CHAPTER 90g. INDIVIDUAL HEALTH CARE FACILITY BENEFITS PROVIDED AS ACCELERATED DEATH BENEFIT OR SETTLEMENT OF DEATH BENEFIT; PROVIDED BY RIDERS OR BUILT INTO POLICIES—STATEMENT OF POLICY

Sec.

Source

The provisions of this Chapter 90g adopted January 18, 1991, effective January 19, 1991, 21 Pa.B. 251, unless otherwise noted.

§ 90g.1. Scope.

An individual health care facility benefit filing complying with the standards of this chapter is acceptable.

§ 90g.2. General provisions.

An individual health care facility benefit filing complying with the following is acceptable:

(1) The submission letter for a form complies with applicable requirements of § 89b.5 (relating to letter of submission). For a rider, the submission letter includes a list of the contracts to which the rider will be attached.

(2) The form is submitted in duplicate. This complies with § 89b.4(a) (relating to general filing procedure).

(3) The form is submitted in the final printed form intended for actual issue, unless the insurer requests tentative approval under § 89.4(d) (Reserved). A form submitted for tentative approval is in draft, printer's-proof, photocopied, ''filer'' or some other legible form.

(4) The form number and the wording of the form are printed in easily readable type.

(5) Logos are or are not present and are more or less prominent than the company name.

(6) The full company name appears on a rider for filing purposes. The name is printed or added by rubber stamp or other appropriate means. This complies with § 89b.11(a) (relating to general contents of forms).

(7) An administrative office address or the home office address is or is not shown. If an address is captioned as ''home office,'' it is the official home office address of record.

(8) The form contains a caption:

(i) Disclosing the coverage provided—health care facilities, long term care or other descriptive disclosure.

(ii) For a rider, disclosing that the form is a rider, endorsement, agreement or amendment. An alternative caption may be used if the form provides that the form is ''attached to and made a part of the policy.''

(9) A rider contains an effective date disclosure, either in the rider or on the specifications page of the policy.

(10) A rider contains a disclosure of a premium, cost of insurance rates or other charges, either in the rider or on the specifications page of the policy. For a benefit built into a policy, the specifications page discloses that the cost of the benefit is included in the basic policy premium. If the benefit provides for other charges, the benefit or specifications page discloses the charges.

(11) The premium, maximum cost of insurance or another charge is guaranteed.

§ 90g.3. Benefit design.

(a) *Benefit paid if elected by owner.*

(1) The form discloses that a benefit will be paid if elected by the owner when the insured receives care from a designated health care facility. The form designates one or more types of health care facilities. The following are types of health care facilities: skilled nursing facility, extended care facility, intermediate care facility, convalescent care facility, personal care facility, home care facility or hospice facility. This is not an all inclusive list of types of health care facilities which may be designated.

(2) The form does or does not provide that the cause for the need of care from the health care facility is sickness or injury.

(3) The cause for the need of care from the health care facility is not restricted to one or more specific medical condition. A medical condition, except as excluded in accordance with § 90g.4 (relating to exclusions and restrictions), is acceptable.

(4) The form does not provide that the cause may not be sickness.

(5) The form does not provide that the cause may not be injury.

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(6) The form does or does not provide that the care from health care facilities is medically necessary. If the form provides that the care from health care facilities is medically necessary, the form contains a definition of ''medically necessary.''

(b) *Form discloses benefit paid.* The form discloses the benefit paid.

(1) The amount of the benefit paid is meaningful. If the benefit is designed as an accelerated benefit, the benefit, including the aggregate of all periodic payments, is meaningful if it is equivalent to at least 2% of the total death benefit affected by the benefit payment.

(2) The form provides an explanation of how the benefit payment is determined.

(3) The benefit is paid periodically or in a lump sum.

(4) The maximum benefit period for each occurrence of health care facility usage is at least 1 year or for a shorter period if the total death benefit affected by the benefit payment is inadequate to support payment of the benefit for a full year.

(5) Any maximum benefit period for home care benefits is or is not identical to that applied to other health care facility benefits.

(6) The form does or does not provide for a maximum monthly benefit amount.

(7) The form discloses the maximum benefit amount that will be paid over the lifetime of the coverage. This amount does not exceed 100% of the total death benefit affected by the benefit payment.

(8) A maximum benefit amount for home care benefits is not less than 50% of the benefit that applies to other health care facility benefits.

(9) The form does not provide for age or duration requirements as to when the insured is first eligible for the benefit.

(c) *Conditions for payment.* The form discloses the conditions for payment of the health care facility benefit.

(1) The insured receives services from a health care facility.

(2) The services are provided during the coverage period.

(3) The services are provided while the rider or the policy, in the case of a built-in benefit, are in force. The form does or does not provide for a continuation of benefit payments during the confinement period if the insured is receiving a benefit at the time the rider or policy terminates.

(4) The form does or does not require that services be provided while the policy is in full force; for example, not under a nonforfeiture option.

(5) If the payment of the benefit requires that the insured enter the health care facility within a period of time from discharge from an institutional confinement, the period of time from discharge is at least 30 days. The original institutional confinement is not required to be greater than 3 days.

(6) The insured is or is not required to receive services for a period of time prior to payment of a benefit. This period of time is referred to as an elimina-

tion or waiting period and does not exceed 90 days, or 180 days if the benefit is designed as a settlement of the life insurance proceeds based on a reduced life expectancy of the insured and there is no scheduled charge for the benefit other than an administrative expense charge made at the time the settlement is elected.

(7) A new elimination or waiting period is or is not applied each time an insured begins receiving services for a new or nonrelated cause, or for the same cause if services by a health care facility have not been provided to the insured for a period of at least 6 months.

(8) A new elimination or waiting period is not applied each time an insured begins receiving services for the same cause if the services are provided less than 6 months from the last time services were provided.

(9) If the form requires that the insured receive services for a period of time prior to payment of a benefit, the form does not require that the period of time be continuous or without interruption or that the period of time immediately precede the period for which a benefit will be paid unless ''continuous,'' ''without interruption'' or ''immediately preceding'' are defined in a manner consistent with paragraphs (7) and (8).

(10) If the form contains a home health care benefit and requires that the insured be confined in a health care facility to establish eligibility for the home health care benefit, the period of confinement is not required to be greater than 30 days.

(11) The owner requests payment of the benefit.

(12) The form does or does not provide that it can not be assigned. If the form provides that it may be assigned, the form does or does not require written consent of any assignee prior to the election of the benefit.

(13) The form does or does not require the written consent of the beneficiary prior to the election of the benefit.

(d) *Death benefit reduced.*

(1) The form contains a clear statement that the death benefit and any accumulation values and cash values will be reduced if a health care facilities benefit is paid. The statement appears immediately following the caption of the form in prominent type on the first page of the rider. If the benefit is built into the policy and the brief description refers to the benefit, the statement appears in close proximity to the brief description of the policy in prominent type on the first page of the policy. If the benefit is not referred to in the brief description, the statement appears in a prominent position in prominent type on the first page of the policy. Prominent type means, for example, all capital letters, contrasting color, underlined or otherwise differentiated from the other type in the form.

(2) This statement is unnecessary if the benefit is designed as a settlement of the life insurance proceeds based on a reduced life expectancy of the insured

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and is equal to 100% of the policy death benefit and the policy terminates upon payment of the settlement amount. The benefit can be paid out in monthly installments.

(e) *Effects of payment of benefit.*

(1) The form describes the effects of the payment of the benefit on the death benefit and any accumulation value, cash value, loan balance and premium payment following payment of a benefit or at settlement of the life insurance proceeds based on a reduced life expectancy of the insured.

(2) If the cash value or accumulation value is reduced by the proportional reduction in the death benefit, the fixed premiums for the policy, affected death benefit riders and health care facilities benefit are reduced by the same proportional amount.

(3) If the cash value or accumulation value is reduced by 100% of the benefit payment amount, as a lien, an adjustment in the premium of the policy, affected death benefit riders and health care facilities benefit may or may not be made.

(4) If the premium for the health care facilities benefit is flexible and the form is attached to or included in a flexible premium policy or with flexible premium affected death benefit riders, an adjustment to the premium payment of the policy, affected death benefit riders and health care facilities benefit may or may not be made. If an adjustment is made, the reasons for the premium adjustment method are explained in writing.

(5) If the benefit payment is reduced by an amount of the loan balance, the loan balance is reduced by the same amount.

(f) *Single premium policy.* If the form is attached to or included in a single premium policy, the benefit payment is increased by the portion of the single premium unearned as of the date of qualification for the benefit corresponding to the amount of the benefit payment.

(g) *Renewable coverage.* If the form provides renewable coverage, the renewability is guaranteed.

(h) *Cancellation.* The form is not subject to cancellation by the insurer during the coverage period, except as provided in the grace period and nonforfeiture provisions.

(i) *Health care facility licensure.* If the form provides that the health care facility must be licensed by the jurisdiction in which it is located, clarification is provided in the form that licensing is only required if the jurisdiction actually requires licensing.

(j) *Pooling of values.*

(1) The form does or does not provide for the pooling of the values of all policies issued on the insured's life by the insurer or by the insurer and affiliated insurers. Pooling is for the purpose of determining the initial eligibility for the benefit or the amount and duration of the benefit. If a form provides for pooling, the insurer certifies that a copy of the form will be included in each

affected policy. As an alternative for policies issued prior to the issuance of the form, the insurer certifies that a certificate listing all the policies eligible for the benefit will be provided to the owner. The form discloses the manner in which the pooling affects any conditions, restrictions or benefits of the form.

(2) The form does not provide for the pooling of the values of all policies issued on the insured by the insurer and nonaffiliated insurers.

§ 90g.4. Exclusions and restrictions.

(a) The form contains none or one or more of the following exclusions and restrictions:

(1) War, declared or undeclared, or an act of war, whether or not serving in the military forces or a civilian noncombatant unit serving with the forces.

(2) Active duty as a member of the armed forces of any nation.

(3) Committing an assault or felony, whether sane or insane.

(4) Participating in a riot or insurrection.

(5) A fight in which the insured is a voluntary participant.

(6) Suicide or attempted suicide, whether sane or insane.

(7) Intentionally self-inflicted injury, whether sane or insane.

(8) Engaging in an illegal occupation.

(9) Travel or flight in an aircraft or spacecraft or descent from such a craft while in flight, or subsequent drowning, if the insured is a pilot, officer or crew member of the craft; is giving or receiving aviation training or instruction; has any duties on or relating to the craft; or is being flown for the purpose of descent from the craft while in flight.

(10) Voluntary taking or injection of drugs unless prescribed or administered by a licensed physician. The wording ''taken as prescribed'' or ''taken in the manner prescribed'' is not present.

(11) Voluntary taking or injection of drugs, whether legal or illegal, unless prescribed or administered by a licensed physician. The wording ''taken as prescribed'' or ''taken in the manner prescribed'' is not present.

(12) The voluntary taking of any drugs prescribed for the insured by a licensed physician and intentionally not taken as prescribed.

(13) The voluntary taking of any drugs, whether legal or illegal, prescribed for the insured by a licensed physician and intentionally not taken as prescribed.

(14) Sensitivity to drugs voluntarily taken, unless prescribed by a physician.

(15) Sensitivity to drugs, whether legal or illegal, voluntarily taken, unless prescribed by a physician.

(16) Drug addiction, unless addiction results from the voluntary taking of drugs prescribed or administered by a licensed physician or from the involuntary taking of drugs.

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(17) Drug addiction, unless addiction results from the voluntary taking of drugs, whether legal or illegal, prescribed or administered by a licensed physician or from the involuntary taking of drugs, whether legal or illegal.

(18) Alcoholism treatment.

(19) Chronic alcoholism.

(20) Loss resulting directly or indirectly from the voluntary taking of alcohol alone or in combination with a drug, medication or sedative when that action results in legal intoxication as defined by Pennsylvania law. The insurer provides a certification that the Pennsylvania legal definition for intoxication will be used if the form does not refer to ''intoxication as defined by Pennsylvania law.''

(21) Care or confinement prescribed for convenience only.

(22) Care or confinement prescribed for custodial purpose only.

(23) Care or confinement prescribed for rest cures.

(24) Benefit payment denial if services are provided by a health care facility operated by a member of the insured's immediate family.

(25) Benefit payment denial if services are provided by a health care facility which does not maintain at least a daily record for each patient.

(26) Mental, nervous, emotional or personality disorder without demonstrable organic disease, including, but not limited to, neurosis, psychoneurosis, psychopathy or psychosis.

(27) Services provided outside either the United States or the United States or Canada.

(28) Reimbursement for services covered by Medicare or another government program.

(b) The form contains none of the following exclusions and restrictions:

(1) Riot or insurrection.

(2) Gunshot or pistol wound, unless unintentionally caused by someone else.

(3) Gunshot or pistol wound, unless intentionally or unintentionally caused by someone else.

(4) Travel in any kind of military aircraft or seacraft or aircraft or seacraft operated for the armed forces.

(5) Air travel.

(6) Air travel except as a fare paying passenger on a regularly scheduled commercial airline.

(7) Illegal drug use.

(8) Drug addiction.

(9) Involuntary taking of drugs or poison.

(10) Voluntary taking of drugs or poison.

(11) Preexisting conditions.

(12) Requirement that the form be in force for a specific period of time prior to eligibility for coverage.

(13) Alzheimer's Disease or another disorder with a demonstrable organic origin.

(14) Benefit payment denial due to the insured's financial resources, income or need.

(15) Benefit payment denial if there is not a reasonable expectation that a significant improvement will occur in the insured's condition.

(16) Benefit payment denial if services are provided by a health care facility for the insured less often than on a daily basis.

(17) Benefit payment denial if services are not provided in the least costly setting.

(18) Benefit payment denial if the health care facility does not accommodate a minimum number of persons.

(19) Benefit payment denial if reimbursement for services is provided by another insurer.

(20) Other exclusions or restrictions that are unfair or unduly restrictive.

Cross References

This section cited in 31 Pa. Code § 90g.3 (relating to benefit design).

§ 90g.5. Claim provisions.

(a) The form contains the following claim provisions:

(1) *Notice of claim.* Written notice of claim is to be given to the insurer within 20 days after the occurrence or commencement of a covered loss or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured to the insurer at _____ (insert the location of the office as the insurer may designate) or to an authorized agent of the insurer, with information sufficient to identify the insured, is deemed notice to the insurer.

(2) *Claim forms.* The insurer upon receipt of a notice of claim, is required to furnish to the claimant forms as are usually furnished by it for filing proofs of loss. If the forms are not furnished within 15 days after the giving of the notice of claim, it is considered that the claimant complied with the requirements of this contract as to proof of loss if the claimant submits, within the time fixed in the contract for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

(3) *Proofs of loss.* Written proof of loss is to be furnished to the insurer at its office, in case of claim for loss for which this contract provides a periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which the insurer is liable, and in case of claim for another loss, within 90 days after the date of the loss. Failure to furnish proof within the time required does not invalidate nor reduce a claim if it was not reasonably possible to give proof within that time, if the proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

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(4) *Time of payment of claims.* Indemnities payable under this contract for any loss other than loss for which this contract provides any periodic payment are due immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this contract provides periodic payment are to be paid _____ (insert period for payment).

(5) *Payment of claims.* Benefits are to be paid to the owner or owner's estate while the insured is living, unless they have been assigned elsewhere.

(6) *Physical examinations.* The insurer as its own expense has the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim thereunder.

(b) In lieu of the claim provisions specified in this section, the form contains other appropriate provisions and the submission letter contains a complete justification for the lack of the claim provisions specified in this section.

§ 90g.6. Facility of payment after death.

The form does not provide for the use of a facility of payment to disburse health care facilities benefit payments after the insured's death. The payments are paid in accordance with the terms of the policy or any assignment.

§ 90g.7. Facility payment while living.

The form does or does not provide for the use of a facility of payment to disburse health care facilities benefit payments while the insured is living.

§ 90g.8. Termination of coverage.

The form discloses the conditions under which the coverage terminates.

(1) *Benefit provided by rider.*

(i) The following conditions are disclosed if the benefit is provided by a rider:

(A) Written request from the owner for termination.

(B) Termination of the policy.

(C) Nonpayment of premium.

(D) The total amount of the paid benefits equals the maximum lifetime benefit amount. This condition is disclosed if a benefit is built into a policy.

(ii) The form may or may not provide for a continuation of benefit payments during a confinement period if the insured is receiving a benefit at the time the policy or rider terminates.

(2) *Termination condition disclosed.* The following termination condition is disclosed if applicable: When a policy nonforfeiture option takes effect. This complies with § 89.42(e) (relating to nonforfeiture value requirements). Alternatively, this termination condition is disclosed in the policy.

(3) *Termination condition not disclosed.* The following termination condition is not disclosed: Attainment of a specified age or contract anniversary, or both, other than at an age or anniversary at which the policy terminates.

§ 90g.9. Prohibited terminology.

The following terminology is not present:

(1) The term ''special,'' unless used in reference to or to designate one or more of the following: a premium payment mode, a premium rating class or a settlement option or options under a policy. This complies with § 89.13(c) (relating to use of certain words and terms).

(2) The term ''deposit,'' unless used in conjunction with the word ''premium'' or the payment establishes a debtor-creditor relationship. This complies with § 87.28 (relating to reference to payment as ''deposit'').

(3) The term ''legal reserve,'' the absence of which complies with Chapter 139 (relating to prohibited phrases).

(4) The term ''franchise.''

(5) The term ''sponsor,'' unless used in reference to an entity which pays all or part of the premium or is a pension or welfare plan sponsor under ERISA.

§ 90g.10. Inconsistent or contradictory language.

The form contains no inconsistent or contradictory language or provisions.

§ 90g.11. Definition.

The form contains a definition or explanation of terminology that in the absence of definition or explanation would not be understood by a lay person of average intelligence.

§ 90g.12. Fraternal benefit society.

If a form will be issued by a fraternal benefit society, nonstandard insurance terminology is or is not used. This complies with § 89.102(b)(3) (relating to guidelines for approval of forms).

§ 90g.13. Riders.

(a) If a rider will be attached to a policy after issue, the form contains an officer's signature. If a rider will be attached to a policy only at issue, an officer's signature is or is not present.

(b) A rider contains a form number. This complies with § 89b.11(b) (relating to general contents of forms).

§ 90g.14. Tax consequences notice.

(a) The form contains a clear statement that the tax status of health care facilities benefit payments is not clear at this time and that the owner should seek

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additional information from his personal tax advisor. The statement appears in a prominent position in prominent type on the first page of the rider, or the policy if the benefit is built into the policy. Prominent type means, for example, all capital letters, contrasting color, underlined or otherwise differentiated from the other type in the form.

(b) If the tax status is determined by legislation or Internal Revenue Service ruling, a tax consequences notice will not be required until further notification.

§ 90g.15. Disclosure and benefit payment notice.

(a) The insurer certifies that no later than the time the application for the benefit is signed, the agent, broker or insurer will provide the applicant with a written disclosure of the benefit providing:

(1) An explanation of how payments of the benefit affect the death benefit and any policy accumulation values, cash values, loan balance and premium.

(2) An explanation of how the termination or maturity of the policy affects the benefit.

(3) A description of the amounts and durations of the benefit and the guaranteed lifetime benefits, if any.

(4) A disclosure of any exclusions, reductions or limitations.

(b) Disclosures required by subsection (a)(1) and (2) appear in a prominent position in prominent type. Prominent type means, for example, all capital letters, contrasting color, underlined or otherwise differentiated from the other type in the form.

(c) The insurer certifies that the disclosure will be provided either as a separate form, included in an outline of coverage, or in the disclosure statement required by Chapter 83 Subchapter A (relating to required disclosures in the solicitation of life insurance).

(d) The insurer certifies that at least annually while benefits are being paid, the insurer will provide the owner with a written benefit payment notice providing:

(1) The dollar amount of benefits paid during the report period.

(2) The dollar amounts of the remaining death benefit and any accumulation values, cash values and loan balance.

(e) The insurer certifies that the benefit payment notice will be provided as a separate form or included in a policy annual report. If included in an annual report, the notice will appear in prominent type. Prominent type means, for example, all capital letters, contrasting color, underlined or otherwise differentiated from the other type in the form.

(f) The form provides a disclosure that the benefit payment notice will be provided annually.

(g) The insurer certifies that information included in the disclosure and benefit payment notice will be based on contract guarantees. No projected or nonguaranteed values or benefits will be shown.

§ 90g.16. Actuarial considerations.

Actuarial considerations for forms designed as a settlement of the life insurance proceeds based on a reduced life expectancy of the insured.

(1) The insurer files the current mortality and interest and the formula used to determine the settlement amount. The insurer also files sample settlement amounts per $1,000 insurance for representative ages and plans and a sample calculation in the format that the Insurance Department can reproduce the settlement amount.

(2) The insurer certifies in writing that it will file all future changes on the basis of the calculation of the settlement amount. It will file changes in the mortality table or formula and changes in the interest rate of more than 1/2 of 1%.

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