PROPOSED REGULATION OF

THE COMMISSIONER OF INSURANCE

LCB File No. R028-10

June 3, 2010

EXPLANATION – Matter in ***italics*** is new; matter in brackets **[**~~omitted material~~**]** is material to be omitted.

AUTHORITY: §§1-84, NRS 679B.130.

A REGULATION relating to insurance; establishing certain requirements for exceptional increases; establishing certain requirements for qualified state long-term care insurance partnership contracts; establishing certain requirements for policy summaries; requiring certain information concerning a denial of a claim under a long-term care insurance contract to be disclosed upon request; providing certain restrictions upon the rescission of a long-term care insurance contract or certificate; establishing various requirements for consideration of premium rate increases; prohibiting certain practices while marketing long-term care insurance; clarifying that long-term care insurance may not limit benefits or exclude coverage for Alzheimer's Disease; providing certain requirements for a person who sells, solicits or negotiates long-term care insurance; revising various provisions relating to long-term care insurance; and providing other matters properly relating thereto.

Section 1. Chapter 687B of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 14, inclusive, of this regulation.

Sec. 2. ***"Exceptional increase" means an increase which is filed by an insurer as exceptional and for which the Commissioner determines the need for the premium rate increase is justified:***

1. Because of changes in laws or regulations applicable to long-term care insurance coverage in this State; or

2. Because of increased and unexpected utilization that affects the majority of insurers of similar products.

Sec. 3. *1. "Long-term care insurance contract" means:*

(a) An insurance policy or contract, or any portion thereof; or

(b) A rider or endorsement to a policy of life insurance, a policy of disability income insurance or an annuity contract, or any portion thereof,

➥ which is delivered or issued for delivery in this State, by an insurer or similar organization, and which principally provides direct or supplemental coverage for long-term care insurance.

2. The term includes:

(a) A qualified long-term care insurance contract.

(b) A qualified state long-term care insurance partnership contract.

3. As used in this section, "insurance policy or contract" has the meaning ascribed to it in NAC 686A.627 and includes a subscriber agreement.

Sec. 4. *"Partnership certificate" means a certificate issued under a group partnership contract.*

Sec. 5. *"Partnership policy" means an insurance policy delivered or issued for delivery in this State that is a "partnership contract" as defined in section 3 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008.*

Sec. 6. *1. "Qualified health actuary" means a person who:*

(a) Is a member in good standing of the Academy or is recognized by the Academy as meeting the qualification standards set forth in paragraph (b); and

(b) Meets the qualification standards set forth in "Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States," approved by the Board of Directors of the Academy.

2. As used in this section, "Academy" means the American Academy of Actuaries or its successor organization.

Sec. 7. *1. Except as otherwise provided in section 13 of this regulation, an exceptional increase is subject to the same requirements as other premium rate schedule increases.*

2. The Commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that a premium rate increase be considered an exceptional increase.

3. The Commissioner, in determining whether the necessary basis for an exceptional increase exists, will also determine any potential offsets to higher claims costs.

Sec. 8. *1. The provisions of this section apply to any qualified state long-term care insurance partnership contract.*

2. An insurer or agent soliciting or offering to sell a long-term care insurance contract that is intended to qualify as a partnership contract shall provide to each prospective applicant a partnership program notice. The partnership program notice must:

(a) Outline the requirements and benefits of a partnership contract.

(b) Be provided with the required outline of coverage.

(c) Be in the following form, unless a similar form is filed with, and approved by, the Commissioner:

PARTNERSHIP PROGRAM NOTICE

Important Consumer Information Regarding the Nevada Long-Term Care Insurance Partnership Program

Some long-term care insurance contracts or certificates sold in Nevada may qualify for the Nevada Long-Term Care Insurance Partnership Program (the "Partnership Program"). The Partnership Program is a partnership between state government and private insurance companies to assist individuals in planning their long-term care needs. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain state and federal requirements. Long-term care insurance contracts or certificates that qualify as partnership contracts or partnership certificates may protect the policyholder's or certificate holder's assets through a feature known as "asset disregard" under Nevada's Medicaid program.

ASSET DISREGARD means that an amount of the policyholder's or certificate holder's assets equal to the amount of long-term care insurance benefits received under a qualified partnership contract or partnership certificate will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified partnership contract or partnership certificate without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply, and special rules may apply to persons whose home equity exceeds $500,000. Asset disregard is not available under a long-term care insurance contract or certificate that is not a partnership contract or partnership certificate. Therefore, you should consider if asset disregard is important to you, and whether a partnership contract or partnership certificate meets your needs. THE PURCHASE OF A PARTNERSHIP CONTRACT DOES NOT AUTOMATICALLY QUALIFY YOU FOR MEDICAID.

WHAT ARE THE REQUIREMENTS FOR A PARTNERSHIP CONTRACT OR PARTNERSHIP CERTIFICATE? In order for a long-term care insurance contract or certificate to qualify as a partnership contract or partnership certificate, it must, among other requirements:

- ***Be issued to a person on or after January 1, 2007;***
- ***Cover a person who was a Nevada resident when coverage first became effective under the long-term care insurance contract or certificate;***
- ***Be a federally tax-qualified long-term care insurance contract;***
- ***Meet stringent consumer protection standards; and***
- ***Meet the following inflation requirements:***
    - ***For persons 60 years of age or younger – provides compound annual inflation protection;***
    - ***For persons 61 to 75 years of age – provides some level of inflation protection; and***
    - ***For persons 76 years of age and older – no purchase of inflation protection is required.***

If you apply and are approved for long-term care insurance coverage, your insurer will provide you with written documentation as to whether or not your long-term care insurance contract or certificate qualifies as a partnership contract or partnership certificate.

WHAT COULD DISQUALIFY A LONG-TERM CARE INSURANCE CONTRACT OR CERTIFICATE AS A PARTNERSHIP POLICY? Certain types of changes to a partnership

contract or partnership certificate could affect whether or not such policy or certificate continues to be a partnership contract or partnership certificate. If you purchase a partnership contract or partnership certificate and later decide to make ANY changes, you should first consult with your insurer to determine the effect of a proposed change. In addition, if you move to a state that does not maintain a partnership program or does not recognize your long-term care insurance contract or certificate as a partnership policy or partnership certificate, you would not receive beneficial treatment of your long-term care insurance contract or certificate under the Medicaid program of that state. The information contained in this disclosure is based on current Nevada and federal law. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your long-term care insurance contract or certificate under Nevada's Medicaid program.

3. A partnership contract delivered or issued for delivery in Nevada must be accompanied by a partnership status disclosure notice. The partnership status disclosure notice must:

(a) Explain the benefits associated with a partnership contract;

(b) Indicate that the long-term care insurance contract is, at the time of issuance, intended to be a qualified state long-term care insurance partnership contract;

(c) Include a statement which indicates that the insured does not automatically qualify for Medicaid by purchasing this partnership policy; and

(d) Be in the following form, unless a similar form is filed with, and approved by, the Commissioner:

PARTNERSHIP STATUS DISCLOSURE NOTICE

Important Information Regarding Your Long-Term Care Insurance Contract's or Certificate's Long-Term Care Insurance Partnership Status

This disclosure notice is issued in conjunction with your long-term care insurance contract.

Some long-term care insurance contracts or certificates sold in Nevada qualify for the Nevada Long-Term Care Insurance Partnership Program. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain state and federal requirements. Long-term care insurance contracts or certificates that qualify as partnership policies or partnership certificates may be entitled to special treatment and, in particular, an "asset disregard" under Nevada's Medicaid program.

ASSET DISREGARD means that an amount of the policyholder's or certificate holder's assets equal to the amount of long-term care insurance benefits received under a qualified partnership contract or partnership certificate will be disregarded for the purposes of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified partnership policy or partnership certificate without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply, and special rules may apply to persons whose home equity exceeds $500,000. Asset disregard is NOT available under a long-term care insurance contract or certificate that is not a partnership contract or partnership certificate. THE

PURCHASE OF A PARTNERSHIP CONTRACT DOES NOT AUTOMATICALLY QUALIFY YOU FOR MEDICAID.

PARTNERSHIP CONTRACT OR PARTNERSHIP CERTIFICATE STATUS. Your long-term care insurance contract or certificate is intended to qualify as a partnership contract or partnership certificate under the Nevada Long-Term Care Insurance Partnership Program as of your contract's or certificate's effective date.

WHAT COULD DISQUALIFY YOUR LONG-TERM CARE INSURANCE CONTRACT OR CERTIFICATE AS A PARTNERSHIP CONTRACT OR PARTNERSHIP CERTIFICATE? If you make any changes to your long-term care insurance contract or certificate, such changes could affect whether your long-term care insurance contract or certificate continues to be a partnership contract or partnership certificate. BEFORE YOU MAKE ANY CHANGES, YOU SHOULD CONSULT WITH YOUR INSURER TO DETERMINE THE EFFECT OF A PROPOSED CHANGE. In addition, if you move to a state that does not maintain a partnership program or does not recognize your long-term care insurance contract or certificate as a partnership contract or partnership certificate, you would not receive beneficial treatment of your long-term care insurance contract or certificate under the Medicaid program of that state. The information contained in this Notice is based on current state and federal law. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your long-term care insurance contract or certificate under Nevada's Medicaid program.

ADDITIONAL INFORMATION. If you have questions regarding your long-term care insurance contract or certificate, please contact your insurer. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Nevada Medicaid office.

4. A partnership contract or partnership certificate must not be delivered or issued for delivery in Nevada unless filed with and approved by the Commissioner.

5. Any long-term care insurance contract submitted for certification as a partnership contract must be accompanied by an Issuer Certification Form and a Partnership Certification Form. Unless a similar form is filed with and approved by the Commissioner:

(a) Form NDOI-951 must be used as, or provide substantially the format for, the Issuer Certification Form; and

(b) Form NDOI-952 must be used as, or provide substantially the format for, the Partnership Certification Form.

6. Insurers requesting to make use of a previously approved long-term care insurance contract form as a qualified state long-term care insurance partnership contract must submit to the Commissioner an Issuer Certification Form signed by an officer of the insurance company. An Issuer Certification Form is required for each long-term care insurance contract form submitted for partnership qualification.

Sec. 9. *1. A policy summary must be delivered to an applicant for an individual policy of life insurance at the time of policy delivery if the policy provides long-term care benefits, whether by rider or within the policy. In the case of direct-response solicitations, the insurer shall deliver the policy summary upon the applicant's request, or not later than the time the policy is delivered. The policy summary must include:*

(a) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

(b) An illustration of the amount of benefits, the length of benefit and the guaranteed lifetime benefits, if any, for each covered person;

(c) Any exclusions, reductions and limitations on benefits for long-term care;

(d) A statement that the protection against inflation required by NAC 687B.076 is not available under this policy; and

(e) If applicable to the policy type:

(1) A disclosure of the effects of exercising other rights under the policy;

(2) A disclosure of guarantees related to long-term care costs of insurance charges; and

(3) Current and projected lifetime benefits.

2. The provisions of the policy summary described in subsection 1 may be incorporated into a basic illustration required to be delivered by NAC 686A.460 to 686A.479, inclusive, or into the contract summary which is required to be delivered by NAC 688A.120.

Sec. 10. *If a claim under a long-term care insurance contract is denied, the issuer shall, not later than 60 days after the date of a written request by the policyholder, certificate holder or a representative thereof:*

1. Provide a written explanation of the reasons for the denial; and

2. Make available all information directly related to the denial.

Sec. 11. *1. For a long-term care insurance contract or certificate that has been in force for less than 6 months, an insurer may rescind the long-term care insurance contract or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.*

2. For a long-term care insurance contract or certificate that has been in force for not less than 6 months but less than 2 years, an insurer may rescind the long-term care insurance contract or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation which is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.

3. After a long-term care insurance contract or certificate has been in force for 2 years, it is not contestable upon the grounds of misrepresentation alone and may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

4. A long-term care insurance contract or certificate may be field-issued if the compensation to the field issuer is not based on the number of long-term care insurance contracts or certificates issued.

5. If an insurer has paid benefits under a long-term care insurance contract or certificate, the benefit payments may not be recovered by the insurer if the long-term care insurance contract or certificate is rescinded.

6. The provisions of this section apply to policies of life insurance which accelerate benefits for long-term care except that, in the event of the death of the insured, this section does not apply to the remaining death benefit of a policy of life insurance that accelerates benefits for long-term care, and the remaining death benefits under such a policy must be governed by NRS 688A.080.

7. As used in this section, "field-issued" means issued by a producer or a third-party administrator pursuant to the underwriting authority granted to the producer or third-party administrator by an insurer, using the insurer's underwriting guidelines.

Sec. 12. *A producer is not authorized to sell, solicit or negotiate with respect to long-term care insurance except as authorized by chapter 683A of NRS.*

Sec. 13. *1. An insurer shall request approval of any increase in a premium rate schedule, including an exceptional increase, from the Commissioner at least 45 days before providing notice of the increase to the policyholders and shall include in the request:*

(a) The information required by section 18 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008;

(b) Certification by a qualified health actuary that:

(1) If the requested rate increase is implemented and the underlying assumptions which reflect moderately adverse conditions are materialized, no further rate increases are anticipated; and

(2) The premium rate filing is in compliance with the provisions of this section;

(c) An actuarial memorandum justifying the rate increase that includes:

(1) Lifetime projections of earned premiums and incurred claims based on the filed rate increase which include the method and assumptions used in determining the projected values and reflection of any assumptions that deviate from those used for pricing other forms currently available for sale, including, without limitation:

(I) Separate actual and projected annual values for the 5 years before and the 3 years after the valuation date;

(II) The development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(III) A demonstration of compliance with subsection 2;

(IV) For an exceptional increase, projections that are limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(V) For an exceptional increase, if the Commissioner determines that offsets may exist, projections which use the appropriate net projected experience;

(2) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(3) Disclosure of the analysis performed to determine why a rate increase is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

(4) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

(5) If it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, information concerning composite rates reflecting projections of new certificates;

(d) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the Commissioner; and

(e) Sufficient information for review and approval of the rate increase by the Commissioner.

2. The Commissioner may approve an increase in a premium rate schedule if the Commissioner determines that:

(a) For an exceptional increase, 70 percent of the present value of projected additional premiums from the exceptional increase will be returned to the policyholders in benefits;

(b) The rate increase is calculated such that 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, will not be less than the sum of:

(1) Fifty-eight percent of the accumulated value of the initial earned premium;

(2) Eighty-five percent of the accumulated value of previous rate increases on an earned basis;

(3) Fifty-eight percent of the present value of future projected initial earned premiums; and

(4) Eighty-five percent of the present value of future projected premiums not included in subparagraph (3) on an earned basis.

(c) If a long-term care insurance contract has an exceptional increase and any other increase, the values in subparagraphs (2) and (4) of paragraph (b) also include 70 percent for exceptional increase amounts; and

(d) All present and accumulated values used to determine rate increases use the maximum valuation interest rate for contract reserves as specified in paragraph (a) of subsection 2 of NRS 681B.120. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

3. For each rate increase that is implemented, the insurer shall file updated projections, as described in subparagraph (1) of paragraph (c) of subsection 1, for approval by the Commissioner annually for each of the 3 years following the increase and shall include a comparison of actual results to projected values. The Commissioner may extend this period beyond 3 years if actual results are not consistent with projected values from previous projections. For group long-term care insurance contracts that meet the conditions of

subsection 11, the projections required by this subsection must be provided to the policyholder in lieu of filing with the Commissioner.

4. If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as described in subparagraph (1) of paragraph (c) of subsection 1, must be filed for approval by the Commissioner every 5 years following the end of the required period in subsection 3. For group long-term care insurance contracts that meet the conditions of subsection 11, the projections required by this subsection must be provided to the policyholder in lieu of filing with the Commissioner.

5. If the Commissioner determines that the actual experience following a rate increase does not adequately match the projected experience and that current projections under moderately adverse conditions demonstrate that incurred claims will not exceed the proportions of premiums specified in subsection 2, the Commissioner may require the insurer to implement:

(a) An adjustment to the premium rate schedule; or

(b) Other measures to reduce the difference between the projected experience and the actual experience.

➥ In determining whether the actual experience adequately matches the projected experience, the Commissioner will consider the provisions of subparagraph (5) of paragraph (c) of subsection 1, if applicable.

6. If the majority of long-term care insurance contracts or certificates to which an increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

(a) The original anticipated lifetime loss ratio and the rate increase that would have been calculated according to subsection 3 had the greater of the original anticipated lifetime loss ratio or 58 percent been used in the calculations described in subparagraphs (1) and (3) of paragraph (b) of subsection 2; and

(b) A plan, subject to the approval of the Commissioner, for improved administration or claims processing designed to eliminate the potential for further deterioration of the long-term care insurance contract requiring further rate increases or to demonstrate that appropriate administration and claims processing have been implemented or are in effect. If the insurer fails to file a plan pursuant to this paragraph, the Commissioner may impose the requirements of subsection 8.

7. The Commissioner will, for all long-term care insurance contracts included in the filing, review the projected lapse rates and past lapse rates during the 12 months following each rate increase to determine if significant adverse lapsation has occurred or is anticipated if:

(a) The rate increase is not the first rate increase requested for the specific policy form or forms;

(b) The rate increase is not an exceptional increase; and

(c) The majority of long-term care insurance contracts or certificates to which the rate increase is applicable are eligible for the contingent benefit upon lapse.

8. If the Commissioner determines that significant adverse lapsation has occurred pursuant to subsection 7, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the Commissioner may determine that a rate spiral exists. Following the

determination that a rate spiral exists, the Commissioner may require the insurer to offer, without underwriting, to all insureds who have long-term care insurance contracts in force and who are 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. For such an offer:

(a) The offer must:

(1) Be subject to the approval of the Commissioner;

(2) Be based on actuarially sound principles but not be based on attained age; and

(3) Provide that maximum benefits under any new policy accepted by an insured will be reduced by comparable benefits already paid under the existing long-term care insurance contract; and

(b) The insurer shall maintain the experience of all the replacement insureds separate from the experience of the insureds originally issued the long-term care insurance contracts. In the event of a request for a rate increase on the long-term care insurance contracts, the rate increase must 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 who were originally issued the long-term care insurance contract plus 10 percent.

9. If the Commissioner determines that the insurer has established a persistent practice of filing inadequate initial premium rates for long-term care insurance, the Commissioner may, in addition to the provisions of subsections 7 and 8, prohibit the insurer from:

(a) Filing and marketing comparable coverage for a period of up to 5 years; or

(b) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent rate increases.

10. Subsections 1 to 9, inclusive, do not apply to long-term care insurance contracts for which the long-term care benefits provided by the long-term care insurance contract are incidental if:

(a) The interest credited internally to determine cash value accumulations, including long-term care, if any, is guaranteed to be not less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(b) The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in:

(1) NRS 688A.290 to 688A.360, inclusive, for life insurance; or

(2) NRS 688A.361 to 688A.369, inclusive, for deferred annuities;

(c) The policy meets the disclosure requirements of section 9 of this regulation and sections 6 and 8 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008;

(d) The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements for:

(1) Policy illustrations as required in NAC 686A.460 to 686A.479, inclusive, for life insurance; or

(2) Disclosure in NAC 688A.470 for deferred annuities; and

(e) An actuarial memorandum is filed with the Division and includes:

(1) A description of the basis on which the rates for long-term care were determined;

(2) A description of the basis for the reserves;

(3) A summary of the type of long-term care insurance contract, benefits, renewability, general marketing method and limits on ages of issuance;

(4) A description and a table of each actuarial assumption used, which includes, for expenses, the percent of premium dollars per long-term care insurance contract and dollars per unit of benefits, if any;

(5) A description and a table of the anticipated reserves for the long-term care insurance contract and additional reserves to be held in each future year for active lives;

(6) The estimated average annual premium per long-term care insurance contract and the average issue age;

(7) A description of the effect of the provisions of the long-term care insurance contract on the required premiums, nonforfeiture values and reserves on the underlying long-term care insurance contract, both for active lives and those in claim status; and

(8) A statement as to whether underwriting is performed at the time of application. The statement must indicate whether underwriting is used and, if used, the statement must include a description of the type of underwriting used, such as medical underwriting or functional assessment underwriting. For a group long-term care insurance contract, the statement must indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs.

11. Subsections 5, 7 and 8 do not apply to a group long-term care insurance contract if:

(a) The contract insures 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or

(b) The policyholder, and not the certificate holder, pays a material portion of the premium, which is not less than 20 percent of the total premium for the group in the calendar year before the year a rate increase is filed.

12. This section applies to long-term care insurance contracts and certificates issued in this State on or after the effective date of this regulation.

13. As used in this section, "incidental" means that the value of the long-term care benefits provided, as measured at the date of issue, is less than 10 percent of the total value of benefits provided over the life of the long-term care insurance contract.

Sec. 14. *1. Except as otherwise provided in subsection 3, after the Division approves a filing associated with the partnership status of a form, the insurer or similar organization issuing the form shall notify each policyholder and certificate holder with a long-term care insurance contract or certificate issued or delivered in this State:*

(a) If the long-term care insurance contract or certificate requires no additional features that would bear additional risk to the insurer to make it a partnership contract or partnership certificate, that the long-term care insurance contract or certificate is now intended to be a partnership contract or partnership certificate.

(b) If the long-term care insurance contract requires additional features that would bear additional risk to the insurer to make it a partnership contract or partnership certificate, of an offer, subject to the conditions described in subsection 4, to upgrade the long-term care insurance contract or certificate with the intention to make it a partnership contract or partnership certificate.

2. The notices described in subsections 2 and 3 of section 8 of this regulation must be provided at the time of notification to the parties notified pursuant to subsection 1.

3. The requirements of subsection 1 do not apply to:

(a) A policy of life insurance or a rider to a policy of life insurance that accelerates benefits for long-term care;

(b) An annuity contract or a rider to an annuity contract that contains benefits for long-term care;

(c) A disability income insurance policy or a rider to a disability income insurance policy that contains long-term care eligibility triggers;

(d) A long-term care insurance contract or certificate issued before January 1, 2007;

(e) A long-term care insurance contract or certificate issued by the insurer or similar organization but not associated with the form approved by the Division for partnership status;

(f) A long-term care insurance contract or certificate issued to any policyholder or certificate holder who:

(1) Is currently eligible for benefits;

(2) Is within an elimination period;

(3) Is on a claim;

(4) Previously received benefits under the long-term care insurance contract or certificate; or

(5) Is not eligible to apply for the new coverage because of limitations under the new long-term care insurance contract or certificate relating to the issue age of the insured.

4. The insurer may condition the offer described in paragraph (b) of subsection 1 on the insured meeting all eligibility requirements for any additional features that bear new risk, including, without limitation, enhancement of protection against inflation to the level

identified in subsection 8 of NAC 687B.076. Eligibility requirements include, without limitation, any underwriting requirements and payment of premiums to add any new coverage.

5. The insurer shall make any new coverage pursuant to the offer described in paragraph (b) of subsection 1 available:

(a) By adding a rider to the existing long-term care insurance contract and charging a separate premium for the rider based on the present age of the insured;

(b) By exchanging the existing long-term care insurance contract 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 long-term care insurance contract or certificate based on premiums paid or reserves held for the previous long-term care insurance contract or certificate;

(c) By exchanging the existing long-term care insurance contract or certificate for a new long-term care insurance contract or certificate in which:

(1) Consideration for past insured status must be recognized by setting the premium for the new long-term care insurance contract or certificate at the issue age of the insured for the long-term care insurance contract or certificate being exchanged; and

(2) The cost for the new long-term care insurance contract or certificate may recognize the difference in reserves between the new long-term care insurance contract or certificate and the original long-term care insurance contract or certificate; or

(d) By an alternative program developed by the insurer and approved by the Commissioner.

6. The forms associated with methods of upgrade described in subsection 5 intended for use by the insurer or similar organization must be included as part of the filing for partnership program status on the form approved by the Division.

7. Not more than 18 months after the Division approves the partnership program status of a filing associated with a long-term care insurance contract or certificate, the insurer or similar organization shall complete:

(a) The conversion of all long-term care insurance contracts and certificates to partnership status as described in paragraph (a) of subsection 1; and

(b) The upgrades identified in subsection 5 for policyholders and certificate holders found eligible pursuant to subsection 4 who have accepted the offer described in paragraph (b) of subsection 1.

8. A long-term care insurance contract or certificate issued pursuant to this section:

(a) Must satisfy the requirements of section 3 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008;

(b) Shall be deemed an exchange; and

(c) Is not subject to the provisions of NAC 687B.125 to 687B.135, inclusive.

9. An insurer or similar organization may upgrade any long-term care insurance contract or certificate associated with a filing approved pursuant to subsection 1 with issue dates before January 1, 2007, to partnership program status at any time. For any such exchange:

(a) The exchange must take place for a new long-term care insurance contract or certificate, as described in paragraph (b) or (c) of subsection 5.

(b) The requirements of paragraph (a) of subsection 8 must be met.

(c) The exchange offer must be made in a uniform and nondiscriminatory fashion, including, without limitation, making the offer for existing long-term care insurance contracts and certificates with an effective date on or after a justifiable date. For the purposes of this paragraph, February 8, 2006, is presumed to be a justifiable date.

(d) The applicability conditions in subsection 3, with the exception of paragraph (d) of subsection 3, apply to the exchange.

10. The provisions of this section do not:

(a) Authorize the transfer of reserves from one form block to another.

(b) Prohibit an insurer or similar organization from offering a long-term care insurance contract or certificate to any policyholder or certificate holder. Insurers and similar organizations may require that policyholders and certificate holders meet all eligibility requirements, including underwriting and payment of required premiums.

(c) Prevent any prospective applicant from applying for the newly available partnership contract or partnership certificate approved by the Division in subsection 1.

Sec. 15. NAC 687B.010 is hereby amended to read as follows:

687B.010 "Applicant" means:

1. In the case of an individual ~~[policy of]~~ long-term insurance ~~[,]~~ ***contract,*** the person who seeks to contract for benefits.

2. In the case of a group ~~[policy of]~~ long-term care insurance ~~[,]~~ ***contract,*** the proposed ~~[holder of the]~~ certificate ~~[.]~~ ***holder.***

Sec. 16. NAC 687B.015 is hereby amended to read as follows:

687B.015 "Certificate" means any certificate issued under a group ~~[policy of]~~ long-term care insurance ***contract*** which is delivered or issued for delivery in this State.

Sec. 17. NAC 687B.019 is hereby amended to read as follows:

687B.019 "Converted policy" means an individual ~~[policy of]~~ long-term care insurance ***contract*** providing benefits identical to, or benefits determined by the Commissioner to be substantially equivalent to, or in excess of, those provided under the group ~~[policy of]~~ long-term care insurance ***contract*** from which conversion is made.

Sec. 18. NAC 687B.025 is hereby amended to read as follows:

687B.025 "Group long-term care insurance" means a ~~[policy of]~~ long-term care insurance ***contract*** which is delivered or issued for delivery in this State to:

1. One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or both, for employees or former employees, or both, or for members or former members, or both, of the labor organizations;

2. Any professional, trade or occupational association for its members or former or retired members, or any combination thereof, if the association:

(a) Is composed of persons who are or were actively engaged in the same profession, trade or occupation; and

(b) Has been maintained in good faith for purposes other than obtaining insurance;

3. An association or trust, or the trustee of a fund, established, created or maintained for the benefit of members of one or more associations; or

4. Any other group, if the Commissioner finds that:

(a) The issuance of the ~~[policy]~~ ***long-term care insurance contract*** to that group is not contrary to the best interests of the public;

(b) The issuance of the ~~[policy]~~ ***long-term care insurance contract*** would result in economies of acquisition or administration; and

(c) The benefits are reasonable in relation to the premiums charged.

Sec. 19. NAC 687B.030 is hereby amended to read as follows:

687B.030 1. "Long-term care insurance" means any ~~[policy of]~~ ***group or individual*** insurance ~~[or rider]~~ advertised, marketed, offered or designed to provide coverage for not less than ~~[24]~~ ***12*** consecutive months for each person covered by the ~~[policy]~~ ***insurance*** on an expense-incurred, indemnity, prepaid or other basis, for necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services provided in a setting other than an acute care unit of a hospital.

2. The term includes ~~[group and individual policies or riders whether issued by insurers, fraternal benefit societies, nonprofit medical, hospital and medical service corporations, health maintenance organizations or any other similar organization.]~~ ***insurance that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity.***

3. The term does not include ~~[any policy of]~~ insurance which is offered primarily to provide:

(a) Basic coverage to supplement Medicare;

(b) Basic coverage for hospital expenses;

(c) Basic coverage for medical-surgical expenses;

(d) Indemnity coverage for confinement in a hospital;

(e) Coverage for major medical expenses;

(f) Coverage to protect income received for ***or to protect assets in the event of*** a disability ~~[;]~~ ***, unless the conditions set forth in paragraph (b) of subsection 6 of NAC 687B.035 are met;***

(g) Coverage for accidents only;

(h) Coverage for specified diseases or accidents; or

(i) Limited benefit health coverage.

4. The term does not include a life insurance policy that:

(a) Accelerates the death benefit specifically for one or more of the following qualifying events:

(1) Terminal illness;

(2) Medical conditions requiring extraordinary medical intervention; or

(3) Medical conditions requiring permanent institutional confinement; and

(b) Provides the option of a lump-sum payment for those benefits where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

Sec. 20. NAC 687B.031 is hereby amended to read as follows:

687B.031 ~~[~~"Provision~~]~~ ***"Basis*** for continuation of coverage" means a provision ~~[~~allowing coverage to be maintained~~]~~ ***that maintains coverage*** under the existing group ~~[~~policy,~~]~~ ***long-term care insurance contract,*** subject only to the continued timely payment of premiums, when such coverage would otherwise terminate.

Sec. 21. NAC 687B.032 is hereby amended to read as follows:

687B.032 ~~[~~"Provision~~]~~ ***"Basis*** for conversion of coverage" means a provision that a person:

1. Whose coverage under the group ~~[~~policy~~]~~ ***long-term care insurance contract*** would otherwise terminate, or whose coverage has been terminated for any reason, including discontinuance of the group ~~[~~policy~~]~~ ***long-term care insurance contract*** in its entirety or with respect to an insured class; and

2. Who has been continuously insured under the group ~~[~~policy~~]~~ ***long-term care insurance contract*** and any group ~~[~~policy~~]~~ ***long-term care insurance contract*** which it replaced for at least the 6 months immediately preceding the date of termination,

➥ is entitled to the issuance of a converted policy by the insurer under whose group ~~[policy]~~ ***long-term care insurance contract*** he is covered, without evidence of insurability.

Sec. 22. NAC 687B.035 is hereby amended to read as follows:

687B.035 1. Except as otherwise provided in this subsection, the provisions of NAC 687B.005 to ~~[687B.135,]~~ ***687B.140,*** inclusive, apply to a ~~[policy of]~~ ***long-term care*** insurance ***contract*** delivered or issued for delivery in this State on or after November 21, 1988. The provisions of NAC 687B.113, 687B.116 and 687B.118 apply to a ~~[policy of]~~ ***long-term care*** insurance ***contract*** delivered or issued for delivery in this State on or after January 11, 1991.

2. The provisions of NAC 687B.005 to ~~[687B.135,]~~ ***687B.140,*** inclusive, ***and sections 2 to 14, inclusive, of this regulation*** do not supersede the obligations of entities subject to them to comply with other applicable regulations insofar as they do not conflict with the provisions of NAC 687B.005 to ~~[687B.135,]~~ ***687B.140,*** inclusive ~~[.]~~ ***, and sections 2 to 14, inclusive, of this regulation.***

3. Applicable regulations governing ~~[policies]~~ ***contracts*** of insurance which supplement Medicare do not apply to ~~[policies of]~~ long-term care insurance ~~[.]~~ ***contracts.***

4. A ~~[policy]~~ ***contract*** of insurance which is not advertised, marketed or offered as long-term care insurance or nursing home insurance is not required to comply with the provisions of NAC 687B.005 to ~~[687B.135,]~~ ***687B.140,*** inclusive ~~[.]~~ ***, and sections 2 to 14, inclusive, of this regulation.***

5. NAC 688B.010 and 689B.010 to 689B.080, inclusive, do not apply to ~~[policies]~~ ***contracts*** of long-term care insurance.

6. Except as otherwise expressly provided in NAC 687B.005 to 687B.140, inclusive, and sections 2 to 14, inclusive, of this regulation, the provisions of NAC 687B.005 to 687B.140, inclusive, and sections 2 to 14, inclusive, of this regulation apply to:

(a) Any long-term care insurance contract, including a qualified long-term care insurance contract, partnership contract, annuity contract and life insurance policy that accelerates benefits for long-term care delivered or issued for delivery in this State on or after the effective date of this regulation by insurers and all similar organizations.

(b) Policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance if:

(1) The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services;

(2) The disability income policy is advertised, marketed or offered as insurance for long-term care services; or

(3) Benefits under the policy may commence after the policyholder has reached the normal retirement age for Social Security unless benefits are designated to replace lost income or pay for specific expenses other than long-term care services.

7. Notwithstanding any other provision of NAC 687B.005 to 687B.140, inclusive, and sections 2 to 14, inclusive, of this regulation, any product advertised, marketed or offered as long-term care insurance is subject to the provisions of NAC 687B.005 to 687B.140, inclusive, and sections 2 to 14, inclusive, of this regulation.

Sec. 23. NAC 687B.040 is hereby amended to read as follows:

687B.040 A policy of insurance ***or rider*** may not be advertised, marketed or offered as long-term care insurance or insurance which provides coverage for care received in a nursing

home unless it complies with the provisions of NAC 687B.005 to 687B.140, inclusive ~~[.]~~ ***, and sections 2 to 14, inclusive, of this regulation.***

Sec. 24. NAC 687B.045 is hereby amended to read as follows:

687B.045 The Commissioner may, upon receiving a written request therefor and after an administrative hearing, issue an order to modify or suspend any provision of NAC 687B.005 to 687B.140, inclusive, ***and sections 2 to 14, inclusive, of this regulation*** with respect to a specific ~~[policy or certificate of]~~ long-term care insurance ~~[,]~~ ***contract or certificate*** upon a written finding that:

1. The modification or suspension would be in the best interest of the insureds;

2. The purposes to be achieved would not be effectively or efficiently achieved without the modification or suspension; and

3. One of the following:

(a) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care;

(b) The ~~[policy]~~ ***long-term care insurance contract*** 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 that community; or

(c) The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another policy of insurance.

Sec. 25. NAC 687B.050 is hereby amended to read as follows:

687B.050 1. Before advertising, marketing or offering a ~~[policy of]~~ group long-term care insurance ***contract*** within this State, the insurer of an association shall file evidence with the Commissioner that it has complied with NAC 679B.036, and that the association has:

(a) At the outset, at least 100 members;

(b) Been organized and maintained in good faith for purposes other than that of obtaining insurance;

(c) Been in active existence for at least 1 year; and

(d) A constitution and bylaws which provide that:

(1) The association holds regular meetings not less than annually to further the purposes of the members;

(2) Except for credit unions, the association collects dues or solicits contributions from members; and

(3) The members have voting privileges and are represented on the governing board and committees.

2. ~~[Thirty]~~ ***Forty-five*** days after filing the evidence required by subsection 1, the association shall be deemed to satisfy those organizational requirements, unless the Commissioner finds otherwise.

Sec. 26. NAC 687B.055 is hereby amended to read as follows:

687B.055 1. No ~~[policy of]~~ group long-term ***care*** insurance may be offered to a resident of this State under a group ~~[policy]~~ ***long-term care insurance contract*** issued in another state to a group described in subsection 4 of NAC 687B.025, unless this State or another state having statutory and regulatory requirements for long-term care insurance substantially similar to those adopted in this State, has made a determination that those requirements have been met.

2. Before an insurer or similar organization offers group long-term care insurance to a resident of this State pursuant to this section, it shall file with the Commissioner evidence that the group ~~[policy]~~ ***long-term care insurance contract*** or certificate issued pursuant thereto has been approved by a state ~~[with similar statutory or regulatory requirements as those adopted in this State.]~~ ***having statutory and regulatory requirements for long-term care insurance substantially similar to those adopted in this State.***

Sec. 27. NAC 687B.060 is hereby amended to read as follows:

687B.060 1. ~~[The holder of an individual policy of]~~ ***An applicant for*** long-term care insurance may return the ~~[policy]~~ ***long-term care insurance contract or certificate*** within 30 days after its delivery and have the premium refunded if, after examining the ~~[policy,]~~ ***long-term care insurance contract or certificate,*** he is not satisfied for any reason.

2. ~~[An individual policy of]~~ ***Except as otherwise provided in subsection 5, a*** long-term care insurance ***contract or certificate*** must contain a notice prominently printed on the first page ~~[of the policy]~~ or attached thereto stating in substance that the ~~[policyholder]~~ ***applicant*** may return the ~~[policy]~~ ***long-term care insurance contract or certificate*** within 30 days after its delivery and have the premium refunded if, after examining the ~~[policy,]~~ ***long-term care insurance contract or certificate,*** he is not satisfied for any reason.

3. If an application for long-term care insurance is denied, any premium paid by the applicant must be refunded.

4. Any refund pursuant to this section must be made within 30 days after the return of the long-term care insurance contract or certificate or the denial of the application, as applicable.

5. Subsection 2 does not apply to a certificate issued pursuant to a long-term care insurance contract issued to a group described in subsection 1 of NAC 687B.025.

Sec. 28. NAC 687B.066 is hereby amended to read as follows:

687B.066 1. A ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ must include a provision which provides that, in the event of a lapse in coverage, coverage will be reinstated if:

(a) The insured provides proof of cognitive impairment ~~[;]~~ ***or loss of functional capacity before the grace period contained in the long-term care insurance contract or certificate expires;***

(b) The insured requests reinstatement of coverage within 5 months of the date of termination of coverage; and

(c) The insured pays any premiums which are past due.

2. For the purposes of subsection 1, the standard of proof of cognitive impairment ***or loss of functional capacity*** must not be more stringent than any criteria regarding cognitive impairment ***or loss of functional capacity*** used in the ~~[policy]~~ ***long-term care insurance contract*** or certificate to determine eligibility for benefits.

Sec. 29. NAC 687B.067 is hereby amended to read as follows:

687B.067 1. An application for a ~~[policy or certificate of]~~ long-term care insurance ***contract or certificate*** that is not guaranteed issue must contain clear and unambiguous questions designed to ascertain the condition of the applicant's health.

2. If an application for a ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ contains a question which asks whether the applicant has had medication prescribed by a physician, the applicant must be required to list any medication that has been prescribed. If an insurer knows, or should know, at the time of application that a medication listed by the applicant on the application is directly related to a medical condition for which

coverage would otherwise be denied, the insurer shall not later rescind the ~~[policy]~~ ***long-term care insurance contract*** or certificate for that condition.

3. Except for a ~~[policy]~~ ***long-term care insurance contract*** or certificate that is guaranteed issue:

(a) A statement in the following form must be set out conspicuously and in close proximity to the block for the applicant's signature on an application for a ~~[policy]~~ ***long-term care insurance contract*** or certificate ***:*** ~~[of long-term care insurance:]~~

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

(b) A statement in substantially the following form must be set out conspicuously on the ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ at the time of delivery:

Caution: The issuance of this [policy] [certificate] of long-term care insurance 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] [certificate]. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers is incorrect, contact the company at this address: [insert address].

(c) Prior to issuing a ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ to an applicant who is at least 80 years old, an insurer shall obtain one of the following:

(1) A report of a physical examination;

(2) An assessment of functional capacity;

(3) An attending physician's statement; or

(4) Copies of medical records.

Sec. 30. NAC 687B.068 is hereby amended to read as follows:

687B.068 An insurer shall deliver a copy of the completed application or enrollment form, whichever is applicable, to the insured no later than at the time of delivery of the ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ unless a copy is retained by the applicant at the time of application.

Sec. 31. NAC 687B.069 is hereby amended to read as follows:

687B.069 An insurer or other entity selling or issuing benefits for long-term care insurance shall maintain a record of all rescissions of its ~~[policies]~~ ***long-term care insurance contracts*** or certificates in this State or in any other state, except those which the insured voluntarily effectuated, and shall, on or before March 1 of each year, furnish this information to the Commissioner ~~[in the following format:~~

~~RESCISSION REPORTING FORM FOR POLICIES OR~~

~~CERTIFICATES OF LONG-TERM CARE INSURANCE~~

~~FOR THE STATE OF NEVADA~~

~~FOR THE REPORTING YEAR .....~~

~~Company Name: .....~~

~~Address: .....~~

~~.....~~

~~.....~~

~~Phone Number: .....~~

~~Due: March 1 annually~~

~~Instructions:~~

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

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

~~Detailed reason for rescission: .....~~

~~.....~~

~~.....~~

~~.....~~

~~.....~~

~~.....~~

~~Signature~~

~~.....~~

~~Name and Title (please type)~~

~~.....~~

~~Date]~~ ***using form NDOI-929, which is available from the Division, or a similar form approved by the Commissioner.***

Sec. 32. NAC 687B.070 is hereby amended to read as follows:

687B.070 A certificate issued pursuant to a ~~[policy of]~~ group long-term care insurance ***contract*** which is delivered or issued for delivery in this State must include:

1. A description of the principal benefits and coverage provided in the ~~[policy;]~~ ***group long-term care insurance contract;***

2. A statement of the principal exclusions, reductions and limitations contained in the ~~[policy;]~~ ***group long-term care insurance contract;*** and

3. A statement that the group master ~~[policy]~~ ***long-term care insurance contract*** determines governing contractual provisions.

Sec. 33. NAC 687B.075 is hereby amended to read as follows:

687B.075 1. An outline of coverage must be delivered to an applicant for a ~~[policy or certificate of]~~ long-term care insurance ~~[at the time of application.]~~ ***contract or certificate before the presentation of an application or enrollment form.*** In the case of direct-response solicitations, the insurer shall deliver the outline of coverage upon the applicant's request, or not later than at the time the ~~[policy]~~ ***long-term care insurance contract*** is delivered.

2. ***The Commissioner will prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage.***

3. Notwithstanding the provisions of subsection 1, for a long-term care insurance contract issued to a group described in subsection 1 of NAC 687B.025, an outline of coverage need not be delivered if all the information otherwise required to be included in an outline of coverage by subsection 4 is contained in other materials relating to enrollment. These other materials must be made available to the Commissioner upon request.

4. The outline of coverage must include:

(a) A description of the principal benefits and coverage provided in the ~~[policy;]~~ ***long-term care insurance contract;***

(b) A statement of the principal exclusions, reductions and limitations contained in the ~~[~~policy;~~]~~ ***long-term care insurance contract;***

(c) A statement of the renewal provisions, including any reservation in the ~~[~~policy~~]~~ ***long-term care insurance contract*** of a right to change premiums ~~[~~;~~]~~ and ***, for group coverage, specific descriptions of provisions for continuation or conversion;***

(d) A statement that the outline of coverage is a summary of the ~~[~~policy~~]~~ ***long-term care insurance contract*** issued or applied for, and that the ~~[~~policy~~]~~ ***long-term care insurance contract*** should be examined to determine governing contractual provisions ~~[~~.

~~3.]~~ ***;***

(e) A description of the terms under which the long-term care insurance contract or certificate may be returned and the premium may be refunded;

(f) A brief description of the relationship of the cost of care and benefits; and

(g) A statement that discloses to the policyholder or certificate holder whether the long-term care insurance contract is intended to be a federally tax-qualified long-term care insurance contract.

5. The outline of coverage must:

(a) Be a separate and complete document;

(b) Be printed in type no smaller than 10-point;

(c) Not include any material of an advertising nature; and

(d) Contain a statement in ~~[~~substantially~~]~~ the following form, set out conspicuously in the following format:

[COMPANY NAME]

[ADDRESS-CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

~~[~~[Policy]~~]~~ ***[Contract*** Number or Group Master ~~[~~Policy~~]~~ ***Contract*** and Certificate Number]

[Except for a ~~[~~policy~~]~~ ***contract*** or certificate that is guaranteed issue, the following statement of caution, or a substantially similar statement, must appear in the outline of coverage.]

Caution: The issuance of this ~~[~~[policy]~~]~~ ***[contract]*** [certificate] of long-term care insurance 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] ~~[.]~~ ***[will be attached to any issued contract] [will be enclosed with any issued contract].*** If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your ~~[~~[policy]~~]~~ ***[contract]*** [certificate]. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers is incorrect, contact the company at this address: [Insert address].

Notice to buyer: This contract 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 limitations in the contract.

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

2. ~~[This [policy] [certificate] [is] [is NOT] intended to be a qualified state long-term care insurance partnership contract.~~

~~3.]~~ PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the ~~[policy.]~~ ***contract.*** You should compare this outline of coverage to outlines of coverage for other ~~[policies]~~ ***contracts*** available to you. This is not a contract of insurance, but only a summary of coverage. Only the individual or group ~~[policy]~~ ***contract*** contains governing contractual provisions. This means that the ~~[policy]~~ ***contract*** or group ~~[policy]~~ ***contract*** 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]]~~ ***[CONTRACT]*** [CERTIFICATE] CAREFULLY!

~~[4.]~~ ***3.*** FEDERAL TAX CONSEQUENCES.

This ~~[[POLICY]]~~ ***[CONTRACT]*** [CERTIFICATE] is intended to be a federally tax-qualified long-term care insurance contract under 26 U.S.C. § 7702B(b).

OR

~~[Federal Tax Implications of this [POLICY] [CERTIFICATE.]]~~

This ~~[[POLICY]]~~ ***[CONTRACT]*** [CERTIFICATE] is not intended to be a federally tax-qualified long-term care insurance contract under 26 U.S.C. § 7702B(b). Benefits received under the ~~[[POLICY]]~~ ***[CONTRACT]*** [CERTIFICATE] may be taxable as income.

~~[5.]~~ ***4.*** TERMS UNDER WHICH THE ~~[[POLICY]]~~ ***[CONTRACT]*** [CERTIFICATE] MAY BE CONTINUED IN FORCE OR DISCONTINUED.

(a) [For a ~~[policy]~~ ***contract*** or certificate of long-term care insurance, describe one of the following permissible provisions regarding renewability of the policy or certificate:

(1) ~~[Policies]~~ ***Contracts*** and certificates that are guaranteed renewable must contain the following statement:] RENEWABILITY: THIS ~~[[POLICY]]~~ ***[CONTRACT]*** [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your ~~[[policy]]~~ ***[contract]*** [certificate], to continue this ~~[[policy]]~~ ***[contract]*** [certificate] as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your ~~[[policy]]~~ ***[contract]*** [certificate] on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) ~~[[Policies]~~ ***[Contracts*** and certificates that are noncancellable must contain the following statement:] RENEWABILITY: THIS ~~[[POLICY]]~~ ***[CONTRACT]*** [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your ~~[[policy]]~~ ***[contract]*** [certificate], to continue this ~~[[policy]]~~ ***[contract]*** [certificate] as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your ~~[[policy]]~~ ***[contract]*** [certificate] on its own and cannot change the premium you currently pay. However, if your ~~[[policy]]~~ ***[contract]*** [certificate] contains a feature to protect against inflation 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 the ~~[provisions]~~ ***basis*** for continuation ***of coverage*** and ***basis for*** conversion ***of coverage*** applicable to the certificate and group ~~[policy.]]~~ ***contract.]***

(c) [Describe the provisions regarding waiver of premium or state that there are no such provisions.]

~~[(d) State]~~

5. TERMS UNDER WHICH THE PREMIUM MAY CHANGE. [In bold type larger than the minimum 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 this right exists, describe clearly and concisely each circumstance under which the premium may change.]

6. TERMS UNDER WHICH THE ~~[[POLICY]]~~ ***[CONTRACT]*** [CERTIFICATE] MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [Provide a brief description of the right to return—the "free look" provision of the ~~[policy]~~ ***contract*** or certificate.]

(b) [Include a statement whether the ~~[policy]~~ ***contract*** or certificate contains provisions for a refund or partial refund of the premium upon the death of an insured or surrender of the ~~[policy]~~ ***contract*** or certificate. If the ~~[policy]~~ ***contract*** or certificate contains such provisions, include a description of them.]

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from the insurance company.

(a) [For agents] Neither [Company Name] nor its agents represent Medicare, the Federal Government or any state government.

(b) [For direct-response] [Company Name] is not representing Medicare, the Federal Government or any state government.

8. LONG-TERM CARE COVERAGE.

(a) ~~[Policies]~~ ***Contracts*** of this category are designed to provide coverage for one or more necessary or medically necessary services related to diagnostic, preventative, therapeutic, rehabilitative, maintenance or personal care, 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.

(b) This ~~[policy]~~ ***contract*** provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to [limitations] [waiting periods] and [requirements regarding coinsurance] set forth in the ~~[[policy]]~~ ***[contract]*** [certificate]. [Modify this paragraph if the ~~[policy]~~ ***contract*** or certificate is not a ~~[policy]~~ ***contract*** or certificate of indemnity.]

9. BENEFITS PROVIDED BY THIS ~~[[POLICY]]~~ ***[CONTRACT]*** [CERTIFICATE].

(a) [Describe covered services, related deductible(s), waiting periods, elimination periods and maximums of benefits.]

(b) [Describe institutional benefits, by skill level.]

(c) [Describe noninstitutional benefits, by skill level.]

~~[Any screening of benefits must be explained in this section. If screens differ for different benefits, an explanation of each screen should accompany a description of each benefit. 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. If screens or criteria concerning the insured's activities of daily living are used to measure the insured's need for long-term care, such criteria or screens must be explained.]~~

(d) Eligibility for Payment of Benefits

[Activities of daily living and cognitive impairment must be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage. Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanations of the triggers should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order for an insured to be eligible for benefits, this too must be specified.]

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Noneligible facility or provider;

(c) Noneligible levels of care (for example, unlicensed providers, care or treatment provided by a family member);

(d) Exclusions or exceptions; and

(e) Limitations.]

[This section should provide a brief, specific description of any provision in the ~~[policy]~~ ***contract*** or certificate which limits, excludes, restricts, reduces, delays or in any other manner operates to qualify payment of benefits for one or more necessary or medically necessary services related to diagnostic, preventative, therapeutic, rehabilitative, maintenance or personal care.]

THIS ~~[[POLICY]]~~ ***[CONTRACT]*** [CERTIFICATE] MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR NEEDS FOR LONG-TERM CARE.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of services related to long-term care 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 level of benefits will not increase over time;

(b) Any provisions regarding automatic adjustment of benefits;

(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 screening of health will be required, the frequency and amounts of the options for upgrading and any significant restrictions or limitations; and

(e) Describe whether there will be any additional charge in premiums imposed and **,** if so, how the additional charge will be calculated.]

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS. [State whether the ~~[[policy] [certificate]]~~ ***that the contract or certificate*** provides coverage for an insured clinically diagnosed as having Alzheimer's disease or a related degenerative and dementing illness. Specifically describe each screening of benefits or other provision in the ~~[policy]~~ ***contract*** or certificate that provides preconditions to the availability of benefits for such an insured.]

13. PREMIUM.

[(a) State the total annual premium for the ~~[policy.]~~ ***contract.***

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

14. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used.

(b) Describe other important features.]

15. CONTACT THE NEVADA STATE HEALTH INSURANCE ADVISORY PROGRAM OF THE AGING SERVICES DIVISION OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR ~~[POLICY]~~ ***CONTRACT*** OR CERTIFICATE.

~~[4.]~~ ***6.*** Text of the outline of coverage which is capitalized ~~[or italicized]~~ in the format set out in paragraph (d) of subsection ~~[3]~~ ***5*** may be emphasized in the outline of coverage by other means which provide prominence equivalent to capitalization ***.*** ~~[or italicizing.]~~

7. Use of the text and sequence of text of the format for an outline of coverage set forth in paragraph (d) of subsection 5 is mandatory unless otherwise specifically indicated in paragraph (d) of subsection 5.

Sec. 34. NAC 687B.076 is hereby amended to read as follows:

687B.076 1. An insurer shall not offer a ~~[policy of]~~ long-term care insurance ***contract*** unless the insurer also offers to the policyholder, in addition to any other protection from inflation, the option to purchase a ~~[policy]~~ ***long-term care insurance contract*** that provides for increasing levels of benefits and increasing maximum benefits at reasonable durations which

account for reasonably anticipated increases in the costs of services related to long-term care covered by the ~~[~~policy.~~]~~ ***long-term care insurance contract.*** An insurer shall offer to each policyholder, at the time of purchase, the option to purchase a ~~[~~policy~~]~~ ***long-term care insurance contract*** with a feature to protect against inflation that is no less favorable than one of the following:

(a) Increases levels of benefits annually in a manner so that the increases are compounded annually at a rate not less than 5 percent;

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

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

2. Except as otherwise provided in subsection 3, if the ~~[~~policy~~]~~ ***long-term care insurance contract*** is issued to a group, the insurer shall make the offer required by subsection 1 to the group policyholder.

3. If the ~~[~~policy~~]~~ ***long-term care insurance contract*** is issued to a group described in ***subsection 4 of*** NAC 687B.025, other than to a retirement community which provides continuing care, the insurer shall make the offer required pursuant to subsection 1 to each proposed ~~[~~holder of a~~]~~ certificate ~~[~~.~~]~~ ***holder.***

4. An insurer offering a ~~[policy of]~~ long-term care insurance ***contract*** shall include the following information in or with the outline of coverage:

(a) A comparison of the levels of benefits of a ~~[policy]~~ ***long-term care insurance contract*** that increases benefits over the ~~[policy]~~ ***contract*** period with a ~~[policy]~~ ***long-term care insurance contract*** that does not increase benefits. The comparison must be made through the use of graphs and must show the levels of benefits over a period of at least 20 years.

(b) Any expected increases in premiums or additional premiums to pay for automatic or optional increases in benefits.

➥ An insurer may use a reasonable hypothetical for the purpose of complying with the requirements of this subsection.

5. Increases in benefits under a ~~[policy]~~ ***long-term care insurance contract*** which provides for increased benefits to protect against inflation must continue without regard to an insured's age, status regarding claims or history of claims or the length of time the person has been insured under the ~~[policy.]~~ ***long-term care insurance contract.***

6. An offer of protection against inflation which provides for automatic increases in benefits must include an offer of a premium which the insurer expects to remain constant and must disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

7. A ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ must include protection against inflation as provided in subsection 1 unless the insurer obtains a rejection of protection against inflation signed by the policyholder. A rejection must be included as a part of the application and must state:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this ~~[policy]~~ ***contract*** with and without protection against inflation. Specifically, I have reviewed Plans ....., and I reject protection against inflation.

8. ***In addition to the other requirements of this section for protection against inflation, a partnership contract must also:***

(a) For a purchaser who has not attained 61 years of age as of the date of purchase, increase levels of benefits annually in a manner so that the increases are compounded annually at a rate of not less than 5 percent;

(b) For a purchaser who has attained 61 years of age but has not attained 76 years of age as of the date of purchase, contain some level of protection against inflation; and

(c) For a purchaser who has attained 76 years of age as of the date of purchase, give the purchaser an option for some level of protection against inflation.

9. The provisions of this section do not apply to ~~[a]~~ ***:***

(a) A policy of life insurance or a rider to a policy of life insurance that contains accelerated benefits for long-term care ~~[.]~~ ***; or***

(b) An annuity contract or a rider to an annuity contract that contains a contract of long-term care insurance which is not a federally tax-qualified long-term care insurance contract..

Sec. 35. NAC 687B.077 is hereby amended to read as follows:

687B.077 An insurer, health care plan or other entity who markets, directly or through its agents or other producers, long-term care insurance in this State shall:

1. Establish procedures regarding marketing to assure that any comparison of ~~[policies]~~ ***long-term care insurance contracts*** by its agents or other producers will be fair and accurate.

2. Establish procedures regarding marketing 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,]~~ ***long-term care insurance contract,*** a statement in substantially the following form:

> "Notice to buyer: This ~~[policy]~~ ***contract*** 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 limitations in the ~~[policy."]~~ ***contract."***

4. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has a policy for accidents and sickness or ***a*** long-term care insurance ***contract*** and the types and amounts of any such insurance ~~[.]~~ ***, except that no inquiry into existing policies for accidents and sickness needs to be made for a prospective applicant or enrollee for a qualified long-term care insurance contract.***

5. Establish auditable procedures for verifying compliance with this section.

6. At the time of solicitation, provide a written notice to the prospective policyholder or ~~[holder of a]~~ certificate ~~[:]~~ ***holder:***

(a) Informing him of the availability of a program which provides counseling to elderly persons concerning health insurance; and

(b) Providing the name, address and telephone number of the program.

7. Provide an applicant with copies of forms NDOI-949 and NDOI-953.

8. Provide an explanation of the contingent benefit upon lapse provided for in subsection 8 of section 32 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008, and, if applicable, the additional contingent benefit upon lapse provided to a long-term care insurance contract with a fixed or limited premium paying period provided for in subsection 9 of section 32 of LCB File No. R121-07.

Sec. 36. NAC 687B.078 is hereby amended to read as follows:

687B.078 An insurer, health care plan or other entity marketing long-term care insurance in this State, directly or through its agents or other producers, shall not use the terms "noncancellable" or "level premium" in reference to a ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ unless the ~~[policy]~~ ***long-term care insurance contract*** or certificate provides that the insured may continue the long-term care insurance by the timely payment of premiums during which period the insurer may not unilaterally make any change in any provision of the insurance or in the premium rate.

Sec. 37. NAC 687B.079 is hereby amended to read as follows:

687B.079 ***1.*** An insurer, health care plan or other entity marketing long-term care insurance in this State, directly or through its agents or other producers, shall not engage in the following acts or practices:

~~[1.]~~ ***(a)*** High pressure tactics, including:

~~[(a)]~~ ***(1)*** Any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright or threat, whether explicit or implied; and

~~[(b)]~~ ***(2)*** Undue pressure to purchase or recommend the purchase of insurance.

~~[2.]~~ ***(b)*** Directly or indirectly making use 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, commonly referred to as "cold lead advertising."

(c) Knowingly making any misleading representation or incomplete or fraudulent comparison of any contract of insurance or insurer for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow or convert any contract of insurance or to take out a contract of insurance with another insurer, commonly referred to as "twisting."

(d) Misrepresenting a material fact in selling or offering to sell a long-term care insurance contract.

2. The provisions of NRS 686A.010 to 686A.325, inclusive, apply to all long-term care insurance contracts.

Sec. 38. NAC 687B.080 is hereby amended to read as follows:

687B.080 A ~~[policy of]~~ long-term care insurance ***contract*** delivered or issued for delivery in this State may not use the following terms unless the terms are defined in the ~~[policy]~~ ***long-term care insurance contract*** as follows:

1. "Activities of daily living" must be defined as including, without limitation, bathing, continence, dressing, eating, toileting and transferring.

2. "Acute condition" must be defined as a condition making a person medically unstable and requiring frequent monitoring of the person by providers of health care, including ***, but not limited to,*** physicians and registered nurses, in order to maintain his status of health.

3. “Adult day care” must be defined as a program, for six or more persons, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired, elderly or disabled adults who can benefit from care in a group setting outside the home.

4. “Bathing” must be defined as washing oneself by sponge bath ~~[,]~~ ***or*** in a tub or ~~[in a]~~ shower, including, without limitation, the task of getting into or out of the tub or shower.

5. “Cognitive impairment” must be defined as a deficiency in:

(a) The short or long-term memory of the person;

(b) Orientation as to person, place and time;

(c) Deductive or abstract reasoning; or

(d) Judgment as it relates to safety awareness.

6. “Continence” must be defined as:

(a) The ability of a person to maintain control of bowel and bladder function; or

(b) If a person is unable to maintain control of bowel or bladder function, the ability of a person to perform associated personal hygiene, including, without limitation, caring for a catheter or colostomy bag.

7. “Dressing” must be defined as putting on and taking off all items of clothing, including, without limitation, any necessary braces, fasteners or artificial limbs.

8. “Eating” must be defined as feeding oneself by getting food into the body, including, without limitation:

(a) From a receptacle, including, without limitation, a plate, cup or table;

(b) By feeding tube; or

(c) Intravenously.

9. "Hands-on assistance" must be defined as physical assistance without which the person would not be able to perform the activity of daily living.

10. ***"Home health care services" must be defined as medical and nonmedical services provided to ill, disabled or infirm persons in their residences. Covered services may include the services of a homemaker, assistance with activities of daily living and respite care.***

11. "Medicare" must be defined as:

(a) "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended";

(b) "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

(c) Any words of similar import.

~~[11.]~~ ***12.*** "Mental or nervous disorder" must not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or a mental or emotional disease or disorder.

~~[12.]~~ ***13. "Personal care" must be defined as the provision of hands-on services to assist a person with activities of daily living.***

14. "Provider of services," including, without limitation, a "skilled nursing facility," "extended care facility," "intermediate care facility," "convalescent nursing home," "personal care facility ~~[" or]~~ ***," "specialized care provider," "assisted living facility" and*** "home care agency" must be defined in relation to the services and facilities required to be available and the level of the licenses ***, certificates, registrations*** or degrees required for persons providing or supervising the services. ~~[The definition may require]~~ ***If the definition requires*** that the provider be appropriately licensed ***,*** ~~[or]~~ certified ~~[.]~~ ***or registered, the definition must also set forth the***

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

~~[13. "Services related to home health care" must be defined as medical and nonmedical services provided to ill, disabled or infirm persons in their residences. Covered services may include the services of a homemaker, assistance with activities of daily living and respite care.~~

~~14. "Services related to personal care" must be defined as the provision of personal services to assist a person with activities of daily~~ ~~living, including, but not limited to, bathing, eating, dressing and toileting.]~~

15. "Skilled nursing care," "intermediate care," ~~["personal care,"]~~ ***"specialized care," "assisted living care,"*** "home care" and any other care received must be defined in relation to the level of skill required, the nature of the care and the setting in which the care must be provided.

16. "Toileting" must be defined as:

(a) Getting to and from the toilet;

(b) Getting on and off the toilet; and

(c) Performing associated personal hygiene.

17. "Transferring" must be defined as moving into or out of a bed, chair or wheelchair.

Sec. 39. NAC 687B.085 is hereby amended to read as follows:

687B.085 1. The terms "guaranteed renewable" and "noncancellable" may not be used in any individual ~~[policy of]~~ long-term care insurance ***contract*** without further explanatory language conforming to the disclosure requirements of NAC 687B.100.

2. No individual ~~[policy of]~~ long-term care insurance ***contract*** may contain renewal provisions other than "guaranteed renewable" or "noncancellable."

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

4. The term "noncancellable" may be used only when the insured has the right to continue the long-term care insurance 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.

5. The term "level premium" may be used only when the insurer has no right to change the premium.

6. In addition to the other requirements of this section, a qualified long-term care insurance contract must be guaranteed renewable in conformance with the provisions of 26 U.S.C. § 7702B(b)(1)(c).

Sec. 40. NAC 687B.090 is hereby amended to read as follows:

687B.090 1. A ~~[policy of]~~ ***long-term care*** insurance ***contract*** may not be delivered or issued for delivery in this State as long-term care insurance if the ~~[policy]~~ ***long-term care insurance contract*** limits or excludes coverage by type of illness, treatment, medical condition or accident, except for:

(a) Preexisting conditions or diseases.

(b) Mental or nervous disorders ***.*** ~~[, except for the exclusion or]~~ ***This exception does not allow a*** limitation of benefits ***or exclusion of coverage*** on the basis of Alzheimer's Disease.

(c) Alcoholism and drug addiction.

(d) Any illness, treatment or medical condition arising out of:

(1) A war or an act of war, whether declared or undeclared.

(2) Participation in a felony, riot or insurrection.

(3) Service in the Armed Forces or units auxiliary thereto.

(4) Suicide, attempted suicide or intentionally self-inflicted injury.

(5) Aviation. This exclusion applies only to passengers who do not pay fares.

(e) Treatment provided in a governmental facility, unless otherwise required by law, services for which benefits are available under Medicare or another governmental program, except Medicaid, and treatment received pursuant to any state or federal program for workmens' compensation, employer's liability or occupational disease.

(f) Treatment provided pursuant to any law governing no-fault insurance for motor vehicles.

(g) Services provided by a member of the insured person's immediate family.

(h) Services for which no charge is normally made in the absence of insurance.

(i) Services or items available from or paid by another long-term care insurance contract.

(j) In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Medicare or would be so reimbursable but for the application of a deductible or coinsurance amount.

2. This section does not prohibit ~~[the exclusion or limitation of coverage by type of provider or]~~ territorial limitations.

3. ***Notwithstanding the provisions of subsection 2, no issuer of long-term care insurance may deny a claim because services are provided in a state other than the state in which the long-term care insurance contract or certificate was issued when the state in which services are provided:***

(a) Does not license, certify or register providers as required in the long-term care insurance contract or certificate, but the provider otherwise satisfies the requirements of the long-term care insurance contract or certificate; or

(b) Licenses, certifies or registers providers under another name.

4. For the purposes of this section, "preexisting condition" means a medical condition of a person for which he has received treatment during the 6 months preceding the effective date of the ~~[policy.]~~ ***long-term care insurance contract.***

Sec. 41. NAC 687B.095 is hereby amended to read as follows:

687B.095 1. Any termination of long-term care insurance must be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination.

2. Such an extension of benefits beyond the period the long-term care insurance is 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 waiting period contained in the ~~[policy]~~ ***long-term care insurance contract*** or any other applicable provision of the ~~[policy.]~~ ***long-term care insurance contract.***

3. An insurer or similar organization issuing a group ~~[policy of]~~ long-term care insurance ***contract*** shall include in the group ~~[policy:]~~ ***long-term care insurance contract:***

(a) ~~[A provision]~~ ***The basis*** for continuation of coverage; or

(b) ~~[A provision]~~ ***The basis*** for conversion of coverage.

4. A group ~~[policy of]~~ long-term care insurance ***contract*** which restricts the provision of benefits and services to certain providers or facilities or which contains incentives to use certain providers or facilities may comply with subsection 3 by containing a provision for the continuation of coverage under a ~~[policy]~~ ***long-term care insurance contract*** which provides benefits which are substantially equivalent to the benefits of the existing group ~~[policy.]~~ ***long-term care insurance contract.*** The Commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, may take into consideration the differences between plans with and without managed care, ***including, but not limited to,*** the arrangement of providing benefits under the plans, the availability of service under the plans, the levels of benefits under the plans and the administrative complexity of the plans.

5. As used in this section, "plan with managed care" means an arrangement for health care or assisted living designed to coordinate care of patients or to control costs through a system that provides, at a minimum, for review of the necessity and appropriateness of the allocation of health care resources and services provided or proposed to be provided to an insured, through management of cases or through use of specific networks of providers.

Sec. 42. NAC 687B.100 is hereby amended to read as follows:

687B.100 1. An individual ~~[policy of]~~ long-term care insurance ***contract*** must contain a provision for renewability ~~[.]~~ ***unless the long-term care insurance contract provides that the right not to renew is reserved solely to the policyholder.*** Such a provision must be appropriately captioned, appear on the first page of the ~~[policy,]~~ ***long-term care insurance contract,*** and clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the ~~[policy]~~ ***long-term care insurance contract*** is issued and for which it may be

renewed. ***If the long-term care insurance contract is not of limited duration, the provision must also clearly state that the coverage is either guaranteed renewable or noncancellable, as appropriate.***

2. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual ~~[policy of]~~ long-term care insurance ~~[,]~~ ***contract,*** all riders or endorsements added to an individual ~~[policy of]~~ long-term care insurance ***contract*** after the date the ~~[policy]~~ ***long-term care insurance contract*** is issued or when the ~~[policy]~~ ***long-term care insurance contract*** is reinstated or renewed, which reduce or eliminate benefits or coverage in the ~~[policy]~~ ***long-term care insurance contract*** must be ***agreed to in writing and*** signed by the insured. After the date the ~~[policy]~~ ***long-term care insurance contract*** is issued, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the term of the ~~[policy]~~ ***long-term care insurance contract*** must be agreed to in writing ***and signed*** by the insured, unless the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charged must be set forth in the ~~[policy,]~~ ***long-term care insurance contract,*** rider or endorsement.

3. A ~~[policy of]~~ long-term care insurance ***contract*** which provides for the payment of benefits based on standards described as “usual and customary,” “reasonable and customary” or words of similar import must include a definition and explanation of those terms in its accompanying outline of coverage.

4. If a ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ contains any limitations with respect to preexisting conditions, the limitations must

appear as a separate paragraph of the ~~[policy]~~ ***long-term care insurance contract*** or certificate and be labeled as "Preexisting Condition Limitations."

5. If a ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ contains any limitations or conditions with respect to eligibility other than those prohibited pursuant to NAC 687B.116, a statement concerning the limitations or conditions must appear as a separate paragraph of the ~~[policy]~~ ***long-term care insurance contract*** or certificate, must be labeled as "Limitations or Conditions on Eligibility for Benefits" and must include a description of the limitations or conditions, including information regarding any required number of days of confinement.

6. If a policy of life insurance or a rider on a policy of life insurance provides accelerated benefits for long-term care, at the time of application for the policy or rider, a statement disclosing that receipt of accelerated benefits may be taxable and that assistance should be sought from a ~~[consultant on taxes]~~ ***personal tax advisor*** must be prominently displayed on the first page of the policy or rider and any other related documents. When a request for payment of accelerated benefits is submitted, a copy of the statement disclosing that receipt of accelerated benefits may be taxable and that assistance should be sought from a ~~[consultant on taxes]~~ ***personal tax advisor*** must be provided to the insured. ***This subsection does not apply to a qualified long-term care insurance contract.***

7. If a qualified annuity contract or a rider on a qualified annuity contract contains benefits for long-term care insurance, at the time of application for the contract or rider, a statement disclosing that receipt of long-term care benefits may be taxable and that assistance should be sought from a personal tax advisor must be prominently displayed on the first page of the contract or rider and any other related documents. When a request for payment of long-

term care benefits is submitted, a copy of the statement disclosing that receipt of long-term care benefits may be taxable and that assistance should be sought from a personal tax advisor must be provided to the insured.

8. If a nonqualified annuity contract or a rider on a nonqualified annuity contract contains nonqualified benefits for long-term care insurance, at the time of application for the contract or rider, a statement disclosing that receipt of long-term care benefits may be taxable and that assistance should be sought from a personal tax advisor must be prominently displayed on the first page of the contract or rider and any other related documents. When a request for payment of long-term care benefits is submitted, a copy of the statement disclosing that receipt of long-term care benefits may be taxable and that assistance should be sought from a personal tax advisor must be provided to the insured. The provisions of this subsection do not apply to a qualified long-term care insurance contract.

9. An individual long-term care insurance contract, other than one for which the insurer has no right to change the premium, must include a provision stating that premium rates may change.

Sec. 43. NAC 687B.105 is hereby amended to read as follows:

687B.105 No ~~[policy of]~~ long-term care insurance ***contract*** may:

1. Be cancelled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured or the ~~[holder of the]~~ certificate ~~[,]~~ ***holder;***

2. Contain a provision establishing a new waiting period if existing coverage is converted to or replaced by a new form within the same company, except with respect to an increase in benefits voluntarily selected by the insured or group policyholder; or

3. Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care provided in a facility than coverage for lower levels of care.

Sec. 44. NAC 687B.108 is hereby amended to read as follows:

687B.108 ***1.*** The premium charged to an insured for long-term care insurance must not increase because of:

~~[1.]~~ ***(a)*** The increasing age of the insured beyond ~~[age 65;]~~ ***65 years of age;*** or

~~[2.]~~ ***(b)*** The duration the insured has been covered under the policy.

2. The purchase of additional coverage must not be considered a premium rate increase, but for calculation purposes, the portion of the premium attributable to the additional coverage must be added to and considered part of the initial annual premium.

3. A reduction in benefits must not be considered a premium change, but for calculation purposes, the initial annual premium must be based on the reduced benefits.

Sec. 45. NAC 687B.111 is hereby amended to read as follows:

687B.111 1. A ~~[policy]~~ ***long-term care insurance contract*** or certificate ***,*** ~~[of long-term care insurance,]~~ other than a ~~[policy]~~ ***long-term care insurance contract*** or certificate issued to a group described in subsection 1 of NAC 687B.025, may not:

(a) Define "preexisting condition" in a more restrictive manner than as a condition for which medical advice or treatment was recommended by, or received from a provider of health care within the 6 months preceding the effective date of coverage of the insured.

(b) Exclude coverage for a loss or confinement which is the result of a preexisting condition unless the loss or confinement begins within the 6 months following the effective date of coverage of the insured.

2. An insurer may use an application form designed to elicit the complete medical history of an applicant, and, on the basis of the answers on that application, underwrite a ~~[policy of insurance]~~ ***long-term care insurance contract*** in accordance with that insurer's established underwriting standards. Unless otherwise provided in the ~~[policy]~~ ***long-term care insurance contract*** or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in paragraph (b) of subsection 1 expires. A ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ may not exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in that paragraph.

3. The Commissioner may extend the periods of limitation set forth in subsection 1 for specific age group categories in specific policy forms upon finding that the extension is in the best interest of the public.

Sec. 46. NAC 687B.113 is hereby amended to read as follows:

687B.113 1. Except as otherwise provided in this section, a shopper's guide to long-term care insurance must be furnished to each prospective applicant. In the case of a group ~~[policy,]~~ ***contract,*** the guide may be delivered to the policyholder for distribution to the certificate holders. The guide must be one developed and approved by the Commissioner or must be in the format developed by the National Association of Insurance Commissioners.

2. An agent who is soliciting an application for long-term care insurance in person shall furnish the prospective applicant with the shopper's guide before giving him an application or enrollment form. In the case of a direct-response solicitation, the shopper's guide must be

~~[furnished upon request, but in any event not later than the time the policy is issued.]~~ ***presented in conjunction with any application or enrollment form.***

3. An insurer who offers a life insurance policy or rider that contains accelerated long-term care benefits is not required to furnish the shopper's guide, but shall furnish the ~~[outline of coverage required by NAC 687B.075]~~ ***policy summary required by section 9 of this regulation*** within the time provided by that section.

Sec. 47. NAC 687B.114 is hereby amended to read as follows:

687B.114 1. A professional, trade or occupational association, as described in subsection 2 of NAC 687B.025, which endorses or sells long-term care insurance to its members, shall educate its members concerning general issues involving long-term care so that its members can make informed decisions regarding the long-term care insurance.

2. The professional, trade or occupational association shall provide objective information regarding ~~[policies]~~ ***long-term care insurance contracts*** or certificates ~~[of long-term care]~~ endorsed or sold by the association and ensure that members of the association receive a complete explanation of the features in the ~~[policies]~~ ***long-term care insurance contracts*** or certificates that are being endorsed or sold.

3. The professional, trade or occupational association shall disclose in any solicitation for long-term care insurance:

(a) The specific nature and amount of compensation, including all fees, commissions and other forms of financial support, that the association receives from endorsement or sale of ~~[policies]~~ ***long-term care insurance contracts*** or certificates to its members; and

(b) A brief description of the process under which such ~~[policies]~~ ***contracts*** and the insurer issuing such ~~[policies]~~ ***contracts*** were selected.

4. If a professional, trade or occupational association and an insurer have common ownership or management, the association shall disclose that fact to its members.

5. The board of directors of a professional, trade or occupational association which sells or endorses ~~[~~policies~~]~~ ***long-term care insurance contracts*** or certificates ~~[~~of long-term care insurance~~]~~ shall review and approve the ~~[~~policies~~]~~ ***long-term care insurance contracts*** and the agreement regarding compensation it receives from endorsement or sale of ~~[~~policies~~]~~ ***long-term care insurance contracts*** or certificates to its members.

6. A professional, trade or occupational association shall:

(a) Actively monitor the efforts regarding marketing of the insurer and its agents or other producers; ~~[~~and~~]~~

(b) Review and approve all marketing materials or other communications regarding ~~[~~policies~~]~~ ***long-term care insurance contracts*** or certificates ~~[~~of long-term care insurance~~]~~ used to promote sales or sent to members ~~[~~.~~]~~ ***; and***

(c) At the time that the association decides to endorse long-term care insurance, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the long-term care insurance contracts, including their benefits, features and rates, and update the examination thereafter in the event of material change.

➥ The provisions of this subsection do not apply to a qualified long-term care insurance contract.

7. Any insurer who offers long-term care insurance that is endorsed or sold by a professional, trade or occupational association shall file with the Division:

(a) The long-term care insurance contract or certificate;

(b) A corresponding outline of coverage; and

(c) All advertisements requested by the Division.

Sec. 48. NAC 687B.115 is hereby amended to read as follows:

687B.115 1. An insurer shall not issue a group ~~[policy or certificate of]~~ long-term care insurance ***contract or certificate*** to a professional, trade or occupational association unless the insurer files with the Division ~~[the following material:~~

~~(a) The policy or certificate; and~~

~~(b) A corresponding outline of coverage.]~~ ***any materials required by this section or NAC 687B.114.***

2. An insurer shall not issue a ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ to a professional, trade or occupational association, or continue to market such a ~~[policy]~~ ***contract*** or certificate, unless the insurer certifies on or before December 31 of each year that the association has complied with the requirements set forth in NAC 687B.114.

3. Failure to comply with the requirements regarding filing and certification contained in this section constitutes an undefined unfair trade practice pursuant to NRS 686A.170.

Sec. 49. NAC 687B.116 is hereby amended to read as follows:

687B.116 1. A ~~[policy of]~~ long-term care insurance ***contract*** delivered or issued for delivery in this State may not:

(a) Condition any benefit upon the hospitalization of the insured;

(b) Condition any benefit for an insured who is institutionalized upon his receiving a higher level of institutional care; or

(c) Condition any benefit, other than a waiver of premium or benefits for postconfinement care, postacute care or any recuperative benefit, upon the institutionalization of the insured.

2. If a ~~[policy]~~ ***long-term care insurance contract*** conditions coverage for noninstitutional care upon the receipt of institutional care, the required period of institutional care must not exceed 30 days.

Sec. 50. NAC 687B.117 is hereby amended to read as follows:

687B.117 1. A ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ that provides benefits for services related to home health care or community care must not limit or exclude benefits:

(a) By requiring that the insured or claimant would need care in a skilled nursing facility if services related to home health care were not provided;

(b) By requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services in a home, community or institutional setting before services related to home health care are covered;

(c) By limiting eligible services provided by registered nurses or licensed practical nurses;

(d) By requiring that a nurse or therapist provide services covered by the ~~[policy]~~ ***long-term care insurance contract*** that can be provided by a home health aide, or other licensed or certified person providing home health care acting within the scope of his licensure or certification;

(e) By excluding coverage for services related to personal care provided by a home health aide;

(f) By requiring that the provision of services related to home health care be at a level of certification or licensure greater than that required by the eligible service;

(g) By requiring that the insured or claimant have an acute condition before services related to home health care are covered;

(h) By limiting benefits to services provided by agencies or providers certified by Medicare; or

(i) By excluding coverage for services related to adult day care.

2. Except as otherwise provided in subsection 3, a ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ that provides for services related to home health care or community care must provide total coverage for home health care or community care in an amount equivalent in dollars to at least one-half of 1 year's benefits for care received in a nursing home pursuant to the coverage available under the ~~[policy]~~ ***long-term care insurance contract*** or certificate at the time covered services related to home health care or community care are being received.

3. The provisions of subsection 2 do not apply to a ~~[policy]~~ ***long-term care insurance contract*** or certificate issued to a resident of a retirement community which provides continuing care.

4. For the purpose of determining the maximum coverage under the terms of the ~~[policy]~~ ***long-term care insurance contract*** or certificate, coverage for home health care may be applied to the benefits provided in the ~~[policy]~~ ***long-term care insurance contract*** or certificate for care other than home health care.

Sec. 51. NAC 687B.118 is hereby amended to read as follows:

687B.118 Each ~~[policy of]~~ long-term care insurance ***contract*** which provides coverage for postconfinement care, postacute care or recuperative services, and each certificate issued under such a ~~[policy,]~~ ***contract,*** must contain a prominent statement of any limitations or conditions ~~[upon]~~ ***on eligibility for*** these benefits. The statement:

1. Must be contained in a separate paragraph of the ~~[policy]~~ ***long-term care insurance contract*** or certificate entitled “limitations or conditions on benefits”; and

2. Must specify the length in days of any period that the insured is required to be confined in an institution as a condition of receiving these benefits.

Sec. 52. NAC 687B.119 is hereby amended to read as follows:

687B.119 1. When benefits for long-term care are provided through the acceleration of benefits under a group or an individual policy of life insurance or a rider to that policy, the reserves for the benefits must be determined in accordance with the provisions of paragraph (g) of subsection 2 of NRS 681B.120. Reserves for a claim must also be established when a policy or rider is in claim status.

2. Reserves for policies and riders subject to the provisions of ~~[this section]~~ ***subsection 1*** must be based on a multiple decrement model using all relevant decrements except those for rates for voluntary termination. An approximation based upon a single decrement model may be used if the calculation produces similar reserves as the multiple decrement model, the reserves are more conservative than the multiple decrement model or the reserves are immaterial. The calculation may take into account the reduction in benefits for life insurance as the result of payment of benefits for long-term care. However, the reserves for the benefit for long-term care and the benefit for life insurance must not be less than the reserves for the benefit for life insurance assuming no benefit for long-term care.

3. In the development and calculation of reserves for policies and riders subject to the provisions of ~~[this section,]~~ ***subsection 1,*** consideration must be given to the applicable provisions of the policy, ***marketing methods,*** administrative procedures and all other factors which have an impact on projected costs of claims, including, but not limited to, the following:

(a) Definition of insured events;

(b) Covered facilities for long-term care;

(c) Existence of coverage for convalescent care at home;

(d) Definition of facilities;

(e) Existence or absence of barriers to eligibility;

(f) Provisions regarding waiver of premiums;

(g) Renewability;

(h) Ability to raise premiums;

(i) Methods of marketing;

(j) Procedures regarding underwriting;

(k) Procedures regarding adjustment of claims;

(l) Waiting periods;

(m) Maximum benefits;

(n) Availability of eligible facilities;

(o) Margins in costs of a claim;

(p) Optional nature of benefits;

(q) Delay in eligibility for benefits;

(r) Provisions regarding protection against inflation; and

(s) Option of guaranteed insurability.

➥ Any valuation table for morbidity consulted in the development and calculation of reserves must be certified as appropriate as a statutory valuation table by a ~~[member of the American Academy of Actuaries.]~~ ***qualified health actuary.***

4. When benefits for long-term care are provided other than by the method described in subsection 1, reserves must be determined using a table that is:

(a) Established by a qualified ***health*** actuary for the purpose of setting reserves; and

(b) Acceptable to the Commissioner.

5. As used in this section, "multiple decrement model" means a model in which people in a defined status at any age are subject to more than one contingency at the next age.

6. As used in this section, "single decrement model" means a model in which people in a defined status at any age are subject to only one contingency during the next age.

Sec. 53. NAC 687B.121 is hereby amended to read as follows:

687B.121 1. For ~~[an individual policy of]~~ ***a*** long-term care insurance ~~[issued before October 1, 2008,]~~ ***contract or certificate to which subsection 2 does not apply,*** the Commissioner shall deem the benefits reasonable in relation to premiums charged if the expected loss ratio is at least 60 percent, calculated in a manner which provides for the adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration will be given to all relevant factors, including:

(a) The statistical credibility of incurred claims experience and earned premiums;

(b) The period for which rates are computed to provide coverage;

(c) Experienced and projected trends;

(d) The concentration of experience within early ~~[policy]~~ ***contract*** duration;

(e) Expected claim fluctuation;

(f) Experience refunds, adjustments or dividends;

(g) Renewability features;

(h) All appropriate expense factors;

(i) Interest;

(j) The experimental nature of the coverage;

(k) ~~[Policy]~~ ***Contract*** reserves;

(l) The mix of business by risk classification; and

(m) Product features such as long elimination periods, high deductibles and high maximum limits.

2. For a policy of life insurance or a rider to a policy of life insurance that contains accelerated benefits for long-term care, the Commissioner shall deem the benefits reasonable in relation to the premiums charged if:

(a) The interest credited internally to determine cash value accumulations, including long-term care, 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;

(b) The portion of the policy that provides benefits for life insurance meets the nonforfeiture requirements of NRS 688A.290 to 688A.360, inclusive;

(c) The policy meets the disclosure requirements of NAC 687B.075 , ***section 9 of this regulation*** and ~~[section]~~ ***sections 6 and*** 8 of ~~[this regulation;]~~ ***LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008;***

(d) Any policy illustration provided satisfies the requirements of NAC 686A.460 to 686A.479, inclusive; and

(e) An actuarial memorandum is filed with, and approved by, the Commissioner that includes, without limitation:

(1) A description of the basis on which the long-term care rates are determined;

(2) A description of the basis for the reserves;

(3) A summary of the type of policy, benefits, provisions for renewal, general marketing method and limits on ages of issuance;

(4) A description and a table of each actuarial assumption used and, for expenses, the percent of premium dollars per policy and dollars per unit of benefits;

(5) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(6) The estimated average annual premium per policy and the average issue age;

(7) A statement which:

(I) Must indicate whether underwriting is performed at the time of application;

(II) If underwriting is performed at the time of application, must include a description of the type or types of underwriting used; and

(III) If the policy is a policy of group long-term care insurance, must indicate whether the enrollee or any dependent will be underwritten and when such underwriting occurs; and

(8) A description of the effect of the long-term care benefits on the required premiums, nonforfeiture values and reserves on the underlying policy of life insurance, both for active lives and those in long-term care claim status.

3. For an annuity contract that pays for benefits for long-term care entirely by accessing the contract value, the Commissioner shall deem the benefits reasonable in relation to the premium charged if:

(a) The interest credited internally to determine cash value accumulations, including long-term care, are guaranteed not to be less than the minimum guaranteed interest rate for cash-value accumulations without long-term care set forth in the contract;

(b) The portion of the contract that provides benefits for long-term care meets the nonforfeiture requirements of NRS 688A.361 to 688A.369, inclusive;

(c) The contract meets the disclosure requirements of NAC 687B.075 and section 8 of ~~[this regulation;]~~ ***LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008;*** and

(d) An actuarial memorandum is filed with, and approved by, the Commissioner that includes, without limitation:

(1) A description of the basis on which the long-term care rates are determined;

(2) A description of the basis for the reserves;

(3) A summary of the type of contract, benefits, provisions for renewal, general marketing method and limits on ages of issuance;

(4) A description and a table of each actuarial assumption used and, for expenses, the percent of premium dollars per contract and dollars per unit of benefits;

(5) A description and a table of the anticipated contract reserves and additional reserves to be held in each future year for active lives;

(6) The estimated average annual premium per contract and the average issue age;

(7) A statement which:

(I) Must indicate whether underwriting is performed at the time of application; and

(II) If underwriting is performed at the time of application, must include a description of the type or types of underwriting used; and

(8) A description of the effect of the long-term care benefits on the required premiums, nonforfeiture values and reserves on the underlying annuity contract, both for active lives and those insureds who are receiving benefits for long-term care.

4. Subsections 1 and 2 do not apply to a long-term care insurance contract or certificate if section 13 of this regulation or section 19 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008, applies to the long-term care insurance contract or certificate.

5. Subsection 3 applies to any annuity contract or rider on an annuity contract which contains benefits for long-term care insurance and which was issued on or after October 1, 2008.

Sec. 54. NAC 687B.122 is hereby amended to read as follows:

687B.122 1. A written application by an insured for a converted policy must be made, and the first premium due, if any, must be paid as directed by the insurer within 31 days of the date of termination of coverage under a group ~~[policy of]~~ long-term care insurance ~~[.]~~ ***contract.*** The converted policy must be issued effective on the day following the termination of coverage under the group ~~[policy]~~ ***long-term care insurance contract*** and must be renewable annually.

2. Unless the group ~~[policy]~~ ***long-term care insurance contract*** from which conversion is made replaced previous group coverage, the premium for the converted policy must be calculated on the basis of the insured's age at inception of coverage under the group ~~[policy]~~ ***long-term care insurance contract*** from which conversion is made. If the group ~~[policy]~~ ***long-term care insurance contract*** from which conversion is made replaced previous group coverage, the premium for the converted policy must be calculated on the basis of the insured's age at inception of coverage under the initial group ~~[policy]~~ ***long-term care insurance contract*** that was replaced.

3. Upon termination of coverage under a group ~~[policy,]~~ ***long-term care insurance contract,*** the insurer shall provide each insured continuation of coverage or shall issue each insured a converted policy unless:

(a) Termination of group coverage resulted from the failure to make any required payment of premium or contribution when due; or

(b) Within 31 days from the date of termination of coverage, the ~~[policy]~~ ***long-term care insurance contract*** is replaced by a group ~~[policy:]~~ ***long-term care insurance contract:***

(1) Effective on the day following the date of termination of coverage.

(2) The premium for which is calculated as set forth in subsection 2.

(3) Providing benefits identical to, or benefits determined by the Commissioner to be substantially equivalent to, or in excess of, those provided by the previous ~~[policy.]~~ ***long-term care insurance contract.***

4. A converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group ~~[policy]~~ ***long-term care insurance contract*** from which conversion is made, must not exceed those that would have been payable had the person's coverage under the group ~~[policy]~~ ***long-term care insurance contract*** remained in force and effect.

5. Notwithstanding any other provision of this section, a converted policy issued to a person who at the time of conversion is covered by another ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. The provision

may be included in the converted policy only if the converted policy also provides for a decrease in the premium or a refund of a part of the premium which reflects the reduction in benefits payable.

6. Notwithstanding any other provision of this section, an insured individual whose eligibility for group long-term care coverage is based upon his relationship to another person is entitled to continuation of coverage under the group ~~[policy]~~ ***long-term care insurance contract*** upon termination of the qualifying relationship by death or dissolution of marriage.

Sec. 55. NAC 687B.125 is hereby amended to read as follows:

687B.125 Application forms for individual ~~[policies of]~~ long-term care insurance ***contracts*** must include the following questions designed to elicit information as to whether the proposed ~~[policy]~~ ***long-term care insurance contract*** is intended to replace any other ~~[policy]~~ ***contract*** for accidents and sickness or long-term care insurance ***contract*** presently in force:

TO BE COMPLETED BY THE APPLICANT

1. Do you currently have another ~~[policy]~~ ***contract*** or certificate of long-term care insurance in force (including a contract for health care services or a contract with a health maintenance organization)?

2. Have you had another ~~[policy]~~ ***contract*** or certificate of long-term care insurance in force during the last 12 months? If so, please answer questions (a) and (b).

(a) With what company was your ~~[policy]~~ ***contract*** or certificate?

(b) If your ~~[policy]~~ ***contract*** or certificate lapsed, when did it lapse?

3. Do you currently have coverage under Medicaid?

4. Do you intend to replace any of your current medical or health insurance coverage with this ~~[[policy]]~~ ***[contract]*** [certificate]?

TO BE COMPLETED BY THE AGENT

1. Have you sold any other ~~[policy]~~ ***contract*** of health insurance to this applicant? If so, please answer questions 2 and 3.

2. List each ~~[policy]~~ ***contract*** you have sold to the applicant that is still in force.

3. List each ~~[policy]~~ ***contract*** you have sold to the applicant within the past 5 years that is no longer in force.

A supplementary application or other form to be signed by the applicant and ***, if the coverage is sold by an agent,*** the agent ***,*** containing such questions may be used. ***For a replacement long-term care insurance contract issued to a group described in subsection 1 of NAC 687B.025, the questions may be modified only to the extent necessary to elicit information about contracts for health insurance or long-term care insurance contracts other than the group long-term care insurance contract being replaced, if the certificate holder has been notified of the replacement.***

Sec. 56. NAC 687B.127 is hereby amended to read as follows:

687B.127 1. If a ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ replaces another ~~[policy]~~ ***long-term care insurance contract*** or certificate ***,*** ~~[of long-term care insurance,]~~ the insurer replacing the ~~[policy]~~ ***long-term care insurance contract*** or certificate shall waive any period of time applicable to preexisting conditions and

probationary periods in the new ~~[policy]~~ ***long-term care insurance contract*** or certificate for similar benefits to the extent that similar ~~[exclusions]~~ ***periods*** have been satisfied under the original ~~[policy.]~~ ***long-term care insurance contract or certificate.***

2. Where replacement of the ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ is intended, the insurer replacing the ~~[policy]~~ ***long-term care insurance contract*** or certificate shall notify, in writing, the existing insurer of the proposed replacement. The insurer replacing the ~~[policy]~~ ***long-term care insurance contract*** or certificate shall identify the existing ~~[policy]~~ ***long-term care insurance contract*** or certificate by the name of the insurer, the name of the insured and either the number of the ~~[policy]~~ ***long-term care insurance contract*** or certificate or the address of the insured, including the zip code. The written notice must be given not less than 5 working days before the date the application is received by the insurer or the date the ~~[policy]~~ ***long-term care insurance contract*** is issued, whichever is sooner.

3. If a life insurance policy that accelerates benefits for long-term care replaces the coverage of a long-term care insurance contract, the insurer shall comply with the provisions of NAC 687B.125 to 687B.140, inclusive. If a life insurance policy that accelerates benefits for long-term care replaces the coverage of a life insurance policy, the insurer shall comply with the replacement requirements of NAC 686A.510 to 686A.570, inclusive. If a life insurance policy that accelerates benefits for long-term care replaces another life insurance policy that accelerates benefits for long-term care, the replacing insurer shall comply with both NAC 686A.510 to 686A.570, inclusive, and NAC 687B.125 to 687B.140, inclusive.

Sec. 57. NAC 687B.130 is hereby amended to read as follows:

687B.130 1. Upon determining that a sale will involve the replacement of a ~~[policy of insurance,]~~ ***long-term care insurance contract,*** an insurer, other than an insurer using ~~[a]~~ direct-response solicitation ~~[,]~~ ***methods,*** or its agent, shall furnish the applicant, before the issuance or delivery of the individual ~~[policy of]~~ long-term care insurance ~~[,]~~ ***contract,*** a notice regarding the replacement of the policy for accidents and sickness or long-term care ~~[insurance.]~~ ***coverage.*** One copy of the notice must be retained by the applicant **,** and an additional copy signed by the applicant must be retained by the insurer.

2. The notice required by subsection 1 must be provided ~~[in the following form:~~

~~NOTICE TO APPLICANT REGARDING REPLACEMENT~~

~~OF INDIVIDUAL POLICY FOR ACCIDENTS~~

~~AND SICKNESS OR LONG-TERM~~

~~CARE INSURANCE~~

~~According to your application information you have furnished, you intend to let lapse or otherwise terminate an existing policy for accidents and sickness or long-term care insurance and replace it with an individual policy of long-term care insurance to be issued by Company Name Insurance Company. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy.~~

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

~~term care is a prudent decision. For your own information and protection, you should be aware of and seriously consider the following factors which may affect the protection available to you under the new policy:~~

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 a denial or delay in the 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 period of time 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. ~~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 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.~~

~~.....~~

~~(Company Name)~~**]** ***using form NDOI-954, which is available from the Division, or a similar form approved by the Commissioner.***

Sec. 58. NAC 687B.135 is hereby amended to read as follows:

687B.135 1. Insurers using a direct-response solicitation shall deliver a notice regarding the replacement of a policy for accidents and sickness or ***a*** long-term care insurance ***contract*** to the applicant upon issuance of the **[**~~policy.~~**]** ***long-term care insurance contract.***

2. The notice required by subsection 1 must be provided **[**~~in the following form:~~

~~NOTICE TO APPLICANT REGARDING REPLACEMENT OF POLICY FOR ACCIDENTS AND SICKNESS OR LONG-TERM CARE INSURANCE~~

~~According to [your application] [information you have furnished], you intend to let lapse or otherwise terminate an existing policy for accidents and sickness or long-term care insurance and replace it with the policy of long-term care insurance delivered with this notice and issued by [Company Name] Insurance Company. Your new policy provides 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~~

~~the following factors which may affect the protection available to you under the new policy:~~

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 a denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.~~
2. ~~State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any period of time 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. ~~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 wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to our 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 30 days if any~~

~~information is not correct and complete, or if any past medical history has been omitted from the application.~~

~~.....~~

~~(Company Name)~~~~]~~ ***using form NDOI-955, which is available from the Division, or a similar form approved by the Commissioner.***

3. The insurer shall collect and retain signed copies of the notice from the applicant. The Commissioner may waive the requirements of this subsection in certain situations, including, but not limited to, electronic enrollment.

Sec. 59. NAC 687B.140 is hereby amended to read as follows:

687B.140 If a group ~~[policy of]~~ long-term care insurance ***contract*** is replaced by another group ~~[policy of]~~ long-term care insurance ***contract*** issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group ~~[policy]~~ ***long-term care insurance contract*** on its date of termination. Coverage provided or offered to an individual by the insurer and the premium charged to persons under the new group ~~[policy]~~ ***long-term care insurance contract*** must not:

1. Result in an exclusion for preexisting conditions that would have been covered under the group ~~[policy]~~ ***long-term care insurance contract*** being replaced; or

2. Vary or otherwise depend on the status of a person's health or disability, experience with claims or use of services related to long-term care.

Sec. 60. Section 2 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008, is hereby amended to read as follows:

Sec. 2. "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" means:

1. Any individual insurance contract or group insurance contract that meets the requirements of 26 U.S.C. § 7702B(b); ~~[or]~~

2. The portion of any life insurance contract which provides long-term care insurance coverage by rider or as part of the contract and which satisfies the requirements of 26 U.S.C. §§ 7702B(b) and 7702B(e) ~~[.]~~ ***; or***

3. The portion of any annuity contract which provides long-term care insurance coverage by rider or as part of the contract and which satisfies the requirements of 26 U.S.C. § 7702B(b), as amended by section 844 of the Pension Protection Act of 2006 (Public Law 109-280, signed by the President on August 17, 2006).

Sec. 61. Section 5 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008, is hereby amended to read as follows:

Sec. 5. 1. "Similar policy forms" means all ~~[policies]~~ ***long-term care insurance contracts*** and certificates ~~[of long-term care insurance]~~ issued by an insurer within the same classification of long-term care benefits as the ~~[policy]~~ ***long-term care insurance contract*** form being considered.

2. A ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ delivered to any group described in subsection 1 of NAC 687B.025 shall be deemed not similar to other ~~[policies]~~ ***long-term care insurance contracts*** and certificates ***,*** ~~[of long-term care insurance,]~~ except that such a ~~[policy]~~ ***contract*** or certificate shall be deemed similar to other comparable ~~[policies]~~ ***long-term care insurance contracts*** and

certificates ~~[of long-term care insurance]~~ with the same long-term care benefit classification.

3. For the purpose of determining whether ~~[policy]~~ ***long-term care insurance contract*** forms are similar, the long-term care benefits provided by ~~[policies]~~ ***long-term care insurance contracts*** and certificates ~~[of long-term care insurance]~~ must be classified as:

(a) Institutional long-term care benefits only;

(b) Noninstitutional long-term care benefits only; or

(c) Comprehensive long-term care benefits.

Sec. 62. Section 6 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008, is hereby amended to read as follows:

Sec. 6. If an insurer approves an application for long-term care insurance, the insurer shall deliver the ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[for the long-term care insurance]~~ to the applicant not later than 30 days after the date on which the application is approved.

Sec. 63. Section 7 of LCB File No. R121-07, as amended by section 1 of LCB File No. R053-09, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on October 27, 2009, is hereby amended to read as follows:

Section 1. Section 7 of LCB File No. R121-07 is hereby amended to read as follows:

Sec. 7. 1. An insurer or similar organization may pay compensation to a producer for the sale of a ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ on the basis of a set schedule. The amount of the compensation paid for the

replacement of a ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ must be made in accordance with the renewal schedule of the replacing insurer unless the ~~[policy]~~ ***long-term care insurance contract*** or certificate cannot be renewed by the original insurer.

2. The compensation provided by the insurer or similar organization for the renewal of a replacement ~~[policy]~~ ***long-term care insurance contract*** in subsequent years by the replacing insurer must be the same compensation schedule as provided by the replacing insurer unless the original insurer cannot renew the ~~[policy]~~ ***long-term care insurance contract*** or certificate ***.*** ~~[of long-term care insurance.]~~

3. If long-term care insurance is provided as part of an annuity, life insurance policy ***,*** ***disability income insurance policy*** or rider, the requirements of this section apply only to the compensation attributable to the long-term care insurance provided by the policy.

4. As used in this section, "compensation" has the meaning ascribed to it in NAC 683A.708.

Sec. 64. Section 9 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008, is hereby amended to read as follows:

Sec. 9. 1. For the enrollment of an insured in a ~~[policy of]~~ long-term care insurance ***contract*** that applies to a group described in subsection 1 of NAC 687B.025, any requirement that the signature of an insured be obtained by an agent or insurer shall be deemed satisfied if:

(a) The necessary consent to enrollment is obtained from the insured by telephonic or electronic enrollment by the group policyholder or insurer;

(b) The enrollment provides necessary and reasonable safeguards to ensure the accuracy, retention and prompt retrieval of records; and

(c) The enrollment provides necessary and reasonable safeguards to ensure the confidentiality of individually identifiable and privileged information.

2. Verification of the enrollment information obtained in the manner set forth in subsection 1 must be provided to the insured.

3. Upon request, the insurer shall make available to the Commissioner any records that demonstrate the ability of the insurer to confirm enrollment and coverage amounts.

Sec. 65. Section 10 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008, is hereby amended to read as follows:

Sec. 10. 1. Except as otherwise provided in subsection 3, an insurer shall not issue an individual ~~[policy of]~~ long-term care insurance ***contract*** in this State unless the insurer has received from the applicant:

(a) A written designation of at least one person, in addition to the applicant, who must receive notice of any lapse or termination of coverage under the policy for nonpayment of premium; or

(b) A written waiver dated and signed by the applicant stating that the applicant has chosen not to designate another person to receive notice of any lapse or termination of coverage for nonpayment of premium.

2. The designation pursuant to subsection 1 of another person to receive notice of any lapse or termination of coverage for nonpayment of premium does not constitute acceptance of any liability by the other person for services provided to the applicant. The

form used for the written designation of another person to receive notice of any lapse or termination of coverage for nonpayment of premium must provide space clearly designated for listing at least one such person. The designation must include the full name and home address of each person designated by the applicant to receive notice of any lapse or termination of coverage for nonpayment of premium. If an applicant does not designate another person to receive notice of any lapse or termination of coverage for nonpayment of premium, the waiver must state, in substantially similar language: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of any lapse or termination of coverage under this policy of long-term care insurance for nonpayment of premium. I understand that notice will not be given until 30 days after the date on which a premium is due and unpaid. I choose NOT to designate a person to receive this notice." The insurer shall notify an insured of the right to change the written designation described in this section not less than once every 2 years.

3. If an insured who pays premiums for long-term care insurance through a payroll or pension deduction plan ceases to make such payments through the plan, the insurer shall comply with the requirements of subsections 1 and 2 not later than 60 days after the date on which the premiums are no longer paid through the plan. The application or enrollment form for a ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ for which the premium is paid through a payroll or pension deduction plan must clearly indicate the payment plan selected by the applicant.

4. An individual ~~[policy of]~~ long-term care insurance ***contract*** must not lapse or be terminated by the insurer for nonpayment of premium unless the insurer, not less than 30 days after a premium is due and unpaid and not less than 30 days before the effective date

of the lapse or termination, has given notice by first-class mail, postage prepaid, to the policyholder and to each person designated by the policyholder to receive notice pursuant to subsection 1 ~~[.]~~ ***at the address provided by the insured for receiving notice of any lapse or termination.*** The notice required by this subsection shall be deemed to have been given 5 days after the date on which the insurer mails the notice.

~~[5. An individual policy of long-term care insurance must provide for the reinstatement of coverage in the event of a lapse in coverage if the insurer is provided proof that the insured was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. The policy must provide that an insured may request such reinstatement not later than 5 months after the date of termination and may provide for the collection of past due premiums, if any. The standard of proof of cognitive impairment or loss of functional capacity must not be more stringent than the criteria to determine eligibility for benefits contained in the policy.]~~

Sec. 66. Section 16 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008, is hereby amended to read as follows:

Sec. 16. 1. Activities of daily living and cognitive impairment must be used to measure the needs of an insured for long-term care and must be described in a ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ in a separate paragraph that must be labeled as "Eligibility for the Payment of Benefits." Any additional benefit triggers must also be explained and must include, without limitation, whether:

(a) Any such benefit triggers differ for different benefits; and

(b) An attending physician or other specified person is required to certify a certain level of functional dependency for the insured to be eligible for benefits.

2. The description of any benefit in a ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ must include an explanation of the benefit trigger.

Sec. 67. Section 17 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008, is hereby amended to read as follows:

Sec. 17. 1. A qualified long-term care insurance contract must include a disclosure statement in the ***qualified long-term care insurance*** contract and in the outline of coverage that the ***qualified long-term care insurance*** contract is intended to be a qualified long-term care insurance contract under 26 U.S.C. § 7702B(b).

2. A ~~[policy]~~ ***long-term care insurance contract*** that is not a qualified long-term care insurance contract must include a disclosure statement in the ~~[policy]~~ ***long-term care insurance contract*** and in the outline of coverage that the ~~[policy]~~ ***long-term care insurance contract*** is not intended to be a qualified long-term care insurance contract under 26 U.S.C. § 7702B(b).

Sec. 68. Section 18 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008, is hereby amended to read as follows:

Sec. 18. 1. For any ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ issued in this State on or after October 1, 2008, other than a ~~[policy]~~ ***long-term care insurance contract*** or certificate for which no applicable increases in premium rates or rate schedules can be made, the insurer shall provide to the applicant:

(a) A statement that the ~~[policy]~~ ***long-term care insurance contract*** or certificate may be subject to rate increases in the future;

(b) An explanation of potential future premium rate revisions, and the options available to the applicant in the event of a premium rate revision;

(c) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

(d) A general explanation for applying adjustments to premium rates or rate schedules that must include:

(1) A description of when such adjustments will be effective; and

(2) A statement that the applicant must be provided with a revised premium rate or rate schedule if the premium rate or rate schedule is changed; ~~[and]~~

(e) Except as otherwise provided in subsection 3, information relating to each increase in premium rates on the ~~[policy]~~ ***long-term care insurance contract*** form or similar policy forms during the previous 10 years for this State or any other state, including, without limitation, information that identifies:

(1) The ~~[policy]~~ ***long-term care insurance contract*** forms for which premium rates have increased;

(2) The calendar years when the ~~[policy]~~ ***long-term care insurance contract*** form was available for purchase; and

(3) The amount or percentage of each rate 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 ~~[.]~~ ***; and***

(f) Any additional explanatory information related to rate increases that the insurer chooses to provide.

2. In addition to the requirements of subsection 1, if an insurer or similar organization acquires a block of ~~[policy]~~ ***long-term care insurance contract*** forms from a nonaffiliated insurer or similar organization and ~~[the]~~ ***:***

(a) The premium rates for the block of ~~[policy]~~ ***long-term care insurance contract*** forms increase within 24 months after the block of ~~[policy]~~ ***long-term care insurance contract*** forms is acquired, the nonaffiliated insurer or similar organization shall provide a statement of the increase in premium rates to the applicant ~~[.]~~ ***; and***

(b) At any time after the acquisition the acquiring insurer files for a rate increase, subsequent to the rate increase described in paragraph (a), on the block of long-term care insurance contract forms, the acquiring insurer shall make all disclosures required by paragraph (e) of subsection 1 and provide a statement of the increase in premium rates to the applicant.

3. The provisions of paragraph (e) of subsection 1 do not apply to:

(a) Any increase in premium rates for any block of ~~[policy]~~ ***long-term care insurance contract*** forms acquired by the insurer from a nonaffiliated insurer if the increases occurred before the acquisition or not later than 24 months after the acquisition; or

(b) Any increase in premium rates for ~~[policies of]~~ long-term care insurance ***contracts*** acquired by the insurer from a nonaffiliated insurer if the increases occurred before the acquisition or not later than 24 months after the acquisition.

4. The insurer shall provide the information required by subsection 1 to the applicant:

(a) At the time of application; or

(b) If the method of application does not allow for delivery of the ~~[policy]~~ ***long-term care insurance contract*** or certificate at the time of application, not later than the time of delivery of the ~~[policy]~~ ***long-term care insurance contract*** or certificate.

5. An applicant must sign an acknowledgment that the insurer provided the information required by subsection 1:

(a) At the time of application; or

(b) If the method of application does not allow for the signing of the acknowledgment at the time of application, not later than the time of delivery of the ~~[policy]~~ ***long-term care insurance contract*** or certificate.

6. An insurer shall use ~~[the]~~ forms ~~[prescribed by the Commissioner]~~ ***NDOI-949 and NDOI-953, available from the Division,*** to comply with the requirements of this section.

7. An insurer shall provide notice of any increase in a premium rate schedule to all affected policyholders or certificate holders not less than 60 days before the effective date of the increase. The notice must include, without limitation, the information required by subsection 1.

Sec. 69. Section 19 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008, is hereby amended to read as follows:

Sec. 19. 1. The provisions of this section do not apply to ~~[a]~~ ***:***

(a) A long-term care insurance contract issued before October 1, 2008;

(b) A policy of life insurance ~~[,]~~ ***or*** a rider to a policy of life insurance ~~[or an annuity contract]~~ that contains accelerated benefits for long-term care ~~[.]~~ ***; or***

(c) An annuity contract or a rider to an annuity contract that contains benefits for long-term care.

2. An insurer shall not offer for sale any form of long-term care insurance in this State unless ***, not later than 45 days before the offer for sale,*** the insurer submits to the Commissioner and the Commissioner approves:

(a) A copy of the disclosures described in section 18 of this regulation; and

(b) An actuarial certification that includes, without limitation:

(1) A statement that 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 ~~[policy]~~ ***long-term care insurance contract*** with no anticipated future premium increases;

(2) A statement that the ~~[policy]~~ ***long-term care insurance contract*** design and the coverage provided by the ~~[policy]~~ ***long-term care insurance contract*** have been reviewed and taken into consideration;

(3) A statement that 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 ~~[policy,]~~ ***long-term care insurance contract,*** which must include, without limitation:

(I) Sufficient detail or sample calculations so as to provide a complete and accurate depiction of the amount of reserves to be held;

(II) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(III) A statement that the net valuation premium for renewal years does not increase, except for attained-age ratings if such increases are authorized; and

(IV) 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 any situations in which this does not occur;

(5) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar ~~[policy]~~ ***long-term care insurance contract*** forms available from the insurer, except for reasonable differences attributable to benefits, or a comparison of the premium rate schedules for similar ~~[policy]~~ ***long-term care insurance contract*** forms that are currently available from the insurer with an explanation of the differences;

(6) ~~[An]~~ ***If requested by the Commissioner, an*** actuarial demonstration that benefits are reasonable in relation to premiums, which must include:

(I) Premium and claims experience on similar ~~[policy]~~ ***long-term care insurance contract*** forms adjusted for any premium or benefit differences;

(II) Relevant and credible data from other studies; or

(III) A combination of premium and claims experience on similar ~~[policy]~~ ***long-term care insurance contract*** forms and relevant and credible data from other studies; and

(7) A statement that the actuarial certification was made by a ~~[person qualified to make such a certification.]~~ ***qualified health actuary.***

3. For the purposes of sub-subparagraph (IV) of subparagraph (4) of paragraph (b) of subsection 2, an aggregate distribution of anticipated issues may be used if the underlying gross premiums maintain a reasonably consistent relationship in accordance with generally

accepted standards of actuarial practice. If the gross premiums for certain age groups appear to be inconsistent, the Commissioner may request a demonstration by the insurer that gross premiums maintain a reasonably consistent relationship based on a standard age distribution in accordance with generally accepted standards of actuarial practice.

4. Any additional information requested by the Commissioner for the purposes of approval pursuant to subsection 2 is not subject to the requirement that the information be submitted not later than 45 days before the long-term care insurance is offered for sale.

5. An initial filing for long-term care insurance must display the issue date clearly on the schedule of benefits page.

Sec. 70. Section 20 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008, is hereby amended to read as follows:

Sec. 20. ***1. A person may not sell, solicit or negotiate long-term care insurance unless the person:***

(a) Is licensed as a producer of insurance for accidents and sickness, health or life insurance;

(b) Has completed a course of training consisting of at least 8 hours; and

(c) Within the past 24 months, has completed a course of training consisting of at least 4 hours.

2. The training required by subsection 1:

(a) Must consist of topics relating to long-term care insurance, long-term care services and, if applicable, qualified state long-term care insurance partnership programs, including, but not limited to:

(1) State and federal regulations and requirements and the relationship between qualified state long-term care insurance partnership programs and other public and private coverage of long-term care, including Medicaid;

(2) Available long-term care services and providers;

(3) Changes or improvements in long-term care services or providers;

(4) Alternatives to the purchase of private long-term care insurance;

(5) The effect of inflation on benefits and the importance of inflation protection; and

(6) Consumer suitability standards and guidelines.

(b) May not include training that is specific to any insurer or company product or that includes any sales or marketing information, materials or training other than those required by state or federal law.

3. A course of training that meets the requirements of subsection 2 may be approved as a continuing education course for licensure pursuant to NAC 683A.330 if the course satisfies the requirements of NAC 683A.335.

4. The satisfaction of the training requirements of this section in any other state shall be deemed to satisfy the training requirements in this State.

5. An insurer subject to the provisions of this section shall:

(a) Obtain verification that a producer of insurance receives the training required pursuant to subsection 1 before the producer of insurance is permitted to sell, solicit or negotiate the insurer's long-term care insurance;

(b) Maintain records of verification of training subject to this State's record retention requirements; and

(c) Make all verifications of training available to the Commissioner upon request.

6. An insurer that provides qualified state long-term care insurance partnership contracts shall:

~~[1.]~~ ***(a)*** On or before March 1 of each year, provide certification to the Commissioner that all partnership contracts issued by the insurer during the immediately preceding calendar year were sold by producers who have received adequate training ***, as described in subsection 2,*** and have demonstrated an understanding of the partnership policies and their relationship to public and private coverage of long-term care, including Medicaid, in this State; and

~~[2.]~~ ***(b)*** Maintain records with respect to the training of its producers concerning the sale of partnership contracts that will allow the Commissioner to provide adequate assurances to the Division of Health Care Financing and Policy of the Department of Health and Human Services that the producers have received adequate training and have demonstrated an understanding of the partnership policies and their relationship to public and private coverage of long-term care, including Medicaid, in this State. The insurer shall maintain the records ***of attendance and examination scores pursuant to NAC 683A.340*** for ~~[not less than 5]~~ ***4*** years and shall make the records available to the Commissioner upon request.

7. An initial partnership contract filing must be accompanied by a list of agents who have satisfied the training requirements of this section for partnership contracts and who are approved to market partnership contracts for the insurer or similar organization.

Sec. 71. Section 21 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008, is hereby amended to read as follows:

Sec. 21. 1. An insurer shall maintain records for each agent which:

(a) Specify the amount of replacement sales by the agent as a percentage of the total annual sales by the agent; and

(b) Specify the amount of lapses in policies sold by the agent as a percentage of the total annual sales by the agent.

2. On or before June 30 of each year, an insurer shall provide to the Commissioner the names of its agents in this State who, as measured by the records maintained pursuant to subsection 1, rank in the top 10 percent of all its agents in this State with the highest percentages of:

(a) Replacement sales in this State; and

(b) Lapses in policies sold by the agent in this State.

3. On or before June 30 of each year, an insurer shall report to the Commissioner the number of lapsed policies issued by the insurer in this State as a percentage of the total annual sales of the insurer in this State and as a percentage of the total number of policies issued by the insurer in this State which are in force on December 31 of the immediately preceding calendar year in this State.

4. On or before June 30 of each year, an insurer shall report to the Commissioner the number of replacement policies issued by the insurer in this State as a percentage of the total annual sales of the insurer in this State and as a percentage of the total number of policies issued by the insurer in this State which are in force on December 31 of the immediately preceding calendar year in this State.

5. On or before June 30 of each year, an insurer shall report to the Commissioner, for qualified long-term care insurance contracts issued by the insurer in this State, the number of claims denied in this State for each class of business, expressed as a percentage of all claims denied in this State.

6. ***An insurer or similar organization that issues partnership contracts or partnership certificates in this State shall report to the Department of Health and Human Services, using a form prescribed by the Department and including the amount of any benefits that have been provided under the contract or certificate, when:***

(a) A partnership contract or partnership certificate is terminated;

(b) Benefits are provided under a partnership contract or partnership certificate; or

(c) The Commissioner or the Department of Health and Human Services requests a report.

7. An insurer shall use:

(a) Form NDOI-946, which is available from the Division, to satisfy the reporting requirements of subsections 2, 3 and 4; and

(b) Form NDOI-948, which is available from the Division, to satisfy the reporting requirements of subsection 5.

8. Reported replacement and lapse rates may not be used as a sole basis for adverse action against an insurer or agent, but may be used as a method to review agent activities regarding the sale of long-term care insurance.

9. Any report made pursuant to this section must be made on the basis of statewide information.

10. As used in this section:

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

(b) "Denied" means the refusal of an insurer to pay a claim for any reason other than:

(1) Failure of the insured to meet an applicable waiting period; or

(2) An applicable preexisting condition.

(c) "Policy" means a policy of long-term care insurance.

Sec. 72. Section 22 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008, is hereby amended to read as follows:

Sec. 22. 1. The provisions of this section do not apply to ~~[a]~~ ***:***

(a) A long-term care insurance contract or certificate issued before October 1, 2008;

(b) A policy of life insurance ~~[,]~~ ***or*** a rider to a policy of life insurance ~~[or an annuity contract]~~ that contains accelerated benefits for long-term care ~~[.]~~ ***;***

(c) An annuity contract or a rider to an annuity contract that contains benefits for long-term care; or

(d) A long-term care insurance contract or certificate which is subject to the provisions of section 13 of LCB File No. R028-10.

2. An insurer shall file with the Commissioner for approval any increase in a premium rate schedule. The filing must include, without limitation:

(a) The information required by section 18 of this regulation;

(b) An actuarial memorandum prepared in accordance with all applicable standards of practice which must include:

(1) A description of the benefits provided under the affected ~~[policy;]~~ ***long-term care insurance contract;***

(2) An actuarial demonstration that the benefits are reasonable in relation to the premiums;

(3) An explanation of the reasons for the rate increase;

(4) The history of any previously approved rate increase, which must include the effective date of each previous rate increase and the percentage increase of each previous rate increase;

(5) A description of any actuarial assumptions and any related tables, including any changes in actuarial assumptions since the last rate increase and since the initial filing of ~~[policy]~~ ***contract*** rates;

(6) An analysis of the expected and the actual experience and projections for claims, premiums, loss ratios, lapses and mortality;

(7) The annual loss ratios expected at the time of the most recent premium filing and the initial rate filing, which must include a comparison of the expected and the actual loss ratios;

(8) The number of its insureds in this State and nationwide;

(9) If a reduction in benefits is offered to offset the rate increase, a complete actuarial justification that the premium changes are actuarially equivalent to the benefit reduction; and

(10) The basis for the interest rate used; and

(c) The percentage amount of the rate increase stated in the filing description of the uniform transmittal document.

3. If the insurer has fewer than 2,000 insureds nationwide, the information required pursuant to subparagraphs (6) and (7) of paragraph (b) of subsection 2 must be provided:

(a) When combined with all similar ~~[policy]~~ ***long-term care insurance contract*** forms; and

(b) For a specific ~~[policy]~~ ***long-term care insurance contract*** form.

Sec. 73. Section 23 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008, is hereby amended to read as follows:

Sec. 23. 1. Except as otherwise provided in subsection 2, every insurer or other organization that markets or offers ~~[policies]~~ ***long-term care insurance contracts*** or certificates ~~[of long-term care insurance]~~ in this State shall ~~[provide]~~ ***:***

(a) Provide to the Commissioner for review and approval a copy of any written, radio or television advertisement for the sale of long-term care insurance intended for use in this State ~~[.]~~ ***; and***

(b) Retain any such advertisement for at least 3 years after the date the advertisement was first used.

2. The Commissioner may exempt an advertisement from the requirements of subsection 1 if, in the opinion of the Commissioner, the provisions of subsection 1 may not be reasonably applied to the advertisement.

Sec. 74. Section 24 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008, is hereby amended to read as follows:

Sec. 24. 1. The provisions of this section do not apply to a policy of life insurance or a rider to a policy of life insurance that contains accelerated benefits for long-term care.

2. Every insurer or other organization that markets or offers ~~[policies]~~ ***long-term care insurance contracts*** or certificates ~~[of long-term care insurance]~~ in this State shall:

(a) Develop standards of suitability to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of an applicant;

(b) Train its agents in the use of the standards of suitability; and

(c) Maintain a copy of the standards of suitability and make the standards available for inspection upon request by the Commissioner.

3. An insurer shall use the standards of suitability developed pursuant to subsection 2 in determining whether it is appropriate to issue long-term care insurance to an applicant.

4. An agent shall use the standards of suitability developed by the insurer pursuant to subsection 2 in marketing long-term care insurance.

5. To determine whether an applicant meets the standards of suitability developed pursuant to subsection 2 for the purchase or replacement of long-term care insurance, the insurer and its agents shall develop policies and procedures that take into consideration:

(a) The ability of the applicant to pay for the proposed coverage;

(b) Any other pertinent financial information relating to the proposed purchase;

(c) The goals or needs of the applicant with respect to long-term care and the advantages and disadvantages of insurance to meet those goals or needs; and

(d) The values, benefits and costs of the existing insurance of the applicant, if any, as compared to the values, benefits and costs of the proposed purchase or replacement.

6. The insurer and its agents shall make reasonable efforts to obtain the information required pursuant to subsection 5, including, without limitation, presenting to the applicant at or before the time of application the worksheet described in subsection 9. The insurer may request that the applicant provide additional information to comply with the standards of suitability.

7. An insurer shall not consider an application unless the applicant completes the worksheet described in subsection 9 and returns the completed worksheet to the insurer, except that the insurer may consider an application without receiving a completed worksheet if the applicant is offered the coverage through a sale of group long-term care insurance to employees and their spouses.

8. An insurer and its agents shall not sell or disseminate outside the company any information obtained from a worksheet described in subsection 9.

9. An insurer shall provide to each applicant ***form NDOI-949, which is available from the Division, or*** a "Long-Term Care Insurance Personal Worksheet" which must contain a statement ~~[in substantially the following form, set out conspicuously in the following format, in not less than 12-point type:~~

~~Long-Term Care Insurance Personal Worksheet~~

~~People buy long-term care insurance for many reasons. Some do not 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 do not want their family to have to pay for care or do not 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.]*~~

~~Rate Increase History~~

~~The company has sold long-term care insurance since _____ (insert year)] and has sold this policy since _____ (insert 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.]~~

~~Questions Relating to Your Income~~

~~How will you pay each year's premium?~~

~~☐ From my income ☐ From my savings and 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 percent? (check one)~~

~~☐ Yes ☐ No~~

~~What is your annual income? (check one)~~

☐ Less than $10,000 ☐ $10,000-$19,999 ☐ $20,000-$29,999 ☐ $30,000-$49,999

☐ $50,000 or more

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

☐ No change ☐ Increase ☐ be more than 7 percent 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 and investments ☐ My family will pay

The national average annual cost of care in [_____ (insert year)] was $_____, but this figure varies across the country. In 10 years the national average annual cost would be about $_____ if costs increase 5 percent annually.**

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 and investments ☐ My family will pay

~~Questions Relating to Your Savings and Investments~~

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

~~☐ Less than $20,000 ☐ $20,000-$29,999 ☐ $30,000-$49,999 ☐ $50,000 or more~~

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

~~☐ Stay about the same ☐ Increase ☐ Decrease~~

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

~~Disclosure Statement~~

~~☐ The answers to the above question describe my financial situation.~~

~~Or~~

~~☐ I choose not to complete this information.~~

~~(Check one.)~~

~~☐ I acknowledge that the insurance company or its agent 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).

The company may contact you to verify your answers.

Signed: _____ Date: _____

(Applicant)

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

Signed: _____ Date: _____

(Agent)

Agent's Printed Name: _____

[In order for us to process your application, please return this signed statement to _____ (insert name of company), along with your application. My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.***

Signed: _____ Date: _____

(Applicant)

~~*Drafter's note: Insurers must use the appropriate bracketed statement. Rate guarantees must not be shown on this form.~~

~~**Drafter's note: In this statement, the second figure equals 163 percent of the first figure.~~

~~***Drafter's note: Choose the appropriate sentences depending on whether this is a direct mail or agent sale.]~~ ***, set out conspicuously and in not less than 12-point type, that is substantially in the format of form NDOI-949.***

10. An insurer shall file with the Commissioner a copy of the worksheet described in subsection 9.

Sec. 75. Section 25 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008, is hereby amended to read as follows:

Sec. 25. 1. If an insurer determines that an applicant does not meet the standards of suitability developed pursuant to section 24 of this regulation, or if the applicant declines to provide any information required by section 24 of this regulation, the insurer may:

(a) Reject the application; or

(b) Mail a letter to the applicant ~~[which contains]~~ ***using form NDOI-950, which is available from the Division, or containing*** a statement ~~[in substantially the following form, set out conspicuously in the following format:~~

~~Dear _____ (Insert name of applicant)]:~~

~~Your recent application for long-term care insurance included a "Long-Term Care Insurance 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 persons 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 entitled "A Shopper's Guide to Long-Term Care Insurance" and the form entitled "Things You Should Know Before Buying Long-Term Care Insurance." The Division of Insurance 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.]*~~

~~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 a policy to you.~~

~~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.~~

~~☐ _____~~

~~(Applicant)~~

~~Please return to [_____ (Insert name of insurer)] at [_____ (Insert address of insurer)] by [_____ (Insert date)].~~

~~*Drafter's note: Choose the appropriate sentences depending on the information received from the applicant.]~~ ***that is substantially in the format of form NDOI-950.***

2. If an applicant declines to provide any financial information required pursuant to section 24 of this regulation, the insurer may use any other method to verify the intent of the applicant.

3. The insurer shall include in the file of the applicant:

(a) The returned letter described in paragraph (b) of subsection 1; or

(b) A record of the alternative method of verification of the intent of the applicant.

Sec. 76. Section 26 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008, is hereby amended to read as follows:

Sec. 26. An insurer shall report annually to the Commissioner ~~[:]~~ ***using form NDOI-947, which is available from the Division:***

1. The number of applications for long-term care insurance received by the insurer from residents of this State;

2. The number of applicants who declined to provide information on the worksheet described in subsection 9 of section 24 of this regulation;

3. The number of applicants who did not meet the standards of suitability developed by the insurer pursuant to section 24 of this regulation; and

4. The number of applicants who chose to purchase long-term care insurance after receiving the letter described in paragraph (b) of subsection 1 of section 25 of this regulation.

Sec. 77. Section 29 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008, is hereby amended to read as follows:

Sec. 29. 1. The provisions of this section do not apply to a policy of life insurance or a rider to a policy of life insurance that contains accelerated benefits for long-term care.

2. Except as otherwise provided in subsections 3, 6 and 7, an insurer shall notify each policyholder or certificate holder of the availability of any new series of ~~[policies of]~~ long-term care insurance ***contracts*** that provides material coverage for long-term care services or providers that was not previously available through the insurer to the general public, not later than 12 months after the date the new series of ~~[policies]~~ ***long-term care insurance contracts*** is made available for sale in this State.

3. The notification required by subsection 2 is not required for any ~~[policy]~~ ***long-term care insurance contract*** or certificate issued:

(a) Before October 1, 2008; or

(b) To any policyholder or certificate holder who:

(1) Is currently eligible for benefits;

(2) Is within an elimination period;

(3) ***Is on a claim;***

(4) Previously received benefits under the ~~[policy]~~ ***long-term care insurance contract*** or certificate; or

~~[(4)]~~ ***(5)*** Is not eligible to apply for the new coverage because of limitations under the new ~~[policy]~~ ***long-term care insurance contract*** relating to the issue age of the insured.

4. The insurer may require that the insured meet all eligibility requirements, including, without limitation, any underwriting requirements and payment of premiums to add any new coverage described in subsection 2.

5. The insurer shall make any new coverage described in subsection 2 available:

(a) By adding a rider to the existing ~~[policy]~~ ***long-term care insurance contract*** and charging a separate premium for the rider based on the attained age of the insured;

(b) By exchanging the existing ~~[policy]~~ ***long-term care insurance contract*** 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]~~ ***long-term care insurance contract*** or certificate based on premiums paid or reserves held for the previous ~~[policy]~~ ***long-term care insurance contract*** or certificate;

(c) By exchanging the existing ~~[policy]~~ ***long-term care insurance contract*** or certificate for a new ~~[policy]~~ ***long-term care insurance contract*** or certificate in which:

(1) Consideration for past insured status must be recognized by setting the premium for the new ~~[policy]~~ ***long-term care insurance contract*** or certificate at the issue age of the

insured for the ~~[policy]~~ ***long-term care insurance contract*** or certificate being exchanged; and

(2) The cost for the new ~~[policy]~~ ***long-term care insurance contract*** or certificate may recognize the difference in reserves between the new ~~[policy]~~ ***long-term care insurance contract*** or certificate and the original ~~[policy]~~ ***long-term care insurance contract*** or certificate; or

(d) By an alternative program developed by the insurer and approved by the Commissioner.

6. An insurer is not required to notify policyholders of a new proprietary ~~[policy]~~ ***long-term care insurance contract*** series created and filed for use in a limited distribution channel except that the insurer must notify any policyholder who purchases such a proprietary ~~[policy]~~ ***long-term care insurance contract*** when a new series of ~~[policies of]~~ long-term care insurance ***contracts*** that provides material coverage for new long-term care services or providers is made available to that limited distribution channel. As used in this subsection, "limited distribution channel" means a discrete entity, including, without limitation, a financial institution or brokerage, through or for which specialized products are available that are not available for sale to the general public.

7. If the new series of ~~[policies of]~~ long-term care insurance ***contracts*** is offered through an employer, labor organization, or professional, trade or occupational association, the insurer is only required to provide notice to the offering entity ~~[.]~~ ***unless the policy is issued to a group described in subsection 4 of NAC 687B.025, in which case notice must be provided to each certificate holder.***

8. A ~~[policy]~~ ***long-term care insurance contract*** or certificate issued pursuant to this section:

(a) Shall be deemed an exchange; and

(b) Is not subject to the provisions of NAC 687B.125 ~~[, 687B.127, 687B.130 and]~~ ***to*** 687B.135 ~~[.]~~ ***, inclusive.***

9. The provisions of this section do not prohibit an insurer from offering any policy, rider, certificate or change in coverage to any policyholder or certificate holder. ***The insurer may require that policyholders meet all eligibility requirements of the offered policy, rider, certificate or change in coverage, including underwriting and the payment of the required premium to add such new services or providers.***

10. Upon request, any policyholder or certificate holder may apply for any currently available coverage that includes any new services or providers described in subsection 2.

Sec. 78. Section 30 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008, is hereby amended to read as follows:

Sec. 30. 1. The provisions of this section do not apply to a policy of life insurance or a rider to a policy of life insurance that contains accelerated benefits for long-term care.

2. Each ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ must include a provision that allows the policyholder or certificate holder to reduce coverage and lower the premium by reducing:

(a) The maximum benefit; or

(b) The daily, weekly or monthly benefit amount.

3. In addition to the provisions of subsection 2, an insurer may include a provision that allows the policyholder or certificate holder to reduce coverage and lower the premium by offering any other option to reduce the premium that is consistent with the other provisions of the ~~[policy]~~ ***long-term care insurance contract*** or certificate or the administrative processes of the insurer.

4. Any provision that allows the policyholder or certificate holder to reduce coverage and lower the premium must include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.

5. For the purposes of reducing coverage pursuant to this section, the age of the insured used to determine the premium for the reduced coverage must be based on the age used to determine the premiums for the current amount of coverage.

6. The insurer may limit any reduction in coverage to plans or options available for that ~~[policy]~~ ***long-term care insurance contract*** form and to those for which benefits will be available after consideration of claims paid or payable.

7. If a ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ is at risk of lapsing, the insurer shall, in addition to the notice required pursuant to section 10 of this regulation, provide written notice to the policyholder or certificate holder of his right to reduce coverage and premiums pursuant to this section. The insurer shall provide notice to the policyholder or certificate holder before the later of:

(a) The date 20 days before the end of the grace period provided by the policy or certificate; or

(b) The date on which the premium becomes past due.

Sec. 79. Section 31 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008, is hereby amended to read as follows:

Sec. 31. 1. Except as otherwise provided in subsection 2, an insurer shall not deliver or issue for delivery in this State a ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ unless the policyholder or certificate holder has been offered the option to purchase a ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ that includes a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. If the policyholder or certificate holder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that must be available to the policyholder or certificate holder for the period following a substantial increase in premium rates specified in section 32 of this regulation.

2. Except as otherwise provided in subsection 3, if an insurer offers a ~~[policy of]~~ group long-term care insurance ~~[,]~~ ***contract,*** the offer required by subsection 1 must be made only to the group policyholder.

3. If an insurer offers a ~~[policy of]~~ group long-term care insurance ***contract*** to a group described in subsection 4 of NAC 687B.025, other than a continuing-care retirement community or other similar entity, the offer required by subsection 1 must be made to each certificate holder.

Sec. 80. Section 32 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008, is hereby amended to read as follows:

Sec. 32. 1. The provisions of this section do not apply to a policy of life insurance or a rider to a policy of life insurance that contains accelerated benefits for long-term care.

2. To satisfy the requirements of section 31 of this regulation:

(a) A ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ offered with nonforfeiture benefits must include the elements of the coverage, requirements for eligibility, benefit triggers and length of benefits that are the same as the coverage issued without nonforfeiture benefits;

(b) If the offer of a nonforfeiture benefit required by section 31 of this regulation is not otherwise described in the outline of coverage or other materials provided to the applicant, the offer must be set out separately and be in writing; and

(c) The nonforfeiture benefit included in the offer must conform to the requirements of this section.

3. ***If the long-term care insurance contract is issued to a group described in subsection 4 of NAC 687B.025, other than to a retirement community which provides continuing care, the insurer shall make the offer required pursuant to subsection 2 to each proposed certificate holder.***

4. If an applicant rejects the offer of a nonforfeiture benefit required by section 31 of this regulation, the insurer shall provide a contingent benefit upon lapse ~~[in accordance with subsection 8.~~

~~4. If an applicant accepts the offer of a nonforfeiture benefit required by section 31 of this regulation, for]~~ ***described in this section.***

5. For a policy with a fixed or limited premium paying period, the insurer shall provide a contingent benefit upon lapse in accordance with subsection ~~[8.]~~ ***9.***

~~[5.]~~ ***6.*** If an applicant rejects the offer of a nonforfeiture benefit required by section 31 of this regulation, for a ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ without nonforfeiture benefits issued on or after October 1, 2008, the insurer shall provide a contingent benefit upon lapse ~~[in accordance with subsection 8.~~

~~6.]~~ ***described in this section.***

7. If a group policyholder chooses to make the nonforfeiture benefit an option to a certificate holder, the certificate must provide the nonforfeiture benefit or the contingent benefit upon lapse ~~[in accordance with subsection 8.~~

~~7.]~~ ***described in this section.***

8. A contingent benefit upon lapse is triggered if an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or greater than the percentage of the initial annual premium of the policyholder or certificate holder, based on the issue age of the insured, as described in the following chart entitled "Triggers for a Substantial Premium Increase (I)," and the affected ~~[policy]~~ ***long-term care insurance contract*** or certificate lapses within 120 days after the due date of the increased premium. ~~[Unless otherwise required, the]~~ ***The*** insurer shall provide notice of the rate increase to a policyholder or certificate holder not less than ~~[30]~~ ***60*** days before the due date of the premium that includes the rate increase. The chart must be set forth as follows:

Triggers for a Substantial Premium Increase (I)	
Issue Age	Percent Increase Over Initial Premium

Triggers for a Substantial Premium Increase (I)	
Issue Age	Percent Increase Over Initial Premium
29 and under	200 percent
30-34	190 percent
35-39	170 percent
40-44	150 percent
45-49	130 percent
50-54	110 percent
55-59	90 percent
60	70 percent
61	66 percent
62	62 percent
63	58 percent
64	54 percent
65	50 percent
66	48 percent
67	46 percent
68	44 percent
69	42 percent
70	40 percent
71	38 percent
72	36 percent

Triggers for a Substantial Premium Increase (I)	
Issue Age	Percent Increase Over Initial Premium
73	34 percent
74	32 percent
75	30 percent
76	28 percent
77	26 percent
78	24 percent
79	22 percent
80	20 percent
81	19 percent
82	18 percent
83	17 percent
84	16 percent
85	15 percent
86	14 percent
87	13 percent
88	12 percent
89	11 percent
90 and over	10 percent

~~[8.]~~ ***9.*** A contingent benefit upon lapse is triggered for any ~~[policy]~~ ***long-term care insurance contract*** with a fixed or limited premium paying period if the insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or greater than the percentage of the initial annual premium of the policyholder or certificate holder, based on the issue age of the insured, as described in the following chart entitled "Triggers for a Substantial Premium Increase (II)," the affected ~~[policy]~~ ***long-term care insurance contract*** or certificate lapses not later than 120 days after the due date of the increased premium and the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period is 0.4 or more. The provision of this benefit is in addition to the benefit described in subsection ~~[7,]~~ ***8,*** and if both benefits are triggered, the insured may choose which benefit must be provided. ~~[Unless otherwise required, the]~~ ***The*** insurer shall provide notice of the rate increase to a policyholder or certificate holder not less than ~~[30]~~ ***60*** days before the due date of the premium that includes the rate increase.

Triggers for a Substantial Premium Increase (II)	
Issue Age	Percent Increase Over Initial Premium
64 and under	50 percent
65-79	30 percent
80 and over	10 percent

~~[9.]~~ ***10.*** On or before the effective date of a substantial premium increase described in subsection ~~[7,]~~ ***8,*** the insurer shall:

(a) Offer to reduce ~~[policy]~~ ***long-term care insurance contract*** benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(b) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subsection ~~[11;]~~ ***12 and allow the policyholder or certificate holder to accept this offer at any time during the 120-day period described in subsection 8;*** and

(c) Notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period described in subsection ~~[7]~~ ***8*** shall be deemed to be the selection of the offer to convert described in paragraph (b), unless the provisions of paragraph (c) of subsection ~~[10]~~ ***11*** apply.

~~[10.]~~ ***11.*** On or before the effective date of a substantial premium increase described in subsection ~~[8,]~~ ***9,*** the insurer shall:

(a) Offer to reduce benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(b) Offer to convert the coverage to a paid-up status where the amount payable for each benefit is equal to 90 percent of the amount payable immediately before the lapse multiplied by the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period ~~[;]~~ ***and allow the policyholder or***

certificate holder to accept this offer at any time during the 120-day period set forth in subsection 9; and

(c) Notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period set forth in subsection ~~[8]~~ ***9*** shall be deemed to be the selection of the offer to convert described in paragraph (b) if the ratio described in paragraph (b) is 0.4 or more.

~~[11.]~~ ***12.*** For the purpose of determining benefits continued as nonforfeiture benefits, including the contingent benefits upon lapse described in subsection ~~[7]~~ ***8*** but not the contingent benefits upon lapse described in subsection ~~[8.]~~ ***9:***

(a) "Attained age rating" means a schedule of premiums starting from the issue date which increases with age ~~[.]~~ ***of at least 1 percent per year before 50 years of age and at least 3 percent per year at and after 50 years of age.***

(b) The nonforfeiture benefit must be for a shortened benefit period providing paid-up long-term care insurance after lapse. The same benefit amounts and frequency of benefits in effect at the time of lapse ***, but not increased thereafter,*** must be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits must be determined as specified in paragraph (c).

(c) The standard nonforfeiture benefit must be equal to 100 percent of the sum of all premiums paid, including the premiums paid before any change in benefits. The insurer may offer additional options for shortened benefit periods if the benefits for each period are equal to or greater than the standard nonforfeiture benefit for that period, except that the minimum nonforfeiture benefit must not be less than 30 times the daily nursing home

benefit in effect at the time of the lapse ~~[.]~~ ***and is subject to the limitations of subsection 13.***

(d) Except as otherwise provided in paragraph (f), the nonforfeiture benefit must begin not later than the end of the third year following the date of issue of the ~~[policy]~~ ***long-term care insurance contract*** or certificate.

(e) Except as otherwise provided in paragraph (f), the contingent benefit upon lapse must be effective from the date of issue of the ~~[policy]~~ ***long-term care insurance contract*** or certificate.

(f) For a ~~[policy]~~ ***long-term care insurance contract*** or certificate with attained age rating, the nonforfeiture benefit must begin on the earlier of:

(1) The end of the 10th year following the date of issue of the ~~[policy]~~ ***long-term care insurance contract*** or certificate; or

(2) The end of the second year following the date on which the ~~[policy]~~ ***long-term care insurance contract*** or certificate is no longer subject to attained age rating.

(g) Nonforfeiture benefits 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.

~~[12.]~~ ***13.*** All benefits paid by an insurer while a ~~[policy]~~ ***long-term care insurance contract*** or certificate is not in premium-paying status and in a paid-up status must not exceed the maximum benefits which would be payable if the ~~[policy]~~ ***long-term care insurance contract*** or certificate remained in premium-paying status.

~~[13.]~~ ***14.*** The minimum nonforfeiture benefits required by this section must be the same for group and individual ~~[policies of]~~ long-term care insurance ~~[.~~

~~14.]~~ ***contracts.***

15. Premiums charged for a ~~[policy]~~ ***long-term care insurance contract*** or certificate containing nonforfeiture benefits or a contingent benefit upon lapse are subject to the loss ratio requirements applicable to the ~~[policy]~~ ***long-term care insurance contract*** as a whole.

~~[15.]~~ ***16.*** To determine whether the provisions of paragraph (c) of subsection ~~[9]~~ ***10*** and paragraph (c) of subsection ~~[10]~~ ***11*** apply, a replacing insurer that purchases or otherwise assumes a block or blocks of ~~[policies of]~~ long-term care insurance ***contracts*** from another insurer shall calculate the percentage increase based on the initial annual premium paid by the policyholder or certificate holder when the ~~[policy]~~ ***long-term care insurance contract*** was first purchased by the policyholder or certificate holder.

~~[16.]~~ ***17.*** An insurer shall offer a nonforfeiture benefit for any qualified long-term care insurance contract that is a level premium contract. The nonforfeiture benefit provision must:

(a) Be appropriately captioned;

(b) Provide a benefit available in the event of a default in the payment of any premiums;

(c) State that the amount of the benefit may be adjusted only as is necessary to reflect changes in claims, persistency and interest, as reflected in changes in rates for premium-paying contracts approved by the Commissioner for the same contract form; and

(d) Provide:

(1) Reduced paid-up insurance;

(2) Extended-term insurance;

(3) A shortened benefit period; or

(4) Any other similar offerings approved by the Commissioner.

Sec. 81. Section 33 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008, is hereby amended to read as follows:

Sec. 33. 1. Except as otherwise provided in this section, the provisions of section 32 of this regulation apply to any ~~[policy or certificate of]~~ long-term care insurance ***contract or certificate*** issued in this State on or after October 1, 2008.

2. The provisions of section 32 of this regulation do not apply to a certificate issued on or after October 1, 2008, to a group described in subsection 1 of NAC 687B.025 under a group ~~[policy of]~~ long-term care insurance ***contract*** which was in force on October 1, 2008.

3. The provisions of subsections ~~[4, 8 and 10]~~ ***5, 9 and 11*** of section 32 of this regulation do not apply to new certificates issued to a group described in subsection 1 of NAC 687B.025 under a group ~~[policy of]~~ long-term care insurance ***contract*** issued on or after April 1, 2009.

4. Except as otherwise provided in subsections 2 and 3, the provisions of subsections ~~[4, 8 and 10]~~ ***5, 9 and 11*** of section 32 of this regulation apply to any ~~[policy or certificate of]~~ long-term care insurance ***contract or certificate*** issued in this State on or after January 1, 2009.

Sec. 82. Section 34 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008, is hereby amended to read as follows:

Sec. 34. 1. A ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ must condition the payment of benefits on a determination of the ability of the insured to perform activities of daily living and on the cognitive impairment of the insured. Eligibility for the payment of benefits must not be more restrictive than requiring a determination that the insured:

(a) Is unable to perform more than three of the activities of daily living; or

(b) Has a cognitive impairment.

2. For the purpose of determining the ability of an insured to perform the activities of daily living pursuant to subsection 1, such activities include, without limitation:

(a) Bathing;

(b) Continence;

(c) Dressing;

(d) Eating;

(e) Toileting;

(f) Transferring; and

(g) Any other activity of daily living defined in the ~~[policy]~~ ***long-term care insurance contract*** or certificate.

3. For the purposes of this section, the determination of a deficiency in the ability of the insured to perform the activities of daily living must not be more restrictive than a determination that the insured:

(a) Requires the hands-on assistance of another person to perform the prescribed activities of daily living; and

(b) If the deficiency is due to a cognitive impairment, requires supervision or verbal cues by another person to protect the insured or other persons.

4. Determinations regarding activities of daily living and cognitive impairment must be performed by a licensed health care practitioner.

5. In addition to the criteria set forth in subsections 1 to 4, inclusive, an insurer may use any other criteria for determining when benefits are payable under a ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ that are not more restrictive than the criteria set forth in subsection 1.

6. A ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ must include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

7. Except for certificates issued on or after October 1, 2008, under a group ~~[policy of]~~ long-term care insurance ***contract issued*** to a group described in subsection 1 of NAC 687B.025 that was in force on October 1, 2008, the provisions of this section apply to any ~~[policy]~~ ***long-term care insurance contract*** or certificate ~~[of long-term care insurance]~~ issued in this State on or after October 1, 2008.

8. As used in this section, "licensed health care practitioner" means a person licensed pursuant to chapters 630 to 633, inclusive, of NRS, a licensed social worker or other individual who meets the requirements prescribed by the Secretary of the Treasury pursuant to 26 U.S.C. § 7702B(c)(4).

Sec. 83. 1. NAC 687B.065 is hereby repealed.

2. Sections 11 to 15, inclusive, and 28 of LCB File No. R121-07, which was adopted by the Commissioner of Insurance and was filed with the Secretary of State on September 18, 2008, are hereby repealed.

Sec. 84. 1. Notwithstanding the provisions of subsection 12 of section 13 of this regulation, section 13 of this regulation does not apply to a long-term care insurance contract or certificate issued on or after the effective date of this regulation until:

(a) Except as otherwise provided in paragraph (b), 6 months after the effective date of this regulation.

(b) For a certificate issued on or after the effective date of this regulation under a group long-term care insurance contract in force on the effective date of this regulation for a group described in subsection 1 of NAC 687B.025, the date of the first anniversary of the contract to occur more than 12 months after the effective date of this regulation.

2. As used in this section:

(a) "Certificate" has the meaning ascribed to it in NAC 687B.015.

(b) "Group long-term care insurance" has the meaning ascribed to it in NAC 687B.025.

(c) "Long-term care insurance contract" has the meaning ascribed to it in section 3 of this regulation.

TEXT OF REPEALED SECTIONS

687B.065 Right to return policies issued pursuant to direct-response solicitation; notice of right. (NRS 679B.130)

1. A person insured under a policy of long-term care insurance issued pursuant to a direct-response solicitation may return the policy within 30 days after its delivery and have the premium refunded if, after examining the policy, he is not satisfied for any reason.

2. A policy of long-term care insurance issued pursuant to a direct-response solicitation must have a notice prominently printed on the first page or attached thereto stating in substance that the insured may return the policy within 30 days after its delivery and have the premium refunded if, after examining the policy, he is not satisfied for any reason.

Section 11 of LCB File No. R121-07:

Sec. 11. 1. Except for a policy of long-term care insurance under which the right not to renew is reserved solely to the policyholder, a policy of long-term care insurance must contain a renewability provision that:

(a) Is appropriately captioned;

(b) Appears on the first page of the policy; and

(c) Clearly states that the coverage is guaranteed renewable or noncancellable.

2. An individual policy of long-term care insurance, other than one for which the insurer does not have the right to change the premium, must include a provision that premium rates may change.

Section 12 of LCB File No. R121-07:

Sec. 12. 1. Except for a rider or endorsement by which an insurer effectuates a request made in writing by the policyholder under an individual policy of long-term care insurance, any rider or endorsement added to an individual policy of long-term care insurance after the date of issue or at reinstatement or renewal that reduces or eliminates benefits or coverage must be agreed to in writing and be signed by the policyholder.

2. After the date of issue of a policy, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the term of an individual policy of long-term care insurance must be agreed to in writing and signed by the policyholder unless the increased benefits or coverage are required by law.

3. If a separate additional premium is charged to a policyholder for benefits provided in connection with riders or endorsements, the premium charge must be set forth separately in the policy, rider or endorsement.

Section 13 of LCB File No. R121-07:

Sec. 13. A policy or certificate of long-term care insurance that provides for the payment of benefits based on standards described as “usual and customary,” “reasonable and customary” or similar words must include a definition of those terms and an explanation of the terms in the outline of coverage that accompanies the policy or certificate.

Section 14 of LCB File No. R121-07:

Sec. 14. 1. If a policy or certificate of long-term care insurance contains any limitations with respect to preexisting conditions, the limitations must appear as a separate paragraph in the policy or certificate that must be labeled as "Preexisting Condition Limitations."

2. If a policy or certificate of long-term care insurance contains any limitations or conditions on eligibility for benefits, a description of the limitations or conditions must appear as a separate paragraph in the policy or certificate that must be labeled as "Limitations or Conditions on Eligibility for Benefits."

Section 15 of LCB File No. R121-07:

Sec. 15. If a policy of life insurance or a rider to a policy of life insurance, other than a qualified long-term care insurance contract, provides for an accelerated benefit for long-term care, the insurer shall provide a disclosure statement at the time of application for the policy or rider and at the time a request for payment of accelerated benefits is submitted which provides that receipt of any accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement must be prominently displayed on the first page of the policy or rider and any other related documents.

Section 28 of LCB File No. R121-07:

Sec. 28. If a policy or certificate of long-term care insurance replaces another policy or certificate of long-term care insurance, the replacing insurer must waive any period applicable to preexisting conditions and any probationary periods in the new policy or certificate for similar benefits to the extent that similar periods have been satisfied under the original policy or certificate.