REGULATIONS OF CONNECTICUT STATE AGENCIES
INSURANCE DEPARTMENT

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(This regulation was effective September 30, 1994.)

Sections 38a-501-1 to 38a-501-7 [REPEALED]

Section 38a-501-8 APPLICABILITY AND SCOPE

Except as otherwise specifically provided, Sections 38a-501-8 to 38a-501-24, inclusive, apply to all individual long-term care insurance policies delivered or issued for delivery in this state on or after the effective date of this regulation by any insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center.

Section 38a-501-9 DEFINITIONS

As used in Sections 38a-501-8 to 38a-501-24, inclusive:

(a) "Long-term care policy" means any individual health insurance policy, or any individual subscriber contract, or any amendment, endorsement or rider to any such policy or subscriber contract delivered or issued for delivery to any resident of this state which is designed to provide benefits on an expense-incurred, indemnity or prepaid basis for necessary care or treatment of an injury, illness or loss of functional capacity provided by a certified or licensed health care provider in a setting other than an acute care hospital, for at least one year after a reasonable elimination period. A long-term care policy shall provide benefits for confinement in a nursing home or confinement in the insured's own home or both. Any additional benefits provided shall be related to long-term treatment of an injury, illness or loss of functional capacity. "Long-term care policy" shall not include any such policy, contract or certificate which is offered primarily to provide basic Medicare supplement coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified accident coverage or limited benefit health coverage.

(b) "Applicant" means the person who seeks to contract for insurance benefits.

Section 38a-501-10 POLICY DEFINITIONS AND TERMS

No insurance policy or subscriber contract may be advertised, solicited or issued for delivery to any resident of this state as a long-term care policy unless the terms used in such policy or subscriber contract conform to the meanings given in this section.

(a) "Accident," "Accidental Injury," or "Accidental Means" shall be defined to employ "result" language and shall not include words which establish an "accidental" means test or use words such as "external, violent, visible wounds" or similar words of description of characterization.

(1) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct

result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(2) Such definition may be further modified to exclude injuries for which benefits are provided under any workers' compensation, employers' liability or similar law, or the basic reparations benefits of a no-fault motor vehicle insurance plan.

(b) "Activities of daily living" means activities such as, for example, bathing, dressing, eating, toileting, and transferring from bed to chair.

(c) "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals such as physicians and registered nurses, in order to maintain his or her health status.

(d) "Adult day care" shall not be defined more restrictively than a program of services prescribed by a physician and provided by an organization that provides a program of adult day care outside the home which: is licensed in accordance with applicable state laws; has a full- time director; has one or more registered nurses (R.N.s) or licensed practical nurses (L.P.N.s) in attendance during operating hours for at least 4 hours a day; operates at least 5 days a week for a minimum of 6 hours a day; maintains a written record of medical services given to each client; and has established procedures for obtaining appropriate aid in the event of a medical emergency.

(e) "Convalescent Nursing Home," "Extended Care Facility," or "Skilled Nursing Facility" shall be defined in relation to its status, facilities and available services. A definition of such home or facility shall not be more restrictive than one requiring that it: (1) be operated pursuant to law; (2) be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested; (3) be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under supervision of a duly licensed physician; (4) provide continuous twenty-four hours a day nursing service by or under the supervision of a registered nurse (R.N.); and (5) maintains a daily medical record of each patient. The definition of such home or facility may provide that such term shall not be inclusive of: (1) any home, facility or part thereof used primarily for rest; (2) a home or facility for the aged or for the care of drug addicts or alcoholics; or (3) a home or facility primarily used for the care and treatment of mental disease or disorders, or custodial or educational care.

(f) "Custodial care" shall not be defined more restrictively than care which is (1) provided primarily to assist the insured in the activities of daily living; (2) can be provided without professional skills or training; and (3) could not be omitted without adversely affecting the insured's physical or mental condition.

(g) A "custodial or intermediate nursing home" is an institution which: (1) is licensed as a nursing home or operated under the law as a nursing home or a hospice; (2) operates primarily to provide nursing care for which a charge is made for three or more persons; (3) provides continuous nursing care under the supervision of a registered nurse (R.N.), a licensed practical nurse (L.P.N.) or a licensed physician; (4) is not a hospital or clinic; (5) is not a home for the aged or mentally ill, a rest home, a community living center, or a place that provides domiciliary, residency, or retirement care; and (6) is not a facility which operates primarily for the treatment of alcoholics or drug addicts, even if it is a section of a nursing home.

(h) "Home health care services" shall not be defined more restrictively than medical and

non-medical services, provided to ill, disabled or infirm persons who reside at home. Such services may include, for example, homemaker/home health aide services, personal care services, adult day care, respite care services and hospice care services.

(i) "Hospice Care" shall not be defined more restrictively than a program that: (1) provides support and care to an insured who is terminally ill, with no reasonable prospect of cure, and who has a life expectancy of 6 months or less as estimated by a physician; (2) is prescribed by and under the direction of a physician; (3) is provided by an organization that meets applicable federal or state requirements for certification or licensing as a hospice care organization. Hospice Care may be defined to exclude services provided to someone other than the insured.

(j) "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals. (1) The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital: (A) be an institution operated pursuant to law; and (B) be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and (C) provide twenty-four hour nursing service by or under the supervision of registered nurses (R.N.s). (2) The definition of the term "hospital" may state that such term shall not be inclusive of: (A) convalescent homes, convalescent, rest, or nursing facilities; (B) facilities primarily affording custodial, educational or rehabilitative care; (C) facilities for the aged, drug addicts or alcoholics; or (D) any military or veterans' or soldiers' home or any hospital contracted or operated by any national government or agency thereof for the treatment of members or former members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

(k) "Loss of Functional Capacity" shall mean that the insured requires care to assist in meeting day-to-day living requirements such as, but not limited to, eating, bathing and dressing.

(l) "Medicare" shall be defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

(m) "Mental or Nervous Disorders" shall not be defined more restrictively than a definition including neuroses, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind, except that Alzheimer's disease shall not be considered a mental or nervous disorder.

(n) "Necessary Care for Confinement in the Insured's Own Home" shall not be defined more restrictively than home health care services provided to an insured who has suffered a loss of functional capacity.

(o) "Necessary Care for Confinement in a Nursing Home" shall not be defined more restrictively than admitted upon recommendation of a physician, other than the proprietor or employee of the skilled nursing care facility, for care which is medically necessary and which is not at first custodial or intermediate in nature but may, after admission, be reduced to a level that is primarily custodial or

intermediate.

(p) "One Period of Confinement" means consecutive days of confinement; it shall be deemed to include successive periods of confinement which are due to the same or related cause and are not separated by at least ninety (90) days during which the covered person is not confined whether at home or in an institution for either skilled nursing care, intermediate or custodial care.

(q) "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

(r) "Physician" shall be defined as a person who is licensed by the state in which he or she practices to give treatment for which benefits are provided under the policy and who is acting within the scope of his or her license.

(s) "Sickness or Illness" shall not be defined more restrictively than the following: Sickness or illness means disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force. The definition may be further modified to exclude diseases for which benefits are provided under any workers' compensation, employers' liability or similar law.

Section 38a-501-11 MINIMUM STANDARDS

No individual insurance policy or subscriber contract shall be advertised, solicited or issued for delivery in this state as a long-term care policy which does not meet the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards. These standards are in addition to all other requirements of this regulation.

(a) Renewability. The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of Section 38a-501-13.

(1) No individual long-term care policy shall contain renewal provisions other than "guaranteed renewable" or "noncancellable."

(2) The term "guaranteed renewable" shall be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(3) The term "noncancellable" shall be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

(b) A long-term care policy shall not deny a claim for loss which occurs or confinement which begins more than six (6) months from the effective date of the policy for a pre-existing condition. The policy or subscriber contract shall not define a pre-existing condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician

within six (6) months before the effective date of coverage.

(c) A long-term care policy shall not idemnify [FN1] against losses resulting from sickness on a different basis from losses resulting from accidents.

(d) Limitations and Exclusions. An individual long-term care insurance policy shall not include limitations or exclusions which are more restrictive than the following:

(1) PRE-EXISTING CONDITIONS LIMITATION-This policy does not pay benefits for loss which occurs or confinement which begins within six months after the effective date of the policy as a result of a pre-existing condition.

(2) OTHER EXCLUSIONS-This policy does not cover: (i) loss which is caused by declared or undeclared war or any act thereof; (ii) loss which is caused by mental disease or disorder without demonstrable organic disease; (iii) loss which is caused by suicide or any attempt thereof (while sane or insane), or intentionally self-inflicted injury; (iv) confinement in a government institution unless a charge is made which the covered person is obligated to pay; (v) confinement due to alcoholism or drug addiction; (vi) confinement in a hospital; or (vii) confinement or care received outside of the United States.

(3) A policy may provide that its benefits shall not duplicate benefits payable by Medicare.

(e) No long-term care policy shall use waivers to exclude, limit or reduce coverage or benefits for specifically named or described pre-existing diseases or physical conditions.

(f) Long-term care policies shall make reasonable provision for waiver of premium. As to benefits for institutional confinement, this requirement is met if the policy provides for a waiver of premium after benefits have been paid for ninety (90) consecutive days and thereafter during the continuance of the consecutive days for which benefits are paid.

(g) Long-term care policies, other than those issued pursuant to direct response solicitation, shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy to the insurer or its agent within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy, the insured person is not satisfied for any reason. Long-term care policies issued pursuant to a direct response solicitation shall have a notice prominently printed on the first page or attached thereto stating in substance that the policyholder shall have the right to return the policy to the insurer within thirty (30) days of its delivery and to have the premium refunded if after examination the insured person is not satisfied for any reason.

(h) Long-term care policies shall not condition benefits upon prior hospitalization or institutionalization.

(i) Long-term care policies shall include a provision which states that upon notification to the company of a person's death, the company will refund on a pro-rata basis any part of a periodic premium paid by that person which applies to the period after death.

(j) Long-term care policies shall not have an elimination period greater than one hundred (100) days

of confinement.

(k) Long-term care policies shall include a provision that the policy shall be incontestable, except for nonpayment of premium, after it has been in force for two years from its date of issue.

(l) Extension of Benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

(m) The premiums charged to an insured for long-term care insurance shall not increase due solely to either the increasing age of the insured at ages beyond sixty-five (65) or the duration the insured has been covered under the policy.

(n) The requirement that a long-term care insurance policy provide benefits for at least one year of confinement after a reasonable elimination period shall be met by providing benefits solely for confinement in a nursing home, solely for confinement at home, or for confinement either in a nursing home or at home.

(o) Payment of Benefits. A long-term care policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

(p) Long-term care policies which only provide benefits for confinement in the insured's own home shall include a statement to that effect on the first page of the policy in bold print.

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

(r) The application for every individual long-term care policy shall include a section inviting the applicant to give the name of an individual who is to receive notice of lapse concurrently with any such notice sent to the policyholder. Along with space for the name and address of such individual, this section shall include a notice to the applicant as follows (or in substantially similar language): YOU

WILL RECEIVE NOTICE IF YOUR POLICY IS ABOUT TO LAPSE (TERMINATE) BECAUSE YOU HAVE NOT PAID PREMIUMS. WE WILL BE GLAD TO SEND A COPY OF THIS NOTICE TO ANOTHER PERSON, IF YOU WOULD LIKE. THAT PERSON WILL NOT BE RESPONSIBLE FOR PAYMENT OF THE PREMIUM, AND YOU WILL ALWAYS RECEIVE YOUR OWN COPY OF THE NOTICE. IF YOU WANT AN EXTRA COPY SENT TO ANOTHER PERSON, PLEASE GIVE US THAT PERSON'S NAME AND ADDRESS.

Section 38a-501-12 PROHIBITION AGAINST PRE-EXISTING CONDITIONS AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES

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

Section 38a-501-13 REQUIRED DISCLOSURE PROVISIONS

(a) Renewability. Individual long-term care insurance policies shall contain a renewability provision. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration of the term of coverage for which the policy is issued and for which it may be renewed.

(b) Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured or exercises a specifically reserved right under a long-term care policy, all riders or endorsements added to a long-term care policy after date of issue or at reinstatement or renewal shall require a signed acceptance by the insured. After date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, except if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.

(c) Limitations. If a long-term care insurance policy contains any limitation with respect to pre-existing conditions, such limitation shall appear as a separate paragraph of the policy and shall be labeled "PRE-EXISTING CONDITIONS LIMITATION."

(d) Other Limitations or Conditions on Eligibility for Benefits. A long-term care insurance policy shall set forth a description of any limitations or conditions for eligibility, including any required number of days of confinement, in a separate paragraph of the policy and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

Section 38a-501-14 PROHIBITION AGAINST POST CLAIMS UNDERWRITING

(a) All applications for long-term care insurance policies except those which are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

(b) If an application for long-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the

medication that has been prescribed. If the medications listed in such application were known by the insurer or should have been known at the time of application to be directly related to a medical condition for which coverage would otherwise be denied, then the policy shall not be rescinded for that condition.

(c) Except for policies which are guaranteed issue:

(1) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy:

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

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

Caution: The issuance of this long-term care insurance policy is based upon your responses to the questions on your application. A copy of your application (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)

(d) A copy of the completed application shall be delivered to the insured no later than at the time of delivery of the policy unless it was retained by the applicant at the time of application.

(e) Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy rescissions, both state and countrywide, except those which the insured voluntarily effectuated.

Section 38a-501-15 FILING REQUIREMENTS

(a) All filings of rates and rating schedules shall be accompanied by an actuarial certification demonstrating that expected claims in relation to premiums comply with the loss ratio required by subsection (b) of Section 38a-501 of the General Statutes when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the required loss ratio standard.

(b) Insurers shall submit a description of the method used to determine the standard for the payment of policy benefits with each policy form subject to subsection (o) of Section 38a-501-11 which they file for approval.

(c) Every insurer, fraternal benefit society, hospital service corporation, medical service corporation or health care center providing individual long-term care insurance in this State shall provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio or television medium to the Commissioner of Insurance for review or approval to the extent this may be required in accordance with regulations adopted pursuant to Section 38a-819 of the General Statutes. All such advertisements shall be retained as provided in Section 38a-819-18 of these regulations.

Section 38a-501-16 STANDARDS FOR MARKETING

(a) Every insurer, fraternal benefit society, hospital service corporation, medical service corporation or health care center marketing long-term care insurance coverage in this state, directly or through its producers shall:

(1) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

(2) Establish marketing procedures to assure excessive insurance is not sold or issued.

(3) Display prominently by type, stamp or other appropriate means on the first page of the outline of coverage and policy the following:

"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."

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance.

(5) Every insurer or other entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this subsection.

(6) Provide, at solicitation, written notice to the prospective policyholder of the availability of any insurance counselling program that may be provided or approved by any state agency for this purpose,

together with the name, address and telephone number of such program.

(b) In addition to the practices prohibited in Sections 38a-815 to 38a-831, inclusive, of the General Statutes 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 of any method of marketing which 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 agent or insurance company.

Section 38a-501-17 SUITABILITY OF RECOMMENDED PURCHASE

(a) An agent who recommends the purchase or replacement of a long-term care policy or certificate shall have reasonable grounds for believing that the recommendation is suitable for the applicant upon the basis of the facts, if any, disclosed by the applicant concerning his or her health and financial circumstances.

(b) Before selling any individual long-term care policy, an agent shall make reasonable efforts to obtain information concerning the applicant's health and financial circumstances.

(c) Before issuing any individual long-term care policy, a direct response insurer shall have reasonable grounds for believing that the purchase of such policy, whether or not it involves the replacement of existing coverage, is suitable for the applicant upon the basis of the facts, if any, disclosed by the applicant concerning his or her health and financial circumstances.

(d) Every direct response insurer shall include questions on its applications for long-term care insurance that are reasonably designed to obtain information concerning the applicant's health and financial circumstances.

Section 38a-501-18 REQUIREMENT TO DELIVER SHOPPER'S GUIDE

A long-term care insurance shopper's guide approved by the Commissioner shall be provided to all prospective applicants for a long-term care insurance policy.

(a) In the case of agent solicitations, an agent shall deliver the shopper's guide prior to the presentation of an application.

(b) In the case of direct response solicitations, the shopper's guide shall be presented in conjunction with any application.

Section 38a-501-19 REQUIREMENT TO OFFER A NON-FORFEITURE BENEFIT

No insurer shall offer for sale a long-term care insurance policy unless the insurer also offers the applicant the option to purchase a policy that provides a non-forfeiture benefit. An insurer shall meet this requirement by providing return of premium, full benefits for a reduced benefit period, reduced benefits for the full benefit period, or another benefit that is acceptable to the Commissioner. A policy that provides a non-forfeiture benefit shall include a schedule of this benefit.

Section 38a-501-20 REQUIREMENT TO OFFER INFLATION PROTECTION

(a) No insurer shall offer for sale a long-term care insurance policy unless the insurer also offers the applicant the option to purchase a policy that provides for meaningful periodic benefit level increases to account for reasonably anticipated increases in the costs of long-term care services. Insurers shall offer each applicant, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

(1) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent (5%);

(2) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent (5%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

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

(b) Insurers shall include the following information 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 twenty (20) year period.

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

An insurer may use a reasonable graphic demonstration for the purposes of this disclosure.

(c) Inflation protection benefit increases under a policy which contains such benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

(d) An offer of inflation protection which provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. Such offer shall disclose in a conspicuous manner the fact that the premium may change in the future unless the premium is guaranteed to remain constant.

(e) Inflation protection as provided in subsection (a) of this section shall be included in a long-term

care insurance policy unless the insurer obtains a rejection of inflation protection signed by the policyholder as required in this subsection. The rejection shall be considered part of the application and shall state:

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

Section 38a-501-21 STANDARD FORMAT OUTLINE OF COVERAGE

(a) No long-term care policy shall be delivered or issued for delivery to any resident of this state unless an appropriate outline of coverage in the format prescribed herein is completed as to such policy, and is delivered to the applicant at the time application or solicitation is made and acknowledgement of receipt or certification of delivery of such outline of coverage is provided to the insurer. In the case of direct response solicitations, the insurer shall deliver the outline of coverage upon the applicant's request, but regardless of such request, shall make such delivery no later than at the time of policy delivery.

(b) The outline of coverage shall be a free standing document, using no smaller than twelve point type.

(c) The outline of coverage shall contain no material of an advertising nature.

(d) Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.

(e) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

(f) Format for outline of coverage:

(COMPANY NAME)
(ADDRESS-CITY & STATE)
(TELEPHONE NUMBER)
LONG-TERM CARE INSURANCE
OUTLINE OF COVERAGE
(Policy Number)

(Except for policies 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 is based upon your responses to the questions on your application. A copy of your application (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 which was issued in Connecticut.

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 policy contains governing contractual provisions. This means that the 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 CAREFULLY!

3. TERMS UNDER WHICH THE POLICY 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 contains provisions providing for a refund or partial refund of premium upon the death of an insured and does or does not contain provisions providing for such a refund upon surrender of the policy. Include a description of all such refund provisions.)

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

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

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

5. 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.)

6. BENEFITS PROVIDED BY THIS POLICY.

(a) (Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.)

(b) (Institutional benefits, by level of care provided.)

(c) (Non-institutional benefits, by level of care provided.)

(An explanation of any qualifying criteria used to determine an insured's eligibility for benefits shall accompany each benefit description. If an attending physician or other specified person must certify to a loss of functional capacity in order for the insured to be eligible for benefits, this shall be specified. If activities of daily living (ADLs) are used to determine an insured's eligibility for benefits then these shall be explained.)

7. LIMITATIONS AND EXCLUSIONS

(Describe:

(a) Any pre-existing conditions provision;

(b) Non-eligible facilities/providers (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(c) Non-eligible levels of care;

(d) Exclusions/exceptions;

(e) Other limitations)

(This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in (6) above.)

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

8. 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 provision;

(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, indicate whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

(e) And finally, indicate whether there will be any additional premium charge imposed, and describe how that is to be calculated.)

9. TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED.

(a) (Describe policy renewability provisions);

(b) (Describe waiver of premium provisions, including whether the insured is entitled to a refund of unearned premium in the event of a waiver);

(c) (State whether or not the company has a right to change premium, and if such a right exists, describe clearly and concisely each circumstance under which premium may change.)

10. 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 any qualifying criteria that determines such an insured's eligibility for policy benefits.)

11. PREMIUM

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

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

12. ADDITIONAL FEATURES

((a) Indicate whether medical underwriting is used;

(b) Describe other important features.)

Section 38a-501-22 REPLACEMENT

(a) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing such questions may be used.

(1) Do you have another long-term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)?

(2) Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months? If so, with which company? 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?

(b) Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold which are still in force.

(2) List policies sold in the past five (5) years which are no longer in force.

(c) Solicitations Other than Direct Response. Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its agent shall furnish the applicant, prior to issuance or delivery of the individual long term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE
(Insurance company's name and address)

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

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

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

STATEMENT TO APPLICANT BY AGENT
(BROKER OR OTHER REPRESENTATIVE)

(Use additional sheets, as necessary.)

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

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

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

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

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

_____

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

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

(Date)

_____

(Applicant's Signature)

(d) Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE
(Insurance company's name and address)

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

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

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

1. Health conditions which you may presently have (pre-existing conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

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

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

4. (To be included only if the application is attached to the policy) If, after due consideration you still wish to terminate your present policy and replace it with new coverage read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (company name and address) within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)

(e) Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Such notice shall be made within five (5) working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

Section 38a-501-23 REPORTING REQUIREMENTS

(a) Every insurer shall report annually by June 30 the number of policies lapsed in the previous calendar year, the average total number of policies in force during the preceding calendar year, and the resulting ratio.

(b) Every insurer shall report annually by June 30 the number of replacement policies sold in the previous calendar year, the total number of policies sold during the preceding calendar year, and the resulting ratio.

(c) Every insurer shall report annually by June 30 the number of replacement policies sold in the previous calendar year, the average total number of policies in force during the preceding calendar year, and the resulting ratio.

(d) Every insurer shall report annually by June 30 the number of rescissions of policies, except those voluntarily effectuated by an insured, in the previous calendar year.

(e) For purposes of this section, "policies" shall mean only individual long-term care insurance policies and "report" shall mean on a statewide and national basis.

Section 38a-501-24 EFFECTIVE DATE; SEPARABILITY

(a) The effective date of Sections 38a-501-8 to 38a-501-24, inclusive, shall be September 30, 1994.

(b) If any provision of Sections 38a-501-8 to 38a-501-24, inclusive, or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of these regulations and the application of such provision to other persons or circumstances shall not be affected thereby.