

State of Rhode Island and Providence Plantations
DEPARTMENT OF BUSINESS REGULATION
Division of Insurance
233 Richmond Street
Providence, RI 02903

INSURANCE REGULATION 44

LONG-TERM CARE INSURANCE

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Section 1 Purpose

The purpose of this Regulation is to implement R.I. Gen. Laws § 27-34.2-1 *et seq.*, to promote the public interest, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages, and to facilitate flexibility and innovation in the development of long-term care insurance. This Regulation is not intended to interfere with the qualification of long-term care policies or certificates as provided for in Chapter 97, SEC. 7702B of the U.S. Internal Revenue Code of 1986, as added by the Health Insurance Portability and Accountability Act of 1996 [P.L. 104-191], as now constituted or later amended.

Section 2 Authority

This Regulation is issued pursuant to the authority vested in the Director under R.I. Gen. Laws § 27-34.2-6(A).

Section 3 Applicability and Scope

Except as otherwise specifically provided, this Regulation applies to all long-term care insurance as defined in R.I. Gen. Laws § 27-34.2-4.

Section 4 Definitions

For the purpose of this Regulation, the terms "long-term care insurance," "group long-term care insurance," "director," "applicant," "policy," "certificate" and "issuer" shall have the meanings set forth in R.I. Gen. Laws § 27-34.2-4.

Section 5 Policy Definitions

No long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

- A. "Activities of daily living" means at least bathing, continence, dressing, eating, toileting and transferring.
- B. "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.
- C. "Adult day care" means a program for six (6) or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other

disabled adults who can benefit from care in a group setting outside the home.

- D. "Bathing" means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- E. "Cognitive impairment" means a deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.
- F. "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).
- G. "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- H. "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.
- I. "Hands-on assistance" means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activity of daily living.
- J. "Home health care services" means medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.
- K. "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 Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.
- L. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.
- M. "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

- N. "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.
- O. "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- P. "Transferring" means moving into or out of a bed, chair or wheelchair.
- Q. All providers of services, including but not limited to facilities licensed under R.I. Gen. Laws §§ 23-17-1 *et seq* and 23-17.4-1 *et seq* and similar facilities licensed under the laws of other jurisdictions, shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

Section 6 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 Section 8 of this Regulation.
 - (1) A policy issued to an individual shall not 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.
- B. Limitations and Exclusions. A policy may not 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:

- (1) Preexisting conditions or diseases;
 - (2) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's disease, other dementias nor organic brain disorder;
 - (3) Alcoholism and drug addiction;
 - (4) Illness, treatment or medical condition arising out of:
 - (a) War or act of war (whether declared or undeclared);
 - (b) Participation in a felony, riot or insurrection;
 - (c) Service in the armed forces or units auxiliary thereto;
 - (d) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;
 - (e) Aviation (this exclusion applies only to non-fare-paying passengers).
 - (5) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (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.
 - (6) This subsection B 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 the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The 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 the 1998 amendments to this section, as provided in Section 23, 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 that maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The director 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 issuer 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 director 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 director, 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 issuer 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 director 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 section.
- (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 that provides benefits on the basis of incurred expenses, may contain a provision that 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. The 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, an 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 issuer 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 issuer and premiums charged to persons under the new group policy:

- (1) Shall not result in an 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 Changes

- (1) The premium charged to an insured 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 Section 19, 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 Section 19, 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 R.I. Gen. Laws § 27-34.2-(4)(i), any requirement that a signature of an insured be obtained by a producer or issuer shall be deemed satisfied if:
 - (a) The consent is obtained by telephonic or electronic enrollment by the group policyholder or issuer. 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 confidentiality is maintained with respect to individually identifiable information, including 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 issuer shall make available, upon request of the director, records that will demonstrate the issuer's ability to confirm enrollment and coverage amounts.

Section 7 Unintentional Lapse -- Reinstatement

In addition to the requirements in R.I. Gen. Laws § 27-34.2-13, a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse if the issuer is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. 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 contained in the policy and certificate.

Section 8 Required Disclosure Provisions

- A. **Renewability.** Individual long-term care insurance policies shall contain a renewability provision. The 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 nonrenew is reserved solely to the policyholder.
- B. **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 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, the premium charge shall be set forth in the policy, rider or endorsement.
- C. **Payment of Benefits.** A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of the terms and an explanation of the terms in its accompanying outline of coverage.
- D. **Limitations.** If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."
- E. **Other Limitations or Conditions on Eligibility for Benefits.** A long-term care insurance policy or certificate containing any limitations or conditions for eligibility 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."

- F. Disclosure of Tax Consequences. With regard to life insurance policies that 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.
- G. 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, explanation of the trigger shall 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 shall be specified.

Section 9 Prohibition Against Post-Claims Underwriting

- A. All applications for long-term care insurance policies or certificates except those which are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.
- B.
 - (1) If an application for long-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.
 - (2) If the medications listed in such application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.
- C. Except for policies or certificates which are guaranteed issue:
 - (1) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate:

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

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

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

- (3) Prior to issuance of a long-term care policy or certificate to an applicant age eighty (80) or older, the insurer shall obtain one of the following:

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

- D. A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.
- E. Every issuer selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those which the insured voluntarily effectuated and shall annually furnish this information to the director in the format in Appendix A.

Section 10 Minimum Standards for Home Health Care Benefits in Long-Term Care Insurance Policies

- A. A long-term care insurance policy or certificate may not, in it provides benefits for home health care or community services, limit or exclude benefits:

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

- C. Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

Section 11 Requirement to Offer Inflation Protection

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

- (1) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent (5%);
 - (2) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent (5%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or
 - (3) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.
- B. Where the policy is issued to a group, the required offer in Subsection A above shall be made to the group policyholder; except, if the policy is issued to a group defined in R.I. Gen. Laws § 27-34.2-4(4)(v) other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.
- C. The offer in Subsection A above shall not be required of life insurance policies or riders containing accelerated long-term care benefits.
- D. (1) Issuers 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 issuer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.
- E. Inflation protection benefit increases under a policy which contains these benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.
- F. An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the issuer expects to

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

- G. (1) Inflation protection as provided in Subsection A (1) of this section shall be included in a long-term care insurance policy unless an issuer obtains a rejection of inflation protection signed by the policyholder as required in this subsection.
- (2) The rejection shall be considered a part of the application and shall state:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I reject inflation protection.

Section 12 Requirements for Replacement

- A. 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 producer, except where the coverage is sold without a producer, containing the questions may be used. With regard to a replacement policy issued to a group defined by R.I. Gen. Laws § 27-34.2-4(4)(i), 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 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. Producers shall list any other health insurance policies they have sold to the applicant.
- (1) List policies sold that are still in force.
- (2) List policies sold in the past five (5) years that are no longer in force.
- C. Solicitations Other Than Direct Response. Upon determining that a sale will involve replacement, an issuer; other than an issuer using direct response solicitation methods, or its producer; 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 issuer. The required notice shall be provided in the following manner:

**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 PRODUCER 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 issuer 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 issuer or its producer 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 Producer or Other Representative)

[Typed Name and Address of Producer]

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

(Applicant's Signature)

(Date)

- D. Direct Response Solicitations. Issuers 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:

**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 issuer 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 issuer or its producer 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 or complete, or if any past medical history has been left out of the application.

[Company Name]

- E. Where replacement is intended, the replacing issuer shall notify, in writing, the existing issuer of the proposed replacement. The existing policy shall be identified by the issuer, name of the insured and policy number or address including zip code. Notice shall be made within five (5) working days from the date the application is received by the issuer or the date the policy is issued, whichever is sooner.
- F. 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 issuer shall comply with the requirements of Insurance Regulation 29. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing issuer shall comply with both the long-term care and the life insurance replacement requirements.

Section 13 Reserve Standards

- A. When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits shall be determined in accordance with R.I. Gen. Laws § 27-4.5-1 *et seq.*
- B. Claim reserves must also be established in the case when the policy or rider is in claim status.

Reserves for policies and riders subject to this subsection should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

In the development and calculation of reserves for policies and riders subject to this subsection, due regard shall be given to the applicable

policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

- (1) Definition of insured events;
- (2) Covered long-term care facilities;
- (3) Existence of home convalescence care coverage;
- (4) Definition of facilities;
- (5) Existence or absence of barriers to eligibility;
- (6) Premium waiver provision;
- (7) Renewability;
- (8) Ability to raise premiums;
- (9) Marketing method;
- (10) Underwriting procedures;
- (11) Claims adjustment procedures;
- (12) Waiting period;
- (13) Maximum benefit;
- (14) Availability of eligible facilities;
- (15) Margins in claim costs;
- (16) Optional nature of benefit;
- (17) Delay in eligibility for benefit;
- (18) Inflation protection provisions; and
- (19) Guaranteed insurability option.

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

- B. When long-term care benefits are provided other than as in Subsection A above, reserves shall be determined in accordance with R.I. Gen. Laws § 27-4.5-10 and regulations promulgated thereunder.

Section 14 Loss Ratio

- A. Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:
- (1) Statistical credibility of incurred claims experience and earned premiums;
 - (2) The period for which rates are computed to provide coverage;
 - (3) Experienced and projected trends;
 - (4) Concentration of experience within early policy duration;
 - (5) Expected claim fluctuation;
 - (6) Experience refunds, adjustments or dividends;
 - (7) Renewability features;
 - (8) All appropriate expense factors;
 - (9) Interest;
 - (10) Experimental nature of the coverage;
 - (11) Policy reserves;
 - (12) Mix of business by risk classification; and
 - (13) Product features such as long elimination periods, high deductibles and high maximum limits.
- B. Subsection A shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

- (1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
- (2) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of R.I. Gen. Laws § 27-4.5-1 *et seq*;
- (3) The policy meets the disclosure requirements of R.I. Gen. Laws §§ 27-34.2-6(j), (k) and (l):
- (4) An actuarial memorandum is filed with the director that includes:
 - (a) A description of the basis on which the long-term care rates were determined;
 - (b) A description of the basis for the reserves;
 - (c) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
 - (d) A description and a table of each actuarial assumption used. For expenses, an issuer must include percent of premium dollars per policy and dollars per unit of benefits, if any;
 - (e) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
 - (f) The estimated average annual premium per policy and the average issue age;
 - (g) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
 - (h) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values

and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

Section 15 Filing Requirements

Approval under this section relates to Rhode Island requirements only. It expresses no opinion concerning federal tax qualification.

- A. Forms Delivered or Issued for Delivery in Rhode Island Used in Connection With Policies Issued or Delivered in Another State That Does Not Have Substantially Similar Requirements as Provided in R.I. Gen. Laws § 27-34.2-5 and Forms Subject To Rhode Island Jurisdiction Under R.I. Gen. Laws § 27-34.2-5.

No long-term care insurance contract shall be issued or delivered to any person in this state nor shall any application, rider, endorsement, individual certificate, subscriber contract, group master contract or outline of coverage to be used in connection therewith be issued or delivered until a copy of the form thereof and of the classification of risks and the premium rates or the rating formula have been approved by the Director. Forms submitted for approval in accordance with this Part must be submitted as follows:

1. A letter in duplicate must be included with each submission which:
 - a. specifies the form number and title of each form being submitted;
 - b. generally describes the purpose of each form;
 - c. states whether the form is new or a replacement of any existing form and describes by title and form number any forms being replaced;
 - d. with respect to applications and other forms which have been previously approved and are submitted in support of such filing, states the date(s) of approval of such form(s).
 - e. with respect to any form that does not include inflation protection in conformance with the requirements of Section 11 of this Regulation, states the form number and date of approval in Rhode Island of the rider of alternative policy to be offered to meet the requirements of Section 11 of this Regulation.

2. One specimen copy of each form in final printed form including a specimen of the application, if any, to be used with such form, whether or not such application has been previously approved (two copies if the insurer wishes to have a stamped copy returned for its records) with all blanks in the printed form filled in with hypothetical information, except that no hypothetical information is required on application forms. With respect to rider, endorsement or other amendment forms for use with individual health benefit contracts, one specimen of each contract form to which it will be attached, whether or not such contract form has been previously approved.
3. One specimen copy of each rate schedule or rating formula together with a complete description of the method by which the rates were calculated and a demonstration that the expected loss ratio complies with Section 14 of this Regulation.
4. One specimen copy of the Standard Format Outline of Coverage to be used with each form.
5. A stamped, self-addressed envelope.

B. Extraterritorial -- Insurance Under Coverage Issued in Another State

Prior to an issuer offering group long-term care insurance to a resident of this state pursuant to R.I. Gen. Laws § 27-34.2-5, it shall file with the Director a copy of the certificate and the outline of coverage, along with evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state.

C. Approval of Materials Filed as Provided in This Section between the Effective Date of the 1998 Amendments to This Regulation and January 1, 1999.

If a section of the letter described in subsection A1 that begins "Re:" contains the words "Intended to comply with 1998 amendments," the material filed with that letter, once approved, will not be required to be re-approved as provided in Section (23) D of this Regulation.

Section 16 Filing Requirements for Advertising

The director may, at his discretion, require any issuer providing long-term care insurance or benefits in this state to provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio or television medium to the director for review or approval by the director to the extent it may be

required under state law. In addition, all advertisements shall be retained by the issuer for at least three (3) years from the date the advertisement was first used.

Section 17 Suitability

- A. This section shall not apply to life insurance policies that accelerate benefits for long-term care.
- B. Every issuer marketing long-term care insurance shall:
 - (1) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;
 - (2) Train its producers in the use of its suitability standards; and
 - (3) Maintain a copy of its suitability standards and make them available for inspection upon request by the director.
- C.
 - (1) To determine whether the applicant meets the standards developed by the issuer, the producer and issuer shall develop procedures that take the following into consideration:
 - (a) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;
 - (b) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and
 - (c) The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.
 - (2) The issuer, and where a producer is involved, the producer shall make reasonable efforts to obtain the information set out in Paragraph (1) above. The efforts shall include presentation to the applicant, at or prior to application, of the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Appendix B, in not less than twelve (12) point type. The issuer may request the applicant to provide additional information to comply with its suitability standards.

- (3) A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be resumed for sales of employer group long-term care insurance to employees and their spouses.
- (4) The sale or dissemination outside the company or agency by the issuer or producer of information obtained through the personal worksheet in Appendix B is prohibited.
- D. The issuer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.
- E. Producers shall use the suitability standards developed by the issuer in marketing long-term care insurance.
- F. At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in Appendix C, in not less than twelve (12) point type.
- G. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to Appendix D. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.
- H. The issuer shall report annually to the director the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

Section 18 Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates

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

Section 19 Nonforfeiture Benefit Requirement

- A. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.
- B. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of R.I. Gen. Laws § 27-34.2-20:
 - (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. The nonforfeiture benefit included in the offer shall be the benefit described in subsection E; and
 - (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.
- C. If the offer required to be made under R.I. Gen. Laws § 27-34.2-20 is rejected, the issuer shall provide the contingent benefit upon lapse described in this section.
- D.
 - (1) After rejection of the offer required under R.I. Gen. Laws § 27-34.2-20, for individual and group policies without nonforfeiture benefits issued after the effective date of this section, as provided in Section 23 of this Regulation, the issuer 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 issuer 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 below based on the insured's issue age, and the policy or certificate lapses within one hundred twenty (120) days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase
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%

- (4) On or before the effective date of a substantial premium as defined in Paragraph (3) above, the issuer 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 with a shortened benefit period in accordance with the terms of Subsection E. This option may be elected at any time during the one hundred twenty (120) day period referenced in Subsection D(3); and
- (c) Notify the policyholder or certificateholder that a default or lapse at any time during the one hundred twenty (120) day period referenced in Subsection D(3) shall be deemed to be the election of the offer to convert in Subparagraph (b) above.

E. 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 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 percent (100%) of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The issuer 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 F.
- (4) (a) The nonforfeiture benefit and the contingent benefit upon lapse shall begin not later than the end of the third year following the policy or certificate issue date.

- (b) Notwithstanding Subparagraph (a), except for a policy or certificate with a contingent benefit upon lapse or 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.
- F. All benefits paid by the issuer 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.
- G. There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.
- H. The requirements set forth in this section shall become effective as provided in Section 23 of this Regulation 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 R.I. Gen. Laws § 27-34.2-4(4)(i), which policy was in force at the time this amended Regulation became effective, the provisions of this section shall not apply.
- I. 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 Section 14 of this Regulation treating the policy as a whole.
- J. To determine whether contingent nonforfeiture upon lapse provisions are triggered under subsection D(3), a replacing issuer that purchased or otherwise assumed a block or blocks of long-term care insurance policies

from another issuer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original issuer.

Section 20 Standards for Benefit Triggers

- A. A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment.
- B.
 - (1) Activities of daily living shall include at least the following as defined in Section 5 and in the policy:
 - (a) Bathing;
 - (b) Continence;
 - (c) Dressing;
 - (d) Eating;
 - (e) Toileting; and
 - (f) Transferring.
 - (2) Issuers may use activities of daily living to trigger covered benefits in addition to those contained in Paragraph (1) as long as they are defined in the policy.
- C. An issuer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in Subsections A and B.
- D. For purposes of this section the determination of a deficiency shall not be more restrictive than:
 - (1) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or
 - (2) If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

- E. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.
- F. Long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.
- G. The requirements set forth in this section shall be effective as provided in Section 23 and shall apply as follows:
 - (1) Except as provided in Paragraph (2), the provisions of this section apply to a long-term care policy issued in this state on or after the effective date of the 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 R.I. Gen. Laws § 27-34.2-4(4)(i), that was in force at the time this amended Regulation became effective, the provisions of this section shall not apply.

Section 21 Standard Format Outline of Coverage

This section of the Regulation implements, interprets and makes specific, the provisions of R.I. Gen. Laws § 27-34.2-6(H) in prescribing a standard format and the content of an outline of coverage.

- A. The outline of coverage shall be a free-standing document, using no smaller than ten-point type.
- B. The outline of coverage shall contain no material of an advertising nature.
- C. Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to such capitalization or underscoring.
- D. Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.
- E. Format for outline of coverage:

[COMPANY NAME]

[ADDRESS -- CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[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 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. The 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 important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!**
3. **TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.**
 - (a) [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:]
 - (1) [Policies and certificates that are guaranteed renewable shall contain the following statement:] **RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE.** This means you have the right, subject to the terms of your policy, [certificate] to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, **IT MAY INCREASE THE PREMIUM YOU PAY.**

- (2) [Policies and certificates that are noncancellable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.
 - (b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]
 - (c) [Describe waiver of premium provisions or state that there are not such provisions;]
 - (d) [State whether or not the company has a right to change premium, and if such right exists, describe clearly and concisely each circumstance under which premium may change.]
- 4. 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.]
- 5. 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 producers] Neither [insert company name] nor its producers 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.
- 6. 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 long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

7. BENEFITS PROVIDED BY THIS POLICY.

- (a) [Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.]
- (b) [Institutional benefits, by skill level.]
- (c) [Non-institutional benefits, by skill level.]
- (d) Eligibility for Payment of Benefits

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.]

[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.]

8. LIMITATIONS AND EXCLUSIONS.

[Describe:

- (a) Preexisting conditions;
- (b) Non-eligible facilities/provider;
- (c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);
- (d) Exclusions/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 (6) above.]

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

9. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:
 - (a) That the benefit level will not increase over time;
 - (b) Any automatic benefit adjustment provisions;
 - (c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;
 - (d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;
 - (e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]
10. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease, other dementias or organic brain disorder. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]
11. 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.]
12. ADDITIONAL FEATURES
 - [(a) Indicate if medical underwriting is used;
 - (b) Describe other important features.]

Section 22 Requirement to Deliver Shopper's Guide

- A. A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioner, or a guide developed or approved by the director, shall be provided to all prospective applicant's of a long-term care insurance policy or certificate.
 - (1) In the case of producer solicitations, a producer must deliver the shopper's guide prior to the presentation of an application or enrollment form.
 - (2) In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.
- B. Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under R.I. Gen. Laws § 27-34.2-6.

Section 23 Effective Date

The 1998 amendments to this Regulation shall become effective as provided in R.I. Gen. Laws § 42-35-3. Issuers must comply with any and all provisions, subject to approval where required, on or after the effective date except as follows:

- A. Forms, rates and practices in conformance with this Regulation as constituted prior to the effective date of the 1998 amendments are permitted until January 1, 1999.
- B. On and after January 1, 1999, issuers must comply with all provisions of this Regulation as amended by the 1998 amendments, which do not require filing and approval.
- C. All materials filed with the director after the effective date of the 1998 amendments which are intended for use on or after January 1, 1999 must comply with this Regulation as amended by the 1998 amendments.
- D. On and after July 1, 1999, issuers may not use materials which were approved prior to January 1, 1999 unless the letter described in Section 15A1 related to those materials contains the words, "Intended to comply with 1998 amendments" in the manner specified in Section 15(C).

EFFECTIVE DATE:	September 28, 1988
AMENDED:	April 28, 1989
	November 23, 1990
	September 8, 1998
REFILED:	December 19, 2001

APPENDIX A

**RESCISSION REPORTING FORM FOR
LONG-TERM CARE POLICIES
FOR THE STATE OF RHODE ISLAND
FOR THE REPORTING YEAR 19[]**

Company Name: _____
Address: _____
Phone Number: _____

Due: March 1 annually

Instructions:

The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Recission

Detailed reason for rescission: _____

Signature

Name and Title (please type)

APPENDIX B**Long Term Care Insurance
Personal Worksheet**

People buy long-term care insurance for a variety of reasons. These reasons include to avoid spending assets for long-term care, to make sure there are choices regarding the type of care received, to protect family members from having to pay for care, or to decrease the chances of going on Medicaid. However, long-term care insurance can be expensive, and is not appropriate for everyone. State law requires the insurance company to ask you to complete this worksheet to help you and the insurance company determine whether you should buy this policy.

Premium

The premium for the coverage you are considering will be [\$ _____ per month, or \$ _____ per year,] [a one-time single premium of \$ _____ .]

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums in the future.] The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The last rate increase for this policy in this state was in [year], when premiums went up by an average of _____ %]. [The company has not raised its rates for this policy.]

Note: The issuer shall use the bracketed sentence or sentences applicable to the product offered. If a company includes a statement regarding not having raised rates, it must disclose the company's rate increases under prior policies providing essentially similar coverage.

[] Have you considered whether you could afford to keep this policy if the premiums were raised, for example, by 20%?

Note: The issuer shall use the bracketed sentence unless the policy is fully paid up or is a noncancellable policy.

Income

Where will you get the money to pay each year's premiums?

[] Income [] Savings [] Family members

What is your annual income? (check one)

[] Under \$10,000 [] \$[10-20,000] [] \$[20-30,000] [] \$ [30-50,000] [] Over \$50,000

Note: The issuer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)

☐ No change ☐ Increase ☐ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Turn the Page

Savings and Investments

Not counting your home, what is the approximate value of all of your assets (savings and investments)? (check one)

☐ Under \$20,000 ☐ \$20,000-\$30,000 ☐ \$30,000-\$50,000 ☐ Over \$50,000

How do you expect your assets to change over the next ten years? (check one)

☐ Stay about the same ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than \$30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

☐ The information provided above accurately describes my financial situation.	☐ I choose not to complete this information.
--	---

Signed: _____
(Applicant) (Date)

☐ I explained to the applicant the importance of completing this information.

Signed: _____
(Producer) (Date)

Producer's Printed Name: _____]

[**Note:** In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My producer has advised me that this policy does not appear to be suitable for me. However, I still want the company to consider my application.]

Signed: _____
(Applicant) (Date)

Note: Choose the appropriate sentences depending on whether this is a direct mail or producer sale.

The company may contact you to verify your answers.

Note: When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.

APPENDIX C

Things You Should Know Before You Buy Long-Term Care Insurance

- | | |
|---|---|
| Long-Term
Care
Insurance | <ul style="list-style-type: none">● A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.● [You should not buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.] |
|---|---|

Note: For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.

- | | |
|----------------------------|---|
| | <ul style="list-style-type: none">● The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs. |
| Medicare | <ul style="list-style-type: none">● Medicare does not pay for most long-term care. |
| Medicaid | <ul style="list-style-type: none">● Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid.● Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.● When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.● Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency. |
| Shopper's
Guide | <ul style="list-style-type: none">● Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy. |

- Counseling** • Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

APPENDIX D

Long-Term Care Insurance Suitability Letter

Dear [Applicant]:

Your recent application for long-term care insurance included a "personal worksheet," which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Shopper's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

Note: Choose the paragraph that applies.

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

- ☐ **Yes**, [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

Note: Delete the phrase in brackets if the applicant did not answer the questions about income.

- ☐ **No**. I have decided not to buy a policy at this time.

APPLICANT'S SIGNATURE

DATE

Please return to [issuer] at [address] by [date].