



IIPRC-LTC-I-3-CORE
CORE STANDARDS FOR INDIVIDUAL LONG-TERM CARE INSURANCE POLICIES

1. Date Adopted: June 26, 2017
2. Purpose and Scope: These standards apply to products advertised, marketed or offered to provide benefits for one or more of the following: nursing home care, assisted living care or home health care and adult day care.

Partnership: Approval by the Interstate Insurance Product Regulation Commission (“IIPRC”) of long-term care insurance product filings in compliance with one or more of the Uniform Standards for Individual Long-Term Care Insurance shall not be deemed as approval to use or provide any component of the product filing pursuant to any federal or state Individual Long-Term Care Insurance Partnership Program (“Partnership”).

3. Rules Repealed, Amended or Suspended by the Rule: In accordance with the Five-Year Commission Review of Rules required by § 119 of the Rule for the Adoption, Amendment and Repeal of Rules for the Interstate Insurance Product Regulation Commission, this rule amends the *Core Standards for Individual Long-Term Care Insurance Policies* originally adopted by the Interstate Insurance Product Regulation Commission on August 13, 2010. The amendments apply only to new filings received after the effective date of the amendments. It is not necessary to resubmit previously approved forms to comply with these amendments, or to suspend use of previously approved forms that do not comply with these amendments. See the **Transmittal Memo** under the Standards History on the Record for a more detailed description of the amendments.
4. Statutory Authority: Among the IIPRC’s primary purposes and powers is to establish reasonable uniform standards for the insurance products covered in the Interstate Insurance Product Regulation Compact (“Compact”), specifically pursuant to Article I §2, Article IV §2 and Article VII §1 of the Compact, as enacted into law by each IIPRC member state.
5. Required Findings: These standards are not available to be used in combination with State Product Components as described in §111(b) of the Operating Procedure for the Filing and Approval of Product Filings, except that these standards are available to be used in combination with state-approved individual life insurance policies and annuity contracts, provided that the long-term care rider and all the components associated with the long-term care rider, e.g. application and rates, are filed and approved in accordance with the applicable uniform standards. These standards are not available to be filed using the Rule for the Self-Certification of Product Components Filed with the Interstate Insurance Product Regulation Commission.
6. Effective Date: October 10, 2017

CORE STANDARDS FOR INDIVIDUAL LONG-TERM CARE INSURANCE POLICIES

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CORE STANDARDS FOR INDIVIDUAL LONG-TERM CARE INSURANCE POLICIES

Scope: These standards apply to individual long-term care insurance. Any product advertised, marketed or offered as long-term care insurance shall be subject to these standards. Long-term care insurance shall provide benefits for one or more of the following: nursing home care, assisted living care or home health care and adult day care. Only those policies, riders, endorsements or amendments that provide all such benefits may be titled “long-term care insurance” without further clarification. Policies, riders, endorsements or amendments that provide less than all such benefits shall be titled appropriately to indicate to the owner the types of coverages available under the policy, and may be filed and approved under these standards.

Partnership: Approval by the Interstate Insurance Product Regulation Commission of long-term care insurance product filings in compliance with one or more of the Uniform Standards for Individual Long-Term Care Insurance shall not be deemed as approval to use or provide any component of the product filing pursuant to any federal or state Individual Long-Term Care Insurance Partnership Program (“Partnership”). Action from the Member State may be required before an insurer may use an Interstate Insurance Product Regulation Commission approved policy or other product component for Partnership. A policy approved by the Interstate Insurance Product Regulation Commission may be eligible to qualify as a Partnership plan in accordance with applicable Partnership filing requirements of the Member State. Upon a company receiving Interstate Insurance Product Regulation Commission approval that a long-term care insurance policy complies with the applicable Uniform Standards, the company may make Partnership certification or request approval of the Interstate Insurance Product Regulation Commission approved policy directly from a Member State where the company wishes to use the Interstate Insurance Product Regulation Commission approved policy to provide Partnership coverage.

To facilitate compliance with state-specific Partnership requirements, § 1C(1) of these standards permits any Partnership language that may be required by a state to be bracketed or otherwise denoted as variable. § 1C(3) requires the company to submit a Statement of Variability discussing the conditions under which the variable item may change and the alternative content to which the variable item may change, which in the case of Partnership plans is intended to facilitate the Member States’ ability to ascertain compliance with Partnership requirements.

Mix and Match: These standards are not available to be used in combination with State Product Components as described in § 111(b) of the Operating Procedure for the Filing and Approval of Product Filings, except that these standards are available to be used in combination with state-approved individual life insurance policies and annuity contracts, provided that the long-term care rider and all the components associated with the long-term care rider, e.g. application and rates, are filed and approved in accordance with the applicable uniform standards.

Self-Certification: These standards are not available to be filed using the Rule for the Self-Certification of Product Components Filed with the Interstate Insurance Product Regulation Commission.

Drafting Notes:

- (1) Member states have mutually agreed, through the enactment of the Compact Statute, the Uniform Standards apply as the law of the respective states with regard to the content and approval of Products filed and approved through the Interstate Insurance Product Regulation Commission, provided a state has not exercised the sovereign right to opt out of a particular Uniform Standard. Article XVI, § 1b of the Compact Statute as enacted in the Member States provides that the Rules, Uniform Standards and other requirements of the Commission “shall constitute the exclusive provisions applicable to the content, approval and certification” of Products approved or certified by the Commission. To the extent a state-specific law, regulation, rule or practice pertains to the content of all or any part of a Product which is the subject of a Uniform Standard, such as an application, the applicable Uniform Standards govern and control as the state’s law (superseding state-specific law). A state-specific requirement that does not pertain to the content of a product, such as an unfair trade practice or requirements pertaining to the marketing sale, and administration of Interstate Insurance Product Regulation Commission approved Product is not affected by the Uniform Standards and each state retains full authority to enforce such requirements as stated in Article VIII, § 4 and Article XVI, § 1a of the Compact statute and related drafting notes thereto.
- (2) The Interstate Insurance Product Regulation Commission will maintain a comprehensive listing of state-specific requirements for both offer and/or issue of minimum daily benefits, maximum elimination periods and minimum benefit periods, based on information reported by Member States.

As used in these standards the following definitions apply:

“Long-term care insurance” is any insurance policy, rider, endorsement or amendment advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital, unless the area of the hospital or unit where the services are provided is licensed or certified as a nursing care facility and the insured is receiving long-term care services and not acute care. The term includes:

- individual annuities, disability income and life insurance policies, riders, endorsements or amendments that provide directly or supplement long-term care insurance;
- policies, riders, endorsements or amendments that provide for payment of benefits based upon cognitive impairment or the loss of functional capacity; and
- qualified long-term care insurance policies.

The term shall not include any insurance policy that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability

income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

With regard to disability income, this term does not include disability income policies, riders, endorsements or amendments having indemnity benefits that are triggered by activities of daily living unless (1) the benefits are dependent upon or vary in amount based on the receipt of long-term care services; (2) the policy or rider, endorsement or amendment is advertised, marketed offered or designed as coverage for long-term care services; or (3) benefits under the policy, rider, endorsement or amendment may commence after the insured has reached Social Security's normal retirement age, unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

With regard to life insurance, this term shall not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, chronic illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. With regard to accelerated death benefits that are advertised, marketed, or offered as providing coverage for long-term care services, these standards shall apply.

With regard to annuities, this term shall not include (a) annuity contracts that include a waiver of surrender charges for an annuitant who needs long-term care services, provided that the waiver is unrelated to the amount of charges incurred for the long-term care services, there is no separate premium for the waiver, and the annuity contract or waiver of surrender charges benefit is not advertised, marketed offered or designed as coverage for long-term care services; and (b) a guaranteed living benefit (GLB) with a guaranteed withdrawal increase for qualifying events of medical condition that is reasonably expected to result in a drastically limited life span; inability to perform two or more activities of daily living; cognitive impairment; and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care services.

“Issue age rate schedules” are rate schedules where premiums are based on issue age and where premiums are not expected to change during the premium-paying period due to attained age or duration since issue. Single premium and limited pay plans (e.g., 20-pay policy) are allowed under this definition. The addition of increases in the benefit level that require additional premium, based on the issue age rate schedule applied at an insured's current age at the time of each increase in the benefit level, are allowed under this definition.

“Model Act” means the NAIC *Long-Term Care Insurance Model Act*, Model #640, as adopted by the NAIC on September 1, 2000 and as subsequently amended.

“Model Regulation” means the NAIC *Long-Term Care Insurance Model Regulation*, Model #641, as adopted by the NAIC on September 1, 2000 and as subsequently amended.

“Modified rate schedules” are rate schedules where premiums are based on issue age and where premiums are scheduled to increase during the premium-paying period according to a specified

pattern due to attained age or duration since issue as permitted by § 2B(6) of the *Rate Filing Standards for Individual Long-Term Care Insurance—Modified Rate Schedules*. Limited pay policies (e.g., 20-pay policy) and noncancellable policies are allowed under this definition.

“Partnership” means a qualified long-term care Partnership program established pursuant to § 1917(b)(5)(B)(iii) of the Social Security Act, 42 U.S.C. § 1396p(b)(5)(B)(iii), in states that have implemented such a program.

Drafting Notes:

- (1) Any reference to “policy” in these standards shall include a rider, endorsement, or amendment used to provide long-term care insurance. “Policy” shall not include a group policy or a group certificate because these standards only apply to individual forms.
- (2) The references to “policy” do not preclude Fraternal Benefit Societies from substituting “certificate” in their forms.
- (3) The references to “policy” shall not preclude the use of the term “contract,” “evidence of coverage,” or other similar terms acceptable to the Interstate Insurance Product Regulation Commission, provided that they are used consistently.
- (4) As the models are revised by the NAIC, specific section numbers referenced may change and shall be changed in the standards accordingly.

§ 1. ADDITIONAL FILING SUBMISSION REQUIREMENTS

The following additional submission requirements shall apply:

A. GENERAL

- (1) For new policy filings, the filing shall indicate the respective application and forms required to be used with the application, the outline of coverage, the rate schedules and the benefit features to be used with the policy, including the nonforfeiture and inflation protection benefits.
- (2) For the filing of changes to a previously approved policy, the changes made shall be highlighted.
- (3) Subsequent long-term care insurance filings submitted for approval shall include only those forms being submitted for approval and should specify any other forms previously approved by the Interstate Insurance Product Regulation Commission that will be used with the subsequently filed form(s).
- (4) The specifications page of a policy shall be completed with hypothetical data that is realistic and consistent with the other contents of the policy and any required actuarial filings.

- (5) If the filing is being submitted on behalf of the company, include a letter or other document authorizing the firm to file on behalf of the company.
- (6) If the filing contains an insert page, include an explanation of when the insert page will be used.
- (7) If the policy contains variable items, include the Statement of Variability. The submission shall also include a certification that any change or modification to a variable item shall be administered in accordance with the requirements in the Variability of Information section, including any requirements for prior approval of a change or modification.
- (8) Include a certification signed by a company officer that the policy has a minimum Flesch score of 50.
- (9) Include a description of any innovative or unique features of each policy form.
- (10) Identify the advertising material to be used with the policy. Identify whether the advertising material has been previously approved by the Interstate Insurance Product Regulation Commission, whether it is being filed concurrently with the policy filing, or whether it will be filed after the policy is approved.

B. ACTUARIAL SUBMISSION REQUIREMENTS

- (1) Include the initial rate filing submission requirements as stated in the applicable Rate Filing Standards for Individual Long-Term Care Insurance.
- (2) Include a certification prepared, dated and signed by a member of the American Academy of Actuaries that the nonforfeiture and contingent nonforfeiture benefits offered or provided under the policy are in compliance with the requirements of § 8, Nonforfeiture Benefits, of the Model Act and with § 28D and E, Nonforfeiture Benefit Requirement, of the Model Regulation or § 28K thereof. This requirement shall not apply to life insurance policies that provide long-term care benefits only in the form of an acceleration of the death benefit.
- (3) Include a certification prepared, dated and signed by a member of the American Academy of Actuaries or a company officer that an inflation protection benefit offered or provided under the policy is in compliance with the requirements of § 13A and F, Requirement to Offer Inflation Protection, of the Model Regulation. This requirement does not apply to life insurance policies that provide long-term care benefits only in the form of an acceleration of the death benefit.

C. VARIABILITY OF INFORMATION

- (1) Any information appearing in the policy that is variable shall be bracketed or otherwise marked to denote variability. Variability shall be limited to: benefit data applicable to the

owner or insured; long-term care insurance benefits, amounts; durations; premium information; descriptions of subsequent elections; the brief description; descriptions of the process for internal and external review of benefit determinations and resolving benefit disputes; and any Partnership language that may be required by a state.

- (a) The variability of minimum daily benefit amounts, when benefits begin (elimination periods), and when benefits will end (benefit periods) shall comply with the maximums and minimums, if any, required by applicable law in the state where the policy is delivered or issued for delivery.

Drafting Note: The Interstate Insurance Product Regulation Commission will maintain a comprehensive listing of state-specific requirements for both offer and/or issue of minimum daily benefits, maximum elimination periods and minimum benefit periods, based on information reported by Member States.

- (2) Any change or modification shall be limited to only new issues of the policy and shall not apply to in force policies.
- (3) The Statement of Variability shall discuss both the conditions under which each variable item may change as well as the alternative content to which the item may change. The Statement of Variability shall present reasonable and realistic ranges for any item that may change. A zero entry for a range of values on the specifications page for any benefit or credit provided for in the language of the policy is unacceptable. Any change to a range requires a re-filing for prior approval and, if applicable, shall be accompanied by an actuarial memorandum signed by a member of the American Academy of Actuaries.
- (4) If the scope or range of any variable item would produce different premiums, the submission shall include the rate schedule for each such scope or range.
- (5) A change in any variable outside of the conditions discussed in the Statement of Variability requires prior approval.
- (6) Notwithstanding § 1.C(1) above, items such as the insurance department address and telephone number, company address and telephone number, officer titles, and signatures of officers located in other areas of the policy may be denoted as variable and changed without notice or prior approval.

D. READABILITY REQUIREMENTS

- (1) The policy text shall achieve a minimum score of 50 on the Flesch reading ease test or an equivalent score on any other approved comparable reading test. See Appendix A for Flesch methodology.
- (2) The policy shall be presented, except for specification pages, schedules and tables, in not less than ten point type, one point leaded.

- (3) The style, arrangement and overall appearance of the policy shall give no undue prominence to any portion of the text of the policy or to any riders, endorsements or amendments.
- (4) The policy shall contain a table of contents or an index of the principal sections of the policy, if the policy has more than 3,000 words printed on three or fewer pages of text or if the policy has more than three pages regardless of the number of words.

§ 2. GENERAL FORM REQUIREMENTS

A. COVER PAGE

- (1) The full corporate name, including city and state of the company shall appear in prominent print on the cover page of the policy. “Prominent print” means, for example, all capital letters, contrasting color, underlined or otherwise differentiated from the other type on the form.
- (2) A marketing name or logo may also be used on the cover page of the policy provided that the marketing name or logo does not mislead as to the identity of the company.
- (3) The company’s complete mailing address for the home office or other office that will administer the policy shall appear on the cover page of the policy. The cover page of the policy shall include a telephone number of the company and, if available, some method of Internet communication. The telephone number of the insurance department of the state where the policy is delivered or issued for delivery is also required on either the cover page or the first specifications page.
- (4) The policy shall contain a brief description that shall appear in prominent print on the cover page of the policy or be visible without opening the policy. The brief description shall contain at least the following information:
 - (a) A caption indicating what the policy covers. The content of the caption shall be substantially as follows:

This is a long-term care insurance policy that covers [company insert categories of coverages under the policy, such as nursing home care, assisted living care or home health care and adult day care.]
 - (b) An indication as to whether or not the policy is intended to be a qualified long-term care policy under § 7702B(b) of the Internal Revenue Code, as amended.
 - (c) An indication as to whether the policy is participating or nonparticipating.
- (5) The policy shall contain a Right To Examine Policy provision that shall appear on the cover page of the policy or be visible without opening the policy.

(6) The policy shall state on the cover page if it is guaranteed renewable or noncancellable. This requirement does not apply to life insurance policies that provide long-term care benefits only in the form of an acceleration of the death benefit.

(7) The policy shall include a statement in prominent print on the cover page as follows:

Notice To Buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.

(8) The policy shall include a statement in prominent print on the cover page as follows:

Caution: The issuance of this policy is based on your responses to the questions on your application. A copy of your application is attached to this policy. 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.

(9) A form identification number shall appear at the bottom of the policy form in the lower left hand corner of the format. The form number shall be adequate to distinguish the form from all others used by the company. The form number shall include a prefix of ICCxx(where xx represents the appropriate year the form was submitted for filing) to indicate it has been approved by the Interstate Insurance Product Regulation Commission.

(10) Two signatures of company officers shall appear on the first or second cover page of the policy.

(11) For life insurance policies that provide long-term care benefits only in the form of an acceleration of the death benefit and which are not qualified long-term care insurance policies, a statement shall be included in prominent print on the first or second cover page of the policy to the effect that receipt of the accelerated long-term care benefits may be taxable and that assistance should be sought from a personal tax advisor.

B. SPECIFICATIONS PAGE

(1) The specifications page shall include the benefits, amounts, durations, the applicable rate schedule, including all premium rates that vary by duration, and any other benefit data applicable to the insured.

C. FAIRNESS

(1) The policy shall not contain inconsistent, ambiguous, unfair, inequitable or misleading clauses, provisions that are against public policy as determined by the Interstate Insurance Product Regulation Commission, or contain exceptions and conditions that

unreasonably affect the risk purported to be assumed in the general coverage of the policy.

§ 3. POLICY PROVISIONS

A. AMENDMENTS, RIDERS AND ENDORSEMENTS

- (1) Except for amendments, riders or endorsements by which the company effectuates a request made in writing by the insured (owner if there is one designated under the policy) under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured (owner if there is one designated under the policy), except if the decreased benefits or coverage are required by federal law. After the date of policy issue, any amendment, rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured (owner if there is one designated under the policy), except if the increased benefits or coverage are required by federal law. Where a separate additional premium is charged for benefits provided in connection with amendments, riders or endorsements, the premium charge shall be set forth in the policy, amendment, rider or endorsement.
- (2) When a company is required to make a change to a qualified policy to conform to changes in the requirements of the Internal Revenue Code, the company shall offer the changes to the insured (owner if there is one designated under the policy), for rejection or acceptance by the insured (owner if there is one designated under the policy). The offer shall also notify the insured (owner if there is one designated under the policy) that if the insured (owner if there is one designated under the policy) rejects the changes, the policy may no longer be tax-qualified under the Internal Revenue Code, and the insured (owner if there is one designated under the policy) should consult a financial planning professional.
- (3) Amendments for use with approved forms are subject to prior approval.

B. ARBITRATION

- (1) Only arbitration provisions that permit voluntary post-dispute binding arbitration shall be allowed in policy forms. With respect to such a provision, the following guidelines apply:
 - (a) Arbitration shall be conducted in accordance with the rules of the American Arbitration Association (“AAA”), before a panel of 3 neutral arbitrators who are knowledgeable in the field of long-term care insurance and appointed from a panel list provided by the AAA.
 - (b) Arbitration shall be held in the city or county where the insured lives.

- (c) The cost of arbitration shall be paid by the company, to include any deposits or administrative fee required to commence a dispute in arbitration, as well as any other fee including the arbitrator's fee.
- (d) Where there is any inconsistency between these guidelines and AAA rules, these guidelines control.

Drafting Note: These standards are modified, as required or permitted by law, to enable fraternal to implement their respective articles and bylaws. See Appendix B.

C. ASSIGNMENT

- (1) The policy may include an assignment provision.
- (2) If included, the provision:
 - (a) Shall not include any restrictions on the availability of policy assignment, except in situations where restrictions are required for tax qualification purposes or for purposes of satisfying applicable laws or regulations;
 - (b) Shall describe procedures for assignments and shall state that assignments, unless otherwise specified by the insured (owner if there is one designated under the policy) shall take effect on the date the notice of assignment is signed by the insured (owner if there is one designated under the policy), subject to any payments made or actions taken by the company prior to the receipt of this notice; and
 - (c) May state that the company shall not be liable for the validity of the assignment.

D. BENEFICIARY

- (1) The policy may include a beneficiary provision for receipt of benefits not subject to assignment.
- (2) If included, the provision shall:
 - (a) Describe the procedures for designating or changing a beneficiary;
 - (b) Indicate when such designation or change is effective; and
 - (c) State that the beneficiary's consent is not required for a change of beneficiary, unless the designation of beneficiary is irrevocable.
- (3) If the policy contains a beneficiary provision, the policy shall also state that changes in the beneficiary, unless otherwise specified by the insured (owner if there is one designated under the policy), shall take effect on the date the notice of change is signed

by the insured (owner if there is one designated under the policy), subject to any payments made, or actions taken by the company prior to receipt of this notice.

E. BENEFITS

- (1) The policy shall include a description of the terms and conditions applicable to all benefits provided by the policy, specifying the due proof requirements, the type of benefits payable, to whom benefits are payable, the benefit amounts payable, benefit limitations (maximums and/or minimums), when benefits begin (elimination periods), and when benefits will end (benefit periods).
- (2) ***Nonforfeiture Benefit.*** This section does not apply to a life insurance policy or rider that provides long-term care benefits only in the form of an acceleration of the death benefit. If the policy does not include a nonforfeiture benefit in compliance with the requirements of § 3T(2) of these standards, then the policy shall contain a contingent benefit on lapse provision in compliance with the requirements of § 3T(3) of these standards.
- (3) ***Benefits for Home Health Care or Community Care.*** A policy that provides benefits for home health care or community care services shall comply with the requirements of § 3O of these standards.
- (4) ***Inflation Protection.*** This section does not apply to a life insurance policy or rider that provides long-term care benefits only in the form of an acceleration of the death benefit. An inflation protection provision, if included in the policy, shall be subject to the following requirements:
 - (a) The policy shall state the benefit levels selected, any increases that apply annually, any options for future increases and any evidence of insurability requirements.

Drafting Note: Compound inflation protection at five percent (5%), if declined, can be replaced by other inflation protection options or benefit increases.

- (b) The policy shall state inflation protection benefit increases 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.
- (5) ***Cross Border Rules.*** The policy shall state that it shall pay benefits for similar services obtained in a state other than the policy state of issue if benefits for those services would have been paid in the policy state of issue, irrespective of any facility licensing, certification or registration requirement (or similar requirements) differences between the states.

F. BENEFIT TRIGGERS

- (1) The 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 two of the activities of daily living or the presence of cognitive impairment.
- (2) Activities of daily living shall include at least all of the following as defined in the policy:
 - (a) Bathing;
 - (b) Continence;
 - (c) Dressing;
 - (d) Eating;
 - (e) Toileting; and
 - (f) Transferring.
- (3) Companies may use activities of daily living in addition to those contained in § 3.F(2) to trigger covered benefits as long as they are defined in the policy.
- (4) Companies may use additional provisions for the determination of when benefits are payable under a policy; however, the provisions shall not restrict, and are not in lieu of, the requirements of § 3.F(1) and 3.F(2) above.
- (5) For purposes of this § 3.F, the determination of a deficiency shall not be more restrictive than:
 - (a) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or
 - (b) 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.
- (6) Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.
- (7) Notwithstanding § 3.F(1) above, policies that are intended to be tax-qualified policies shall comply with § 3.G of these standards.

G. ADDITIONAL BENEFIT TRIGGERS FOR TAX-QUALIFIED LONG-TERM CARE INSURANCE POLICIES

- (1) A tax-qualified policy shall state that the policy shall provide benefits only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

Drafting Note: The federal tax requirements for the term “qualified long-term care services” has been added to assist states in regulating qualified long-term care insurance policies, which are defined in § 7702B(b) of the Internal Revenue Code of 1986, as amended. The Internal Revenue Code of 1986 is subject to amendment by Congress and to interpretation by the Treasury Department, the Internal Revenue Service and the courts.

- (2) A tax-qualified long-term care insurance policy shall state that the payment of benefits is conditioned on a determination of the insured’s inability to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity or to severe cognitive impairment.

Drafting Note: § 7702B of the Internal Revenue Code of 1986, as amended, includes a provision for triggering benefits that is different from that found in § 3F of these standards. The definitions used in the triggering of benefits in § 7702B (substantial assistance, loss of functional capacity, substantial supervision and severe cognitive impairment) have been defined in guidance promulgated by the Department of the Treasury.

- (3) A tax-qualified policy shall state that certifications regarding activities of daily living and cognitive impairment required pursuant to § 3.G(2) shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the Treasury.
- (4) A tax-qualified policy shall state that certifications required pursuant to § 3.G(2) may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the ninety-day period.

Drafting Note: Standard based on § 30, Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts, of the Model Regulation.

H. CONFORMITY WITH INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION STANDARDS

- (1) The policy shall state that it was approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission standards. The policy

shall also state that any provision of the policy that on the provision's effective date is in conflict with the applicable Interstate Insurance Product Regulation Commission standards for this product type in effect as of the provision's effective date of Commission policy approval is hereby amended to conform to the applicable Interstate Insurance Product Regulation Commission standards in effect as of the provision's effective date of Commission policy approval.

I. DEFINITIONS AND CONCEPTS

- (1) The policy shall define certain terms or describe concepts that, as used in the policy, will have specific meanings. If the policy contains the terms or concepts set forth below, the respective definitions or descriptions shall be consistent with, or no less favorable to the insured than, the standards set forth below. The actual term or concept to be included in the policy, as well as the respective definition or description, may vary as long as the intent is consistent with the standards set forth below. The terms may be defined or concepts described in a definitions section of the policy or in a policy provision that is a logical place for such definitions or concept descriptions.
- (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 state licensed or certified program for a specified number of individuals providing social or health-related or both types of services 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) "Assisted living care" means personal/custodial monitoring and assistance with activities of daily living provided in a residential setting in a state licensed or certified facility.
 - (e) "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.
 - (f) (i) "Chronically ill individual" has the meaning prescribed for this term by § 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:
 - (I) Being unable to perform (without substantial assistance from another individual) at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity; or

- (II) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.
 - (ii) The term “chronically ill individual” shall not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner has certified that the individual meets these requirements.
- (g) “Cognitive impairment” means a deficiency in an individual’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.
- (h) “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).
- (i) “Dressing” means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- (j) “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.
- (k) “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.
- (l) “Home health care services” means medical and non-medical 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.
- (m) “Licensed health care practitioner” means a physician, as defined in § 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the Secretary of the Treasury.
- (n) “Maintenance or personal care services” means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).
- (o) “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.

- (p) “Nursing home care” means nursing care and related services provided on an in-patient basis by a state licensed or certified facility, other than a hospital (except for an area of a hospital or unit that is licensed or certified as a nursing care facility and that is not providing acute care).
 - (q) “Personal care” means the provision of hands-on services to assist an individual with activities of daily living.
 - (r) “Qualified long-term care services” means services that meet the requirements of § 7702B(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.
 - (s) “Skilled nursing care,” “personal care,” “home care,” “specialized care,” “assisted living care,” “nursing 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 shall be delivered.
 - (t) “Toileting” means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
 - (u) “Transferring” means moving into or out of a bed, chair or wheelchair.
- (2) All providers of services, including but not limited to “adult day care provider,” “skilled nursing facility,” “extended care facility,” “convalescent nursing home,” “personal care facility,” “specialized care provider,” “assisted living facility,” and “home care agency” and other terms used to define providers of services shall be defined in relation to the services and facilities required to be available and the licensure, certification, registration or degree status of those providing or supervising the services in the state where the policy was issued. When the definition requires that the provider be appropriately licensed, certified or registered, it shall also state what requirements a provider shall meet in lieu of licensure, certification or registration when the state in which the service is to be furnished does not require a provider of such services to be licensed, certified or registered, or if the state licenses, certifies or registers the provider of services under another name.

J. DEPENDENT AND FAMILY MEMBER COVERAGE

- (1) The policy may provide coverage for dependents and family members. If the policy provides such coverage:

- (a) The policy shall comply with the applicable state law where the policy is delivered or issued for delivery, with respect to the coverage and benefits available to a person who is in a legally-sanctioned domestic partnership or civil union and to their families, or available to a person who is in a legally-sanctioned marriage with the insured and to their families; and
- (b) Nothing in this provision shall be construed as requiring a company to provide coverage or benefits to any person who is in a domestic partnership, civil union, or marriage or to their families in a state where such relationships are not legally recognized.

K. ELIGIBILITY FOR BENEFITS

- (1) The policy shall include provisions addressing initial and subsequent conditions of eligibility for benefits.
- (2) A long-term care policy which conditions eligibility 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 these terms and an explanation of the terms in its accompanying outline of coverage.
- (3) Subject to all policy provisions, any plan of care required under the policy shall be provided by a licensed health care practitioner and shall not require company approval. The company may provide a predetermination of benefits payable pursuant to the plan of care. This does not prevent the company from having discussions with the licensed health care practitioner to amend the plan of care. The company may also verify that the plan of care is appropriate and consistent with generally accepted standards.
- (4) Activities of daily living and cognitive impairment benefit triggers shall be described in the policy in a separate paragraph and shall be labeled “Eligibility for the Payment of Benefits.” If an attending physician or other specified person shall certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

L. ENTIRE CONTRACT

- (1) The provision shall state that the policy, the insured’s (owner’s if there is an owner designated under the policy) application, and any rider, endorsements or amendments to the policy shall constitute the entire contract between the company and the insured (owner if there is one designated under the policy). No document may be included by reference.
- (2) The entire contract provision shall state that no agent has authority to change the policy or to waive any of its provisions.

Drafting Note: These standards are modified, as required or permitted by law, to enable fraternal to implement their respective articles and bylaws. See Appendix B.

M. EXTENSION OF BENEFITS

- (1) The policy shall contain a provision to the effect that termination of the long-term care policy shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care policy was in force and continues without interruption after termination. The extension of benefits beyond the period the long-term care policy 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.

N. GRACE PERIOD

- (1) The policy shall contain a grace period provision and include the conditions of the provision.
- (2) A minimum of 30-day grace period shall be provided for the payment of any premium due except the first.
- (3) The coverage shall continue in force during the grace period.
- (4) The policy may provide that if the insured dies during the grace period the overdue premium will be deducted in any settlement under the policy.

O. HOME HEALTH CARE OR COMMUNITY CARE BENEFITS

- (1) A policy that provides benefits for home health care or community care shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of the nursing home benefits under the policy, at the time covered home health or community care services are being received.
- (2) The policy shall not limit or exclude benefits:
 - (a) By requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided;
 - (b) By requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community or institutional setting before home health care services are covered;
 - (c) By limiting eligible services to services provided by registered nurses or licensed practical nurses;

- (d) 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;
 - (e) By excluding coverage for personal care services provided by a home health aide;
 - (f) 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;
 - (g) By requiring that the insured or claimant have an acute condition before home health care services are covered;
 - (h) By limiting benefits to services provided by Medicare-certified agencies or providers; or
 - (i) By excluding coverage for adult day care services.
- (3) The policy may state that home health care benefits may be applied to the non-home health care benefits provided in the policy when determining maximum coverage under the terms of the policy.

Drafting Note: Standard based on § 12, Minimum Standards for Home Health and Community Care Benefits in Long-term Care Insurance Policies of the Model Regulation.

P. INCONTESTABILITY

- (1) The policy shall contain an incontestability provision and include the conditions of the provision.
- (2) The incontestability provisions shall be no less favorable to the insured than the following:
 - (a) For a policy that has been in force for less than six months a company may rescind a long-term care insurance policy or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.
 - (b) For a policy that has been in force for at least six months but less than two years a company may rescind a long-term care insurance policy or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.
 - (c) After a policy has been in force for two years it is not contestable upon the grounds of misrepresentation alone; such policy may be contested only upon a

showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

- (3) The policy may allow a separate contestability period for any increase in benefits that was subject to evidence of insurability. The contestability provision for the increased benefits shall be limited to the amount of the increase and the evidence provided for such increases.
- (4) Coverage may only be contested on a statement contained in an application made a part of the policy. If the issuing company expects to rely on an application to contest the policy, the company shall attach to or endorse the application as part of the policy.
- (5) Policy forms shall not contain an incontestability provision that excludes the riders that may be attached to the form unless those riders contain their own incontestability provisions.
- (6) A policy that is reinstated may be contested in accordance with § 2.P(1) through (5) of this provision and § 2.Y(9) of the Reinstatement provision.

Q. LEGAL ACTION

- (1) A policy may include a legal action provision. If included, the provision shall state that a legal cause of action related to the policy shall comply with the laws of the state in which the policy was delivered or issued for delivery

R. LIMITATIONS AND EXCLUSIONS

- (1) The policy shall contain a provision indicating that benefits may not be limited or excluded by type of illness, treatment, medical condition or accident, except under conditions no less favorable to the insured than the following:
 - (a) Loss occurring within six months with respect to a preexisting condition or disease. A "preexisting condition" means a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services, within six months preceding the effective date of an insured's coverage.
 - (b) 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 and shall be labeled as "Preexisting Condition Limitations."
 - (c) Alcoholism and drug addiction.
 - (d) Illness, treatment or medical condition arising out of any of the following
 - (i) Declared or undeclared war or act of war;

Drafting Note: Companies may consider additional language and in that case the Interstate Insurance Product Regulation Commission shall use the following guidelines: Declared or undeclared war or act of war is understood to be military activity by one or more national governments and does not include terrorist acts, other random acts of violence not perpetrated by the insured, or civil war or community faction. Civil activity as a whole cannot be excluded, except for direct participation or instigation by the insured.

- (ii) Participation in a felony, riot or insurrection or involvement in an illegal occupation;

Drafting Note: Companies may consider additional language and in that case the Interstate Insurance Product Regulation Commission shall use the following guidelines: An exclusion for riot or insurrection is limited to instigators and those pursuing participation and does not include civil commotion, disorder, injury as an innocent bystander, or injury for self defense.

- (iii) Active duty in the armed forces of any nation or international governmental authority or units auxiliary thereto or the National Guard or similar government organizations (except that this limitation or exclusion shall not be construed to deny an insured any statutory or regulatory rights to suspend coverage while serving in the armed forces of any nation or international governmental authority or units auxiliary thereto or the National Guard or similar government organizations and to resume coverage after such service on terms more favorable than an initial applicant for coverage, with a refund of the pro rata portion of any premium collected for the period of suspension). The company will refund any pro rata portion of any premium paid for the period that the insured was on active duty in the armed forces of any nation or international governmental authority or units auxiliary thereto or the National Guard or similar government organizations;
- (iv) Suicide, attempted suicide or intentionally self-inflicted injury;
- (v) Aviation (this exclusion applies only to non-fare-paying passengers).
- (e) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental 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.
- (f) In the case of a qualified long-term care insurance policy, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.

- (g) § 2.R(1)(a) through (h) are not intended to prohibit exclusions and limitations by type of provider.
 - (h) § 2.R(1)(a) through (h) are not intended to prohibit territorial limitations.
- (2) A long-term care policy containing post-confinement, post-acute care, or recuperative benefits shall include in a separate policy provision entitled “Limitations or Conditions on Eligibility for Benefits” the limitations or conditions applicable to these benefits, including any required number of days of confinement.

S. MISSTATEMENT OF AGE OR SEX

- (1) The policy shall contain a misstatement of age provision or, if the policy is written on a sex distinct basis, a misstatement of age or sex provision, providing that the amount payable as a benefit shall be such as the premium paid would have purchased at the correct age or the correct age and sex.

T. NONFORFEITURE BENEFITS

- (1) This section does not apply to a life insurance policy or rider that provides long-term care benefits only in the form of an acceleration of the death benefit.
- (2) The nonforfeiture benefit provision contained in a long-term care policy, or added by rider, endorsement, or amendment to a long-term care policy at issue, shall be subject to the following requirements:
- (a) The nonforfeiture benefit shall be appropriately captioned in the policy, rider, endorsement, or amendment;
 - (b) The policy shall state that the nonforfeiture benefit shall begin not later than the end of the third year following the policy issue date;
 - (c) A policy offered with the nonforfeiture benefit shall have coverage elements, eligibility, benefit triggers and benefit lengths that are the same as those offered in an otherwise similar policy issued without nonforfeiture benefits;
 - (d) The nonforfeiture benefit shall be described in the policy and shall provide paid-up long-term care insurance coverage after lapse or termination by the insured (owner if there is one designated under the policy). Unless the nonforfeiture benefits is a shortened benefit period with the same benefits (amount and frequency in effect at the time of lapse but not increased thereafter) as described in § 3.T(3) below, the inclusion of another nonforfeiture benefit shall not eliminate the requirement for a contingent benefit on lapse provision in the policy as provided in § 3.T(4) below.

- (e) The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to policy issue, as long as the policy is in force and a nonforfeiture benefit is not in effect only as necessary to reflect changes in claims, persistency and interest as reflected in changes in claims in the premium rate schedule for premium paying policies approved by the Interstate Insurance Product Regulation Commission for the same policy form; and
 - (f) The nonforfeiture provision shall provide at least one of the following:
 - (i) Reduced paid-up insurance
 - (ii) Extended term insurance
 - (iii) Shortened benefit period, or
 - (iv) Other similar offerings approved for use by the Interstate Insurance Product Regulation Commission.
- (3) A shortened benefit period nonforfeiture benefit shall provide paid-up long-term care insurance coverage after lapse as follows:
- (a) The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) shall be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in § 3T(3)(b), below;
 - (b) The standard nonforfeiture credit shall be described in the policy and shall be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The company 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 shall be subject to the limitation in § 3T(4), below;
 - (c) The policy shall state that nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy, up to the limits specified in the policy;
- (4) The contingent benefit on lapse benefit contained in a long-term care policy, or added by rider, endorsement, or amendment to a long-term care policy at issue, shall be subject to the following requirements:
- (a) The policy shall indicate that a contingent benefit on lapse shall be triggered for an insured every time a company increases the premium rate schedule (issue age

or modified) to a level which results in a cumulative increase in the insured's premium equal to or exceeding the percentage of the insured's initial premium rate schedule set forth below, based on the insured's issue age, and the policy lapses within 120 days of the due date of the premium so increased. The insured (owner if there is one designated under the policy) shall be notified at least sixty (60) days prior to the due date of the premium reflecting the premium rate schedule increase.

**Triggers for a Substantial
 Premium Increase**

Issue Age	Percent Increase Over Initial Premium Rate Schedule
29 and under	100%
30-34	100%
35-39	100%
40-44	100%
45-49	100%
50-54	100%
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%

- (i) In the event any long-term care policy was issued at least twenty (20) years prior to the effective date of the increase, a value of zero percent (0%) shall be used in place of all values in the table;
- (b) The policy shall also indicate that a contingent benefit on lapse will also be triggered for an insured for policies with a fixed or limited premium paying period every time the company increases the premium rate schedule (issue age or modified) to a level that results in a cumulative increase in the premium rate schedule for the insured equal to or exceeding the percentage of the insured's initial premium rate schedule set forth below based on the insured's issue age, the policy lapses within 120 days of the due date of the premium rate schedule so increased, and the ratio in § 3.T(4)(d)(ii) is forty percent (40%) or more. The insured (owner if there is one designated under the policy) shall be notified at least sixty (60) days prior to the due date of the premium reflecting the premium rate schedule increase.

Triggers for a Substantial Premium Increase

<u>Issue Age</u>	<u>Percent Increase Over Initial Premium Rate Schedule</u>
Under 65	50%
65-80	30%
Over 80	10%

This provision shall be in addition to the contingent benefit provided by § 3.T(4)(a) above and where both are triggered, the benefit provided shall be at the option of the insured (owner if there is one designated under the policy).

- (c) The policy shall indicate on or before the effective date of a substantial premium increase as defined in § 3.T(4)(a) above, the company shall:
 - (i) Offer to reduce policy benefits provided by the current coverage consistent with the requirements of § 3.BB so that required premium payments are not increased;

Drafting Note: The insured's right to reduce policy benefits in the event of the premium increase shall not affect any other right to elect a reduction in benefits provided under the policy.

- (ii) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of § 3.T(4)(d) and (e), if applicable. This option may be elected at any time during the 120-day period referenced in § 3.T(4)(a); and
 - (iii) Notify the insured (owner if there is one designated under the policy) that a default or lapse at any time during the 120-day period referenced in § 3.T(4)(a) shall be deemed to be the election of the offer to convert in § 3.T(4)(c)(ii) above unless the automatic option in § 3.T(4)(d)(iii) applies.
- (d) The policy shall indicate on or before the effective date of a substantial premium increase as defined in § 3.T(4)(b) above, the company shall:
- (i) Offer to reduce policy benefits provided by the current coverage consistent with the requirements of § 3.BB so that required premium payments are not increased;

Drafting Note: The insured's right (owner's right if there is one designated under the policy) to reduce policy benefits in the event of the premium increase does not affect any other right to elect a reduction in benefits provided under the policy.

- (ii) Offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety percent (90%) of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120-day period referenced in § 3.T(4)(b); and
 - (iii) Notify the insured (owner if there is one designated under the policy) that a default or lapse at any time during the 120-day period referenced in § 3.T(4)(b) shall be deemed to be the election of the offer to convert in § 3.T(4)(d)(ii) above if the ratio is forty percent (40%) or more.
- (e) The policy shall state that the contingent benefit upon lapse shall be effective from the policy issue date.
- (f) The contingent benefit on lapse benefit shall be appropriately captioned in the policy, rider, endorsement, or amendment;
- (5) The policy shall state that all benefits paid by the company while the policy is in premium paying status and in the paid up status shall not exceed the maximum benefits which would be payable if the policy had remained in premium paying status.

- (6) If the policy has a fixed or limited premium paying period and contains a nonforfeiture benefit, the policy shall contain the contingent benefit on lapse described in § 3.T(4)(a) and (b).

Drafting Note: Standard based on § 28, Nonforfeiture Benefit Requirement, of the Model Regulation.

U. OWNERSHIP

- (1) The policy may contain an owner provision.
- (2) If included, the provision shall:
 - (a) Describe the rights of the owner as distinct from the rights of the insured;
 - (b) Describe the procedures for designating or changing the owner and indicating when the designation is effective; and
 - (c) State that changes in owner designation, unless otherwise specified by the owner, shall take effect on the date the notice of change is signed by the owner, subject to any payments made or actions taken by the company prior to receipt of this notice.
- (3) If the ownership provision allows for third party ownership, the provision shall also state that the word “insured” as used in specified sections of the policy shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured, or from being entitled under such policy to any indemnities, benefits and rights provided in the policy.
- (4) The policy shall not include any restriction on change of owner except in situations where restrictions are required for tax qualification purposes or for purposes of satisfying applicable laws or regulations.

V. PARTICIPATING POLICY

A policy may be non-participating; however, if the policy is participating in the divisible surplus of the company, then the following shall apply:

- (1) The conditions of the participation shall be included in the policy.
- (2) The policy shall provide that the company shall annually ascertain and apportion any divisible surplus, beginning not later than the first year for which dividends were illustrated.

W. PAYMENT OF CLAIMS AND REVIEW OF BENEFIT DETERMINATIONS

- (1) The policy shall include provisions addressing the payment of claims.
- (2) The policy shall include a clear description of the process for internal and external review of benefit determinations and resolving benefit disputes consistent with the applicable laws and regulations where the policy is delivered or issued for delivery.

Drafting Note: The policy may specify when and in what manner the details and requirements of the review process will be provided.

X. PAYMENT OF PREMIUM

- (1) There shall be a provision describing the terms and conditions for the payment of premiums.
- (2) The policy shall provide for payment of the initial premium on or before the policy effective date. This standard should not be construed to abrogate any rights that an applicant has under a conditional receipt, interim insurance agreement or other similar form issued by the company when the company or its agent accepts initial premium for coverage at time of application.
- (3) A refund of unearned premium shall be made in the event of death or at the insured's (owner's if there is one designated under the policy) request to discontinue coverage.
- (4) There shall be a provision describing the procedures applicable to a change in the premium rate schedule for the policy. The provision shall include a statement that a notice of any such change will be provided to the insured (owner if there is one designated under the policy) at least 60 days prior to the implementation of the premium rate schedule increase by the company.

Y. REINSTATEMENT

- (1) The policy shall contain a provision for reinstatement if the policy lapses for nonpayment of premiums. The policy shall include the conditions of the reinstatement.
- (2) The policy shall provide that if the renewal premium is not paid before the Grace Period ends, the policy will lapse. Later acceptance of premium by the company (or by a producer, agent or broker duly authorized to accept payment) without requiring an application for reinstatement shall reinstate the policy.
- (3) When the insured (owner if there is one designated under the policy) does not timely pay a premium and if the company or its duly authorized producer, agent or broker requires an application for reinstatement and issues a conditional receipt or interim insurance agreement for the premium tendered for reinstatement of the policy, this provision shall state that the policy is reinstated upon approval of the application by the company; or, if

the company does not act to approve the application, the policy is reinstated on the 45th day following the date of the conditional receipt or interim insurance agreement unless the company has given notice to the insured (owner if there is one designated under the policy) of company disapproval of the application previous to the expiration of the 45 day time limit.

- (4) Except to the extent provided in § 2.Y(8) below, the policy shall state that the reinstated policy shall provide coverage for cognitive impairment or loss of functional capacity that occurs after the date of reinstatement. In all other respects, the rights of the insured (owner if there is one designated under the policy) and the company will remain the same, subject to any provisions noted or attached to the reinstated policy.
- (5) The period during which a policy may be reinstated shall not be less than six months from the date of lapse.
- (6) Evidence of insurability may be required, except as provided in § 2.Y(8).
- (7) Payment of overdue premiums may be required. Interest may be charged at a rate not exceeding 6%.
- (8) A long-term care policy shall provide for reinstatement of coverage in the event of lapse if the company is provided proof that the insured 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 (owner if there is one designated under the policy) if requested within five 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. Evidence of insurability shall not be required for reinstatement pursuant to this item.
- (9) The contestability standards described in § 2.P(2)(a), (b) and (c), Incontestability, shall apply to the reinstated policy.

Z. RENEWABILITY

- (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 (owner if there is one designated under the policy) has the right to continue the policy in force by the timely payment of premiums and when the company 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 company on a class basis.
- (3) The term “noncancellable” may be used only when the insured has the right to continue the policy in force by the timely payment of premiums during which period the company

has no right to unilaterally make any change in any provision of the policy or in the premium rate schedule shown in the policy.

- (4) A long-term care insurance policy, other than one where the company does not have the right to change the premium, shall include a statement that premium rates may change.
- (5) In addition to the other requirements of this § 2.Z, a qualified long-term care insurance policy shall be guaranteed renewable, within the meaning of § 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.
- (6) The term “level premium ” may only be used to describe long-term care coverage that is noncancellable and where the premium rate schedule for the coverage is level for all policy years where a premium is required.

AA. RIGHT TO EXAMINE POLICY

- (1) The Right to Examine Policy provision appearing on the cover page or that is visible without opening the policy shall include the following:
 - (a) A minimum of 30 days to examine the policy. The 30 days shall begin on the date the policy is received by the insured (owner if there is one designated under the policy);
 - (b) A requirement for the return of the policy to the company or an agent of the company. Policy is considered void from the beginning and the parties shall be in the same position as if no policy had been issued; and
 - (c) A statement that the premium shall be refunded if the policy is returned.
- (2) The company shall refund any premium paid within 30 days of the return, directly to the payer, if the policy is returned.

BB. Right to Reduce Coverage and Lower Premiums

- (1) This section does not apply to a life insurance policy or rider that provides long-term care benefits only in the form of an acceleration of the death benefit.
- (2) The policy shall include a provision that allows the insured (owner if there is one designated under the policy) to reduce coverage and lower the policy or premium in at least one of the following ways:
 - (a) Reducing the maximum benefit; or
 - (b) Reducing the daily, weekly or monthly benefit amount.

- (3) The company may also offer other reduction options that are consistent with the policy design or the company's administrative processes.
- (4) In the event the reduction in coverage involves the reduction or elimination of the inflation protection provision, the company shall allow the insured (owner if there is one designated under the policy) to continue the benefit amount in effect at the time of the reduction.
- (5) The policy shall contain the following conditions with respect to the right to reduce coverage and lower premiums benefit, consistent with the requirements of § 27 of the Model Regulation:
 - (a) The provision shall include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.
 - (b) The premium for the reduced coverage shall:
 - (i) be based on the same age and underwriting class used to determine the premium for the coverage currently in force; and
 - (ii) be consistent with the approved rate table.
 - (c) The company 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.
 - (d) If a policy is about to lapse, the company shall provide a written reminder to the insured (owner if there is one designated under the policy) of his or her right to reduce coverage and premiums in the notice required by § 3CC(2) of this standard.

CC. UNINTENTIONAL LAPSE

- (1) The policy shall provide the right to name at least one person who is to receive the notice of termination for nonpayment of premium, in addition to the insured (owner if there is one designated under the policy). The form used shall provide space clearly designated for listing at least one person. The policy shall provide that the company shall notify the insured (owner if there is one designated under the policy) of the right to change this written designation, no less often than once every two years.
- (2) The policy shall provide that it shall not lapse or be terminated for nonpayment of premium unless the company, at least 30 days before the effective date of the lapse or termination, has given notice to the insured (owner if there is one designated under the policy) and to those persons designated pursuant to § 2.CC(1) above, at the address provided by the insured (owner if there is one designated under the policy) for purposes of

receiving notice of lapse or termination. The policy shall provide that notice shall be given by first class United States mail, postage prepaid; and notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of five days after the date of the mailing.

DD. TERMINATION

- (1) If, during the premium-paying period, the insured (owner if there is one designated under the policy) terminates the policy, the company shall refund a pro-rata share of any modal premium paid by the insured (owner if there is one designated under the policy) for any period past the requested month of termination.
- (2) Any refund due the insured (owner if there is one designated under the policy) upon termination by the insured (owner if there is one designated under the policy) is not in lieu of nonforfeiture benefits, if any.

§ 4. ADDITIONAL STANDARDS FOR FRATERNAL BENEFIT SOCIETIES

A. GENERAL

The policy may include the following provisions:

(1) MEMBERSHIP

The certificate may include a provision stating that the insured and/or owner is a member and that the form that has been issued to evidence coverage is a certificate of membership and insurance.

(2) MAINTENANCE OF SOLVENCY

The certificate may include a provision setting forth the legal rights and obligations in the case of a fraternal's financial impairment.

Appendix A

FLESCH METHODOLOGY

The following measuring method shall be used in determining the Flesch score:

- (1) For policy forms containing 10,000 words or less of text, the entire form shall be analyzed. For policy forms containing more than 10,000 words, the readability of two, 200-word samples per page may be analyzed instead of the entire form. The sample shall be separated by at least 20 printed lines.
- (2) The number of words and sentences in the text shall be counted and the total number of words divided by the total number of sentences. The figure obtained shall be multiplied by a factor of 1.015.
- (3) The total number of syllables shall be counted and divided by the total number of words. The figure obtained shall be multiplied by a factor of 84.6.
- (4) The sum of the figures computed under (2) and (3) subtracted from 206.835 equals the Flesch reading ease score for the policy form.
- (5) For purposes of (2), (3), and (4), the following procedures shall be used:
 - (a) A contraction, hyphenated word, or numbers and letters, when separated by spaces, shall be counted as one word;
 - (b) A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, shall be counted as a sentence; and
 - (c) A syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. Where the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.
- (6) The term “text” as used in this section shall include all printed matter except the following:
 - (a) The name and address of the company; the name, number or title of the policy; the table of contents or index; captions and sub-captions; specifications pages, schedules or tables; and;
 - (b) Any policy language which is drafted to conform to the requirements of any federal law or regulation; any policy language required by any collectively bargained agreement; any medical terminology; any words which are defined in the policy; and any policy language required by law or regulation; provided, however, the company identifies the language or terminology excepted by this

item and certifies, in writing, that the language or terminology is entitled to be excepted by this item.

- (7) At the option of the company, riders, endorsements, amendments, applications and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used.

Appendix B

FRATERNAL BENEFIT SOCIETIES

Fraternal Benefit Societies (“fraternals”) are subject to separate fraternal codes in all jurisdictions due to their unique structure, operations and legal obligations. The Drafting Notes included at the ends of the Scope, **ARBITRATION** and **ENTIRE CONTRACT** standards, the section entitled **ADDITIONAL STANDARDS FOR FRATERNAL BENEFIT SOCIETIES**, and **Appendix B** are included in the standards to allow fraternals to experience the benefits of participating in the single point of filing and review process that the Interstate Insurance Product Regulation Commission offers, without jeopardizing their ability to meet their unique obligations and to operate as required or permitted by law.

By law, a fraternal is defined by five basic elements:

1. one without capital stock;
2. one conducted solely for the benefit of its members and their beneficiaries by providing life, health and annuity benefits and by operating one or more social, educational, charitable, patriotic, or religious purposes for the benefit of members and others;
3. one that is a benevolent and charitable institution and not for profit;
4. one operated on a lodge system that may carry out charitable and other activities; and
5. one that has a representative form of government with a governing body and direct election of its members.

The laws governing fraternals impact the standards in several ways. Fraternals are required by law to issue insurance contracts that incorporate the laws of the Society and the application for membership. Thus, the contract must consist not only of the policy or certificate issued, and the application for insurance, but also the application for membership and the articles and bylaws. Further, the laws governing fraternals require or permit that the articles and bylaws address the structure of lodges, membership requirements, form of governance, grievance procedures, and eligible beneficiaries. Any amendments to the articles or bylaws made after issuance of a certificate must be applied consistently to all members retroactively. However, no amendment shall eliminate or reduce contractual benefits.

By law, fraternals are membership organizations. Because of this, the law refers to the insurance forms issued to members of a fraternal as “certificates” or “certificates of membership and insurance”. Further, due to the membership requirements, fraternal certificates often include a provision stating that the insured and/or owner is a member and that the form that has been issued to evidence coverage is a certificate of membership and insurance. In addition, fraternal certificates may include a Maintenance of Solvency provision setting forth the legal rights and obligations in the case of a fraternal’s financial impairment.