Section 1. Purpose
Section 2. Authority
Section 3. Applicability and Scope
Section 4. Definitions
Section 5. Policy Definitions
Section 6. Policy Practices and Provisions
Section 7. Unintentional Lapse
Section 8. Required Disclosure Provisions
Section 9. Required Disclosure of Rating Practices to Consumer
Section 10. Initial Filing Requirements
Section 11. Prohibition Against Post Claims Underwriting
Section 12. Minimum Standards for Home and Community Care Benefits in Limited Long-Term Care Insurance Policies
Section 13. Requirement to Offer Inflation Protection
Section 14. Requirements for Application Forms and Replacement Coverage
Section 15. Reporting Requirements
Section 16. Licensing
Section 17. Discretionary Powers of Commissioner
Section 18. Reserve Standards
Section 19. Premium Rate Schedule Increases
Section 20. Filing Requirement
Section 21. Filing Requirements for Advertising
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(3) The term “noncancellable” may be used only when the insured has the right to continue the limited 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 t-ys The -0.6 (24)-3.8 (c 0.004 Tw ld(-)Tj)-5.2(er)-1r

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(5) For the purposes of this section, "converted policy" means an individual policy of limited 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 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

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

(b) The right to a revised premium rate or rate schedule as provided in Paragraph (3) if the premium rate or rate schedule is changed;

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

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

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

(iii) The amount or percent of each increase. The percentage may be expressed as a perce6 ( )-51r7.6 (er)-1. noate o hrt1.8 (c)1013 13eeoalabhoT1.295 7 T

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States should be aware of, and review situations,

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

(2) If the medications listed in the application were known by the insurer or should have been

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

B. Where the policy is issued to a group, the required offer in Subsection A above shall be made to the group certificateholder.

C. (1) Insurers shall include the following information in or with the outline of coverage:

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

(b) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

(2) An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

: It is intended that meaningful inflation protection be provided. Meaningful benefit minimums or durations could include providing increases to attained age,fen.7 (l)3.4 (at)3.4 (n)-0-1 (as)-u7 ( )-6.6 7.1 (po)-4 -0, t6 (h)-0.6l0.6 (c)4 (r)3.3 (e)-1[(at)2 24 (n)-0 (,).2 ynleefmuat

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[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 limited long-term care insurance or long-term care insurance and replace it with an individual limited 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 limited long-term care insurance 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 limited 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 that 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 limited long-term care insurance or 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 your sign it, reread it carefully to be certain that all information has been properly recorded.

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(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:

_____ _____

(Applicant's Signature) (Date)

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[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 limited long-term care insurance or long-term care insurance and replace it with the limited long-term care insurance policy delivered herewith issued by [company name] Insurance Company. t

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(b) An actuarial memorandum dated and signed by a member of the American Academy of Actuaries who prepares the information shall be prepared to support the actuarial certification and provide at least the following information:

(i) A detailed explanation of the data sources and review performed by the actuary prior to making the statement in Paragraph (2)(a).

(ii) A complete description of experience assumptions and their relationship to the initial pricing assumptions.

: Actuarial Standard of Practice (ASOP) No. 18, the NAIC *Guidance Manual for the Rating Aspects of the Long-Term Care Insurance Model Regulation* (#641) and the Academy of Actuaries Practice Note "Long-Term Care Insurance, Compliance with the NAIC Long-Term Care Insurance Model Regulation Relating to Rate Stability" all provide details concerning the key pricing assumptions, underlying actuarial judgments and the manner in which experience should be monitored.

(iii) A description of the credibility of the experience data.

(iv) An explanation of the analysis and testing performed in determining the current presence of margins.

(c) The [illegible]

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

C. (1) With respect to the obligations set forth in this subsection, the primary responsibility of an association, as defined in [insert citation to Section 4E(2) of the NAIC *Limited Long-Term Care Insurance Model Act*] (#642), when endorsing or selling limited long-term care insurance shall be to educate its members concerning limited long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding limited long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

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

(a) The policy and certificate,

(b) A corresponding outline of coverage, and

(c) All advertisements requested by the insurance e 0 Td0.7 ( )-5.5 (po)-3 (l)-0.Ct3S-3.5 (e)1.2 (e)

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

A. An insurer shall notify policyholders of the availability of a new limited long-

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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 who purchased such a new proprietary policy shall be notified when a new limited long-term care policy series that provides coverage for new limited 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 notrl insn2 sse,35c

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(1) Be based on the same age and underwriting class used to determine the premium for the coverage currently in force; and

(2) Be consistent with the approved rate table.

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 Section 7A(3) of this regulation.

F. The requirements of Subsections A through E shall apply to any limited long-term care policy issued in this state on or after [insert date that is twelve (12) months after adoption of the regulation].

G. A premium increase notice required by Section 9E of this regulation shall include:

(1) An offer to reduce policy benefits provided by the current coverage consistent with the requirements of this section;

(2) A disclosure stating that all options available to the policyholder may not be of equal value; and

H. The requirements of Subsection G shall apply to any rate increase implemented in this state on or after [insert date that is twelve (12) months after adoption of the regulation].

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C. (1) After rejection of the offer made under [insert reference to Section 8 of the NAIC *Limited Long-Term Care Insurance Model Act* (#642)], 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.

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(3) The nonforfeiture benefit shall begin no 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.

(4) 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.

E. 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.

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

G. To determine whether contingent nonforfeiture upon lapse provisions are triggered under S(d)-0.6 r9w ari 37 (b)-Tj-0.001 Tc 0.256 Tw 2.3D0.257 03 ( )]TJ43(.)TTj0.036 Tw(3e t) or4.73Tj-0.001 Tc 3D0.2

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D. For purposes of this section, the determination of a deficiency shall not be more restrictive than:

(1) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

(2) If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

E. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses, or social workers.

F. Limited long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

A. For purposes of this section, "authorized representative" is authorized to act as the covered person's personal representative within the meaning of 45 CFR 164.

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C. Internal Appeal. The insured or the insured's authorized representative may appeal the insurer's adverse benefit trigger determination by sending a written request to the insurer, along with any additional supporting information, within 120 calendar days after the insured and the insured's authorized representative, if applicable, receives the insurer's benefit determination notice. The internal appeal shall be considered by an individual or group of individuals designated by the insurer, provided that the individual or individuals making the internal appeal decision may not be the same individual or individuals who made the initial benefit determination. The internal appeal shall be completed, and written notice of the internal appeal decision shall be sent to the insured and the insured's authorized representative, if applicable, within thirty (30) calendar days of the insurer's receipt of all necessary information upon which a final determination can be made.

(1) If the insurer's original determination is upheld upon internal appeal, the notice of the internal appeal decision shall describe any additional internal appeal rights offered by the insurer. Nothing herein shall require the insurer to offer any internal appeal rights other than those described in this subsection.

(2) If the insurer's original determination is upheld after the internal appeal process has been exhausted, and new or additional information has not been provided to the insurer, the insured has the right to contact their State Department of Insurance and their State Health Insurance Program (SHIP) office.

A. For purposes of this section:

(1) "Claim" means a request for payment of benefits under an in-force policy, regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.

(2) "Clean claim" means a claim that has no defect or /AMCID 20 BDC ed-1.7 (p)-0.6f d-1.7 (p)-0.6fa

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D. If an insurer fails to comply with S

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[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

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

1. This policy is [an individual policy of insurance] [a group policy] which was issued in the [indicate jurisdiction in which group policy was issued].

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the

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4. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

[In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium, and if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

5. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [Provide a brief description of the right to return–"free look" provision of the policy.]

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

6. THIS IS NOT TRADITIONAL LONG-TERM CARE COVERAGE. THIS IS LIMITED LONG-TERM CARE COVERAGE AND DOES NOT MEET THE MINIMUM STANDARDS OF TRADITIONAL LONG-TERM CARE INSURANCE

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government, or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the federal government, or any state government.

8. LIMITED LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered limited long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

9. BENEFITS PROVIDED Bx ( )-2.9 (n)-0.6 a cIS1 (ix)h. 0.2497MC /P <</MCID 22 >>BDC 0 -1.219 4D(9)Tj0(a h)2.4-0(a h)2j0.279

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[Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the triggers should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.]

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Non-eligible facilities and provider;

(c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) Exclusions and exceptions;

(e) Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in Number 5 above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LIMITED LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS

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13. PREMIUM.

[(a) State the total annual premium for the policy;

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option

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_____ *Insurers shall provide all of the following information to the applicant regarding premium, premium adjustments, potential premium increases, and policyholder options in the event of a premium increase except as*

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For the State of _____ For the Reporting Year of _____

Company Name: _____ Due: June 30 annually
Company Address: _____ Company NAIC Number: _____
Contact Person: _____ Phone Number: (____)_____

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Chronological Summary of Action (all references are to the Proceedings of the NAIC).

4th Quarter 2018 (adopted new model)

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