

Arizona Administrative REGISTER

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From the Publisher

ABOUT THIS PUBLICATION

The paper copy of the *Administrative Register* (A.A.R.) is the official publication for rules and rulemaking activity in the state of Arizona.

Rulemaking is defined in Arizona Revised Statutes known as the Arizona Administrative Procedure Act (APA), A.R.S. Title 41, Chapter 6, Articles 1 through 10.

The Office of the Secretary of State does not interpret or enforce rules published in the *Arizona Administrative Register* or *Code*. Questions should be directed to the state agency responsible for the promulgation of the rule as provided in its published filing.

The *Register* is cited by volume and page number. Volumes are published by calendar year with issues published weekly. Page numbering continues in each weekly issue.

In addition, the *Register* contains the full text of the Governor's Executive Orders and Proclamations of general applicability, summaries of Attorney General opinions, notices of rules terminated by the agency, and the Governor's appointments of state officials and members of state boards and commissions.

ABOUT RULES

Rules can be: made (all new text); amended (rules on file, changing text); repealed (removing text); or renumbered (moving rules to a different Section number). Rules activity published in the *Register* includes: proposed, final, emergency, expedited, and exempt rules as defined in the APA.

Rulemakings initiated under the APA as effective on and after January 1, 1995, include the full text of the rule in the *Register*. New rules in this publication (whether proposed or made) are denoted with underlining; repealed text is stricken.

WHERE IS A "CLEAN" COPY OF THE FINAL OR EXEMPT RULE PUBLISHED IN THE REGISTER?

The *Arizona Administrative Code* (A.A.C.) contains the codified text of rules. The A.A.C. contains rules promulgated and filed by state agencies that have been approved by the Attorney General or the Governor's Regulatory Review Council. The *Code* also contains rules exempt from the rulemaking process.

The printed *Code* is the official publication of a rule in the A.A.C. is prima facie evidence of the making, amendment, or repeal of that rule as provided by A.R.S. § 41-1012. Paper copies of rules are available by full Chapter or by subscription. The *Code* is posted online for free.

LEGAL CITATIONS AND FILING NUMBERS

On the cover: Each agency is assigned a Chapter in the *Arizona Administrative Code* under a specific Title. Titles represent broad subject areas. The Title number is listed first; with the acronym A.A.C., which stands for the *Arizona Administrative Code*; following the Chapter number and Agency name, then program name. For example, the Secretary of State has rules on rulemaking in Title 1, Chapter 1 of the *Arizona Administrative Code*. The citation for this chapter is 1 A.A.C. 1, Secretary of State, Rules and Rulemaking

Every document filed in the office is assigned a file number. This number, enclosed in brackets, is located at the top right of the published documents in the *Register*. The original filed document is available for 10 cents a copy.

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A price list for the *Arizona Administrative Code* is available online. You may also request a paper price list by mail. To purchase a paper Chapter, contact us at (602) 364-3223.

PUBLICATION DEADLINES
Publication dates are published in the back of the *Register*. These dates include file submittal dates with a three-week turnaround from filing to published document.

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Participate in the Process

Look for the Agency Notice

Review (inspect) notices published in the *Arizona Administrative Register*. Many agencies maintain stakeholder lists and would be glad to inform you when they proposed changes to rules. Check an agency's website and its newsletters for news about notices and meetings.

Feel like a change should be made to a rule and an agency has not proposed changes? You can petition an agency to make, amend, or repeal a rule. The agency must respond to the petition. (See A.R.S. § 41-1033)

Attend a public hearing/meeting

Attend a public meeting that is being conducted by the agency on a Notice of Proposed Rulemaking. Public meetings may be listed in the Preamble of a Notice of Proposed Rulemaking or they may be published separately in the *Register*. Be prepared to speak, attend the meeting, and make an oral comment.

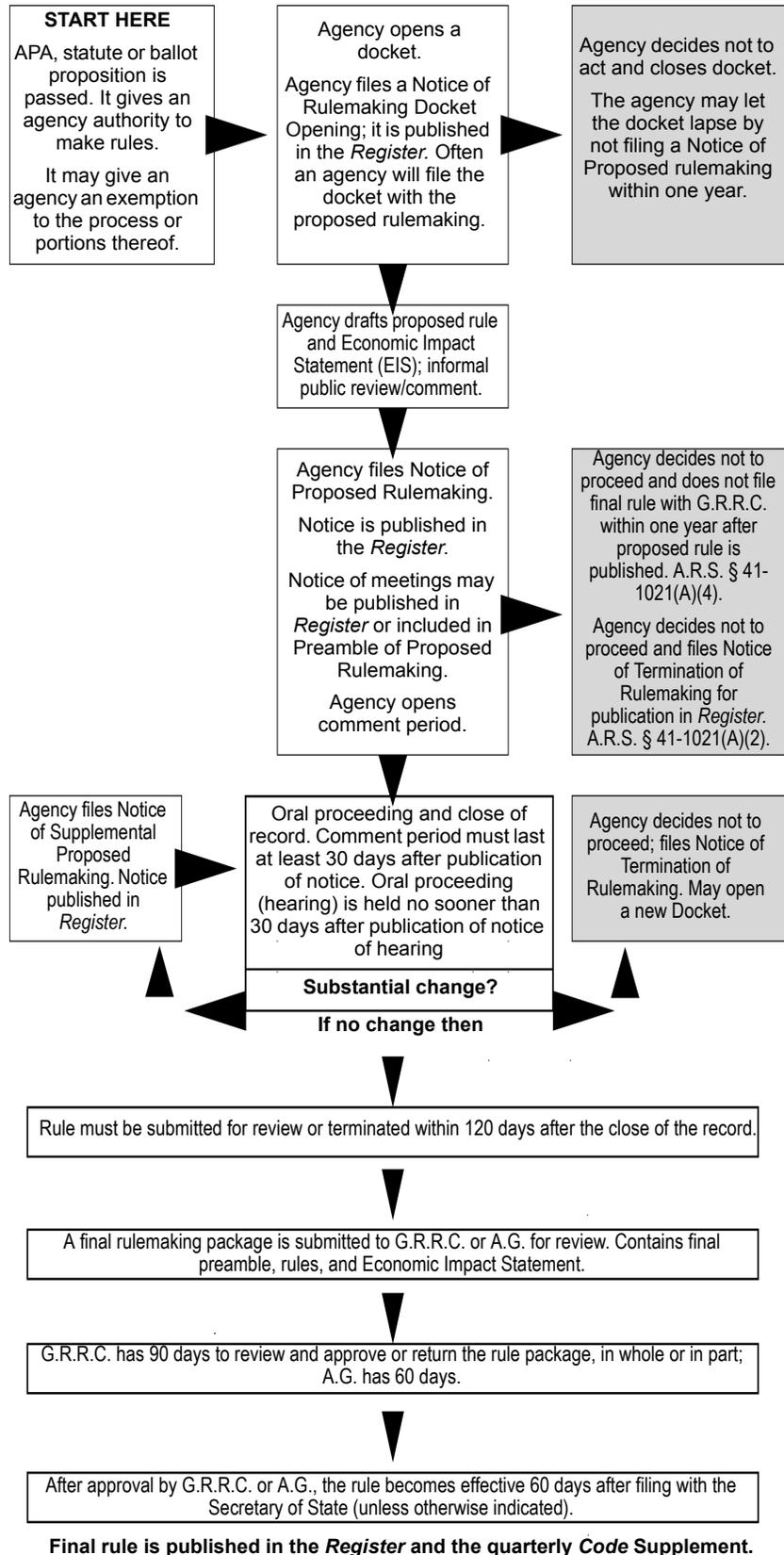
An agency may not have a public meeting scheduled on the Notice of Proposed Rulemaking. If not, you may request that the agency schedule a proceeding. This request must be put in writing within 30 days after the published Notice of Proposed Rulemaking.

Write the agency

Put your comments in writing to the agency. In order for the agency to consider your comments, the agency must receive them by the close of record. The comment must be received within the 30-day comment timeframe following the *Register* publication of the Notice of Proposed Rulemaking.

You can also submit to the Governor's Regulatory Review Council written comments that are relevant to the Council's power to review a given rule (A.R.S. § 41-1052). The Council reviews the rule at the end of the rulemaking process and before the rules are filed with the Secretary of State.

Arizona Regular Rulemaking Process



Definitions

Arizona Administrative Code (A.A.C.): Official rules codified and published by the Secretary of State's Office. Available online at www.azsos.gov.

Arizona Administrative Register (A.A.R.): The official publication that includes filed documents pertaining to Arizona rulemaking. Available online at www.azsos.gov.

Administrative Procedure Act (APA): A.R.S. Title 41, Chapter 6, Articles 1 through 10. Available online at www.azleg.gov.

Arizona Revised Statutes (A.R.S.): The statutes are made by the Arizona State Legislature during a legislative session. They are compiled by Legislative Council, with the official publication codified by Thomson West. Citations to statutes include Titles which represent broad subject areas. The Title number is followed by the Section number. For example, A.R.S. § 41-1001 is the definitions Section of Title 41 of the Arizona Administrative Procedures Act. The "§" symbol simply means "section." Available online at www.azleg.gov.

Chapter: A division in the codification of the *Code* designating a state agency or, for a large agency, a major program.

Close of Record: The close of the public record for a proposed rulemaking is the date an agency chooses as the last date it will accept public comments, either written or oral.

Code of Federal Regulations (CFR): The *Code of Federal Regulations* is a codification of the general and permanent rules published in the *Federal Register* by the executive departments and agencies of the federal government.

Docket: A public file for each rulemaking containing materials related to the proceedings of that rulemaking. The docket file is established and maintained by an agency from the time it begins to consider making a rule until the rulemaking is finished. The agency provides public notice of the docket by filing a Notice of Rulemaking Docket Opening with the Office for publication in the *Register*.

Economic, Small Business, and Consumer Impact Statement (EIS): The EIS identifies the impact of the rule on private and public employment, on small businesses, and on consumers. It includes an analysis of the probable costs and benefits of the rule. An agency includes a brief summary of the EIS in its preamble. The EIS is not published in the *Register* but is available from the agency promulgating the rule. The EIS is also filed with the rulemaking package.

Governor's Regulatory Review (G.R.R.C.): Reviews and approves rules to ensure that they are necessary and to avoid unnecessary duplication and adverse impact on the public. G.R.R.C. also assesses whether the rules are clear, concise, understandable, legal, consistent with legislative intent, and whether the benefits of a rule outweigh the cost.

Incorporated by Reference: An agency may incorporate by reference standards or other publications. These standards are available from the state agency with references on where to order the standard or review it online.

Federal Register (FR): The *Federal Register* is a legal newspaper published every business day by the National Archives and Records Administration (NARA). It contains federal agency regulations; proposed rules and notices; and executive orders, proclamations, and other presidential documents.

Session Laws or "Laws": When an agency references a law that has not yet been codified into the Arizona Revised Statutes, use the word "Laws" is followed by the year the law was passed by the Legislature, followed by the Chapter number using the abbreviation "Ch.," and the specific Section number using the Section symbol (§). For example, Laws 1995, Ch. 6, § 2. Session laws are available at www.azleg.gov.

United States Code (U.S.C.): The Code is a consolidation and codification by subject matter of the general and permanent laws of the United States. The Code does not include regulations issued by executive branch agencies, decisions of the federal courts, treaties, or laws enacted by state or local governments.

Acronyms

A.A.C. – *Arizona Administrative Code*

A.A.R. – *Arizona Administrative Register*

APA – *Administrative Procedure Act*

A.R.S. – *Arizona Revised Statutes*

CFR – *Code of Federal Regulations*

EIS – *Economic, Small Business, and Consumer Impact Statement*

FR – *Federal Register*

G.R.R.C. – *Governor's Regulatory Review Council*

U.S.C. – *United States Code*

About Preambles

The Preamble is the part of a rulemaking package that contains information about the rulemaking and provides agency justification and regulatory intent.

It includes reference to the specific statutes authorizing the agency to make the rule, an explanation of the rule, reasons for proposing the rule, and the preliminary Economic Impact Statement.

The information in the Preamble differs between rulemaking notices used and the stage of the rulemaking.



NOTICES OF PROPOSED EXEMPT RULEMAKING

This section of the *Arizona Administrative Register* contains Notices of Proposed Exempt Rulemaking. An agency may be exempt from rulemaking standards outlined in the Arizona Administrative Procedures Act (APA).

An agency's exemption is listed in the Preamble of the rulemaking as specified under: A.R.S. §§ 41-1005 or 41-1057; or a specific statute; or if a rule is promulgated by the Corporation Commission, it is exempt from Attorney General review under a court decision as determined by the Commission.

If an agency determines it is exempt under the law or court decision, the law may still require publication of the Proposed Exempt Rulemaking in this section to solicit and review public comments on the rulemaking.

Some agencies, even though completely exempt, may still elect to follow certain provisions of the APA, such as circulating its exempt rulemaking for comment. If an agency chooses this option, our office encourages filing the notice with our office for publication in the *Register*.

Please note, if a statute dictates that an agency is completely exempt from the rulemaking process, the agency is authorized to file a Notice of Exempt Rulemaking.

In all cases, an agency must still follow the procedures as established by our office in order to have its rulemaking package published.

The Office of the Secretary of State is the filing office and publisher of these rules. Questions about the interpretation of the proposed exempt rule should be directed to the agency proposing them. Refer to Item #5 of the Preamble to contact the person charged with the rulemaking.

**NOTICE OF PROPOSED EXEMPT RULEMAKING
TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE
CHAPTER 6. DEPARTMENT OF INSURANCE**

[R16-295]

PREAMBLE

<u>I. Article, Part or Section Affected (as applicable)</u>	<u>Rulemaking Action</u>
R20-6-1001	Amend
R20-6-1002	Amend
R20-6-1003	Amend
R20-6-1004	Amend
R20-6-1005	Amend
R20-6-1006	Amend
R20-6-1007	Amend
R20-6-1008	Amend
R20-6-1009	Amend
R20-6-1010	Amend
R20-6-1011	Amend
R20-6-1012	Repeal
R20-6-1012	Re-number
R20-6-1012	Amend
R20-6-1013	Re-number
R20-6-1013	Amend
R20-6-1014	Re-number
R20-6-1014	Amend
R20-6-1015	Re-number
R20-6-1015	New Section
R20-6-1017	Amend
R20-6-1018	Amend
R20-6-1019	Amend
R20-6-1020	Amend
R20-6-1021	Amend
R20-6-1023	Amend
R20-6-1024	Re-number
R20-6-1024	New Section
R20-6-1025	New Section
R20-6-1026	Re-number
Appendix A	Amend
Appendix B	Amend
Appendix C	Amend
Appendix D	Amend
Appendix E	Amend
Appendix F	Amend



Appendix H	Amend
Appendix I	Amend
Appendix J	Amend

2. Citations to the agency’s statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific), and the statute or session law authorizing the exemption:

Authorizing statute: A.R.S. § 20-143

Implementing statute: A.R.S. § 20-1691.02

Statute or session law authorizing the exemption: SB 1441 (L. 2016, Ch. 280); Long-Term Care; Rates; Premiums, enacted into law under an emergency clause effective May 17, 2016.

3. The effective date of the rule and the agency’s reason it selected the effective date:

April 15, 2017. This date provides the insurers with adequate time to comply with the new rule for anticipated filings and complies with the requirement in the session law that the Department allow a 60-day comment period.

4. A list of all notices published in the Register as specified in R1-1-409(A) that pertain to the record of the exempt rulemaking:

Notice of Rulemaking Docket Opening: 22 A.A.R. 3708, December 30, 2016

5. The agency’s contact person who can answer questions about the rulemaking:

Name: Mary E. Kosinski
Address: Department of Insurance
2910 N. 44th St., Suite 210
Phoenix, AZ 85018
Telephone: (602) 364-3471
Fax: (602) 364-3470
E-mail: mkosinski@azinsurance.gov

6. An agency’s justification and reason why a rule should be made, amended, repealed, or renumbered to include an explanation about the rulemaking:

Chapter 6, Article 10 governs Long-Term Care Insurance, which is insurance designed to cover long-term services and supports including personal and custodial care in a variety of settings. Long-term care insurance policies reimburse policyholders a daily amount (up to a pre-selected limit) for services to assist them with activities of daily living (bathing, dressing or eating), home health care, respite care, hospice care or adult day care. Care may be provided in a nursing home, an assisted living facility, a hospice facility, a day care facility or in the person’s home. Long-Term care may also include care management services which evaluate a person’s needs and coordinates and monitors their long-term care services.

The purpose of this regulation is to revise the existing regulation that implemented the Long-Term Care Insurance Act (A.R.S. §§ 20-1691 through 20-1691.12), to promote the public interest, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages and to allow innovation in the development of long-term care insurance products.

The current regulation is patterned after the National Association of Insurance Commissioners’ (NAIC) Long-Term Care Model Regulation, which the NAIC adopted in 2000. Since that version, the NAIC has updated and improved the Model Regulation. The NAIC adopted the current version of the Long-Term Care Model Regulation in 2014.

SB 1441 (L. 2016, Ch. 280); Long-Term Care; Rates; Premiums, enacted into law under an emergency clause effective May 17, 2016, required the Department to adopt rules relating to long-term care insurance that substantially conform to those adopted in model regulations adopted by the NAIC, including the 2014 revisions. The bill exempted the Department from rulemaking requirements for one year from the effective date of the Act except that the Department is required to provide public notice and an opportunity for public comment on the proposed rules at least 60 days before rule adoption or amendment.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

Not applicable

8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:

The rule will not diminish a previous grant of authority of a political subdivision of this state.

9. The summary of the economic, small business, and consumer impact, if applicable:

Upon adoption, this rule will result in greater uniformity for insurers operating in states with later versions of the NAIC Model Regulation resulting in reduced compliance costs.

The most significant change to the Article is to allow consideration of a rate increase that is lower than required by the actuarial certification. Other changes include a definition of Moderately Adverse Experience to encourage more conservative pricing; annual submission of an actuarial certification to encourage rate increase requests when needed rather than delay and request a larger increase; replacing a loss ratio test with one is aimed at better evaluating the reasonableness of a rate increase; strengthening consumer disclosure requirements; and providing greater value to consumers who decide to lapse their policy after a rate increase.

10. A description of any changes between the proposed rulemaking, including any supplemental proposed rulemaking, and the final rulemaking package (if applicable):

Not applicable



11. An agency’s summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments, if applicable:

No comments received as of this date. A 60-day public comment period will begin upon publication of this Notice. Public comments can be submitted to the following e-mail address: public_comments@azinsurance.gov.

A public hearing will be held at a date to be determined. The Department will publish a Notice of Oral Proceeding On Proposed Rulemaking in the *Arizona Administrative Register* announcing the date, time and place of the Oral Proceeding.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules. When applicable, matters shall include, but not be limited to:

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

No permit is required.

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than the federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

No federal law is applicable.

c. Whether a person submitted an analysis to the agency that compares the rule’s impact of the competitiveness of business in this state to the impact on business in other states:

No person submitted an analysis.

13. A list of any incorporated by reference material and its location in the rule:

R20-6-1002, R20-6-1003, R20-6-1004(H)(1), R20-6-1010(A), R20-6-1014(A)(2), R20-6-1014(M), R20-6-1015(A)(2), R20-6-1015(M), R20-6-1019(H)(2), R20-6-1020(G)(2) and R20-6-1024(F) incorporate definitions found at A.R.S. § 20-1691.

R20-6-1002(A): “Benefit trigger” incorporates the definition for a tax-qualified long-term care insurance contract from Section 7702B(b) of the Internal Revenue Code of 1968, as amended.

R20-6-1002(G): “Personal information” incorporates the definition prescribed in A.R.S. § 20-2102(19).

R20-6-1002(H): “Privileged information” incorporates the definition prescribed in A.R.S. § 20-2102(22).

R20-6-1003(A)(4): “Agent” incorporates the definition prescribed in A.R.S. § 20-281(5).

R20-6-1003(A)(6): “Chronically ill individual” incorporates the meaning prescribed by Section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended.

R20-6-1003(A)(13): “Home health services” incorporates the services described at A.R.S. § 36-151.

R20-6-1003(A)(20): “Qualified long-term care services” incorporates the meaning for services that meet the requirements of Section 7702B(c)(1) of the Internal Revenue Code of 1986, as amended.

R20-6-1009(D) incorporates the period referenced in A.R.S. § 20-1691.08.

R20-6-1010(E) incorporates methods that constitute “direct response solicitations” found at A.R.S. § 20-1661.

R20-6-1015(C)(5) incorporates the maximum valuation interest rate for contract reserves as specified in A.R.S. § 20-508.

14. Whether the rule was previously made, amended, repealed or renumbered as an emergency rule. If so, the agency shall state where the text changed between the emergency and the exempt rulemaking packages:

Not applicable

15. The full text of the rules follows:

**TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE
CHAPTER 6. DEPARTMENT OF INSURANCE**

ARTICLE 10. LONG-TERM CARE INSURANCE

Section

- R20-6-1001. Applicability and Scope
- R20-6-1002. Definitions
- R20-6-1003. Policy Terms
- R20-6-1004. Required Policy Provisions
- R20-6-1005. Unintentional Lapse
- R20-6-1006. Inflation Protection
- R20-6-1007. Required Disclosure Provisions
- R20-6-1008. Required Disclosure of Rating Practices to Consumers
- R20-6-1009. Initial Filing Requirements
- R20-6-1010. Requirements for Application Forms and Replacement Coverage, Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates; Reporting Requirements
- R20-6-1011. Prohibition Against Post-claims Underwriting
- R20-6-1012. ~~Discretionary Powers of Director~~ Repealed
- ~~R20-6-1013~~-R20-6-1012. Reserve Standards
- ~~R20-6-1014~~-R20-6-1013. Loss Ratio
- ~~R20-6-1015~~-R20-6-1014. Premium Rate Schedule Increases
- R20-6-1015. Premium Rate Schedule Increases for Policies Subject to Loss Ratio Limits Related to Original Filings
- R20-6-1017. Standards for Marketing



- R20-6-1018. Suitability
- R20-6-1019. Nonforfeiture Benefit Requirement
- R20-6-1020. Standards for Benefit Triggers
- R20-6-1021. Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts
- R20-6-1023. Requirement to Deliver Shopper’s Guide
- R20-6-1024. Availability of New Services or Providers
- R20-6-1025. Right to Reduce Coverage and Lower Premiums
- ~~R20-6-1024~~R20-6-1026. Instructions for Appendices
 - Appendix A. Long-term Care Insurance Personal Worksheet
 - Appendix B. Long-term Care Insurance Potential Rate Increase Disclosure Form
 - Appendix C. Notice to Applicant Regarding Replacement of Individual Health or Long-Term Care Insurance
 - Appendix D. Notice to Applicant Regarding Replacement of Health or Long-Term Care Insurance
 - Appendix E. Long-term Care Insurance Replacement and Lapse Reporting Form
 - Appendix F. Long-term Care Insurance Claims Denial Reporting Form
 - Appendix H. Things You Should Know Before You Buy Long-term Care Insurance
 - Appendix I. Long-term Care Insurance Suitability Letter
 - Appendix J. Long-term Care Insurance Outline of Coverage

ARTICLE 10. LONG-TERM CARE INSURANCE

R20-6-1001. Applicability and Scope

~~Except as otherwise specifically provided, this Article applies to all long-term care insurance policies delivered or issued for delivery in this state.~~

Except as otherwise specifically provided, this Article applies to all long-term care insurance policies, including qualified long-term care contracts and life insurance policies that accelerate benefits for long-term care, delivered or issued for delivery in this state by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health care service organizations and all similar organizations.

R20-6-1002. Definitions

The definitions in A.R.S. § 20-1691 and the following definitions apply in this Article.

- ~~A.~~ “Benefit trigger.” for purposes of a tax-qualified long-term care insurance contract, as defined in Section 7702B(b) of the Internal Revenue Code of 1968, as amended, “benefit trigger” shall include a determination by a licensed health care practitioner that an insured is a chronically ill individual.
- ~~B.~~ “Exceptional increase” means only those rate increases that an insurer has filed as exceptional and that the Director determines the need for the premium rate increase is justified due to changes in laws or regulations applicable to long-term care coverage in this state; or due to increased and unexpected utilization that affects the majority of insurers of similar products.
 - ~~1.~~ Except as provided in Sections R20-6-1014 and R20-6-1015, exceptional increases are subject to the same requirements as other premium rate schedule increases.
 - ~~2.~~ The Director may request independent actuarial review on the issue of whether an increase should be deemed an exceptional increase.
 - ~~3.~~ The Director may also determine whether there are any potential offsets to higher claims costs.
- ~~1-C.~~ “Incidental” “Incidental,” as used in R20-6-1014(L) and R20-6-1015(L), means that the value of the long-term care benefits provided is less than 10% of the total value of the benefits provided over the life of the policy, with value measured as of the date of issue.
- ~~4-D.~~ “Licensed health care professional” means an individual qualified by education and experience in an appropriate field, to determine, by record review, an insured’s actual functional or cognitive impairment.
- ~~2-E.~~ “Long-term care benefit classification” means one of the following:
 - ~~a-1.~~ Institutional long-term care – benefits only;
 - ~~b-2.~~ Non-institutional long-term care – benefits only; or
 - ~~e-3.~~ Comprehensive long-term care benefits.
- ~~3-F.~~ “Managed care plan” means a health care or assisted living ~~agreement~~ arrangement designed to coordinate patient care or control costs through utilization review, case management, use of specific provider networks, or a combination of these methods.
- ~~4-G.~~ “Personal information” has the same meaning prescribed in A.R.S. § 20-2102(19).
- ~~5-H.~~ “Privileged information” has the same meaning prescribed in A.R.S. § 20-2102(22).
- ~~6-I.~~ “Qualified actuary” means a member in good standing of the American Academy of Actuaries.
- ~~7-J.~~ “Similar policy forms” means all long-term care insurance policies and certificates that are issued by a particular insurer and that have the same long-term care benefit classification as a policy form being reviewed.

R20-6-1003. Policy Terms

- A. A long-term care insurance policy delivered or issued for delivery in this state shall not use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:
 - 1. “Activities of daily living” means eating, toileting, transferring, bathing, dressing, or continence.
 - 2. “Acute condition” means that an individual is medically unstable and requires frequent monitoring by medical professionals, such as physicians and registered nurses, to maintain the individual’s health status.
 - 3. “Adult day care” means a program of social and health-related services for six or more individuals, that is 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 the services and care in a setting outside the home.
 - 4. “Agent” means an insurance producer as defined in A.R.S. § 20-281(5).



5. "Bathing" means washing oneself by sponge bath, or in a tub or shower, and includes the act of getting in and out of the tub or shower.
 6. "Chronically ill individual" has the meaning prescribed for this term by A.R.S. § 20-1691(3) and Section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended.
 - a. 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 2 activities of daily living for a period of at least 90 days due to loss of functional capacity; or
 - ii. Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.
 - b. The term "chronically ill individual" does not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a license health care practitioner has certified that the individual meets these requirements.
 - ~~6-7.~~ "Cognitive impairment" means a deficiency in a person's:
 - a. Short or long-term memory;
 - b. Orientation as to person, place, or time;
 - c. Deductive or abstract reasoning; or
 - d. Judgment as it relates to safety awareness.
 - ~~7-8.~~ "Contenance" means the ability to maintain control of bowel and bladder function, or when unable to maintain control, the ability to perform associated personal hygiene, such as caring for a catheter or colostomy bag.
 - ~~8-9.~~ "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
 - ~~9-10.~~ "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.
 - ~~10-11.~~ "Guaranteed renewable" means the insured has the right to continue a long-term-care insurance policy in force by the timely payment of premiums and 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 the insurer may revise rates on a class basis.
 - ~~11-12.~~ "Hands-on assistance" means physical help to an individual who could not perform an activity of daily living without help from another individual, and includes minimal, moderate, or maximal help.
 - ~~12-13.~~ "Home health services" means the services described at A.R.S. § 36-151.
 - ~~13-14.~~ "Level premium" means that an insurer does not have any right to change the premium, even at renewal.
 15. "Licensed health care practitioner" has the same meaning as A.R.S. § 20-1691(7).
 16. "Maintenance or personal care services" has the same meaning as A.R.S. § 20-1691(10).
 - ~~14-17.~~ "Medicare" means "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.
 - ~~15-18.~~ "Noncancellable" means 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 cancel or make any change in any provision of the insurance or in the premium rate.
 - ~~16-19.~~ "Personal care" means the provision of hands-on assistance to help an individual with activities of daily living in relation to the level of skill required, the nature of the care, and the setting in which the care must be delivered.
 20. "Qualified long-term care services" has the meaning prescribed for this term under A.R.S. § 20-1691(14) and means services that meet the requirements of Section 7702B(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventative, 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.
 - ~~17-21.~~ "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing tasks associated with personal hygiene.
 - ~~18-22.~~ "Transferring" means moving into or out of a bed, chair, or wheelchair.
- B.** Any long-term care policy delivered or issued for delivery in this state shall include the following policy terms and provisions as specified in this subsection:
1. "Home care" shall be defined in relation to the level of skill required, the nature of the care, and the setting in which the care must be delivered.
 2. "Intermediate care" shall be defined in relation to the level of skill required, the nature of the care, and the setting in which the care must be delivered.
 3. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.
 4. "Skilled nursing care," "specialized care," "assisted living 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 is delivered.
 5. Service providers, including "skilled nursing facility," "extended care facility," ~~"intermediate care facility,"~~ "convalescent nursing home," "personal care facility," "specialized care providers," "assisted living facility" and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure, certification, registration or degree status of those providing or supervising the services ~~and may require that the provider be appropriately licensed or certified.~~ When the definition requires that the provider be appropriately licensed, certified or registered, it shall also state what requirements a provider must meet in lieu of licensure, certification or registration when the state in which the service is to be furnished does not



require a provider of these services to be licensed, certified or registered, or when the state licenses, certifies or registers the provider of services under another name.

R20-6-1004. Required Policy Provisions

A. Renewability

1. An individual long-term care insurance policy shall contain a renewability provision- which shall be either “guaranteed renewable” or “noncancellable.” The renewability provision shall be appropriately captioned, shall appear on the first page of the policy, and shall state that the coverage is guaranteed renewable or noncancellable. This requirement does not apply to a long-term care insurance policy that is part of or combined with a life insurance policy that does not contain a renewability provision and that reserves the right not to renew solely to the policyholder.
2. An insurer shall not use the terms “guaranteed renewable” and “noncancellable” in any individual long-term care insurance policy without further explanatory language according to the disclosure requirements of this Article.
3. A qualified long-term care insurance policy shall have the guaranteed renewability provisions specified in Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended, in the policy.
4. A long-term care insurance policy or certificate shall include a statement that premium rates are subject to change, unless the policy does not afford the insurer the right to raise premiums.

B. Limitations and Exclusions

1. 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.”
2. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility not prohibited by A.R.S. §§ 20-1691.03 and 20-1691.05 shall describe the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label the paragraph “Limitations or Conditions on Eligibility for Benefits.”
3. A policy shall not be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:
 - a. Preexisting conditions or disease;
 - b. Mental or nervous disorders; however, this shall not permit exclusion or limitation of the benefits on the basis of Alzheimer’s Disease;
 - c. Alcoholism and drug addiction;
 - d. Illness, treatment or medical condition arising out of:
 - i. War, declared or undeclared, or act of war;
 - ii. Participation in a felony, riot or insurrection;
 - iii. Service in the armed forces or auxiliary units;
 - iv. Suicide, attempted suicide, or intentionally self-inflicted injury; or
 - v. Aviation, if non-fare-paying passenger.
 - e. Treatment provided in a government facility, unless otherwise required by law;
 - f. Services for which benefits are available under Medicare or other governmental program, except Medicaid;
 - g. Any state or federal workers’ compensation, employer’s liability or occupational disease law, or any motor vehicle no-fault law;
 - h. Services provided by a member of the covered person’s immediate family subject to the provisions of A.R.S. § 20-1376.09 and services for which no charge is normally made in the absence of insurance;
 - i. Expenses for services or items available or paid under another long-term care insurance or health insurance policy; or
 - j. 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 reimbursable but for the application of a deductible or coinsurance amount;
4. Subsection ~~(B)(2)~~ (B) does not prohibit exclusions and limitations by type of provider or territorial limitations. No long-term care issuer may deny a claim because services are provided in a state other than the state of policy issued under the following conditions:
 - a. When the state other than the state of policy issue does not have the provider licensing, certification or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification or registration; or
 - b. When the state other than the state of policy issue licenses, certifies or registers the provider under another name.
5. “State of policy issue” means the state in which the insurer issued the individual policy or certificate.

C. Extension of benefits. A long-term care insurance policy shall provide that termination of long-term care insurance is 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. An insurer may limit this extension of benefits period to the duration of the benefit period, if any, or to payment of the maximum benefits and the insurer may still apply any policy waiting period and all other applicable provisions of the policy.

D. Reinstatement. A long-term care insurance policy shall include a provision for reinstatement of coverage if a lapse occurs if the insurer receives proof that the insured was cognitively impaired or had a loss of functional capacity before expiration of the grace period in the policy. The option to reinstate shall be available to the insured for at least five months after the date of termination and shall allow for the collection of past due premiums, as appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria for these conditions set forth in the original long-term care policy.

E. Continuation or conversion

1. A group long-term care insurance policy shall provide covered individuals with a basis for continuation or conversion of coverage as specified in this subsection.



2. The policy shall include a provision that maintains coverage under the existing group policy when the coverage would otherwise terminate, subject only to the continued timely payment of premiums when due. A group policy that restricts provision of benefits and services to, or has 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 provider system arrangements, service availability, benefit levels and administrative complexity.
 3. The policy shall include a provision that an individual, whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuation of the group policy in its entirety or with respect to an insured class, 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, is entitled to the issuance of a converted policy by the insurer under whose group policy the individual is covered, without evidence of insurability.
 4. A converted policy shall be an individual policy of long-term care insurance providing benefits identical to or benefits that the Director determines 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, and other plan elements.
 5. An insurer may require an individual seeking a conversion policy to make a written application for the converted policy and pay the first premium due, if any, as directed by the insurer not later than 31 days after termination of coverage under the group policy. The insurer shall issue the converted policy effective on the day following the termination of coverage under the group policy. The converted policy shall be renewable annually.
 6. Unless the group policy from which conversion is made replaced previous group coverage, the insurer shall calculate the premium for the converted policy on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. If 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. An insurer is required to provide continuation of coverage or issuance of a converted policy as provided in this subsection, unless:
 - 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 31 days after termination, by group coverage that
 - i. Is effective on the day following the termination of coverage;
 - ii. Provides benefits identical to or benefits the Director determines to be substantially equivalent to or in excess of those provided by the terminating coverage; and
 - iii. Has a premium calculated in a manner consistent with the requirements of subsection (E)(6).
 8. Notwithstanding any other provision of this Section, a converted policy that an insurer issues to an individual who at the time of conversion is covered by another long-term care insurance policy providing benefits on the basis of incurred expenses, may contain a provision that reduces 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% of incurred expenses. An insurer may include this provision in the converted policy only if the converted policy also provides for a premium decrease or refund that reflects the reduction in payable benefits.
 9. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.
 10. Notwithstanding any other provision of this Section, ~~any~~ an insured individual whose eligibility for group long-term care coverage is based upon the individual's relationship to another person, is entitled to continuation of coverage under the group policy ~~upon~~ if the qualifying relationship terminates by death or dissolution of marriage.
- F.** Discontinuance and replacement. If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:
1. Shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and
 2. Shall not vary or otherwise depend on the individual's health or disability status, claim experience, or use of long-term care services.
- G.** Premium Increases.
1. An insurer shall not increase the premium charged to an insured because of:
 - a. ~~The insured aging beyond age 65; The increasing age of the insured at ages beyond sixty-five (65);~~ or
 - b. The duration of coverage under the policy.
 2. Purchase of additional coverage is not considered a premium rate increase, however, for the calculation required under R20-6-1019, an insurer shall add to and consider the portion of the premium attributable to the additional coverage as part of the initial annual premium.
 3. A reduction in benefits is not considered a premium change, however, for the calculation required under R20-6-1019, an insurer shall base the initial annual premium on the reduced benefits.
- H.** Electronic enrollment for group policies.
1. For coverage offered to a group defined in A.R.S. § 20-1691(5)(a), any requirement that an insurer or insurance producer obtain an insured's signature is satisfied if:



- a. The group policyholder or insurer obtains the insured’s consent by telephonic or electronic enrollment, and provides the enrollee with verification of enrollment information within five business days of enrollment; and
- b. The telephonic or electronic enrollment process has necessary and reasonable safeguards to assure the accuracy, retention, and prompt retrieval of records, and the confidentiality of ~~personal~~ individually identifiable and privileged information.
- 2. If the Director requests, the insurer shall make available records showing the insurer’s ability to confirm enrollment and coverage amounts.
- I. Minimum standards for home health and community care benefits.
 - 1. If an insurer issues a long-term care insurance policy or certificate that provides benefits for home-health or community care, the policy or certificate shall not ~~limit or exclude~~ benefits by any of the following:
 - a. Requiring that the insured would need skilled care in a skilled nursing facility if home health services are not provided;
 - b. Requiring that the insured first or simultaneously receive nursing or therapeutic services, or both, in a home, ~~or~~ community or institutional setting before home health services are covered;
 - c. Requiring that eligible services be provided by a registered nurse or licensed practical nurse;
 - d. 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 licensure or certification;
 - e. Requiring that the insured or claimant have an acute condition before home health services are covered;
 - f. Limiting benefits to services provided by Medicare-certified agencies or providers;
 - g. Excluding coverage for personal care services provided by a home health aide;
 - h. Requiring that home health care services be provided at a level of certification or licensure greater than that required by the eligible service; or
 - i. Excluding coverage for adult day care services.
 - 2. If a long-term care insurance policy provides benefits for home health or community care services, it shall provide home health or community care coverage that equals a dollar amount equivalent to at least one-half of one year’s missing home benefit coverage available at the time covered home health or community care services are being received. This requirement does not apply to policies or certificates issued to residents of continuing care retirement communities.
 - ~~2-3.~~ An insurer may apply home health care coverage to non-home health care benefits in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.
- J. Appeals. Policy shall include a clear description of the process for appealing and resolving benefit determinations.

R20-6-1005. Unintentional Lapse

- A. An insured may designate in writing at least one person to receive notice of lapse ~~and~~ or termination of a long-term care insurance policy for nonpayment of premium, in addition to the insured. Designation shall not constitute acceptance of any liability by the third-party notice recipient for services provided to the insured.
- B. An insurer shall not issue ~~a~~ an individual long-term care insurance policy or certificate until the applicant has provided either a written designation of at least one person, in addition to the applicant, who shall receive notice of lapse or termination; of the policy or certificate for nonpayment of premium, with the person’s full name and home address, or the applicant’s written waiver, dated and signed, indicating that the applicant chooses not to designate a notice recipient.
- C. The insurer shall use a form for written designation or waiver that provides space clearly delineated for the designation. The insurer shall include the following language on the form for waiver of the right to name a designated recipient: “Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that this notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice.”
- D. At least once every two years, an insurer shall notify the insured of the right to change the person designated to receive notice in subsection (A). An insured may add, delete, or change a designated recipient or change a designated recipient at any time by notifying the insurer in writing, and providing the name and home address for the new designated recipient or the designated recipient to be deleted.
- E. If the insured pays premiums for the long-term care insurance policy or certificate through a payroll or pension deduction plan, the insurer is not required to comply with the requirements in subsections (A) through (D) until 60 days after the insured is no longer on the payment plan.
- F. An individual long-term care insurance policy shall not lapse or be terminated for nonpayment of premium unless the insurer gives the insured and any recipient designated under subsections (A) through (D) written notice at least 30 days before the effective date of termination or lapse, by first class mail, postage prepaid- at the address provided by the insured for purposes of receiving notice of lapse or termination. An insurer shall not give notice until 30 days after the date on which a premium is due and unpaid. Notice is deemed given five days after the date of mailing.
- G. Reinstatement. In addition to the requirement in subsections (A) through (D), a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of a lapse if the insurer 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 or certificate. Reinstatement after termination for other than unintentional lapse shall be governed by A.R.S. § 20-1348.

R20-6-1006. Inflation Protection

- A. An insurer shall not offer a long-term care insurance policy unless the insurer offers to the policyholder, at the time of purchase, in addition to any other inflation protection, the option to purchase a policy with an inflation protection provision ~~to address the reduction or limitation on the value of benefits that may result from inflation over time.~~ 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. The terms of the required provision shall be no less favorable than one of the following:

1. A provision that provides for annual increases in benefit levels compounding annually at a rate of ~~no not~~ less than 5%; or
 2. A provision that ~~allows~~ guarantees an insured the right to periodically increase benefit levels without providing evidence of insurability or health status, if the insured did not decline the option for the previous period. The increased benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of ~~no less than~~ at least 5% for the period beginning from the purchase of the existing benefit and extending until the year in which the offer is made; or
 3. A provision for coverage of a specified percentage of actual or reasonable charges that is not subject to a maximum specified indemnity amount or limit.
- B. If the policy is issued to a group, the insurer shall extend the offer required by subsection (A) to the group policyholder; except, if the policy is issued under A.R.S. § 20-1691.04(C) to a group, other than to a continuing care retirement community, the insurer shall make the offer to each proposed certificateholder.
- C. An insurer is not required to make the offer in subsection (A) for life insurance policies or riders with accelerated long-term care benefits.
- D. An insurer shall include the information listed in this subsection in or with the outline of coverage.
1. 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 20-year period.
 2. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall provide a revised schedule of attained-age premiums. An insurer may use a reasonable hypothetical or a graphic demonstration for this disclosure.
- E. Inflation-protection benefit increases shall continue without regard to an insured's age, claim status, claim history, or length of time the person has been insured under the policy.
- F. An insurer's offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium that the insurer expects to remain constant. The insurer shall disclose in the offer in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.
- G. An insurer shall include in a long-term care insurance policy inflation protection as provided in subsection (A)(1) unless ~~at~~ the insurer obtains a rejection of inflation protection signed by the insured as required in subsection (H). The rejection may be either on the application form or on a separate form.
- H. A rejection of inflation protection is deemed part of an 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 reviewed Plans [insert description of plans], and I reject inflation protection."

R20-6-1007. Required Disclosure Provisions

- A. Riders and endorsements. Except for riders or endorsements by which an insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, if an insurer adds a rider or endorsement to an individual long-term care insurance policy after date of issue or at reinstatement or renewal that reduces or eliminates benefits or coverage in the policy, the insurer shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term shall require the signed written agreement of the insured unless the increased benefits or coverage are required by law. If the insurer charges a separate additional premium for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider, or endorsement.
- B. 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 define the terms and explain them in its accompanying outline of coverage.
- C. Disclosure of tax consequences. For life insurance policies that provide an accelerated benefit for long-term care, an insurer shall provide a disclosure statement 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 adviser. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This subsection shall not apply to qualified long-term care insurance contracts.
- D. Benefit triggers. A long-term care insurance policy shall use activities of daily living and cognitive impairment to measure an insured's need for long-term care. The long-term care insurance policy ~~or certificate~~ shall describe these terms and provisions in a separate paragraph in the policy ~~or certificate~~ labeled "Eligibility for the Payment of Benefits" that includes and explains:
1. Any additional benefit triggers;
 2. Benefit triggers that result in payment of different benefit levels;
 3. Any requirement that an attending physician or other specified person certify a certain level of functional dependency for the insured to be eligible for benefits.
- E. A long-term care insurance ~~policy or certificate~~ contract shall contain a disclosure statement in the policy and in the outline of coverage indicating whether it is intended to be a qualified long-term care insurance contract as specified in the outline of coverage in Appendix J, paragraph 3. The contract shall also include a Specification Page which 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.

R20-6-1008. Required Disclosure of Rating Practices to Consumers

- A. This Section applies as follows:
1. Except as provided in subsection (A)(2), this Section applies to any long-term care policy or certificate issued in this state on or after May 10, 2005.
 2. For certificates issued under an in-force, long-term care insurance policy issued to a group as defined in A.R.S. § 20-1691(5)(a), the provisions of this Section apply on the first policy anniversary that occurs on or after November 10, 2005.



- B. Unless a policy is one for which an insurer ~~can not cannot~~ increase the applicable premium rate or rate schedule, the insurer shall provide the information listed in this subsection to the applicant at the time of application or enrollment. If the method of application does not allow for delivery at that time, the insurer shall provide the information to the applicant no later than at the time of delivery of the policy or certificate.
 - 1. A statement that the policy may be subject to rate increases in the future.
 - 2. An explanation of potential future premium rate revisions, and the policyholder’s or certificateholder’s option if a premium rate revision occurs.
 - 3. The premium rate or rate schedules applicable to the applicant that will be in effect until the insurer makes a request for an increase.
 - 4. A general explanation for applying premium rate or rate schedule adjustments that includes:
 - a. A description of when premium rate or rate-schedule adjustments will be effective (e.g., next anniversary date, next billing date); and
 - b. The insurer’s right to a revised premium rate or rate schedule as provided in subsection (B)(3) if the premium rate or rate schedule is changed.
 - 5. Information regarding each premium rate increase on this policy form or similar policy form over the past 10 years for this state or any other state; that, at a minimum, identifies:
 - a. The policy forms for which premium rates have been increased;
 - b. The calendar years when the form was available for purchase; and
 - c. The amount or percent of each increase, which may be expressed as a percentage of the premium rate before the increase, or as minimum and maximum percentages if the rate increase is variable by rating characteristics.
 - 6. The insurer may, in a fair manner, provide explanatory information related to the rate increases in addition to the information required under subsection (B)(5).
- C. An insurer may exclude from the disclosure required under subsection (B)(5), premium rate increases applicable to:
 - 1. Blocks of business acquired from other nonaffiliated insurers; and
 - 2. Policies acquired from other nonaffiliated insurers if the increases occurred before the acquisition.
- D. If an acquiring insurer files for a rate increase on a long-term care insurance policy form or a block of policy forms acquired from a nonaffiliated insurer on or before the later of the January 10, 2005, or the end of a 24-month period following the acquisition of the policies or block of policies, the acquiring insurer may exclude that rate increase from the disclosure required under subsection (B)(5). However, the nonaffiliated insurer that sells the policy form or a block of policy forms shall include that rate increase in the disclosure required under subsection (B)(5). If the acquiring insurer files for a subsequent rate increase, even within the 24-month period, on the same policy form acquired from a nonaffiliated insurer or block of policy forms acquired from nonaffiliated insurers, the acquiring insurer shall make all disclosures required by subsection (B)(5), including disclosure of the earlier rate increase.
- E. Unless the method of application does not allow an insured to sign an acknowledgement that the insurer made the disclosures required under subsection (B) at the time of application, the applicant shall sign an acknowledgement of disclosure at that time. Otherwise, the applicant shall sign a disclosure acknowledgement no later than at the time of delivery of the policy or certificate.
- F. An insurer shall use the forms in Appendix A and Appendix B to comply with the requirements of subsections (B) through (E). The text and format of an insurer’s forms shall be substantially similar to the text and format of Appendices A and B.
- G. An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least 45 days before the effective date of the increase. The notice shall include the information required by subsection (B).

R20-6-1009. Initial Filing Requirements

- A. This Section applies to any long-term care policy issued in this state on or after May 10, 2005.
- B. At the time of making a filing under A.R.S. § 20-1691.08, an insurer shall provide the Director a copy of the disclosure documents required under R20-6-1008 and an actuarial certification that includes the following:
 - 1. The initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;
 - 2. The policy design and coverage provided have been reviewed and taken into consideration;
 - 3. The underwriting and claims adjudication processes have been reviewed and taken into consideration;
 - 4. ~~A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:~~
 - a. ~~Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;~~
 - b. ~~A statement that the assumptions used for reserves contain reasonable margins for adverse experience;~~
 - c. ~~A statement that the net valuation premium for renewal years does not increase (except for attained age rating where permitted); and~~
 - d. ~~A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur;~~
 - i. ~~An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;~~
 - ii. ~~If the gross premiums for certain age groups appear to be inconsistent with this requirement, the Director may request a demonstration under subsection (C) based on a standard age distribution; and~~
 - 4. The premiums contain at least the minimum margin for moderately adverse experience as defined in subsection (4)(a) or the specification of and justification for a lower margin as required by subsection (4)(b).
 - a. A composite margin shall not be less than ten percent (10%) of lifetime claims.
 - b. A composite margin that is less than ten percent (10%) may be justified in uncommon circumstances. The proposed amount, full justification of the proposed amount and methods to monitor developing experience that would be the basis for withdrawal of approval for such lower margins must be submitted.



- c. A composite margin lower than otherwise considered appropriate for the stand-alone long-term care policy may be justified for long-term care benefits provided through a life policy or an annuity contract. Such lower composite margin, if utilized, shall be justified by appropriate actuarial demonstration addressing margins and volatility when considering the entirety of the product.
- d. A greater margin may be appropriate in circumstances where the company has less credible experience to support its assumptions used to determine the premium rates.
- 5. A statement that the premium rate schedule:
 - a. Is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or
 - b. A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.
- 6. A statement that reserve requirements have been reviewed and considered. Support for this statement shall include:
 - a. Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held; and
 - b. A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship.
- C. The Director may require an insurer to provide an actuarial demonstration that benefits provided under a long-term care policy are reasonable in relation to premiums charged. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both. An actuarial memorandum shall be included that is signed by a member of the Academy of Actuaries and that addresses and supports each specific item required as part of the actuarial certification and provides as least the following:
 - 1. An explanation of the review performed by the actuary prior to making the statements in subsections (B)(2) and (B)(3);
 - 2. A complete description of pricing assumptions;
 - 3. Sources and levels of margins incorporated into the gross premiums that are the basis for the statement in subsection (B)(1) of the actuarial certification and an explanation of the analysis and testing performed in determining the sufficiency of the margins. The actuary shall clearly describe deviations in margins between ages, sexes, plans or states. Deviations in margins required to be described are other than those produced utilizing generally accepted actuarial methods for smoothing and interpolating gross premium scales; and
 - 4. A demonstration that the gross premiums include the minimum composite margin specified in subsection (B)(4).
- D. In any review of the actuarial certification and actuarial memorandum, the Director may request review by the an actuary with experience in long-term care pricing who is independent of the insurer. In the event the Director asks for additional information as a result of any review, the period in A.R.S. § 20-1691.08 does not include the period during which the insurer is preparing the requested information.

R20-6-1010. Requirements for Application Forms and Replacement Coverage, Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates; Reporting Requirements

- A. An insurer's application form for a long-term care insurance policy shall include the questions listed in this Section 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 health or long-term care policy or certificate presently in force. An insurer may include the questions in a supplementary application or other form to be signed by the applicant and insurance producer, except where the coverage is sold without an insurance producer. For a replacement policy issued to a group as defined in A.R.S. § 20-1691(5)(a), the insurer may modify the questions only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced if the ~~certificate holder~~ 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 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 or certificate?
- B. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan the applicant selects.
- C. An insurance producer shall list any other health insurance policies the insurance producer has sold to the applicant, including:
 - 1. Policies that are still in force.
 - 2. Policies sold in the past five years that are no longer in force.
- D. Solicitations Other than Direct Response. On determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its insurance producer, shall furnish the applicant, before issuing or delivering of the individual long-term care insurance policy, a notice that substantially conforms to the form prescribed in Appendix C or D regarding replacement of health or long-term care coverage. The insurer shall:
 - 1. Give one copy of the notice to the applicant; and
 - 2. Keep an additional copy signed by the applicant.
- E. Direct Response Solicitations. Insurers using direct response solicitation methods as defined in A.R.S. § 20-1661 shall deliver a notice that substantially conforms to the form prescribed in Appendix C or D regarding replacement of health or long-term care coverage to the applicant upon issuance of the policy.



- F. If replacement is intended, the replacing insurer shall send the existing insurer written notice of the proposed replacement within five working days from the date the replacing insurer receives the application or issues the policy, whichever is sooner. The notice shall identify the existing policy by name of the insurer and the insured, and policy number or insured’s address including zip code.
- G. A life insurance policy that accelerate benefits for long-term care shall comply with this Section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of Title 20, Chapter 6, Article 1.1. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with the requirements of this Section and with Title 20, Chapter 6, Article 1.1.
- H. 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 insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits if similar exclusions are satisfied under the original policy.
- I. Reporting requirements
 - 1. An insurer shall maintain the following records for each insurance producer:
 - a. The amount of the insurance producer’s replacement sales as a percent of the insurance producer’s total annual sales; and
 - b. The amount of lapses of long-term care insurance policies sold by the insurance producer as a percent of the insurance producer’s total annual sales.
 - 2. No later than June 30 of each year, on the forms specified in Appendix E and Appendix F, an insurer shall report the following information for the preceding calendar year to the Department:
 - a. The 10% of its insurance producers licensed in Arizona with the greatest percentages of lapses and replacements as measured by subsection ~~(H)(1)~~; ~~(I)(1)~~; and
 - b. The number of lapsed policies as a percent of the total annual sales and as a percent of the insurer’s total number of policies in force as of the end of the preceding calendar year.
 - c. The number of replacement policies sold as a percent of the insurer’s total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year; and
 - d. For qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied.
- J. In subsection (I),
 - 1. “Claim” means a request for payment of benefits under an in-force policy, regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;
 - 2. “Denied” means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition;
 - 3. “Policy” means only long-term care insurance; and
 - 4. “Report” means on a statewide basis.
- K. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance. Reports required under this Section shall be filed with the Director.
- L. Annual rate certification requirements. This subsection applies to any long-term care policy issued in Arizona on or after April 15, 2017. The following annual submission requirements apply subsequent to initial rate filings for individual long-term care insurance policies made under this Section:
 - 1. An actuarial certification prepared, dated and signed by a member of the American Academy of Actuaries which contains a statement of the sufficiency of the current premium rate schedule, including:
 - a. For the rate schedules currently marketed, that the premium rate schedule continues to be sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated or a statement that margins for moderately adverse experience may no longer be sufficient. For a statement that margins for moderately adverse experience may no longer be sufficient, the insurer shall provide to the Director, within sixty days of the date the actuarial certification is submitted to the Director, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience so that the ultimate premium rate schedule would be reasonably expected to be sustainable over the future life of the form with no future premium increases anticipated. Failure to submit a plan of action to the Director within sixty days or to comply with the time frame stated in the plan of action constitutes grounds for the Director to withdraw or modify approval of the form for future sales pursuant to A.R.S. § 20-1691.08.
 - b. For the rate schedules that are no longer marketed, that the premium rate schedule continues to be sufficient to cover anticipated costs under best estimate assumptions or that the premium rate schedule may no longer be sufficient. If the premium rate schedule is no longer sufficient, the insurer shall provide to the Director, within sixty days of the date the actuarial certification is submitted to the Director, a plan of action, including time frame, for the re-establishment of adequate margins for moderately adverse experience.
 - 2. A description of the review performed that led to the statement.
 - 3. An actuarial memorandum dated and signed by a member of the American Academy of Actuaries who prepares the information shall be prepared to support the actuarial certification and provide at least the following information:
 - a. A detailed explanation of the data sources and review performed by the actuary prior to making the statement in subsection (L)(1).
 - b. A complete description of experience assumptions and their relationship to the initial pricing assumptions.
 - c. A description of the credibility of the experience data.
 - d. An explanation of the analysis and testing performed in determining the current presence of margins.



4. The actuarial certification required pursuant to subsection (L)(1) must be based on calendar year data and submitted annually starting in the second year following the year in which the initial rate schedules are first used. The actuarial memorandum required pursuant to subsection (L)(3) must be submitted at least once every three years with the certification.

R20-6-1011. Prohibition Against Post-claims Underwriting

- A. An application for a long-term care insurance policy or certificate that is not guaranteed issue shall meet the requirements of this Section.
1. The application shall contain clear and unambiguous questions designed to ascertain the applicant's health condition.
 - a. If the application has a question asking whether the applicant has had medication prescribed by a physician, the application shall also ask the applicant to list the prescribed medication.
 - b. If the insurer knew or reasonably should have known that the medications listed in the application are related to a medical condition for which coverage would otherwise be denied, the insurer shall not rescind the policy or certificate for that condition.
 2. The application shall include the following language which shall be set out conspicuously and in close conjunction with the applicant's signature block: "**Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy.**"
 3. The policy or certificate shall contain, at the time of delivery, the following language, or language substantially similar to the following, set out conspicuously: "**Caution: The issuance of this long-term care insurance [policy] [certificate] is based on 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].**"
- B. Before issuing a long-term care insurance policy or certificate that is not guaranteed issue to an applicant age 80 or older, the insurer shall obtain one of the following:
- ~~a-1.~~ A report of a physical examination;
 - ~~b-2.~~ An assessment of functional capacity;
 - ~~e-3.~~ An attending physician's statement; or
 - ~~d-4.~~ Copies of medical records.
- C. The insurer or ~~it's~~ its insurance producer shall deliver a copy of the completed application or enrollment form, as applicable, to the insured no later than at the time of delivery of the policy or certificate unless the insurer gave a copy to the applicant at the time of application.
- D. An insurer selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state- and country-wide, except those which the insured voluntarily effectuated.
- E. On or before March 31 of each year, an insurer shall report the following information to the Director for the preceding calendar year, using the form prescribed in Appendix G:
1. Insurer name, address, phone number;
 2. As to each rescission except those voluntarily effectuated by the insured:
 - a. Policy form number;
 - b. Policy and certificate number;
 - c. Name of the insured;
 - d. Date of policy issuance;
 - e. Date claim submitted;
 - f. Date of rescission; and
 - g. Detailed reason for rescission.
 3. Signature, name and title of the preparer, and date prepared.

R20-6-1012. Discretionary Powers of Director Repealed

~~The Director may, on written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provision of this Article with respect to a specific long-term care insurance policy or certificate upon a written finding that:~~

- ~~1. The modification or suspension would be in the best interest of the insureds; and~~
- ~~2. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and~~
 - ~~a. The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or~~
 - ~~b. The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or~~
 - ~~e. The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.~~

~~R20-6-1013~~R20-6-1012. Reserve Standards

- A. If long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders, an insurer shall determine; policy reserves for long-time care benefits under A.R.S. § 20-510. An insurer shall also establish claim reserves for a policy or rider in claim status.
- B. An insurer shall base reserves for policies and riders under subsection (A) on the multiple decrement model using all relevant decrements except for voluntary termination rates. An insurer may use single decrement approximations if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The insurer, when calculating reserves, may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. The insurer



shall not set the reserves for the long-term care benefit and the life insurance benefit to be less than the reserves for the life insurance benefit assuming no long-term care benefit.

- C. In the development and calculation of reserves for policies and riders subject to this Section, an insurer shall give due regard to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which impact projected claim costs including 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;
 19. Guaranteed insurability option; and
 20. Other similar or comparable factors affecting risk.
- D. A member of the American Academy of Actuaries shall certify an insurer's use of any applicable valuation morbidity table as appropriate as a statutory valuation table.
- E. When long-term care benefits are provided other than as described in subsection (A), an insurer shall determine reserves under A.R.S. § 20-508.

~~R20-6-1014~~R20-6-1013. Loss Ratio

- A. This Section applies to policies and certificates issued any time prior to May 10, 2005.
- B. Benefits under an individual long-term care insurance policy is deemed reasonable in relation to premiums if the expected loss ratio is at least 60% calculated in a manner that provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, the director shall consider ~~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.
- ~~C.~~ A premium rate schedule or proposed revision to a premium rate schedule that is expected to produce, over the lifetime of the long-term care insurance policy, benefits that are less than 60% of the proposed premium rate schedule is deemed to be unreasonable.
- ~~C-D.~~ Subsection (B) does ~~Subsections (B) and (C) do~~ 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 deemed to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following:
 1. The interest credited internally to determine cash value accumulations, including long-term care, if any, is 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 complies with the nonforfeiture requirements of A.R.S. § 20-1231;
 3. The policy complies with the disclosure requirements of A.R.S. § 20-1691.06(A) through (E);
 4. At the time of making a filing under A.R.S. § 20-1691.08, the insurer files an actuarial memorandum that includes the following information:
 - 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 insurer shall 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, including:
 - i. Time of underwriting;
 - ii. A description of the type of underwriting used, such as medical underwriting or functional assessment underwriting; and
 - iii. For a group policy, whether an enrollee's dependents are subject to underwriting; and
- h. A description of the effect of the long-term care policy provisions 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.

~~R20-6-1015~~R20-6-1014. Premium Rate Schedule Increase

~~B.A.~~ This Section applies to any long-term care policy or certificate issued in this state on or after May 10, 2005 and prior to April 15, 2017.

~~C.B.~~ An insurer shall notify the Director of a proposed premium rate schedule increase, including an exceptional increase, at least ~~30~~ 60 days before issuing notice to its policyholders. The notice to the Director shall include:

1. Information required by R20-6-1008;
2. Certification by a qualified actuary that:
 - a. If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;
 - b. The premium rate filing complies with the provisions of this Section;
 - c. The insurer may request a premium rate schedule increase less than what is required under this Section and the Director may approve the premium rate schedule increase, without submission of the certification required by subsection (B)(2)(a), if the actuarial memorandum discloses the premium rate schedule increase necessary to make the certification required by subsection (B)(2)(a), the premium rate schedule increase filing satisfies all other requirements of this Section, and is, in the opinion of the Director, in the best interest of the policyholders.
3. An actuarial memorandum justifying the rate schedule change request that includes:
 - a. Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including the following:
 - i. Any assumptions that deviate from those used for pricing other forms currently available for sale;
 - ii. Annual values for the five years preceding and the three years following the valuation date, provided separately;
 - iii. Development of the lifetime loss ratio, unless the rate increase is an exceptional increase;
 - iv. A demonstration of compliance with subsection ~~(D)~~ and (C).
 - b. For exceptional increases, the actuarial memorandum shall also include:
 - i. The projected experience that is limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and
 - ii. If the Director determines under ~~subsection (A)~~ Section R20-6-1002(B)(3) that offsets may exist, the insurer shall use appropriate net projected experience;
 - c. Disclosure of how reserves have been incorporated in this rate increase when the rate increase will trigger contingent benefit upon lapse;
 - d. Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and any other actions of the insurer on which the actuary has relied;
 - e. A statement that the actuary has considered policy design, underwriting, and claims adjudication practices; ~~and~~
 - f. Composite rates reflecting projections of new certificates in the event it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase; and
 - g. A demonstration that actual and projected costs exceed costs anticipated at the time of the initial pricing under moderately adverse experience and that the composite margin specified in R20-6-1009(B)(4) is projected to be exhausted.
4. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless the insurer provides the Director with documentation justifying the greater rate; and
5. Upon the Director's request, other similar and related information the Director may require to evaluate the premium rate schedule increase.

~~D.C.~~ ~~The following requirements apply to all~~ All premium rate schedule increases shall be determined in accordance with the following requirements:

1. The insurer shall return 70% of the present value of projected additional premiums from an exceptional increase to policyholders in benefits;
2. The sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, shall not be less than the sum of the following:
 - a. The accumulated value of the initial earned premium times 58%;
 - b. 85% of the accumulated value of prior premium rate schedule increases on an earned basis;
 - c. The present value of future projected initial earned premiums times 58%; and
 - d. 85% of the present value of future projected premiums not in subsection ~~(D)(2)(e)~~ (C)(2)(c) on an earned basis;
3. If a policy form has both exceptional and other increases, the values in subsection ~~(D)(2)(b)~~ and (D)(2)(d) (C)(2)(b) and (C)(2)(d) shall also include 70% for exceptional rate increase amounts; and
4. All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in the NAIC Accounting Practices and Procedures Manual to which insurers are subject under A.R.S. § 20-223. The actuary shall disclose the use of any appropriate averages in the actuarial memorandum required under subsection (B)(3).

~~E.D.~~ For each rate increase that is implemented, the insurer shall file for approval by the Director updated projections, as defined in ~~Subsection (C)(3)(a); subsection (B)(3)(a),~~ annually for the next three years and shall include a comparison of actual results to projected values. The Director may extend the period to greater than three years if actual results are not consistent with projected values from



prior projections. For group insurance policies that meet the conditions in ~~Subsection (K)~~, subsection (M), the projections required by this ~~Subsection~~ subsection shall be provided to the policyholder ~~instead in lieu~~ of filing with the Director.

- ~~F.E.~~ If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, the insurer shall file lifetime projections, as defined in ~~Subsection (C)(3)(a)~~, subsection (B)(3)(a), for the Director's approval every five years following the end of the required period in ~~Subsection (E)~~, subsection (D). For group insurance policies that meet the conditions in ~~subsection (L)~~, (M), the insurer shall provide the projections required by this ~~Subsection~~ subsection to the policyholder instead of filing with the Director.
- ~~G.F.~~ If the Director finds that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in ~~subsection (D)~~, (C), the Director may require the insurer to implement premium rate schedule adjustments or other measures to reduce the difference between the projected and actual experience. In determining whether the actual experience matches the projected experience, the Director shall consider ~~subsection (C)(3)(f)~~, (B)(3)(f), if applicable.
- ~~H.G.~~ If the majority of the policies or certificates to which the increase applies are eligible for the contingent benefit upon lapse, the insurer shall file:
 1. A plan, subject to Director approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form experience requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the Director may impose the ~~condition in subsection (I) through (K)~~; conditions in subsections (H) through (J); and
 2. The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to ~~subsection (D) (C)~~ had the greater of the original anticipated lifetime loss ratio or 58% has been used in the calculations described in ~~Subsections (D)(2)(a) and (D)(2)(c)~~, subsections (C)(2)(a) and (C)(2)(c).
- ~~I.H.~~ For a rate increase filing that meets the criteria listed in this subsection, the Director shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if lapsation in excess of projected lapsation has occurred or is anticipated:
 1. The rate increase is not the first rate increase requested for the specific policy form or forms;
 2. The rate increase is not an exceptional increase; and
 3. The majority of the policies or certificates to which the increase applies are eligible for the contingent benefit upon lapse.
- ~~J.I.~~ If the Director finds excess lapsation under ~~subsection (H)~~, (H) has occurred, is anticipated in the filing or is evidenced in the actual results as presenting in the updated projections provided by the insurer following the requested rate increase, the Director may find that a rate spiral exists and may require the insurer to offer, without underwriting, to all in-force insureds subject to the rate increase, the option to replace existing ~~information coverage with one or more reasonably comparable products being offered by the insurer or its affiliates~~. The information communicating the offer ~~are~~ is subject to the Director's approval. The offer shall:
 1. Be based on actuarially sound principles, but not on attained age; and
 2. Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy; and
 3. Allow the insured the option of retaining the existing coverage.
- ~~K.J.~~ The insurer shall maintain the experience of the insureds whose coverage was replaced under ~~subsection (I) (L)~~ separate from the experience of insureds originally issued the policy forms. If the insurer requests a rate increase on the policy form, the rate increase shall be limited to the lesser of:
 1. The maximum rate increase determined based on the combined experience; and
 2. The maximum rate increase determined based only on the experience of the insureds originally issued the form, plus ten percent.
- ~~L.K.~~ If the Director finds that an insurer has exhibited a history or pattern of filing inadequate initial premium rates for long-term care insurance, after considering the total number of policies filed over a period of time and the percentage of policies with inadequate rates, the Director may, in addition to remedies available under ~~Subsections (I) through (K)~~, subsections (H) through (J), prohibit the insurer from the following:
 1. Filing and marketing comparable coverage for a period of up to five years; and
 2. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.
- ~~M.L.~~ ~~Subsections (B) through (L) (A) through (K)~~ shall not apply to a policy for which long-term care benefits provided by the policy are incidental, ~~as provided under subsection (A)~~, as defined under R20-6-1002(C), 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 insurance benefits other than long-term care coverage meets the applicable nonforfeiture requirements under state law, including A.R.S. §§ 20-1231, 20-1232 and 20-2636;
 3. The policy meets the disclosure requirements of A.R.S. § 20-1691.06;
 4. The portion of the policy that provides insurance benefits other than long-term care coverage meets the disclosure requirements as applicable in the following:
 - a. Title 20, Chapter 6, Article 1.2; and
 - b. Title 20, Chapter 16, Article 2.
 5. At the time of making a filing under A.R.S. § 20-1691.08, the insurer files an actuarial memorandum that includes:
 - a. Description of the bases on which the actuary determined the long-term care rates and the reserves;
 - b. A summary of the type of policy, benefits, renewability provisions, general marketing method, and limits on ages of issuance;
 - c. A description and a table of each actuarial assumption used, with the percent of premium dollars per policy and dollars per unit of benefits, if any, for expenses;



- d. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
- e. The estimated average annual premium per policy and the average issue age;
- f. A statement as to whether the insurer performs underwriting at the time of application with an explanation of the following:
 - i. Whether underwriting is used, and, if used, a description of the type of underwriting, such as medical underwriting or functional assessment underwriting; and
 - ii. For a group policy, whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
- g. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

M. Subsections (F) and (H) through (J) shall not apply to group insurance as defined in A.R.S. § 20-1691(6) where:

1. The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or
2. The policyholder, and not the certificateholder, pays a material portion of the premium, which shall not be less than 20% of the total premium for the group in the calendar year prior to the year a rate increase is filed.

R20-6-1015. Premium Rate Schedule Increases for Policies Subject to Loss Ratio Limits Related to Original Filings

A. This Section applies to any long-term care policy or certificate issued in this state on or after April 15, 2017.

B. An insurer shall notify the Director of a proposed premium rate schedule increase, including an exceptional increase, at least 60 days before issuing notice to its policyholders. The notice to the Director shall include:

1. Information required by R20-6-1008;
2. Certification by a qualified actuary that:
 - a. If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;
 - b. The premium rate filing complies with the provisions of this Section;
 - c. The insurer may request a premium rate schedule increase less than what is required under this Section and the Director may approve the premium rate schedule increase, without submission of the certification required by subsection (B)(2)(a), if the actuarial memorandum discloses the premium rate schedule increase necessary to make the certification required by subsection (B)(2)(a), the premium rate schedule increase filing satisfies all other requirements of this Section, and is, in the opinion of the Director, in the best interest of the policyholders.
3. An actuarial memorandum justifying the rate schedule change request that includes:
 - a. Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including the following:
 - i. Any assumptions that deviate from those used for pricing other forms currently available for sale;
 - ii. Annual values for the five years preceding and the three years following the valuation date, provided separately;
 - iii. Development of the lifetime loss ratio, unless the rate increase is an exceptional increase;
 - iv. A demonstration of compliance with subsection (C).
 - b. For exceptional increases, the actuarial memorandum shall also include:
 - i. The projected experience that is limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and
 - ii. If the Director determines under Section R20-6-1002(B)(3) that offsets may exist, the insurer shall use appropriate net projected experience;
 - c. Disclosure of how reserves have been incorporated in this rate increase when the rate increase will trigger contingent benefit upon lapse;
 - d. Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and any other actions of the insurer on which the actuary has relied;
 - e. A statement that the actuary has considered policy design, underwriting, and claims adjudication practices;
 - f. Composite rates reflecting projections of new certificates in the event it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase; and
 - g. A demonstration that actual and projected costs exceed costs anticipated at the time of the initial pricing under moderately adverse experience and that the composite margin specified in R20-6-1009(B)(4) is projected to be exhausted.
4. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless the insurer provides the Director with documentation justifying the greater rate; and
5. Upon the Director's request, other similar and related information the Director may require to evaluate the premium rate schedule increase.

C. All premium rate schedule increases shall be determined in accordance with the following requirements:

1. Exceptional increases shall provide that 70% of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;
2. The insurer shall calculate premium rate increases such that the sum of the lesser of either the accumulated value of the actual incurred claims (without the inclusion of active life reserves) or the accumulated value of historic expected claims (without the inclusion of active life reserves) plus the present value of the future expected incurred claims (projected without the inclusion of active life reserves) will not be less than the sum of the following:
 - a. The accumulated value of the initial earned premium times the greater of 58% or the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience;
 - b. 85% of the accumulated value of prior premium rate schedule increases on an earned basis;
 - c. The present value of future projected initial earned premiums times the greater of 58% or the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience; and
 - d. 85% of the present value of future projected premiums not in subsection (C)(2)(c) on an earned basis;



3. Historic expected claims shall be calculated based on the original filing assumptions assumed until new assumptions are filed as part of a rate increase. New assumptions shall be used for all periods beyond each requested effective date of a rate increase. Historic expected claims are calculated for each calendar year based on the in-force at the beginning of the calendar year. Historic expected claims shall include margins for moderately adverse experience; either amounts included in the claims that were used to determine the lifetime loss ratio consistent with the original filing or as modified in any rate increase filing;
 4. In the event that a policy form has both exceptional and other increases, the values in subsections (C)(2)(b) and (C)(2)(d) will also include 70% for exceptional rate increase amounts; and
 5. All present and accumulated values used to determine rate increases, including the lifetime loss ratio consistent with the original filing reflecting margins for moderately adverse experience, shall use the maximum valuation interest rate for contract reserves as specified in A.R.S. § 20-508. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.
- D.** For each rate increase that is implemented, the insurer shall file for approval by the Director updated projections, as defined in subsection (B)(3)(a), annually for the next three years and shall include a comparison of actual results to projected values. The Director may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subsection (M), the projections required by this subsection shall be provided to the policyholder in lieu of filing with the Director.
- E.** If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, the insurer shall file lifetime projections, as defined in subsection (B)(3)(a), for the Director's approval every five years following the end of the required period in subsection (D). For group insurance policies that meet the conditions in subsection (M), the insurer shall provide the projections required by this subsection to the policyholder instead of filing with the Director.
- F.** If the Director finds that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection (C), the Director may require the insurer to implement premium rate schedule adjustments or other measures to reduce the difference between the projected and actual experience. In determining whether the actual experience matches the projected experience, the Director shall consider subsection (B)(3)(f), if applicable.
- G.** If the majority of policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file a plan, subject to approval by the Director, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form experience requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect. Otherwise, the Director may impose the conditions in subsections (H) through (J).
- H.** For a rate increase filing that meets the criteria listed in this subsection, the Director shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if lapsation in excess of projected lapsation has occurred or is anticipated:
1. The rate increase is not the first rate increase requested for the specific policy form or forms;
 2. The rate increase is not an exceptional increase; and
 3. The majority of the policies or certificates to which the increase applies are eligible for the contingent benefit upon lapse.
- I.** If the Director finds excess lapsation under subsection (H) has occurred, is anticipated in the filing or is evidenced in the actual results as presenting in the updated projections provided by the insurer following the requested rate increase, the Director may find that a rate spiral exists and may require the insurer to offer, without underwriting, to all in-force insureds subject to the rate increase, the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates. The information communicating the offer is subject to the Director's approval. The offer shall:
1. Be based on actuarially sound principles, but not on attained age; and
 2. Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy; and
 3. Allow the insured the option of retaining the existing coverage.
- J.** The insurer shall maintain the experience of the insureds whose coverage was replaced under subsection (I) separate from the experience of insureds originally issued the policy forms. If the insurer requests a rate increase on the policy form, the rate increase shall be limited to the lesser of:
1. The maximum rate increase determined based on the combined experience; and
 2. The maximum rate increase determined based only on the experience of the insureds originally issued the form, plus ten percent.
- K.** If the Director finds that an insurer has exhibited a history or pattern of filing inadequate initial premium rates for long-term care insurance, after considering the total number of policies filed over a period of time and the percentage of policies with inadequate rates, the Director may, in addition to remedies available under subsections (H) through (J), prohibit the insurer from the following:
1. Filing and marketing comparable coverage for a period of up to five years; and
 2. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.
- L.** Subsections (A) through (K) shall not apply to a policy for which long-term care benefits provided by the policy are incidental, as defined under R20-6-1002(C), 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 insurance benefits other than long-term care coverage meets the applicable nonforfeiture requirements under state law, including A.R.S. §§ 20-1231, 20-1232 and 20-2636;
 3. The policy meets the disclosure requirements of A.R.S. § 20-1691.06;
 4. The portion of the policy that provides insurance benefits other than long-term care coverage meets the disclosure requirements as applicable in the following:
 - a. Title 20, Chapter 6, Article 1.2; and



- b. Title 20, Chapter 6, Article 2.
5. At the time of making a filing under A.R.S. § 20-1691.08, the insurer files an actuarial memorandum that includes:
- a. Description of the bases on which the actuary determined the long-term care rates and the reserves;
 - b. A summary of the type of policy, benefits, renewability provisions, general marketing method, and limits on ages of issuance;
 - c. A description and a table of each actuarial assumption used, with the percent of premium dollars per policy and dollars per unit of benefits, if any, for expenses;
 - d. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
 - e. The estimated average annual premium per policy and the average issue age;
 - f. A statement as to whether the insurer performs underwriting at the time of application with an explanation of the following:
 - i. Whether underwriting is used, and, if used, a description of the type of underwriting, such as medical underwriting or functional assessment underwriting; and
 - ii. For a group policy, whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
 - g. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.
- M. Subsections (F) and (H) through (J) shall not apply to group insurance as defined in A.R.S. § 20-1691(6) where:
1. The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or
 2. The policyholder, and not the certificateholder, pays a material portion of the premium, which shall not be less than 20% of the total premium for the group in the calendar year prior to the year a rate increase is filed.

R20-6-1017. Standards for Marketing

- A. Every insurer marketing long-term care insurance coverage in this state, directly or through an insurance producer shall:
1. Establish marketing procedures to assure that any comparison of policies by its insurance producers is fair and accurate, and that excessive insurance is not sold or issued.
 2. Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy, the following language: "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."
 3. Provide the applicant with copies of the disclosure forms in Appendices A and B.
 4. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has health or long-term care insurance and the types and amounts of any such insurance.
 5. Provide an explanation of contingent benefit upon lapse as provided for in ~~R20-6-1019(E)~~, R20-6-1019(D)(2).
 6. Provide written notice to an applicant or prospective policyholder or certificateholder advising of this state's senior insurance counseling program (SHIP), and the name, address, and phone number for the SHIP, at the time of solicitation.
 7. Establish auditable procedures for verifying compliance with this ~~Section~~ subsection (A).
- B. In addition to the practices prohibited in A.R.S. § 20-441 et seq., the following acts and practices are prohibited:
1. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.
 2. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.
 3. Cold lead advertising. Making use directly or indirectly or any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company.
 4. Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.
- C. An insurer shall not market or issue a long-term care policy or certificate to an association unless the insurer files the information required under R20-6-1016(B) and annually certifies that the association has complied with the requirements of this Section.

R20-6-1018. Suitability

- A. This Section does not apply to life insurance policies that accelerate benefits for long-term care.
- B. Every insurer or other person marketing long-term care insurance, including an insurance producer or managing general agent, (the "issuer") 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 insurance producers in the use of its suitability standards; and
 3. Maintain a copy of its suitability standards and make them available for inspection upon the Director's request.
- C. To determine whether an applicant meets an issuer's suitability standards, the insurance producer and issuer shall develop procedures that take the following into consideration:
1. The applicant's ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;
 2. 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
 3. 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.
- D. The issuer shall make reasonable efforts to obtain the information set out in subsection ~~(C)(4)~~, (C), including giving the applicant the "Long-Term Care Insurance Personal Worksheet" prescribed in Appendix A, to complete before or at the time of application. The issuer shall use a personal worksheet that contains, at a minimum, the information contained in Appendix A, in substantially the same



text and format, in not less than 12 point type. The issuer may ask the applicant to provide additional information to comply with its suitability standards. An issuer shall file a copy of its personal worksheet with the Director.

- E. An issuer shall not consider an applicant for coverage until the issuer has received the applicant's completed personal worksheet, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.
F. No one shall sell or disseminate information obtained through the personal worksheet outside the issuer that obtains the worksheet.
G. The issuer shall use its suitability standards to determine whether issuance of long-term care insurance coverage to a particular applicant is appropriate.
H. An insurance producer shall use the suitability standards developed by the issuer in marketing long-term care insurance.
I. When giving an applicant a personal worksheet, the issuer shall also provide the applicant with a disclosure form entitled 'Things You Should Know Before You Buy Long-Term Care Insurance.' The form shall be in substantially the same format and text contained in Appendix H, in not less than 12 point type.
J. 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 that is substantially similar to Appendix I. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent to purchase the long-term care policy. The issuer shall have either the applicant's returned Appendix I letter or a record of the alternative method of verification as part of the applicant's file.
K. 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 as prescribed in subsection (J).

R20-6-1019. 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 A.R.S. § 20-1691.11, an insurer shall meet the following requirements:
1. A policy or certificate offered with nonforfeiture benefits shall have the same coverage elements, eligibility, benefit triggers and benefit length as a policy or certificate issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subsection (E).
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 A.R.S. § 20-1691.11 is rejected, the insurer shall provide the contingent benefit upon lapse described in this Section. Even if the non-forfeiture benefit offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in subsection (D)(4) shall still apply.
D. Contingent Benefit Upon Lapse.
1. If a prospective policyholder rejects the offer of a nonforfeiture benefit, the insurer shall provide the contingent benefit upon lapse described in this Section for individual and group policies without the nonforfeiture benefit, issued after January 10, 2005.
2. If a group policyholder elects to make the nonforfeiture benefit an option to a certificateholder, the certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.
3. The contingent benefit on lapse is triggered when:
a. An insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in the chart below, based on the insured's issue age; and
b. The policy or certificate lapses within 120 days of the due date of the increased premium.
c. Unless otherwise required, an insurer shall notify policyholders at least 30 days before the due date of the premium reflecting the rate increase.

Table with 3 columns: Issue Age, Percent Increase Over Initial Premium. Rows show percentages for issue ages from 29 and under to 65.



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%

- G. Unless otherwise required, an insurer shall notify policyholders at least 30 days before the due date of the premium reflecting the rate increase.
 - 4. A contingent benefit on lapse is also triggered for policies with a fixed or limited premium paying period when:
 - a. An insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in the chart below, based on the insured's issue age; and
 - b. The policy or certificate lapses within 120 days of the due date of the increased premium; and
 - c. The ratio in subsection (D)(6)(b) is 40% or more;
 - d. Unless otherwise required, an insurer shall notify policyholders at least 30 days before the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase on policies with a fixed or limited premium paying period		
Issue Age		Percent Increase Over Initial Premium
<u>Under 65</u>		<u>50%</u>
<u>65-80</u>		<u>30%</u>
<u>Over 80</u>		<u>10%</u>

- e. This provision shall be in addition to the contingent benefit provided by subsection (D)(3) and where both are triggered, the benefit provided shall be at the option of the insured.
- H.5. On or before the effective date of a substantial premium increase as defined in subsection (F), (D)(3), an insurer shall:
 - 1-a. Offer the insured the option of reducing policy benefits under the current coverage without additional underwriting consistent with the requirements of R20-6-1025 so that required premium payments are not increased;
 - 2-b. Offer to convert the coverage to a paid-up status with a shortened benefit period according to the terms of subsection (H), (E), which the insured may elect at any time during the 120-day period referenced in subsection (F)(2); (D)(3); and
 - 3-c. Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in subsection (F)(2) (D)(3) is deemed to be the election of the offer to convert under subsection (H)(2); (5)(b) unless the automatic option in subsection (D)(6)(c) applies.
- 6. On or before the effective date of a substantial premium increase on policies with a fixed or limited premium paying period as defined in subsection (D)(4), an insurer shall:
 - a. Offer the insured the option of reducing policy benefits under the current coverage consistent with the requirements of R20-6-1025 so that required premium payments are not increased;



- b. Offer to convert the coverage to paid-up status where the amount payable for each benefit is 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. The insured may elect this option at any time during the 120-day period referenced in subsection (D)(4); and
 - c. Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in subsection (D)(4) is deemed to be the election of the offer to convert under subsection (D)(6)(b) if the ratio is 40% or more.
7. For any long-term care policy issued on or after April 15, 2017, that an insurer issued at least 20 years prior to the effective date of a substantial premium increase, the insurer shall use a rate increase value of 0% in place of all values in the above tables.
- ~~I.E.~~ In this Section, “benefits Benefits continued as nonforfeiture benefits,” including contingent benefits upon lapse, ~~in accordance with subsection (D)(3) but not subsection (D)(4),~~ mean any of the following:
1. Attained age rating is defined as a schedule of premiums starting from the issue date that increases age at least one percent per year before age 50, and at least three percent per year beyond age 50.
 2. ~~The~~ For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in subsection ~~(H)(3); (E)(3).~~
 3. The standard nonforfeiture credit equals 100% of the sum of all premiums paid, including the premiums paid before any change in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. The minimum nonforfeiture credit shall not be less than 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); (F).~~
 4. When the nonforfeiture benefit begins.
 - a. The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three years, and thereafter.
 - ~~5.~~ b. Notwithstanding subsection ~~(H)(4); (E)(4)(a),~~ for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:
 - ~~a.~~ i. The end of the tenth year following the policy or certificate issue date; or
 - ~~b.~~ ii. The end of the second year following the date the policy or certificate is no longer subject to attained age rating.
 - 6.5. 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.
- ~~J.E.~~ All benefits paid by the insurer while the policy or certificate is in premium-paying status and in the ~~paid-up~~ paid-up status shall not exceed the maximum benefits that would be payable if the policy or certificate had remained in premium-paying status.
- ~~K.C.~~ There shall be no difference in the minimum nonforfeiture benefits for group and individual policies.
- ~~L.H.~~ The requirements in this Section are effective on or after November 10, 2005 and shall apply as follows:
1. Except as provided in subsection ~~(L)(2); (H)(2) and (H)(3),~~ this Section applies to any long-term care policy issued in this state on or after January 10, 2005.
 2. The provisions of this Section do not apply to certificates issued on or after January 10, 2005, under a group long-term care insurance policy as defined in A.R.S. § 20-1691(5)(a), that was in force on January 10, 2005.
 3. The provisions of this Section that apply to fixed or limited premium paying period policies shall only apply to policies issued on or after April 15, 2017.
- ~~M.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 R20-6-1013, R20-6-1014, or R20-6-1015, whichever is applicable, treating the policy as a whole.
- ~~N.J.~~ To determine whether contingent nonforfeiture upon lapse provisions are triggered under subsection ~~(F); (D)(3) or (D)(4),~~ a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium the insured paid when first buying the policy from the original insurer.
- ~~O.K.~~ An insurer shall offer a nonforfeiture benefit for a qualified long-term care insurance contract that is a level premium contract and the benefit shall meet the following requirements:
1. The nonforfeiture provision shall be separately captioned using the term “nonforfeiture benefit” or a substantially similar caption.
 2. The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the insurer may adjust the amount of the benefit initially granted only as needed to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the Director under to A.R.S. § 20-1691.08 for the same contract form; and
 3. The nonforfeiture provision shall provide at least one of the following:
 - a. Reduced paid-up premiums,
 - b. Extended term insurance,
 - c. Shortened benefit period; or
 - d. Other similar offerings that the Director has approved.

R20-6-1020. 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. Except as otherwise provided in R20-6-1021, 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 of the activities of daily living or the presence of cognitive impairment.
- B. Activities of daily living shall include at least the following as defined in R20-6-1003 and in the policy:
 1. Bathing;



2. Contingence;
 3. Dressing;
 4. Eating;
 5. Toileting; and
 6. Transferring;
- C. An insurer may use additional activities of daily living to trigger covered benefits if the activities are defined in the policy.
- D. An insurer may use additional provisions to determine when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements in subsections ~~(A) and (B)~~. (A), (B) and (C).
- E. 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, requiring supervision or verbal cueing by another person to protect the insured or others.
- F. Licensed or certified professionals, such as physicians, nurses or social workers, shall perform assessments of activities of daily living and cognitive impairment.
- G. The requirements in this Section are effective on and after November 10, 2005 and shall apply as follows:
1. Except as provided in subsection (G)(2), the provisions of this Section apply to a long-term care policy issued in this state on or after January 10, 2005.
 2. The provisions of this Section do not apply to certificates issued on or after January 10, 2005, under a long-term care insurance policy issued to a group as defined in A.R.S. § 20-1691(5)(a), which policy was in force on January 10, 2005.

R20-6-1021. Additional Standards for Benefit Triggers for Qualified Long-term Care Insurance Contracts

- A. A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided under a plan of care prescribed by a licensed health care practitioner, ~~which is not subject to approval or modification by the insurer.~~
- B. A qualified long-term care insurance contract shall condition the payment of benefits on a certified determination of the insured's inability to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity or to severe cognitive impairment.
- C. ~~Licensed or certified professionals, including physicians, registered professional nurses, and licensed social workers,~~ health care practitioners shall perform the certified determinations regarding activities of daily living and cognitive impairment required under subsection (B).
- D. Certified determinations required under ~~to~~ subsection (B) may be performed 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 90 days due to a loss of functional capacity and the insured is in claim status, the certified determination may not be rescinded and additional certified determinations may not be performed until after the expiration of the 90-day period.

R20-6-1023. Requirement to Deliver Shopper's Guide

- A. All prospective applicants of a long-term care insurance policy or certificate shall receive a long-term care insurance shopper's guide approved by the Director. This requirement may be satisfied by delivery of the current edition of the long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners.
1. In the case of insurance producer solicitation, an insurance producer shall deliver the shopper's guide before presenting an application or enrollment form.
 2. In the case of direct response solicitations, the insurer shall provide the shopper's guide with any application or enrollment form.
- B. A prospective applicant for a life insurance policy or rider containing accelerated long-term care benefits is not required to receive the guide described in subsection ~~A~~, (A), but shall receive the policy summary required under A.R.S. § 20-1691.06.

R20-6-1024. Availability of New Health Care Services or Providers

- A. An insurer shall notify policyholders of the availability of a new long-term policy series that provides coverage for new long-term care services or health care providers material in nature and not previously available through the insurer to the general public. The notice shall be provided within 12 months of the date the new policy series is made available for sale in this state.
- B. Notwithstanding subsection (A), notification is not required for any policy issued prior to the effective date of this Section or to any policyholder or certificateholder who is currently eligible for benefits, within an elimination period or on a claim, or who previously had been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.
- C. The insurer shall make the new coverage available in one of the following ways:
1. By adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age;
 2. By exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The premium credits shall be based on premiums paid or reserves held for the prior policy or certificate;
 3. By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status shall be recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost for the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or
 4. By an alternative program developed by the insurer that meets the intent of this Section if the program is filed with and approved by the Director.



- D. An insurer is not required to notify policyholders of a new proprietary policy series created and filed for use in a limited distribution channel. For purposes of this subsection, “limited distribution channel” means through a discrete entity, such as a financial institution or brokerage, for which specialized products are available that are not available for sale to the general public. Policyholders who purchased such a new proprietary policy shall be notified when a new long-term care policy series that provides coverage for new long-term care services or providers material in nature is made available to that limited distribution channel.
- E. Policies issued pursuant to this Section shall be considered exchanges and not replacements. These exchanges shall not be subject to R20-6-1010(A), (C) through (G) and R20-6-1018 and are not subject to the reporting requirements of R20-6-1010(I)(1), (I)(2)(a) through (I)(2)(c).
- F. Where an employer, labor organization, professional, trade or occupational association offers the policy, the required notification in subsection (A) shall be made to the offering entity. However, if the policy is issued to a group defined in A.R.S. § 20-1691(5), the notification shall be to each certificateholder.
- G. Nothing in this Section shall prohibit an insurer from offering any policy, rider, certificate or coverage change to any policyholder or certificateholder. However, upon request, any policyholder may apply for currently available coverage that includes the new services or providers. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium, to add such new services or providers.
- H. This Section does not apply to life insurance policies or riders containing accelerated long-term care benefits.
- I. This Section shall become effective on or after April 15, 2017.

R20-6-1025. Right to Reduce Coverage and Lower Premiums

- A. Every long-term care insurance policy and certificate shall include a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:

 1. Reducing the maximum benefit; or
 2. Reducing the daily, weekly or monthly benefit amount.
- B. The insurer may also offer other reduction options that are consistent with the policy or certificate design or the carrier’s administrative processes.
- C. In the event the reduction in coverage involves the reduction or elimination of the inflation protection provision, the insurer shall allow the policyholder to continue the benefit amount in effect at the time of the reduction.
- D. The provision in subsection (A) shall include a description of the process for requesting and implementing a reduction in coverage.
- E. The premium for the reduced coverage shall:

 1. Be based on the same age and underwriting class used to determine the premium for the coverage currently in force; and
 2. Be consistent with the approved rate table.
- F. The issuer 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.
- G. If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificateholder of his or her right to reduce coverage and premiums in the notice required by R20-6-1005(F).
- H. This Section does not apply to life insurance policies or riders containing accelerated long-term benefits.
- I. The requirements of subsections (A) through (H) shall apply to any long-term care policy issued in this state on or after April 15, 2017.
- J. A premium increase notice required by R20-6-1008(G) shall include:

 1. An offer to reduce policy benefits provided by the current coverage consistent with the requirements of this Section;
 2. A disclosure stating that all options available to the policyholder may not be of equal value; and
 3. In the case of a partnership policy, a disclosure that some benefit reduction options may result in a loss in partnership status that may reduce policyholder protections.
- K. The requirements of subsection (J) shall apply to any rate increase implemented in this state on or after April 15, 2017.

~~R20-6-1024~~R20-6-1026. Instructions for Appendices

Information that is designated as a “Drafting Instruction” in a form appended to this Article is not required to be included as part of the form. Any person using the form shall abide by the instructions when drafting, preparing, or completing the form.



APPENDIX A
Long-term Care Insurance
Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers _____

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

Type of Policy (noncancellable/guaranteed renewable): _____

The Company's Right to Increase Premiums: _____

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

Rate Increase History

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increases.]

(Drafting Instruction: A company may use the first bracketed sentence above only if it has never increased rates under any prior policy forms in this state or any other state. The issuer shall list each premium increase it has instituted on this or similar policy forms in this state or any other state during the last 10 years. The list shall provide the policy form, the calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase. The insurer shall provide minimum and maximum percentages if the rate increase is variable by rating characteristics. The insurer may provide, in a fair manner, additional explanatory information as appropriate.)

Questions Related to Your Income

How will you pay each year's premium?

From my Income From my Savings/Investments My Family will Pay

[Have you considered whether you could afford to keep this policy if the premiums went up, for example, by ~~20%~~ 50%?]

(Drafting Instruction: The issuer is not required to use the bracketed sentence if the policy is fully paid up or is a noncancellable policy.)

What is your annual income? (check one) Under \$10,000 \$[10-20,000] \$[20-30,000] \$[30-50,000] Over \$50,000

(Drafting Instruction: 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.

Will you buy inflation protection? (check one) Yes No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

From my Income From my Savings/Investments My Family will Pay

The national average annual cost of care in [insert year] was [insert \$ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert \$ amount] if costs increase 5% annually.

(Drafting Instruction: The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.)

What elimination period are you considering? Number of days _____ Approximate cost \$ _____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

From my Income From my Savings/Investments My Family will Pay

Questions Related to Your Savings and Investments

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (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

Form box containing disclosure options:
 The answers to the questions above describe my financial situation.
or
 I choose not to complete this information. (Check one.)
 I acknowledge that the carrier and/or its agent insurance provider (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. I understand that the rates for this policy may increase in the future. (This box must be checked).

Signed: _____ (Applicant) _____ (Date)

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

Signed: _____ (Insurance Producer) _____ (Date)

Insurance Producer's Printed Name: _____]



APPENDIX B

Long-term Care Insurance

Potential Rate Increase Disclosure Form

Instructions:

This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

Insurers shall provide all of the following information to the applicant:

Long-term Care Insurance

Potential Rate Increase Disclosure Form

1. [Premium Rate] [Premium Rate Schedules]: [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and [approved] for an increase [is][are] [on the application][(\$_____)]

2. The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.

3. Rate Schedule Adjustments:

The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): _____.

4. Potential Rate Revisions:

This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- [] Pay the increased premium and continue your policy in force as is.
- [] Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- [] Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
- [] Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

*Contingent Nonforfeiture

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
• You lapse (not pay more premiums) within 120 days of the increase.

Turn the Page

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you have paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.



Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered “paid-up” with no further premiums due.

Example:

- You bought the policy at age 65 and paid the \$1,000 annual premium for 10 years, so you have paid a total of \$10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or \$500 for a new annual premium of \$1,500, and you decide to lapse the policy (not pay any more premiums).
- Your “paid-up” policy benefits are \$10,000 (provided you have a least \$10,000 of benefits remaining under your policy.)

Turn the Page

Contingent Nonforfeiture <u>Cumulative Premium Increase over Initial Premium</u> That qualifies for Contingent Nonforfeiture	
(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time 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%



APPENDIX C

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL HEALTH 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 health 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 health 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 [INSURANCE 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 that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, even though 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 probation periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its insurance 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.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing health 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 health 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 [INSURANCE 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 that you may presently have (preexisting conditions), may not be immediately or fully covered under your new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.



- 2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

- 3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all of 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 Insurance Producer or Other Representative)

(Company Name)

(Typed Name and Address of Insurance Producer)

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

(Date)

(Applicant's Signature)



APPENDIX D

NOTICE TO APPLICANT REGARDING REPLACEMENT OF HEALTH 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 health or long-term care insurance and replace it with the long-term care insurance policy being delivered and issued by [company name] Insurance Company. Your new policy gives you thirty (30) days to decide, without cost, whether you want to keep the policy. For your own information and protection, you should be aware of and seriously consider certain facts which may affect the insurance protection available to you under the new policy.~~

~~You should review this new coverage carefully, comparing it with all health 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.~~

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing health or long-term care insurance and replace it with the long-term care insurance policy being delivered and issued by [company name] Insurance Company. Your new policy gives you thirty (30) days to decide, without cost, whether you want 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 health 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, even though a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent insurance 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 and complete, or if any past medical history has been left out of the application.

[COMPANY NAME]



APPENDIX E
Long-term Care Insurance
Replacement and Lapse Reporting Form

For the State of _____

For the Reporting Year of _____

Company Name: _____ Due: June 30 annually

Company Address: _____ Company NAIC Number: _____

Contact Person: _____ Phone Number: (____) _____

Instructions

The purpose of this form is to report on a statewide basis information regarding long-term care insurance policy replacements and lapses. Every insurer shall maintain the following records for each insurance producer: (1) the amount of long-term care insurance replacement sales as a percent of the insurance producer's total annual sales and (2) the amount of lapses of long-term care insurance policies sold by the insurance producer as a percent of the insurance producer's total annual sales. The tables below should be used to report the ten percent (10%) of the insurer's insurance producers with the greatest percentages of replacements and lapses.

Listing of the 10% of Insurance Producers with the Greatest Percentage of Replacements

Table with 4 columns: Insurance Producer's Name, Number of Policies Sold By This Insurance Producer, Number of Policies Replaced By This Insurance Producer, Number of Replacements as % of Number of Policies Sold By This Insurance Producer

Listing of the 10% of Insurance Producers with the Greatest Percentage of Lapses

Table with 4 columns: Insurance Producer's Name, Number of Policies Sold By This Insurance Producer, Number of Policies Lapsed By This Insurance Producer, Number of Lapses As % of Number Sold By This Insurance Producer

Company Totals

Percentage of Replacement Policies Sold to Total Annual Sales ____%

Percentage of Replacement Policies Sold to Policies In Force (as of the end of the preceding calendar year) ____%

Percentage of Lapsed Policies to Total Annual Sales ____%

Percentage of Lapsed Policies to Policies In Force (as of the end of the preceding calendar year) ____%



APPENDIX F

Long-term Care Insurance

Claims Denial Reporting Form

For the State of _____

For the Reporting Year of _____

Company Name: _____ Due: June 30 annually

Company Address: _____

Company NAIC Number: _____

Contact Person: _____ Phone Number: _____

Line of Business: Individual Group

Instructions

~~The purpose of this form is to report all long-term care claim denials under in-force long-term care insurance policies. "Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.~~

The purpose of this form is to report all long-term care claim denials under in-force long-term care insurance policies. Indicate the manner of reporting by checking one of the boxes below:

Per Claimant - counts each individual who makes one or a series of claim requests

Per Transaction - counts each claim payment request

"Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition. It does not include a request for payment that is in excess of the applicable contractual limits.

Inforce Data

	State Data	Nationwide Data¹
<u>Total Number of Inforce Policies [Certificates] as of December 31st</u>		

Claims & Denial Data

		State Data	Nationwide Data¹
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		
7	Number of Long-Term Care Claim Denied due to:		
8	• Long-Term Care Services Not Covered under the Policy ²		



9	• Provider/Facility Not Qualified under the Policy ³		
10	• Benefit Eligibility Criteria Not Met ⁴		
11	• Other		

1. The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.
2. Example—home health care claim filed under a nursing home only policy.
3. Example—a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.
4. Examples—a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.



APPENDIX H

Things You Should Know Before You Buy

Long-term Care Insurance

**Long-Term
Care
Insurance**

- 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.

- **[WARNING!]** You should **not** buy this insurance policy unless you can afford to pay the premiums every year. You are making a multi-year financial commitment. [Remember that the company can increase premiums in the future.]

(Drafting Instruction: For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.)

- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

- Medicare does **not** pay for most long-term care.

Medicaid

- 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**

- 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.

Facilities

- Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move into a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.



APPENDIX I

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.]

(Drafting Instruction: 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.~~

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.

Drafting Instruction: 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].



APPENDIX J

[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, shall appear as follows in the outline of coverage.]~~

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, shall 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]~~

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. This policy is [an individual policy of insurance] [a group policy] which was issued in the [indicate jurisdiction in which group policy was issued].
2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the 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. FEDERAL TAX CONSEQUENCES

~~This [POLICY] [CERTIFICATE] is intended to be a federally tax-qualified long-term care insurance contract under Section 7702(B)(b) of the Internal Revenue Code of 1986, as amended.~~

This [POLICY] [CERTIFICATE] is intended to be a federally tax-qualified long-term care insurance contract under Section 7702(B)(b) of the Internal Revenue Code of 1986, as amended.

~~or~~OR

~~Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE] is not intended to be a federally tax-qualified long-term care insurance contract under Section 7702(B)(b) of the Internal Revenue Code of 1986, as amended. Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.~~

Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE] is not intended to be a federally tax-qualified long-term care insurance contract under Section 7702(B)(b) of the Internal Revenue Code of 1986, as amended. Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.

4. 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;]

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS_

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

6. 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.]

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

- (a) [For insurance producers] Neither [insert company name] nor its [agents or insurance 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.

8. 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.]~~

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.]

9. 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 shall be defined and described as part of the outline of coverage.]~~

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

~~[Any additional benefit triggers shall be explained in this Section. If these triggers differ for different benefits, explanation of the triggers 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 must be specified.]~~

[Any additional benefit triggers shall be explained in this Section. If these triggers differ for different benefits, explanation of the triggers 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 must be specified.]

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

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

~~[This Section shall 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 paragraph 6 above.]~~

[This Section shall 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 paragraph 6 above.]

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

11. 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) Describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.



~~[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer’s disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]~~

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer’s disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

13. PREMIUM.

- [(a) State the total annual premium for the policy;
- (b) If the premium varies with an applicant’s choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

14. ADDITIONAL FEATURES.

- [(a) Indicate if medical underwriting is used;
- (b) Describe other important features.]

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.



NOTICES OF SUBSTANTIVE POLICY STATEMENT

The Administrative Procedure Act (APA) requires the publication of Notices of Substantive Policy Statement issued by agencies (A.R.S. § 41-1013(B)(14)).

Substantive policy statements are written expressions which inform the general public of an agency's current approach to rule or regulation practice.

Substantive policy statements are advisory only. A substantive policy statement does not include internal procedural documents that only affect the internal

procedures of the agency. It does not impose additional requirements or penalties on regulated parties or include confidential information or rules made in accordance with the APA.

If you believe that a substantive policy statement does impose additional requirements or penalties on regulated parties you may petition the agency under A.R.S. § 41-1033 for a review of the statement.

NOTICE OF SUBSTANTIVE POLICY STATEMENT

DEPARTMENT OF HEALTH SERVICES

[M16-298]

1. **Title of the Substantive Policy Statement and the substantive policy statement number by which the substantive policy statement is referenced:**
SP-042-PHL-CCL: Clarification of "High School Diploma for Individuals who were Homeschooled"
2. **Date the substantive policy statement was issued and the effective date of the policy statement if different from the issuance date:**
Effective date: January 1, 2017
3. **Summary of the contents of the substantive policy statement:**
The substantive policy statement notifies the public of the Arizona Department of Health Service's interpretation of the phrase "high school diploma" in provider requirements in the staff qualification requirements in Arizona Administrative Code (A.A.C.) Title 9, Chapters 3 and 5, for individuals who have a high school diploma based on the individual receiving instruction in a home-school.
4. **Federal or state constitutional provision; federal or state statute, administrative rule, or regulation; or final court judgment that underlies the substantive policy statement:**
A.R.S. §§ 36-883(A)(2) and 36-897.02(A)
5. **A statement as to whether the substantive policy statement is a new statement or a revision:**
This is a new substantive policy statement
6. **The agency contact person who can answer questions about the substantive policy statement:**
Name: Thomas Salow, Deputy Assistant Director
Address: Department of Health Services
Public Health Licensing Services
Child Care Licensing
150 N. 18th Ave., Suite 400
Phoenix, AZ 85007
Telephone: (602) 364-1935
Fax: (602) 364-4808
E-mail: thomas.salow@azdhs.gov
or
Name: Robert Lane, Manager
Address: Department of Health Services
Office of Administrative Counsel and Rules
150 N. 18th Ave., Suite 201
Phoenix, AZ 85007
Telephone: (602) 542-1020
Fax: (602) 364-1150
E-mail: robert.lane@azdhs.gov
7. **Information about where a person may obtain a copy of the substantive policy statement and the costs for obtaining the policy statement:**
A copy of the substantive policy statement is available, free of charge, from the Department of Health Services, Office of Administrative Counsel and Rules at the following web address: <http://www.azdhs.gov/director/administrative-counsel-rules/rules/index.php#sps-licensing>. A copy of the substantive policy statement may also be obtained from the Department of Health Services, Public Health Licensing Services, 150 N. 18th Ave., Suite 400, Phoenix, AZ 85007, for 25 cents per page. Payment is accepted in cash or money order made payable to the Arizona Department of Health Services.



NOTICE OF SUBSTANTIVE POLICY STATEMENT
DEPARTMENT OF INSURANCE

[M16-299]

- 1. Title of the Substantive Policy Statement and the substantive policy statement number by which the substantive policy statement is referenced:
Expiration of A.A.C. R20-6-204; Surplus Lines Brokers' Filing Requirements; List of Unauthorized Insurers
Regulatory Bulletin 2016-05
2. Date the substantive policy statement was issued and the effective date of the policy statement if different from the issuance date:
The Department issued the substantive policy statement on December 19, 2016.
3. Summary of the contents of the substantive policy statement:
Regulatory Bulletin 2016-05 notifies all surplus lines brokers that, as of December 16, 2016, A.A.C. R20-6-204 is expired. It clarifies that A.R.S. § 20-413 still requires a surplus lines broker to file an initial certification to propose the addition of an unauthorized insurer to the Department's list of recognized unauthorized insurers (White List), but that expiration of the rule removes the annual certification requirement.
4. Federal or state constitutional provision; federal or state statute, administrative rule, or regulation; or final court judgment that underlies the substantive policy statement:
A.A.C. R20-6-204
5. A statement as to whether the substantive policy statement is a new statement or a revision:
This is a new statement.
6. The agency contact person who can answer questions about the substantive policy statement:
Name: Scott Greenberg
Address: Department of Insurance
2910 N. 44th St., Suite 210
Phoenix, AZ 85018-7269
Email: sgreenberg@azinsurance.gov
Telephone: (602) 364-3764
Web site: https://insurance.az.gov/regulatory-bulletins
7. Information about where a person may obtain a copy of the substantive policy statement and the costs for obtaining the policy statement:
Copies of this policy are available via the internet at http://insurance.az.gov/regulatory-bulletins or from the person listed in question #6 for \$0.25 per page.



REGISTER INDEXES

The *Register* is published by volume in a calendar year (See “General Information” in the front of each issue for more information).

Abbreviations for rulemaking activity in this Index include:

PROPOSED RULEMAKING

PN = Proposed new Section
 PM = Proposed amended Section
 PR = Proposed repealed Section
 P# = Proposed renumbered Section

SUPPLEMENTAL PROPOSED RULEMAKING

SPN = Supplemental proposed new Section
 SPM = Supplemental proposed amended Section
 SPR = Supplemental proposed repealed Section
 SP# = Supplemental proposed renumbered Section

FINAL RULEMAKING

FN = Final new Section
 FM = Final amended Section
 FR = Final repealed Section
 F# = Final renumbered Section

SUMMARY RULEMAKING

PROPOSED SUMMARY

PSMN = Proposed Summary new Section
 PSMM = Proposed Summary amended Section
 PSMR = Proposed Summary repealed Section
 PSM# = Proposed Summary renumbered Section

FINAL SUMMARY

FSMN = Final Summary new Section
 FSMM = Final Summary amended Section
 FSMR = Final Summary repealed Section
 FSM# = Final Summary renumbered Section

EXPEDITED RULEMAKING

PROPOSED EXPEDITED

PEN = Proposed Expedited new Section
 PEM = Proposed Expedited amended Section
 PER = Proposed Expedited repealed Section
 PE# = Proposed Expedited renumbered Section

SUPPLEMENTAL EXPEDITED

SPEN = Supplemental Proposed Expedited new Section
 SPEM = Supplemental Proposed Expedited amended Section
 SPER = Supplemental Proposed Expedited repealed Section
 SPE# = Supplemental Proposed Expedited renumbered Section

FINAL EXPEDITED

FEN = Final Expedited new Section
 FEM = Final Expedited amended Section
 FER = Final Expedited repealed Section
 FE# = Final Expedited renumbered Section

EXEMPT RULEMAKING

EXEMPT PROPOSED

PXN = Proposed Exempt new Section
 PXM = Proposed Exempt amended Section
 PXR = Proposed Exempt repealed Section
 PX# = Proposed Exempt renumbered Section

EXEMPT SUPPLEMENTAL PROPOSED

SPXN = Supplemental Proposed Exempt new Section
 SPXR = Supplemental Proposed Exempt repealed Section
 SPXM = Supplemental Proposed Exempt amended Section
 SPX# = Supplemental Proposed Exempt renumbered Section

FINAL EXEMPT RULEMAKING

FXN = Final Exempt new Section
 FXM = Final Exempt amended Section
 FXR = Final Exempt repealed Section
 FX# = Final Exempt renumbered Section

EMERGENCY RULEMAKING

EN = Emergency new Section
 EM = Emergency amended Section
 ER = Emergency repealed Section
 E# = Emergency renumbered Section
 EEXP = Emergency expired

RECODIFICATION OF RULES

RC = Recodified

REJECTION OF RULES

RJ = Rejected by the Attorney General

TERMINATION OF RULES

TN = Terminated proposed new Sections
 TM = Terminated proposed amended Section
 TR = Terminated proposed repealed Section
 T# = Terminated proposed renumbered Section

RULE EXPIRATIONS

EXP = Rules have expired
 See also “*emergency expired*” under *emergency rulemaking*

CORRECTIONS

C = Corrections to Published Rules

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RULEMAKING ACTIVITY INDEX

Rulemakings are listed in the Index by Chapter, Section number, rulemaking activity abbreviation and by volume page number. Use the page guide above to determine the *Register* issue number to review the rule. Headings for the Subchapters, Articles, Parts, and Sections are not indexed.

THIS INDEX INCLUDES RULEMAKING ACTIVITY THROUGH ISSUE 2 OF VOLUME 23.

<p>Accountancy, Board of</p> <p>R4-1-101. PM-97 R4-1-341. PM-97 R4-1-345. PM-97 R4-1-453. PM-97 R4-1-454. PM-97 R4-1-455. PM-97 R4-1-455.01. PM-97 R4-1-455.02. PM-97 R4-1-455.03. PM-97 R4-1-455.04. PM-97</p> <p>Agriculture, Department of - Animal Services Division</p> <p>R3-2-205. EXP-135 R3-2-403. EXP-135 R3-2-621. EXP-135 R3-2-622. EXP-135</p> <p>Arizona Health Care Cost Containment System - Administration</p> <p>R9-22-712.90. FN-22</p> <p>Clean Elections Commission, Citizens</p> <p>R2-20-101. FXM-113 R2-20-104. FXM-115 R2-20-105. FXM-117 R2-20-107. FXM-119 R2-20-109. FXM-121 R2-20-110. FXM-124 R2-20-111. FXM-126 R2-20-112. FXM-128 R2-20-402.01. FXM-130 R2-20-402.02. FXN-131</p>	<p>R2-20-703. FXM-133</p> <p>Environmental Quality, Department of - Air Pollution Control</p> <p>R18-2-1701. EXP-135 Table 1. EXP-135 R18-2-1702. EXP-135 R18-2-1703. EXP-135 R18-2-1704. EXP-135 R18-2-1705. EXP-135 R18-2-1706. EXP-135 R18-2-1707. EXP-135 R18-2-1708. EXP-135 Table 3. EXP-135 R18-2-1709. EXP-135 R18-2-1701. EXP-135</p> <p>Insurance, Department of</p> <p>R20-6-204. EXP-136</p> <p>Pharmacy, Board of</p> <p>R4-23-407.1. PN-5; EN-31</p> <p>Retirement System Board, State</p> <p>R2-8-201. EXP-34 R2-8-207. EXP-34</p> <p>Revenue, Department of - General Administration</p> <p>R15-10-301. PM-108 R15-10-302. PM-108 R15-10-303. PM-108 R15-10-304. PM-108 R15-10-305. PM-108</p>	<p>R15-10-306. PM-108</p> <p>Transportation, Department of - Commercial Programs</p> <p>R17-5-301. PM-7 R17-5-302. PM-7 R17-5-303. PM-7 R17-5-305. PM-7 R17-5-306. PM-7 R17-5-307. PM-7 R17-5-308. PM-7 R17-5-309. PM-7 R17-5-311. PM-7 R17-5-313. PM-7 R17-5-315. PM-7 R17-5-318. PM-7 R17-5-323. PM-7 R17-5-401. PN-16 R17-5-402. PM-16 R17-5-405. PM-16 R17-5-406. PM-16 R17-5-407. PM-16 R17-5-408. PM-16</p> <p>Transportation, Department of - Title, Registration, and Driver Licenses</p> <p>R17-4-703. EXP-34 R17-4-711. EXP-34</p>
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OTHER NOTICES AND PUBLIC RECORDS INDEX

Other notices related to rulemakings are listed in the Index by notice type, agency/county and by volume page number. Agency policy statements and proposed delegation agreements are included in this section of the Index by volume page number. Public records, such as Governor Office executive orders, proclamations, declarations and terminations of emergencies, summaries of Attorney General Opinions, and county notices are also listed in this section of the Index as published by volume page number.

THIS INDEX INCLUDES OTHER NOTICE ACTIVITY THROUGH ISSUE 2 OF VOLUME 23.

County Notices Pursuant to A.R.S. § 49-112

Maricopa County; pp. 37-71

Rulemaking Docket Opening, Notices of

Pharmacy, Board of; 4 A.A.C. 23; p. 137
Revenue, Department of; 15 A.A.C. 10; p. 138

Proposed Delegation Agreement, Notices of

Environmental Quality, Department of; pp. 35-36



RULE EFFECTIVE DATES CALENDAR

A.R.S. § 41-1032(A), as amended by Laws 2002, Ch. 334, § 8 (effective August 22, 2002), states that a rule generally becomes effective 60 days after the day it is filed with the Secretary of State's Office. The following table lists filing dates and effective dates for rules that follow this provision. Please also check the rulemaking Preamble for effective dates.

Table with 12 columns: January, February, March, April, May, June. Each month has sub-columns for Date Filed and Effective Date. Rows list dates from 1/1 to 1/31 and corresponding effective dates.



July		August		September		October		November		December	
Date Filed	Effective Date										
7/1	8/30	8/1	9/30	9/1	10/31	10/1	11/30	11/1	12/31	12/1	1/30
7/2	8/31	8/2	10/1	9/2	11/1	10/2	12/1	11/2	1/1	12/2	1/31
7/3	9/1	8/3	10/2	9/3	11/2	10/3	12/2	11/3	1/2	12/3	2/1
7/4	9/2	8/4	10/3	9/4	11/3	10/4	12/3	11/4	1/3	12/4	2/2
7/5	9/3	8/5	10/4	9/5	11/4	10/5	12/4	11/5	1/4	12/5	2/3
7/6	9/4	8/6	10/5	9/6	11/5	10/6	12/5	11/6	1/5	12/6	2/4
7/7	9/5	8/7	10/6	9/7	11/6	10/7	12/6	11/7	1/6	12/7	2/5
7/8	9/6	8/8	10/7	9/8	11/7	10/8	12/7	11/8	1/7	12/8	2/6
7/9	9/7	8/9	10/8	9/9	11/8	10/9	12/8	11/9	1/8	12/9	2/7
7/10	9/8	8/10	10/9	9/10	11/9	10/10	12/9	11/10	1/9	12/10	2/8
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7/13	9/11	8/13	10/12	9/13	11/12	10/13	12/12	11/13	1/12	12/13	2/11
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7/28	9/26	8/28	10/27	9/28	11/27	10/28	12/27	11/28	1/27	12/28	2/26
7/29	9/27	8/29	10/28	9/29	11/28	10/29	12/28	11/29	1/28	12/29	2/27
7/30	9/28	8/30	10/29	9/30	11/29	10/30	12/29	11/30	1/29	12/30	2/28
7/31	9/29	8/31	10/30			10/31	12/30			12/31	3/1



REGISTER PUBLISHING DEADLINES

The Secretary of State's Office publishes the Register weekly. There is a three-week turnaround period between a deadline date and the publication date of the Register. The weekly deadline dates and issue dates are shown below. Council meetings and Register deadlines do not correlate. Also listed are the earliest dates on which an oral proceeding can be held on proposed rulemakings or proposed delegation agreements following publication of the notice in the Register.

Table with 3 columns: Deadline Date (paper only) Friday, 5:00 p.m., Register Publication Date, and Oral Proceeding may be scheduled on or after. Rows list dates from October 2016 to April 2017.



GOVERNOR’S REGULATORY REVIEW COUNCIL DEADLINES

The following deadlines apply to all Five-Year-Review Reports and any adopted rule submitted to the Governor’s Regulatory Review Council. Council meetings and Register deadlines do not correlate. We publish these deadlines as a courtesy.

All rules and Five-Year Review Reports are due in the Council office by 5 p.m. of the deadline date. The Council’s office is located at 100 N. 15th Ave., Suite 402, Phoenix, AZ 85007. For more information, call (602) 542-2058 or visit www.grrc.state.az.us.

GOVERNOR’S REGULATORY REVIEW COUNCIL DEADLINES FOR 2017

[M16-300]

DEADLINE FOR PLACEMENT ON AGENDA	FINAL MATERIALS SUBMITTED TO COUNCIL	DATE OF COUNCIL STUDY SESSION	DATE OF COUNCIL MEETING
Tuesday November 22, 2016	Tuesday December 20, 2016	Wednesday December 28, 2016	Wednesday January 4, 2017
Tuesday December 27, 2016	Tuesday January 24, 2017	Tuesday January 31, 2017	Tuesday February 7, 2017
Tuesday January 24, 2017	Tuesday February 21, 2017	Tuesday February 28, 2017	Tuesday March 7, 2017
Tuesday February 21, 2017	Tuesday March 21, 2017	Tuesday March 28, 2017	Tuesday April 4, 2017
Tuesday March 21, 2017	Tuesday April 18, 2017	Tuesday April 25, 2017	Tuesday May 2, 2017
Tuesday April 25, 2017	Tuesday May 23, 2017	Wednesday May 31, 2017	Tuesday June 6, 2017
Tuesday May 23, 2017	Tuesday June 20, 2017	Tuesday June 27, 2017	Thursday July 6, 2017
Tuesday June 20, 2017	Tuesday July 18, 2017	Tuesday July 25, 2017	Tuesday August 1, 2017
Tuesday July 25, 2017	Tuesday August 22, 2017	Tuesday August 29, 2017	Wednesday September 6, 2017
Tuesday August 22, 2017	Tuesday September 19, 2017	Tuesday September 26, 2017	Tuesday October 3, 2017
Tuesday September 26, 2017	Tuesday October 24, 2017	Tuesday October 31, 2017	Tuesday November 7, 2017
Tuesday October 24, 2017	Tuesday November 21, 2017	Tuesday November 28, 2017	Tuesday December 5, 2017
Tuesday November 21, 2017	Tuesday December 19, 2017	Wednesday December 27, 2017	Wednesday January 3, 2018

*Materials must be submitted by 5 P.M. on dates listed as a deadline for placement on a particular agenda. Placement on a particular agenda is not guaranteed.