10-5-129.1(b)(5)(a), or with a plan or in a program described in Section 365:10-5-129.1(b)(6), may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

(e) **Products to which eligible persons are entitled.** The Medicare supplement policy to which eligible persons are entitled under:

(1) **Section 365:10-5-129.1(b)(1), (2), (3) and (4).** Section 365:10-5-129.1(b)(1), (2), (3) and (4) is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer.

(2) **Section 365:10-5-129.1(b)(5).**

(A) Subject to subparagraph (B), Section 365:10-5-129.1(b)(5) is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Section 365:10-5-129.1(c)(1).

(B) After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in this subparagraph is: The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or at the election of the policyholder, an A, B, C, F (including F with a high deductible, K or L) policy that is offered by any issuer;

(3) **Section 365:10-5-129.1(b)(6)(A).** Section 365:10-5-129.1(b)(6)(A) shall include any Medicare supplement policy offered by any issuer.

(4) **Section 365:10-5-129.1(b)(6)(B).** Section 365:10-5-129.1(b)(6)(B) is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible, K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage .

(f) **Notification provisions.**

(1) At the time of an event described in Section 365:10-5-129.1(b) because of which an individual loses coverage or benefits due to the termination of a contract or agreement,

policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Section 365:10-5-129.1(a). Such notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in Section 365:10-5-129.1(b) because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Section 365:10-5-129.1(a). Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

365:10-5-134. Required disclosure provisions

(a) General rules.

(1) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of such provision shall be consistent with the type of contract issued. Such provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(2) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

(3) Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import.

(4) If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

(5) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(6) If the issuer does not return any premiums or moneys paid therefor within thirty (30) days from the date of cancellation, the issuer shall pay interest on the proceeds which shall be the same rate of interest as the average United States Treasury Bill rate of the preceding calendar year as certified to the State Insurance Commissioner by the State Treasurer on the first regular business day in January of each year, plus two percentage points which shall accrue from the date of cancellation until the premiums or moneys are returned. In such event, the policy shall be deemed to have been cancelled on the date the policy was placed in the United States mails in a properly addressed, postage paid envelope; or, if not so posted, on the date of delivery of such policy to the issuer.

(7) Issuers of accident and health policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis, to a person(s) eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the CMS and in a type size no smaller than 12 point type. Delivery of the Guide shall be made whether or not such policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this Part. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgement of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered. For purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

(b) **Notice requirements.**

(1) As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificateholders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the Commissioner. Such notice shall:

(A) Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate, and

(B) Inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare.

(2) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

(3) Such notices shall not contain or be accompanied by any solicitation.

(c) **MMA notice requirements.**

Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

(d) **Outline of coverage requirements for Medicare supplement policies.**

(1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of such outline from the applicant.

(2) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany such policy or certificate when it is delivered and contain the following

statement, in no less than twelve (12) point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

(3) The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed in Appendix S of this Chapter in no less than twelve (12) point type. All plans ~~A-E~~ shall be shown on the cover page, and the plan(s) that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(4) The outline of coverage shall include the items described in Appendix S of this Chapter, in the order prescribed by Appendix S. The appropriate version of the outline of coverage as set out in Appendix S shall be used.

(e) **Notice regarding policies or certificates which are not Medicare supplement policies.**

(1) Any accident and health insurance policy or certificate, other than a Medicare supplement policy, a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. ' 1395 et seq.), disability income policy, or other policy identified in 365:10-5-122(b), issued for delivery in this State to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than twelve (12) point type and shall contain the following language:

"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

(2) Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in Subsection (d)(1) of this Section shall disclose, using the applicable statement in Appendix V, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

365:10-5-143. Prohibition Against Use of Genetic Information and Requests for Genetic Testing

(a) This Section applies to all policies with policy years beginning on or after May 21, 2009.

(b) An issuer of a Medicare supplement policy or certificate:

(1) Shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a pre-existing condition) on the basis of the genetic information with respect to such individual; and

- (2) Shall not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.
- (c) Nothing in Subsection (a) shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from
- (1) Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or
- (2) Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group).
- (d) An issuer of a Medicare supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.
- (e) Subsection (c) shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under part C of title XI and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) and consistent with Subsection (a).
- (f) For purposes of carrying out Subsection (d), an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.
- (g) Notwithstanding Subsection (c), an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:
- (1) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.
- (2) The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that:
- (A) compliance with the request is voluntary; and
- (B) non-compliance will have no effect on enrollment status or premium or contribution amounts.
- (3) No genetic information collected or acquired under this Subsection shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.
- (4) The issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this Subsection, including a description of the activities conducted.
- (5) The issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this Subsection.
- (h) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.
- (i) An issuer of a Medicare supplement policy or certificate shall not request, require, or

purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

(j) If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of Subsection (h) if such request, requirement, or purchase is not in violation of Subsection (g).

(k) For the purposes of this Section only:

(1) "Issuer of a Medicare supplement policy or certificate" includes third-party administrator, or other person acting for or on behalf of such issuer.

(2) "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.

(3) "Genetic information" means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual.

(4) "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

(5) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(6) "Underwriting purposes" means,

(A) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;

(B) the computation of premium or contribution amounts under the policy;

(C) the application of any pre-existing condition exclusion under the policy; and

(D) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

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

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

~~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 [REVOKED]

~~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 [REVOKED]

~~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 [REVOKED]

~~(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 benefits shall not be conditioned upon the payment or receipt of premiums before coverage is provided.~~

~~(6) — Premiums for the extension of benefits may be withheld from any claim payment for covered expenses incurred and due during the extension of benefits 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 [REVOKED]

~~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 [REVOKED]

~~(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.~~

SUBCHAPTER 27. PRENEED LIFE INSURANCE MINIMUM STANDARDS FOR DETERMINING RESERVE LIABILITIES AND NONFORFEITURE VALUES REGULATION

365:10-27-1. Authority

This regulation is promulgated by the Insurance Commissioner pursuant to Sections 1510(A)(4)(iii) and 4029(H)(4)(h)(vi) of Title 36 of the laws of this state.

365:10-27-2. Scope

This regulation applies to preneed insurance, as defined in Section 365:10-27-4 of this regulation, and to similar policies and certificates. The Insurance Commissioner shall have the authority to determine what constitutes similar policies and certificates.

365:10-27-3. Purpose

The purpose of this regulation is to establish for preneed insurance products minimum mortality standards for reserves and nonforfeiture values, and to require the use of the 1980 Commissioners Standard Ordinary (CSO) Mortality Table for use in determining the minimum standard of valuation of reserves and the minimum standard nonforfeiture values for preneed insurance products. Research completed by the Deloitte University of Connecticut Actuarial Center and commissioned by the Society of Actuaries as a part of a study of preneed mortality determined that the 2001 CSO Mortality Table, currently recognized as the prevailing table for the purposes of calculating reserves and nonforfeiture values both on a statutory basis and on a tax basis, produced inadequate reserves for insurance policies issued in support of a prearrangement agreement which provides goods and services at the time of an insured's death.

365:10-27-4. Definitions

The following words and terms when used in this Subchapter shall have the following meaning unless the context clearly indicates otherwise:

"2001 CSO Mortality Table" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the American Academy of Actuaries CSO Task Force from the Valuation Basic Mortality Table developed by the Society of Actuaries Individual Life Insurance Valuation Mortality Task Force, and adopted by the NAIC in December 2002. The 2001 CSO Mortality Table is included in the *Proceedings of the NAIC (2nd Quarter 2002)*. Unless the context indicates otherwise, the "2001 CSO Mortality Table" includes both the ultimate form of that table and the select and ultimate form of that table and includes both the smoker and nonsmoker mortality tables and the composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality tables.

"Ultimate 1980 CSO" means the Commissioners' 1980 Standard Ordinary Mortality

Tables (1980 CSO) without ten-year (10-year) selection factors, incorporated into the 1980 amendments to the NAIC Standard Valuation Law approved in December 1983.

"Preneed insurance" means for purposes of this regulation any insurance policy or certificate that is issued for the purpose of funding contracts for prepaid funeral benefits pursuant to Section 6125.2 of Title 36 of the laws of this state and the Prepaid Funeral Benefits Act, 36 O.S. § 6121, et seq.

365:10-27-5. Minimum valuation mortality standards

For preneed insurance and similar insurance policies and certificates, the minimum mortality standard for determining reserve liabilities and nonforfeiture values for both male and female insureds shall be the Ultimate 1980 CSO.

365:10-27-6. Transition rules

(a) For preneed insurance policies issued on or after the effective date of this regulation and before January 1, 2012, the 2001 CSO Mortality Table may be used as the minimum standard for reserves and minimum standard for nonforfeiture benefits for both male and female insureds.

(b) If an insurer elects to use the 2001 CSO Mortality Table as a minimum standard for any policy issued on or after the effective date of this regulation and before January 1, 2012, the insurer shall provide, as a part of the actuarial opinion memorandum submitted in support of the company's asset adequacy testing, an annual written notification to the domiciliary commissioner. The notification shall include:

(1) A complete list of all preneed insurance policy forms that use the 2001 CSO Mortality Table as a minimum standard;

(2) A certification signed by the appointed actuary stating that the reserve methodology employed by the company in determining reserves for the preneed insurance policies issued after the effective date and using the 2001 CSO Mortality Table as a minimum standard, develops adequate reserves. For the purposes of this certification, the preneed insurance policies using the 2001 CSO as a minimum standard cannot be aggregated with any other policies.; and

(3) Supporting information regarding the adequacy of reserves for preneed insurance policies issued after the effective date of this regulation and using the 2001 CSO Mortality Table as a minimum standard for reserves.

(c) Preneed insurance policies issued on or after January 1, 2012, must use the Ultimate 1980 CSO in the calculation of minimum nonforfeiture values and minimum reserves.

**APPENDIX EE. TRIGGERS FOR A SUBSTANTIAL PREMIUM INCREASE
[REVOKED AND REENACTED]**

**TABLE 1. TRIGGERS FOR A SUBSTANTIAL PREMIUM INCREASE
PURSUANT TO O.A.C. 365:10-5-48.6(g)(3)**

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

**TABLE 2. TRIGGERS FOR A SUBSTANTIAL PREMIUM INCREASE
PURSUANT TO O.A.C. 365:10-5-48.6(g)(4)**

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

**APPENDIX LL. NOTICE TO APPLICANT REGARDING REPLACEMENT OF
INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE
INSURANCE FOR SOLICITATIONS OTHER THAN DIRECT RESPONSE
[NEW]**

**NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL
ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE**

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]:

(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right,

but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

(Signature of Agent, Broker or Other Representative)
[Typed Name and Address of Agent or Broker]

The above "Notice to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)

APPENDIX MM. NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE FOR DIRECT RESPONSE SOLICITATIONS [NEW]

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)