CHAPTER 12 - LIFE AND HEALTH DIVISION

SECTION .0100 - GENERAL ORGANIZATION AND FUNCTIONS

11 NCAC 12 .0101 GENERAL PROVISIONS

In this Chapter, unless the context otherwise requires:

(1) "Deemer clause" or "deemer provision" shall mean any clause or provision which establishes a period of time certain, e.g. 90 days, etc., within which time the commissioner must disapprove a particular matter before him or set a hearing and which if no action is taken by the commissioner within the period of time certain, said matter before the commissioner is deemed approved.

(2) "Division" shall mean the life, accident and health division of the North Carolina Department of Insurance.

(3) "Form" shall consist of but not be limited to the application, rider, certificate, policy, etc.

History Note: *Authority G.S. 58-9; 58-54; 58-254.7; 58-347;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. April 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0102 PURPOSE OF DIVISION
11 NCAC 12 .0103 PERSONNEL OF DIVISION

History Note: *Authority G.S. 58-4; 58-9;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Repealed Eff. July 1, 1988.

SECTION .0200 - DESCRIPTIONS OF FORMS

11 NCAC 12 .0201 PRE-EXISTING CONDITIONS AND RENEWABLE AT COMPANY OPTION

The notices for pre-existing conditions and policies renewable at the option of the company are used as examples of acceptable wording for stickers placed on or notices printed on the face of accident and health policies identifying the pre-existing condition exclusions and the provisions for a policy renewable at the option of the company. These forms include a heading, descriptive paragraph and other pertinent information.

History Note: *Authority G.S. 58-2-40; 58-65-1; 58-65-40;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0202 COMPARATIVE INFORMATION FORM
11 NCAC 12 .0203 REPLACEMENT NOTICE

History Note: *Authority G.S. 58-9; 59-42; 58-42.1; 58-54.4; 58-195; 58-199;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. July 1, 1982; July 5, 1979;
Repealed Eff. October 1, 1985.

11 NCAC 12 .0204 NOTICE FOR REVISION OF RATES FOR NON-PROFIT SERVICE CORP

The form of notice of public hearing on revision of rates of nonprofit hospital, medical or dental service corporations is a guide for the preparation and publication of the notice of public hearing pursuant to G.S. 58-65-45 on the revision of rates of a nonprofit hospital, medical or dental service corporation. This form includes the time, date and

location of the public hearing, the company proposing the revision, a complete description of the proposed revision and any other pertinent information.

History Note: *Authority G.S. 58-2-40; 58-65-45;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. April 8, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0205 NC BUYER'S GUIDE TO LIFE INSURANCE
11 NCAC 12 .0206 PRELIMINARY POLICY SUMMARY: WHOLE LIFE
11 NCAC 12 .0207 PRELIMINARY POLICY SUMMARY: TERM POLICIES

History Note: *Authority G.S. 58-9; 58-25.1; 58-26; 58-33; 58-42; 58-42.1; 58-54.4; 58-195; 58-198; 58-199;*
Eff. April 26, 1979;
Repealed Eff. June 16, 1979.

11 NCAC 12 .0208 MEDICARE AND MEDICAID - BUYER'S GUIDE

(a) The North Carolina Buyer's Guide to Health Insurance and Medicare and Medicaid is provided pursuant to 11 NCAC 12 .0548. This form consists of information regarding North Carolina law and regulations pertaining to the people eligible for Medicare and Medicaid and other pertinent information.

(b) The Buyer's Guide shall be printed in at least 14 point type in a 16 point base in contrasting colors of red and black on matte paper with dull ink. The format shall be as prescribed by the commissioner. The commissioner shall consider written requests for deviations on a case by case basis.

History Note: *Authority G.S. 58-2-40; 58-54-25; 58-249; 58-250.1; 58-252; 58-254.5; 58-254.7;*
Eff. October 24, 1981;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

SECTION .0300 - GENERAL PROVISIONS

11 NCAC 12 .0301 GENERAL PROVISIONS

History Note: *Authority G.S. 58-9;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Repealed Eff. July 1, 1988.

11 NCAC 12 .0302 APPLICATION FOR INSURANCE REQUIRED

History Note: *Authority G.S. 58-344;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. July 1, 1986;
Repealed Eff. April 1, 1989.

11 NCAC 12 .0303 REBATES ON INSURANCE COMPANIES EMPLOYEES: PROHIBITED

History Note: *Authority G.S. 58-54.4(8);*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Repealed Eff. February 1, 1992.

11 NCAC 12 .0304 SEX DISCRIMINATION ON APPLICATIONS

An insurer may not discriminate based on sex in any manner on a life or accident and health insurance application.

History Note: *Authority G.S. 57-1; 57-4; 58-9; 58-44;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0305 TWISTING OR OTHER PRACTICES INJURIOUS TO THE PUBLIC

History Note: *Authority G.S. 58-9(1); 58-42.1; 58-54.4;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Repealed Eff. February 1, 1992.

11 NCAC 12 .0306 LIFE: HEALTH AND ACCIDENT COVERAGES: POLICY OUT OF STATE

Where a group master policy is written upon application taken outside this jurisdiction covering individuals in this state the certificate covering lives within this state shall be considered "North Carolina business" and reported through the office of some general agent, resident in or having territory within the state. This Rule does not apply to group mortgage and blanket scholastic policies where the policy must be issued in North Carolina.

History Note: *Authority G.S. 58-3-1; 58-2-40;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. February 1, 1992; July 1, 1986;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0307 FILING APPROVAL: LIFE: ACCIDENT AND HEALTH FORMS

History Note: *Authority G.S. 58-2-40; 58-6-5; 58-51-1; 58-54-35; 58-55-30; 58-58-1; 58-65-1; 58-65-40; 58-67-50; 58-67-150;*
Eff. February 1, 1976;
Amended Eff. November 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. August 1, 2002; February 1, 1996; February 1, 1992; April 1, 1989;
Repealed Eff. July 1, 2006.

11 NCAC 12 .0308 BANK CREDIT CARD FACILITY AVAILABLE FOR PREMIUM PAYMENT

History Note: *Authority G.S. 58-61.2;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. April 1, 1989;
Temporary Repeal Eff. December 1, 1999;
Repealed Eff. July 1, 2000.

11 NCAC 12 .0309 APPLICATION: BYLAWS: RULES: PART OF THE POLICY CONTRACT

The bylaws or constitution of a mutual insurance company, association, order, society, or reciprocal exchange need not be attached to each policy in order to be a part of the policy contract if the policy contract contains all of the benefits available to the insured.

History Note: *Authority G.S. 58-2-40; 58-51-1; 58-51-15; 58-58-1;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0310 INDUSTRIAL INSURANCE

The following is departmental policy on industrial insurance.

With respect to industrial business in this state an agent shall not be permitted to accept any money in payment of the premiums which are in arrears on any industrial insurance policy that has lapsed and which the insured seeks to reinstate unless the insured is enabled thereby to reinstate the policy. In other words, the agent cannot accept payment of part of the arrears and hold the money in his hands until he can collect the balance.

Any advance premium which is paid by an industrial policyholder shall be recorded in the receipt book of the insured and the record book of the agent in exactly the same manner as current premiums are recorded. There shall be no such things as blind entries in either book and the policyholder's receipt book and the record book of the agent shall be in exact agreement at all times.

Violation of this Rule will result in the initiation of license revocation proceedings. Companies will be expected to report any violation of this Rule to the commissioner.

History Note: *Authority G.S. 58-9(1);*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0311 LIMITATION ON AMOUNT OF CREDIT INSURANCE WRITTEN

History Note: *Authority G.S. 57-1; 57-4; 58-9; 58-344;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Repealed Eff. April 1, 1989.

11 NCAC 12 .0312 ACCIDENTAL DEATH BENEFIT: INHALATION OF GAS: ETC

A policy or rider providing benefits for accidental death may not exclude the following:

(1) The involuntary inhalation of gas and fumes and the involuntary taking of poison.
(2) Accidental death as a result of involuntary exposure to nuclear explosion, nuclear energy or nuclear elements.
(3) The involuntary exposure to hazardous waste and other toxins.
(4) Unintentionally self-inflicted bodily injury.
(5) Bacterial infection resulting from accidental injury.
(6) Accidental ptomaine poisoning.

History Note: *Authority G.S. 58-2-40; 58-3-30; 58-3-150; 58-51-1; 58-51-95;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. February 1, 1992; April 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0313 DISABILITY BENEFIT: CONFINEMENT INDOORS

A policy or rider providing benefits for disability may not require confinement indoors or at home.

History Note: *Authority G.S. 58-2-40(1);*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0314 INSURER LIABILITY: PREMIUM ACCEPTED FROM INELIGIBLE DEBTOR

History Note: *Authority G.S. 57-1; 57-4; 58-9; 58-344;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Repealed Eff. April 1, 1989.

11 NCAC 12 .0315 CALCULATION OF UNEARNED PREMIUM REFUNDS: CREDIT INSURANCE
11 NCAC 12 .0316 MISSTATEMENT OF AGE: CREDIT

History Note: *Authority G.S. 58-346; 58-351;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Repealed Eff. April 1, 1989.

11 NCAC 12 .0317 ORIGIN OF SICKNESS: DESCRIPTION
The use of a term more restrictive than "first manifested" in the determination of when a disease or sickness begins is prohibited. The term "prudent person" cannot be used as a condition to establish when a disease or sickness begins.

History Note: *Authority G.S. 58-2-40; 58-51-95; 58-58-1; 58-65-1; 58-65-40; 58-67-50; 58-67-150;*
Eff. September 26, 1978;
Amended Eff. February 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0318 PREMIUM INCREASES: GROUP

History Note: *Authority G.S. 57-1; 57-4; 58-9; 58-195; 58-249; 58-254.7; 58-293;*
Eff. September 26, 1978;
Repealed Eff. February 1, 1992.

11 NCAC 12 .0319 SUBROGATION PROHIBITED
Life or accident and health insurance forms shall not contain a provision allowing subrogation of benefits.

History Note: *Authority G.S. 58-2-40; 58-51-1; 58-51-85; 58-51-95; 58-58-1; 58-65-1; 58-65-40;*
Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0320 SOUND HEALTH SHALL BE DEFINED
An application for life and accident and health insurance shall not contain a question asking if the applicant is in sound or good health unless the term is defined.

History Note: *Authority G.S. 58-2-40; 58-58-1; 58-65-1; 58-65-40;*
Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0321 RATE FILING: HMO

History Note: *Authority G.S. 58-67-50; 58-67-150;*
Eff. January 22, 1980;
Amended Eff. February 1, 1992;
Repealed Eff. July 1, 2020.

11 NCAC 12 .0322 REGULAR CARE AND ATTENDANCE OF A PHYSICIAN

As used in life, accident and health and disability policies, "regular care and attendance of a physician" shall not be construed to require insureds to see or be under the care of a physician on a regular basis if it can be shown that the insured has reached his maximum point of recovery yet is still disabled under the terms of the insurance contract. This requirement shall not, however, restrict the right of the insurer, at its own expense, to periodically examine or cause to have examined the insured according to the terms of the contract of insurance.

History Note: *Authority G.S. 58-2-40; 58-51-1; 58-65-1;*
Eff. April 1, 1989;
Amended Eff. February 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0323 COMPLICATION OF PREGNANCY

Complications of pregnancy may not be treated differently from any other illness or sickness under the contract. A non-elective cesarean section is considered a complication of pregnancy.

History Note: *Authority G.S. 58-2-40; 58-3-120; 58-51-1; 58-51-95; 58-63-15(7);*
Eff. April 1, 1989;
Amended Eff. February 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0324 HIV AND AIDS DISCRIMINATION PROHIBITED

Human Immunodeficiency Virus (HIV) infection (symptomatic and asymptomatic) and Acquired Immune Deficiency Syndrome (AIDS) must be treated as any other illness or sickness under health insurance policy provisions and policy applications. HIV and AIDS must be defined within the application if any questions are asked about HIV and AIDS.

History Note: *Authority G.S. 58-2-40; 58-3-150; 58-51-1; 58-51.85; 58-51-95;*
Eff. April 1, 1989;
Amended Eff. October 1, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0325 OCCUPATIONAL INJURIES OR DISEASES

History Note: *Authority G.S. 58-2-40; 58-3-150; 58-51-1; 58-51-85; 58-51-95;*
Eff. February 1, 1992;
Amended Eff. October 1, 1994;
Repealed Eff. July 1, 2012.

11 NCAC 12 .0326 APPLICATION FOR INSURANCE REQUIRED

(a) Applications for individual life, and accident or health insurance and annuities intended to insure North Carolina residents shall, except in the case of direct response business, be signed by a North Carolina licensed agent. The signature of the licensed agent must be his or her actual signature.

(b) Applications for insurance shall not include questions related to membership in substance or chemical dependency support groups. The applicant may be required to complete any medical question related to actual treatment, confinement, or diagnosis of such conditions.

History Note: *Authority G.S. 58-2-40; 58-33-25(o)(5); 58-50-5;*
Eff. February 1, 1992;
Amended Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0327 Y2K INTERIM CLAIM PAYMENTS

History Note: *Authority G.S. 58-2-40; 58-2-235;*
Temporary Adoption Eff. January 1, 2000;
Amended Eff. July 1, 2000;
Repealed Eff. September 1, 2002.

11 NCAC 12 .0328 ELIGIBLE INDIVIDUAL COVERAGE

(a) As used in this Rule, "designated health plan" means a guaranteed available plan an insurer must issue to an eligible individual under G.S. 58-68-60.

(b) As used in this Rule, "eligible individual" has the same meaning as in G.S. 58-68-60(b).

(c) As used in this Rule, "insurer" means an entity licensed under G.S. Chapter 58 that offers health insurance coverage in the individual market in this State.

(d) An insurer shall market each of its designated health plan(s) to eligible individuals.

(e) In marketing the designated health plan(s) to eligible individuals, an insurer shall use at least the same sources and methods of distribution that it uses to market other health benefit plans to individuals. An agent authorized by an insurer to market health benefit plans to individuals in this State shall also be authorized to market to eligible individuals.

(f) An insurer shall offer at least the designated health plan(s) to any eligible individual who applies for or makes an inquiry regarding health insurance coverage from the insurer. The offer may be provided directly to the eligible individual or delivered through an agent. The offer shall be in writing and shall include at least the following information:

(1) A general description of the benefits contained in the designated health plan(s) and any other health benefit plan being offered to the eligible individual; and

(2) Information describing how the eligible individual may enroll in the plans.

(g) An insurer shall provide a price quote to an eligible individual (directly or through an authorized agent) within 10 working days of receiving a request for a quote and information necessary to provide the quote. An insurer shall notify an eligible individual within five working days of receiving a request for a quote of any additional information needed by the insurer to provide the quote.

(h) An insurer shall not apply more stringent or detailed requirements related to the application process for an eligible individual than are applied for other individual applicants for other health benefit plans offered by the insurer.

(i) If an insurer denies coverage under a health benefit plan to an eligible individual, the denial shall be in writing and shall state with specificity the reasons for the denial, subject to any restrictions related to confidentiality of medical information. The written denial shall be accompanied by a written explanation of the guaranteed availability of coverage under the designated health plan(s) from the insurer. The explanation shall include at least the following:

(1) A general description of the benefit contained in each designated health plan;

(2) A price quote for each designated health plan; and

(3) Information describing how the eligible individual may enroll in a designated health plan.

(j) The written information described in Paragraph (i) of this Rule shall be provided within the time periods provided in Paragraph (g) of this Rule and may be provided directly to the eligible individual or delivered through an authorized agent.

(k) An insurer shall maintain a toll-free telephone service that answers its telephone calls in a timely manner to provide information to eligible individuals about the availability of the designated health plan(s) in this State. The service shall provide information to callers on how to apply for designated health plan coverage from the insurer. The information may include the names and telephone numbers of agents located near to the caller or other information designed to assist the caller to locate an authorized agent or to otherwise apply for coverage.

(l) An insurer shall not require, as a condition to the offer or sale of a designated health plan to an eligible individual, that the eligible individual purchase or qualify for any other insurance product or service.

(m) An insurer shall not create financial incentives or disincentives for agents to sell or to not sell any of its individual heath benefit plans, including designated health plans.

History Note: *Authority G.S. 58-2-40(1); 58-68-60;*
Eff. April 1, 2003;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0329 SUBMISSION REQUIREMENTS: FORM AND RATE FILINGS

Any insurer, as defined by G.S. 58-1-5(3), that files with the Commissioner for review or approval product forms of life, annuity, accident and health, multiple employer welfare arrangements or managed care provider contract forms and supporting documents, or premium rates, shall comply with the following:

(1) Include a cover letter, or the NAIC Adopted Uniform Transmittal Document in lieu thereof, that:
   (a) Includes the name and address of the submitting company.
   (b) States the company issuing the form.
   (c) Includes the toll-free telephone number and valid electronic e-mail address of the filer.
   (d) Provides a unique identifying form number of each form submitted and its descriptive title.
   (e) Indicates whether the form is new or a form revision.
   (f) Identifies, for any revised forms, the form being replaced by its form number, assigned tracking number, and approval date.

(2) Submitted either via:
   (a) Paper.
   (b) Electronic E-Mail compressed in Adobe Acrobat.
   (c) The National Association of Insurance Commissioners system for electronic rate and form filings (SERFF).

(3) Using the following forms and formats:
   (a) Variable text or benefit ranges shall be in brackets.
   (b) If applications, riders, endorsements or certificates are filed separately, the filer shall indicate policy forms with which they are used.
   (c) Rates by age and mode of payment, including a signed actuarial memorandum, shall be attached to each form requiring a premium.
   (d) Forms shall include a unique form number located in the lower left-hand corner of the first page.
   (e) Filing shall be comprised of one clean copy of the entire submission.
   (f) Electronic submissions shall be formatted in Portable Document Format Adobe Acrobat.
   (g) Red-line side by side comparisons shall be provided with initial submissions that are revising previously-approved forms. An officer of the company shall provide a statement certifying that no changes, other than those red-lined, were made to the form(s).
   (h) Red-line side by side comparisons shall be provided with each resubmission of forms revised during the review process as requested by the Commissioner.

(4) Rates:
   (a) Individual or non-group accident and health products subject to Chapter 58 of the General Statutes shall demonstrate and describe the development of the requested premium. All 30 of the State's "Additional Data Requirements" as required in 11 NCAC 16 .0205 shall be addressed.
   (b) Credit involuntary unemployment insurance, credit life, credit accident and health, and credit property products subject to Article 57 of Chapter 58 of the General Statutes shall demonstrate and describe the development of the requested premium. All applicable data elements as required in 11 NCAC 16. 0400 or 16 .0500 shall be addressed;
   (c) Health maintenance organizations subject to Article 67 of Chapter 58 of the General Statutes shall demonstrate and describe the development of the requested premium. All data elements as required in 11 NCAC 16 .0400 and 16 .0600 shall be addressed;
   (d) Service Corporations subject to Article 65 of Chapter 58 of the General Statutes shall demonstrate and describe the development of the requested premium adjustment in accordance with sound actuarial principles and standards.

(5) No form or rate shall be deemed approved by statute unless the filer provides the Commissioner with written notice.

(6) Submissions that have been disapproved and are not brought into compliance within 60 days of initial receipt shall be closed. File closure shall not prevent revised subsequent submissions but such will be treated as a new filing.

(7) The Commissioner may reject and disapprove incomplete submissions.

History Note: *Authority G.S. 58-2-40; 58-51-1; 58-51-95; 58-54-20; 58-54-35; 58-55-30; 58-55-31; 58-57-30; 58-58-1; 58-65-1; 58-65-40; 58-67-50; 58-67-150;*
Eff. July 1, 2006;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0330 NOTICE OF A CLOSED BLOCK OF INDIVIDUAL BUSINESS

(a) Definitions. As used in this rule:

(1) "Accident and health coverage" has the same meaning as in G.S. 58-3-275.
(2) "Block of business" has the same meaning as in G.S. 58-3-275.
(3) "Closed block of business" has the same meaning as in G.S. 58-3-275.
(4) "Insurer" has the same meaning as in G.S. 58-3-275.
(5) "Policyholder" means the primary insured under an individual accident and health coverage and includes an applicant as described in G.S. 58-3-275(c)(6).
(6) "Qualified actuary" means a member in good standing of the American Academy of Actuaries.

(b) Notices required under G.S. 58-3-275 shall conform to the following:

(1) The notice to the Commissioner shall be submitted to the Life & Health Division of the Department; as applicable, be accompanied by a sample copy of the notices required by G.S. 58-3-275(a)(2) and G.S. 58-3-275(a)(3), in accordance with paragraphs (b)(2) and (b)(3) of this Rule; and include:
    (A) Identification of the policy form(s) for which the insurer has determined to cease active marketing, sale and issuance.
    (B) The date the cessation of sales will be effective.
    (C) The number of North Carolina policyholders and covered individuals currently covered under the listed forms and riders. The number of covered individuals may be estimated by the company.
    (D) At the option of the company, a statement by a qualified actuary that the actuary estimates that the expected impact of ceasing sales of the policy form(s) will not result in premium increases in excess of 5.0% per annum, as provided in G.S. 58-3-275(a)(1).
(2) The notice to a policyholder shall be provided by first-class mail to the policyholder's current address or, if not known, to the policyholder's last known address; if the policyholder is an applicant, as defined in G.S. 58-3-275(c)(6), the notice shall be provided no later than the date the policy is delivered to the policyholder; and the notice shall include:
    (A) Identification of the policy form(s) of the policyholder for which the insurer has determined to cease active marketing.
    (B) The effective date of the cessation of sales, and the closure date as defined in G.S. 58-3-275(c)(4).
    (C) Information regarding the availability of the Commissioner's office for assistance, including the telephone number and address of the office.
    (D) A toll-free telephone number for the insurer to which a policyholder may direct questions and inquiries regarding the closure.
    (E) An explanation of the insurer's decision to cease the sales of the affected products and the possible effects upon future premiums.
    (F) A general explanation of the 12-month premium rate guarantee required by G.S. 58-51-95(f).
    (G) Language similar in content and meaning to the following:

"<INSERT INSURER'S NAME> has decided to stop selling the health insurance policy that you own, creating a closed block of business. With no new sales of this product, future premium rate increases may be greater than they would have been if sales of this product had continued."

(3) The notice to an agent/broker shall include:
    (A) Identification of the policy form(s) for which the insurer has determined to cease active marketing, sale and issuance.
    (B) The date the cessation of sales will be effective and the closure date as defined in G.S. 58-3-275(c)(4).
    (C) An explanation of the insurer's decision to cease the sales of the affected products and the possible effects upon future premiums.

(c) The company's performance of contractual obligations that are contained in policies that are in the closed block of business, including coverage continuation, conversion, or replacement obligations, are not activities inconsistent with the term "closed block of business."

History Note: *Authority G.S. 58-2-40(1); 58-3-275; 58-51-95;*
Eff. July 1, 2006;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0331 HEALTH INSURANCE RISK POOL NOTICE LANGUAGE REQUIREMENTS

History Note: *Authority G.S. 58-2-40; 58-3-276;*
Eff. February 1, 2010;
Repealed Eff. August 23, 2013 pursuant to G.S. 150B-21.7;
Expired Eff. June 1, 2018 pursuant to G.S. 150B-21.3A.

11 NCAC 12 .0332 REVIEW/AUDIT OF THIRD PARTY ADMINISTRATORS

(a) Definitions. As used in this rule:

(1) "Certification" means the certification required by G.S. 58-56-26(c).
(2) "Insurer" has the same meaning as in G.S. 58-56-2(4).
(3) "Third party administrator" or "TPA" has the same meaning as in G.S. 58-56-2(5).

(b) For the certification submitted on July 1, 2010, the insurer shall submit a certification signed by an officer of the insurer, which identifies the name and federal tax identification number of the TPA that is the subject of the certification. The certification shall contain the following language:

"I, (name and title of the officer of the insurer), am familiar with the requirements of G.S. 58-56-26(c), and hereby certify that (insurance company full licensed name and federal tax identification number) performed a review, an on-site audit, or both in accordance with G.S. 58-56-26(c) for every third party administrator identified in or attached to this certification for calendar year 2009."

The certification shall contain the names of TPAs to which G.S. 58-56-26(c) does not apply and the reasons for the exception of each TPA.

(c) For certifications submitted on July 1, 2011 and each subsequent year, each insurer shall certify that the insurer's review and on-site audit include:

(1) An assessment of the TPA's business practices and procedures and evaluations of all of the following:
    (A) The TPA's compliance with provisions of the written agreement with the insurer;
    (B) The TPA's compliance and adherence to the TPA's internal policies and procedures for contract management, claims administration, and general administration, if applicable;
    (C) The TPA's performance of claims adjudication and payment, if applicable;
    (D) The TPA's performance of underwriting services, if applicable; and
    (E) The TPA's performance of collecting premiums or other monies; and
(2) A written summary of the objectives and scope of the review or on-site audit and the results of the review or on-site audit, including a corrective action plan addressing any deficiencies found during the review or on-site audit.

(d) An on-site audit shall include an inspection of the TPA's place of business and shall verify the accuracy, integrity, and completeness of the information received during a review conducted by the insurer under G.S. 58-56-26(c).

(e) In addition to a statement certifying compliance with the requirements of Paragraphs (c) and (d) of this Rule, a certification submitted on or after July 1, 2011 and each subsequent year shall be dated and include:

(1) The insurer's name as it appears on the insurer's license or certificate of authority and the insurer's federal tax identification number;
(2) The name and federal tax identification number of every TPA with which the insurer has a written administrative agreement under G.S. 58-56-6;
(3) Any exceptions to the certification identifying each excepted TPA by name and federal tax identification number and an explanation for the exception of the TPA;
(4) The year for which the certification is made; and
(5) The name, title and signature of an officer of the insurer making the certification.

(f) A sample format for the certification is available free of charge from the Life and Health Division at the Department of Insurance Web site at www.ncdoi.com.
(g) An insurer that did not have any written administrative agreements with TPAs during the reporting year for which the certification is required shall submit a report instead of a certification. This report shall include the information required under Paragraph (e) of this Rule; except the information required by Subparagraphs (e)(2) and (e)(3) of this Rule need not be included.
(h) A review may be conducted on the premises of the insurer or at another location designated by the insurer and may be conducted by electronic means. A review or on-site audit may be performed by either the insurer or the insurer's designated representative. The insurer's designated representative shall not be an employee of or independent contractor with the TPA and shall be an independent, disinterested person or entity.
(i) The certification shall be submitted annually to the Life and Health Division through the NAIC system for electronic rate and form filings ("SERFF" or its successor system or program). If an insurer is unable to use the NAIC system or program, the insurer shall submit the certification by way of the U.S. Postal Service or other mail delivery service or by way of electronic mail, compressed in Adobe Acrobat (PDF).

History Note: *Authority G.S. 58-2-40; 58-56-26;*
Eff. July 1, 2010;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

SECTION .0400 - LIFE: GENERAL NATURE

11 NCAC 12 .0401 LIFE: GENERAL NATURE

History Note: *Authority G.S. 58-9;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Repealed Eff. July 1, 1988.

11 NCAC 12 .0402 FAMILY LIFE POLICIES AND DEPENDENT TERM RIDERS

History Note: *Authority G.S. 58-195;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Repealed Eff. February 1, 1992.

11 NCAC 12 .0403 TERMINATION OF LIFE INSURANCE: EMPLOYEE-EMPLOYER CONTRACTS

Individual life policies issued pursuant to G.S. 58-58-150 may be terminated by the insurance company when the following conditions occur:

(1) All like policies issued to employees of an employer are terminated;
(2) When the employee terminates his employment with that employer.

History Note: *Authority G.S. 58-2-40; 58-58-150;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. April 8, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0404 APPLICATIONS WHICH FINANCE THE FIRST YEAR'S PREMIUM

(a) Applications to be used with the sale of life insurance in which the first year's premium is financed shall comply with 11 NCAC 4 .0318.
(b) The information required in Subsection (a) of this Rule may be attached to instead of printed on the application. A rubber stamp shall not be used.

History Note: *Authority G.S. 58-2-40; 58-58-1;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. February 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0405 LIFE INSURANCE: TOTAL AND PERMANENT DISABILITY BENEFITS

Departmental policy with regard to total and permanent disability provisions of life insurance policies is as follows:

(1) Total and permanent disability provisions of individual or group life insurance and individual or group annuities, whether contained in the policies or in supplementary contracts, shall satisfy in substance the requirements set forth below. In construing these requirements:
   (a) Waiver of premium includes refund of waived premiums if paid;
   (b) The term "income payments" means monthly payments made in addition to waiver of premium and all benefits otherwise provided by the contract;
   (c) The term "disability benefits" means waiver of premium, or both waiver of premium and income payments, whichever may be specified in the provision;
   (d) The term "maturity" means, in the case of endowment policies, the date at which the policy becomes payable as an endowment, and in the case of deferred annuities, the date on which payment of annuity commences;
   (e) The term "age 60" means either actual or rated age 60 of the insured or the policy anniversary nearest thereto as may be specified in the provision, and the term "age 65" shall be similarly construed.

(2) The following provisions or those more favorable to the insured are prescribed:
   (a) Language defining total disability shall be included in the policy;
   (b) That total disability which has been continuous for a period specified in the provisions (not less than four months nor more than one year) shall be presumed permanent;
   (c) That written notice of claim must be given to the company:
      (i) during the lifetime of the insured; and
      (ii) during the period of disability; Failure to give notice within the time provided in the policy shall not invalidate any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible;
   (d) That if total and permanent disability is established pursuant to this Rule, any premium or installment thereof which fell due during such total continuous disability and during a period specified in the provision of the policy contract (not less than six months) immediately preceding notice of claim shall be waived;
   (e) That if total and permanent disability is established pursuant to this Rule, which began after the due date of a premium or installment thereof in default, but not later than the last day of grace, provided such due date was within a period specified in the provision (not less than six months) immediately preceding notice of claim, disability benefits shall be allowed as if the default has not occurred, but the insured shall be liable for the premium in default with interest thereon, if any;
   (f) That any dividends which would otherwise have become payable during disability shall be allowed as though the disability has not occurred, unless an annuity is provided as permitted by Subsection (3)(d) of this Rule;
   (g) That upon recovery of the insured from total disability, disability benefits shall cease and premiums or installments thereof becoming due after such recovery shall be payable.

(3) The following provisions are permitted:
   (a) that the entire and irrecoverable loss of sight of both eyes or the severance of (or alternatively, the entire and irrecoverable loss of the use of) both hands or of both feet, or of one hand and one foot, shall be deemed total disability;
   (b) that disability occasioned by certain risks or hazards specified in the provisions shall be excluded from the coverage;
   (c) that disability benefits shall be payable either to the insured or to a beneficiary;

(d) that in lieu of income payments, there shall be payable an annuity certain for a period of not more than 10 years, the present value of which shall be equal to the amount of insurance, but that upon recovery such annuity shall cease, and the insurance shall be restored at a proportionate premium for an amount equal to the present value of the unpaid installments;

(e) that in the case of endowment policies or deferred annuities income payments shall be made during the continuance of disability, after maturity, provided disability occurred prior to maturity and prior to the insured's attaining age 62;

(f) any other provision not inconsistent with these requirements which may be necessary to the efficient administration of the coverage provided and the protection of the interests of the insurer or the insured; The intention is to permit, among others, provisions such as the following:

(i) that proof of disability shall be made at the time and in the form and manner as specified in the provisions;

(ii) that the insurer may require proof of continuance of disability, including examination of the insured by the insurer at reasonable intervals;

(iii) that the insured may not convert the policy to a higher premium plan during continuance of disability;

(iv) that the insured may not change the mode of premium payment during the continuance of disability;

(v) that a proportionate reduction of income payments, accompanied by return of premiums paid on the amount of such reduction, may be made in case the aggregate monthly amount payable to the insured on account of disability exceeds the percentage specified in the provision (not to exceed 100 percent) of monthly earned income at date of disability, or alternatively at date of application.

(4) The following provisions are prohibited:

(a) the requirement of house or room confinement in the definition of total disability;

(b) that the face amount of insurance shall be reduced by the amount of any disability benefits (except in accordance with Subsection (3)(d) of this Rule);

(c) that in the case of deferred annuities with maturity at age 70 or earlier the monthly disability income payment shall not exceed one-twelfth of the annual annuity or in the case of deferred annuities with maturity at a later age a monthly income disability payment shall be allowed.

History Note: *Authority G.S. 58-2-40; 58-51-1;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0406 GROUP LIFE INSURANCE: COLLECTION FEE

No insurance company licensed in North Carolina will be permitted to pay a collection fee to any person for the collection of premiums under group life insurance contracts, salary savings plans, or any other plan of group life insurance who does not devote a majority of his or her time to the life insurance business and who is not licensed by this department.

History Note: *Authority G.S. 58-2-40; 58-33-25(j); 58-33-85;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0407 GROUP LIFE INSURANCE: DEPENDENT BENEFIT

Dependent life insurance may be written in connection with group life insurance in amounts as allowed by an insurer's underwriting practices.

History Note: *Authority G.S. 58-2-40; 58-58-135;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. April 1, 1989; April 2, 1979;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0408 RULES FOR REPLACEMENT OF LIFE INSURANCE: PURPOSE
11 NCAC 12 .0409 REPLACEMENT OF LIFE INSURANCE: DEFINED
11 NCAC 12 .0410 REPLACEMENT OF LIFE INSURANCE: EXEMPTIONS
11 NCAC 12 .0411 DUTIES OF SOLICITING AGENT
11 NCAC 12 .0412 DUTIES OF INSURERS
11 NCAC 12 .0413 VIOLATIONS

History Note: *Temporary Restraining Order Issued Eff. May 8, 1979;*
Authority G.S. 58-9; 58-9(1); 58-42; 58-42.1; 58-54.4; 58-195; 58-199; 58-210;
Eff. February 1, 1976;
Amended Eff. January 1, 1978;
Readopted Eff. September 26, 1978;
Amended Eff. July 5, 1979;
TRO dissolved June 30, 1981;
Amended Eff. July 1, 1982;
Repealed Eff. October 1, 1985.

11 NCAC 12 .0414 GROUP LIFE: STATE EMPLOYEES: OTHER POLITICAL SUBDIVISION

History Note: *Authority G.S. 58-210(6);*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Repealed Eff. February 1, 1992.

11 NCAC 12 .0415 LIFE APPLICATION
All life and annuity applications used to solicit life insurance or annuities in North Carolina shall inquire whether or not the replacement of existing life insurance or annuities is involved in the transaction.

History Note: *Authority G.S. 58-2-40(1); 58-3-150; 58-33-75; 58-58-1;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0416 LIFE APPLICATION: GUARANTEED ISSUE
When a life insurance policy or certificate is sold on a guaranteed issue basis, the application for such life insurance used in the solicitation may not contain questions or statements regarding an applicant's health.

History Note: *Authority G.S. 58-2-40(1); 58-3-150; 58-58-1;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0417 REFUND OF UNEARNED PREMIUM AT DEATH: CREDIT INSURANCE
11 NCAC 12 .0418 SUICIDE: CREDIT

History Note: *Authority G.S. 58-9; 58-349; 58-351;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Repealed Eff. April 1, 1989.

11 NCAC 12 .0419 FILING AND APPROVAL OF VARIABLE ANNUITY CONTRACTS

After a life insurance company has been granted the authority to write variable annuities the company must submit its variable annuity contract forms to the department for approval. The same requirements which are applicable under existing statutes and rules with respect to the filing and approval of individual and group life insurance and annuity contract forms shall apply to variable annuity contracts.

No company may submit variable annuity contracts for approval until its license has been amended to include the authority to write such variable annuity contracts.

History Note: *Authority G.S. 58-2-40; 58-7-95;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0420 APPROVAL OF CONTRACTS: ADDITIONAL INFORMATION REQUIRED

A company submitting variable annuity contracts to the Department for approval shall furnish the following information with each variable annuity contract filing:

(1) Evidence that a copy of all appropriate information has been registered with the Securities and Exchange Commission,
(2) A copy of all sales promotion material to be used in North Carolina,
(3) A copy of the variable annuity application form,
(4) A copy of the "Suitability Questionnaire" form, and
(5) A copy of all proposed riders to be used with the variable annuity contract.

The "Suitability Questionnaire" form required by this Rule may be a separate form or a part of the policy application and shall contain questions designed to determine whether the proposed variable annuity contract meets the reasonable objectives and needs of the applicant.

History Note: *Authority G.S. 58-2-40; 58-7-95;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. February 1, 1992; April 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0421 PREPARATION OF VARIABLE ANNUITY CONTRACT FILINGS

A company submitting variable annuity contracts to the department for approval must prepare such filings in the following manner:

(1) Separate filings should be made for individual and group contracts, with all supplementary material grouped accordingly.
(2) The filing letter should include a listing of all form numbers and a description of the contracts being filed.
(3) The filing letter should state whether or not the annuity mortality table developed from the company's experience is used, and if so, a copy of such table should accompany the filing.
(4) The filing letter should clearly indicate the states in which the subject contract has been filed and approved.

History Note: *Authority G.S. 58-2-40; 58-7-95;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. April 1, 1989;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0422 CONTRACTS PROVIDING FOR VARIABLE BENEFITS

Any variable contract providing benefits payable in variable amounts delivered or issued for delivery in this state shall contain a statement of the essential features of the procedures to be followed by the company in determining the dollar amount of such variable benefits. Any such contract, including a group contract and any certificate in evidence of variable benefits issued thereunder, shall state that such dollar amount will vary to reflect investment experience and shall contain on its first page a statement to the effect that the benefits thereunder are on a variable basis.

Illustrations of benefits payable under any variable contract shall not include projections of past investment experience into the future or attempted predictions of future investment experience; provided that nothing contained herein is intended to prohibit use of hypothetical assumed rates of return to illustrate possible levels of benefits. Any individual variable annuity contract delivered or issued for delivery in this state shall stipulate the investment increment factors to be used in computing the dollar amount of variable benefits or other contractual payments or values thereunder, and shall guarantee that expense and mortality results shall not adversely affect such dollar amounts.

In computing the dollar amount of variable benefits or other contractual payments or values under an individual variable annuity contract:

(1) The annual new investment increment assumption shall not exceed five percent, except with the approval of the commissioner.

(2) To the extent that the level of benefits may be affected by mortality results, the mortality factor shall be determined from the Annuity Mortality Table for 1949, Ultimate, or any modification of that table not having a lower life expectancy at any age, or, if approved by the commissioner, from another table.

"Expense," as used in this Rule, may exclude some or all taxes, as stipulated in the contract.

History Note: *Authority G.S. 58-2-40; 58-7-95;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0423 REQUIRED REPORTS ON VARIABLE ANNUITY BUSINESS

Any company issuing individual variable annuity contracts shall mail to the contract holder at least once in each contract year after the first year at his last address known to the company, a statement or statements reporting the investments held in the separate account, and in the case of contracts under which payments have not yet commenced, a statement reporting as of a date not more than four months previous to the date of mailing:

(1) the number of accumulation units credited to such contracts and the dollar value of a unit, or

(2) the value of the contract holder's account.

History Note: *Authority G.S. 58-2-40; 58-7-95;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. July 18, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0424 LIFE INSURANCE ADVERTISING: DEFINITIONS

For the purpose of 11 NCAC 12 .0424 to .0433:

(1) "Policy" shall include any policy, plan, certificate, contract, agreement, statement of coverage, rider, or endorsement which provides for life insurance or annuity benefits.

(2) "Insurer" shall include any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyd's, fraternal benefit society, and any other legal entity which is defined as an "insurer" in the insurance code of this state or issues life insurance or annuities in this state and is engaged in the advertisement of a policy.

(3) "Advertisement" shall be material designed to create public interest in life insurance or annuities or in an insurer, or to induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy including:
  (a) printed and published material, audiovisual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio, and television scripts, billboards, and similar displays;
  (b) descriptive literature and sales aids of all kinds issued by an insurer or agent, including but not limited to, circulars, leaflets, booklets, depictions, illustrations, and form letters;
  (c) material used for the recruitment, training, and education of an insurer's sales personnel, agents, solicitors, and brokers which is designed to be used or is used to induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy;
  (d) prepared sales talks, presentations and material for use by sales personnel, agents, solicitors and brokers.

(4) "Advertisement" for the purpose of 11 NCAC 12 .0405 to .0433 shall not include:
  (a) communications or materials used within an insurer's own organization and not intended for dissemination to the public;
  (b) communications with policyholder other than material urging policyholders to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy;
  (c) a general announcement from a group policyholder to eligible individuals on an employment or membership list that a policy or program has been written or arranged; provided the announcement clearly indicates that it is preliminary to the issuance of a booklet explaining the proposed coverage.

(5) "Nonguaranteed Policy Element" shall mean any premium, cash value, death benefit, endowment value, dividend or other policy benefit or pricing element or portion thereof whose amount is not guaranteed by the terms of the contract.

History Note: *Authority G.S. 58-2-40; 58-3-150; 58-58-40;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. April 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0425 LIFE INSURANCE ADVERTISING: APPLICABILITY

(a) These rules shall apply to any life insurance or annuity advertisement intended for dissemination in this state.

(b) Every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All such advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer.

History Note: *Authority G.S. 58-2-40; 58-3-150; 58-58-40;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0426 LIFE INSURANCE ADVERTISING: FORM AND CONTENT

(a) Advertisements shall be truthful and not misleading in fact or by implication. The form and content of an advertisement of a policy shall be sufficiently complete and clear so as to avoid deception. It shall not have the capacity or tendency to mislead or deceive.

Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined by the Commissioner of Insurance from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

(b) No advertisement shall use the terms "investment," "investment plan," "founder's plan," "charter plan," "certificate of deposit," "expansion plan," "profit," "profits," "profit sharing," "interest plan," "savings," "savings plan" or other similar terms in connection with a policy in a context or under such circumstances or conditions as to have the capacity or tendency to mislead a purchaser or prospective purchaser of such policy to believe that he will

receive, or that it is possible that he will receive, something other than a policy or some benefit not available to other persons of the same class and equal expectation of life.

History Note: *Authority G.S. 58-2-40; 58-58-40; 58-63-15;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. February 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0427 LIFE INSURANCE ADVERTISING: DISCLOSURE REQUIREMENTS

(a) The information required to be disclosed by 11 NCAC 12 .0424 to .0433 shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the text of the advertisement so as to be confusing or misleading.

(b) No advertisement shall omit material information or use words or phrases in other than their customary insurance meaning or use words, phrases, statements, references or illustrations if such omission or such use has the capacity, tendency, or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, premium payable or state or federal tax consequences. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale, or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.

(c) In the event an advertisement uses "Non-Medical", "No Medical Examination Required" or similar terms where issue is not guaranteed, such terms shall be accompanied by a further disclosure of equal prominence and in juxtaposition thereto to the effect that issuance of the policy may depend upon the answers to the health questions.

(d) An advertisement shall not use as the name or title of a life insurance policy any phrase that does not include the words "life insurance" unless accompanied by other language clearly indicating it is life insurance.

(e) An advertisement shall prominently describe the type of policy advertised.

(f) An advertisement of a policy marketed by the direct response techniques shall not state or imply that because there is no agent or commission involved there will be cost saving to prospective purchasers unless such is the fact.

(g) An advertisement for a policy containing graded or modified benefits shall prominently display any limitation of benefits. If the premium is level and coverage decreases or increases with age or duration, such fact shall be prominently disclosed.

(h) An advertisement for a policy with non-level premiums shall prominently describe the premium changes.

(i) Nonguaranteed Policy Elements:

(1) An advertisement shall not utilize or describe nonguaranteed policy elements in a manner that is misleading or has the capacity or the tendency to mislead.

(2) An advertisement shall not state or imply that the payment or amount of nonguaranteed policy elements is guaranteed. If nonguaranteed policy elements are illustrated, they must be based on the insurer's current scale and the illustration must contain a statement to the effect that they are not to be construed as guarantees or estimates of amounts to be paid in the future.

(3) An advertisement that includes any illustrations or statements containing or based upon nonguaranteed elements shall set forth with equal prominence comparable illustrations or statements containing or based upon the guaranteed element.

(4) If an advertisement refers to any nonguaranteed policy element, it shall indicate that the insurer reserves the right to change any such element at any time and for any reason. However, if an insurer has agreed to limit this right in any way, such as, for example, if it has agreed to change these elements only at certain intervals or only if there is a change in the insurer's current or anticipated experience, the advertisement may indicate any such limitation of the insurer's right.

(5) An advertisement shall not refer to dividends as "tax free"use words of similar import, unless the tax treatment of dividends is fully explained and the nature of the dividend as a return of premium is indicated clearly.

(j) An advertisement shall not state that a purchaser of a policy will share in or receive a stated percentage or portion of the earnings on the general account assets of the company.

(k) Testimonials or Endorsements by Third Parties:

(1) Testimonials used in advertisements must be genuine; represent the current opinion of the author; be applicable to the policy advertised, if any; and be accurately reproduced. In using a testimonial,

the insurer makes as its own all of the statements contained therein, and such statements are subject to all provisions of 11 NCAC 12 .0424 to .0433.

(2) If the individual making a testimonial or an endorsement has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee or otherwise, or receives any benefit directly or indirectly other than required union scale wages, such fact shall be disclosed in the advertisement.

(3) An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by a group of individuals, society, association or other organization unless such is the fact and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial is owned, controlled or managed by the insurer, or receives any payment or other consideration from the insurer for making such endorsement or testimonial, such fact shall be disclosed in the advertisement.

(l) An advertisement shall not contain statistical information relating to any insurer or policy unless it accurately reflects recent and relevant facts. The source of any such statistics used in an advertisement shall be identified therein.

(m) Introductory, Initial or Special Offers and Enrollment Periods:

(1) An advertisement of an individual policy or combination of such policies shall not state or imply that such policy or combination of such policies is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such is the fact. An advertisement shall not describe an enrollment period as "special" or "limited" or use similar words or phrases in describing it when the insurer uses successive enrollment periods as its usual method of marketing of its policies.

(2) An advertisement shall not state or imply that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy.

(3) An advertisement shall not offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the reduced initial premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, all references to the reduced initial premium shall be followed by an asterisk or other appropriate symbol that refers the reader to that specific portion of the advertisement that contains the full rate schedule for the policy being advertised.

(4) An enrollment period during which a particular insurance policy may be purchased on an individual basis shall not be offered within this state unless there has been a lapse of not less than three months between the close of the immediately preceding enrollment period for the same policy and the opening of the new enrollment period with the number of enrollment periods being limited to no more than two in any one calendar year for a particular insurance product. The advertisement shall specify the date by which the applicant must mail the application, which shall not be later than 10 days and not more than 40 days on which such enrollment period is advertised for the first time. This shall apply to all advertising media--i.e., mail, newspapers, radio, television, magazines and periodicals--by any one insurer. The phrase "any one insurer" includes all the affiliated companies of a group of insurance companies under common management or control. This does not apply to the use of a termination of cutoff date beyond which an individual application for a guaranteed issue policy will not be accepted by an insurer in those instances where the application has been sent to the applicant in response to his request. It is also inapplicable to solicitations of employees or members of a particular group or association which otherwise would be eligible under specific provisions of the insurance code for group insurance. In cases where an insurance product is marketed on a direct mail basis to prospective insureds by reason of some common relationship with a sponsoring organization, this shall be applied separately to each such sponsoring organization.

(n) An advertisement of a particular policy shall not state or imply that prospective insureds shall be or become members of a special class, group or quasi-group and as such enjoy special rates, dividends or underwriting privileges unless such is the fact.

(o) An advertisement shall not make unfair or incomplete comparisons of policies, benefits, dividends or rates of other insurers. An advertisement shall not falsely or unfairly describe other insurers, their policies, services or methods of marketing.

(p) An advertisement shall not make use of any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance agency.

History Note: *Authority G.S. 58-2-40; 58-58-40; 58-63-15;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. February 1, 1992; April 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0428 LIFE INSURANCE ADVERTISING: IDENTITY OF INSURER

(a) The name of the insurer shall be clearly identified in all advertisements, and if any specific individual policy is advertised it shall be identified either by form number or other appropriate description. If an application is a part of the advertisement, the name of the insurer shall be shown on the application. An advertisement shall not use a trade name, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device or reference without disclosing the name of the insurer, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the insurer or create the impression that a company other than the insurer would have any responsibility for the financial obligation under a policy.

(b) No advertisement shall use any combination of words, symbols or physical materials which by their content, phraseology, shape, color or other characteristics are so similar to a combination of words, symbols or physical materials used by a governmental program or agency or otherwise appear to be of such nature that they tend to mislead prospective insureds into believing that the solicitation is in some manner connected with such governmental program or agency.

History Note: *Authority G.S. 58-2-40; 58-58-40; 58-63-15;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. April 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0429 LIFE INSURANCE ADVERTISING: LICENSING: STATUS OF INSURER

(a) An advertisement which is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond such limits.

(b) An advertisement may state that an insurer is licensed in the state where the advertisement appears, provided it does not exaggerate such fact or suggest or imply that competing insurers may not be so licensed.

(c) An advertisement shall not create the impression that the insurer, its financial condition or status, the payment of its claims, or the merits, desirability, or advisability of its policy forms or kinds of plans of insurance are recommended or endorsed by any governmental entity. However, where a governmental entity has recommended or endorsed a policy form or plan, such recommendation or endorsement may be stated if the entity authorizes such use.

History Note: *Authority G.S. 58-2-40; 58-58-40; 58-63-15;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. April 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0430 LIFE INSURANCE ADVERTISING: STATEMENTS ABOUT THE INSURER

An advertisement shall not contain statements, pictures or illustrations which are false or misleading, in fact or by implication, with respect to the assets, liabilities, insurance in force, corporate structure, financial condition, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly defines the scope and extent of the recommendation.

History Note: *Authority G.S. 58-2-40; 58-58-40; 58-63-15;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0431 LIFE INSURANCE ADVERTISING: ENFORCEMENT PROCEDURES

(a) Each insurer shall maintain at its home or principal office a complete file containing a specimen copy of every printed, published or prepared advertisement of its policies, hereafter disseminated in this state, with a notation indicating the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to inspection by this department. All such advertisements shall be maintained in said file for a period of either three years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

(b) Each insurer subject to the provisions of 11 NCAC 12 .0424 to .0433 shall file with this department with its annual statement a certificate of compliance executed by an authorized officer of the insurer wherein it is stated that to the best of his knowledge, information and belief the advertisements which were disseminated by or on behalf of the insurer in this state during the preceding statement year, or during the portion of such year when 11 NCAC 12 .0424 to .0433 were in effect, complied or were made to comply in all respects with the provisions of 11 NCAC 12 .0425 to .0433 and the insurance laws of this state as implemented and interpreted by 11 NCAC 12 .0424 to .0433.

(c) Every written advertisement created or developed by an insurance agent that describes a policy in any manner shall be filed with and approved by the home office of the insurance company offering the policy before the advertisement may be used by the agent.

History Note: *Authority G.S. 58-2-40; 58-58-40; 58-63-15;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. February 1, 1992; April 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0432 LIFE INSURANCE ADVERTISING: ADVERTISING EXPENSE

Total advertising expense incurred by the insurer or by an affiliated corporation on behalf of the insurer for the purposes of solicitation and conservation of life insurance business shall be included as line items in the expense exhibits of all statutory financial statements filed by a licensed insurer with the department.

History Note: *Authority G.S. 58-2-40; 58-58-40; 58-63-15;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0433 LIFE INSURANCE ADVERTISING: PRIOR REVIEW OR PRIOR APPROVAL

The commissioner may, when in his discretion he deems it in the public interest, require the filing of all or any part of the advertising material of an insurer with this department for review prior to its use. All advertising material subject to review prior to its use shall be filed with this department 30 days prior to its intended use. In instances where charges are pending against an insurer, the commissioner may, during the period such charges are pending but not to exceed 30 days unless extended by consent order, by order require all or any part of the advertising material be filed for review prior to its use or for prior approval. The commissioner may within his discretion refuse to approve all or any part of the advertising material so filed. All advertising material subject to prior approval shall be filed with this department 60 days prior to its intended use. When it has been determined by the commissioner after notice and hearing that an insurer has violated any of the insurance laws of this state or rules of the commissioner, the commissioner may in his discretion, by order require that all or any part of the advertising material be filed with this department for review prior to its use or for prior approval. The commissioner may within his discretion refuse to approve all or any part of the advertising material so filed. In any case where review prior to its use or prior approval is required, a shorter period of time may be allowed by the commissioner.

History Note: *Authority G.S. 58-2-40; 58-58-40; 58-63-15;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0434 VARIABLE LIFE INSURANCE: DEFINITIONS

As used in this Rule and in 11 NCAC 12 .0435 through 11 NCAC 12 .0443:

(1) "Affiliate" of an insurer means any person, directly or indirectly, controlling, controlled by, or under common control with such insurer; any person who regularly furnishes investment advice to such insurer with respect to its variable life insurance separate accounts for which a specific fee or commission is charged; or any director, officer, partner, or employee of any such insurer, controlled person, or person providing investment advice or any member of the immediate family of such person.

(2) "Agent" means any person, corporation, partnership, or other legal entity which is licensed by this state as a life insurance agent.

(3) "Assumed investment rate" means the rate of investment return which would be required to be credited to a variable life insurance policy, after deduction of charges for taxes, investment expenses and mortality and expense guarantees to maintain the variable death benefit equal at all times to the amount of death benefit, other than incidental insurance benefits, which would be payable under the plan of insurance if the death benefit did not vary according to the investment experience of the separate account.

(4) "Benefit base" means the amount not less than the amount specified under 11 NCAC 12 .0438(b)(2), specified by the terms of the variable life insurance policy to which the difference between the net investment return and the assumed investment rate is applied in determining the variable benefits of the policy.

(5) "Commissioner" means the Insurance Commissioner of this state.

(6) "Control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing more than 10 percent of the voting securities of any other person. This presumption may be rebutted by a showing made to the satisfaction of the commissioner that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(7) "General account" means all assets of the insurer other than assets in separate accounts established pursuant to G.S. 58-7-95, or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer, whether or not for variable life insurance.

(8) "Incidental insurance benefit" means all insurance benefits in a variable life insurance policy, other than the variable death benefit and the minimum death benefit, including but not limited to accidental death and dismemberment benefits, disability income benefits, guaranteed insurability options, family income, or fixed benefit term riders.

(9) "May" is permissive.

(10) "Minimum death benefit" means the amount of the guaranteed death benefit, other than incidental insurance benefits, payable under a variable life insurance policy regardless of the investment performance of the separate account.

(11) "Net investment return" means the rate of investment return in a separate account to be applied to the benefit base after deduction of charges for taxes, investment expenses and mortality and expense guarantees in accordance with the terms of the policy.

(12) "Person" means an individual, corporation, partnership, association, trust, or fund.

(13) "Separate account" means a separate account established for variable life insurance pursuant to G.S. 58-7-95 or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer.

(14) "Shall" is mandatory.

(15) "Variable death benefit" means the amount of the death benefit, other than incidental insurance benefits, payable under variable life insurance policy dependent on the investment performance of the separate account, which the insurer would have to pay in the absence of the minimum death benefit.

(16) "Variable life insurance policy" means any individual or group policy which provides for life insurance the amount or duration of which varies according to the investment experience of any separate account or accounts established and maintained by the insurer as to such policy, pursuant to G.S. 58-7-95 or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer.

History Note: *Authority G.S. 58-2-40; 58-7-95;*
Eff. January 1, 1978;
Readopted Eff. September 26, 1978;
Amended Eff. February 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0435 QUALIFICATION OF INSURER TO ISSUE VARIABLE LIFE INSURANCE

The following requirements are applicable to all insurers either seeking authority to issue variable life insurance in this state or which have authority to issue variable life insurance in this state:

(1) Licensing and Approval to do Business in This State. An insurer shall not deliver or issue for delivery in this state any variable life insurance policy unless:

(a) The insurer is licensed or organized to do a life insurance business in this state;

(b) Either:

(i) The state of domicile of such insurer requires that permissible investments be substantially the same as provided in .0438(c) of this Section and that changes in the investment policy of the variable life insurance separate account be regulated in a manner substantially similar to that required under .0438 of this Section for such separate accounts operated by insurers domiciled in this state; or

(ii) The insurer's investment policy, as described in the statement required to be filed under (2)(c) of this Rule conforms to .0438(c) of this Section, and the commissioner is satisfied that the procedures for changing the investment policy of a variable life insurance separate account, as described in the statement required to be filed under (2)(c) of this Rule, provide safeguards consistent with those provided under .0438(f) of this Section;

(c) The insurer has obtained the written approval of the commissioner for the issuance of variable life insurance policies in this state. The commissioner shall grant such written approval only after he has found that:

(i) The plan of operation for the issuance of variable life insurance policies is not unsound;

(ii) The general character, reputation, and experience of the management and those persons or firms proposed to supply consulting, investment, administrative, or custodial services to the insurer are such as to reasonably assure competent operation of the variable life insurance business of the insurer in this state; and

(iii) The present and foreseeable future financial condition of the insurer and its method of operation in connection with the issuance of such policies is not likely to render its operation hazardous to the public or its policyholders in this state. The commissioner shall consider, among other things:

(A) the history of operation and financial condition of the insurer;

(B) the qualification, fitness, character, responsibility, reputation, and experience of the officers and directors and other management of the

insurer and those persons or firms proposed to supply consulting, investment, administrative, or custodial services to the insurer;

(C) the applicable law and regulations under which the insurer is authorized in its state of domicile to issue variable life insurance policies; The state of entry of an alien insurer shall be deemed its state of domicile for this purpose; and

(D) if the insurer is a subsidiary of, or is affiliated by common management or ownership with another company, its relationship to such other company and the degree to which the requesting insurer, as well as the other company, meet these standards.

(2) Filing for Approval to do Business in This State. Before any insurer shall deliver or issue for delivery any variable life insurance policy in this state, it must file with this department the following information for the consideration of the commissioner in making the determination required by (1)(c) of this Rule:

(a) copies of and a general description of the variable life insurance policies it intends to issue;

(b) a general description of the methods of operation of the variable life insurance business of the insurer, including the names of those persons or firms proposed to supply consulting, investment, administrative, or custodial services to the insurer;

(c) with respect to any separate account maintained by an insurer for any variable life insurance policy, a statement of the investment policy the insurer intends to follow for the investment of the assets held in such separate account, and a statement of the procedures for changing such investment policy; The statement of investment policy shall include a description of the investment objective and orientation intended for the separate account;

(d) a description of any investment advisory services contemplated as required by .0438(10) of this Section;

(e) if requested by the commissioner, a copy of the statutes and regulations of the state of domicile of the insurer under which it is authorized to issue variable life insurance policies; and

(f) if requested by the commissioner, biographical data with respect to officers and directors of the insurer on the National Association of Insurance Commissioners Uniform Biographical Data Form.

(3) Standards of Suitability. Every insurer seeking approval to enter into the variable life insurance business in this state shall adopt by formal action of its board of directors and file with the commissioner a written statement specifying the standards of suitability to be used by the insurer and applicable to its officers, directors, employees, affiliates, and agents with respect to the suitability of variable life insurance for the applicant. Such standards of suitability shall be binding on the insurer and those to whom it refers, and shall specify that no recommendation shall be made to an applicant to purchase a variable life insurance policy and that no variable life insurance policy shall be issued in the absence of reasonable grounds to believe that the purchase of such policy is not unsuitable for such applicant on the basis of information furnished after reasonable inquiry of such applicant concerning the applicant's insurance and investment objectives, financial situation and needs, and any other information known to the insurer or to the agent making the recommendation. Lapse rates for variable life insurance within the first two policy years which are significantly higher than both those encountered by the insurer or an affiliate thereof for corresponding fixed benefit life insurance policies and lapse rates of other insurers issuing variable life insurance policies shall be considered by the commissioner in determining whether the guidelines adopted by the insurer are reasonable and also whether the insurer and its agents are engaging, as a general business practice, in the sale of variable life insurance to persons for whom it is unsuitable. For purposes of this Subsection, conversions from variable life insurance policies pursuant to this Regulation shall not be considered lapses.

(4) Use of Sales Materials. An insurer authorized to transact variable life insurance business in this state shall not use any sales material, advertising material, or descriptive literature or other materials of any kind in connection with its variable life insurance business in those states which is false, misleading, deceptive, or inaccurate.

(5) Requirements Applicable to Contractual Services

(a) Any contract between an insurer and suppliers of consulting, investment, administrative, sales, marketing, custodial, or other services which are material with respect to variable life operations shall be in writing and provide that the supplier of such services shall furnish the commissioner with any information or reports in connection with such services which the commissioner may request in order to ascertain whether the variable life insurance operations of the insurer are being conducted in a manner consistent with these regulations and any other applicable law or regulations.

(b) Such contract shall be fair and equitable to all parties and not endanger any policyholders of the insurer in this state.

(c) Such contract shall not relieve the insurer from any responsibilities or obligations imposed upon the operations of its variable life insurance business by this Regulation or any other law or regulation.

(6) Reports to the Commissioner. Any insurer authorized to transact the business of variable life insurance in this state shall submit to the commissioner, in addition to any other materials which may be required by this Regulation or any other applicable laws or regulations:

(a) An annual statement of the business of its variable life insurance separate account or accounts in such form as may be prescribed by the National Association of Insurance Commissioners; and

(b) Prior to the use in this state any information furnished to applicants as provided for in .0439 of this Section; and

(c) Prior to the use in this state the form of any of the reports to policyholders as provided for in .0441 of this Section; and

(d) Such additional information concerning its variable life insurance separate accounts as the commissioner shall deem necessary;

(e) Any material submitted to the commissioner shall be disapproved if it is found to be false, misleading, deceptive, or inaccurate in any material respect and, if previously distributed, the commissioner shall require the distribution of an amended report.

(7) Authority of Commissioner to Disapprove. Any material required to be filed with the commissioner, or approved by him, shall be subject to disapproval if at any time it is found by him not to comply with the standards established by this Regulation.

History Note: *Authority G.S. 58-2-40(1); 58-7-95;*
Eff. January 1, 1978;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0436 INSURANCE POLICY REQUIREMENTS

The Commissioner shall not approve any variable life insurance form filed pursuant to this Rule unless it conforms to the requirements of this Section:

(1) Filing of Variable Life Insurance Policies. All variable life insurance policies, and all riders, endorsements, applications and other documents which are to be attached to and made a part of the policy and which relate to the variable nature of the policy, shall be filed with the Commissioner and approved by him in writing prior to delivery or issuance for delivery in this state:

(a) The procedures and requirements for such filing and approval shall be, to the extent appropriate and not inconsistent with this Rule, the same as those otherwise applicable to other life insurance policies.

(b) The Commissioner may approve variable life insurance policies and related forms with provisions the Commissioner deems to be not less favorable to the policyholder and the beneficiary than those required by this Rule.

(c) The requirements of Sub-item (3)(e) of this Rule shall not apply to variable life insurance policies and related forms issued in connection with pension, profit-sharing and retirement plans if separate accounts for such policies are exempt pursuant to Section 3(c)(11) of the Investment Company Act of 1940.

(2) Mandatory Policy Benefit and Design Requirements. Variable life insurance policies delivered or issued for delivery in this state shall comply with the following minimum requirements:

(a) The mortality and expense risk shall be borne by the insurer.

(b) Gross premiums for death benefits shall be a level amount for the duration of the premium payment period, but this Subsection shall not be construed to prohibit temporary or permanent additional premiums for incidental insurance benefits or substandard risks. This Subsection shall not be deemed to prohibit the use of fixed benefit preliminary term insurance for a period not to exceed 120 days from the date of the application for a variable life insurance policy. The premium rate for such preliminary term insurance shall be stated separately in the application or receipt.

(c) A minimum death benefit shall be provided in an amount at least equal to the initial face amount of the policy so long as premiums are duly paid [subject to the provisions of Sub-item (4)(b) of this Rule].

(d) The policy shall provide that the variable death benefit shall reflect the investment experience of the variable life insurance separate account established and maintained by the insurer and that the excess, positive or negative, of the net investment return over the assumed investment rate, as applied to the benefit base of each variable life insurance policy, shall be used to provide:

(i) fully paid-up variable life insurance providing coverage for the same period as the basic insurance under the policy or fully paid-up term insurance amounts for a term of annual periods of not less than one year nor more than five years, positive or negative, as the case may be, or a combination thereof; or

(ii) variable life insurance amounts, positive or negative, as the case may be, so that the reserve maintains the same percentage relationship to the variable death benefit as it would have on a corresponding fixed benefit policy; or

(iii) any other form of insurance benefits as the Commissioner may approve.

(e) Each variable life insurance policy shall be credited with the full amount of the net investment return applied to the benefit base.

(f) Changes in variable death benefits of each variable life insurance policy shall be determined at least annually.

(g) The cash value of each variable life insurance policy shall be determined at least monthly. The method of computation of cash values and other non-forfeiture benefits, as described either in the policy or in a statement filed with the Commissioner of the state in which the policy is delivered, or issued for delivery, shall be in accordance with actuarial procedures that recognize the variable nature of the policy. The method of computation must be such that, if the net investment return credited to the policy at all times from the date of issue should be equal to the assumed investment rate with premiums and benefits determined accordingly under the terms of the policy, then the resulting cash values and other non-forfeiture benefits must be at least equal to the minimum values required by G.S. 58-58-55 of the insurance laws of this state (Standard Non-forfeiture Law) for a fixed benefit policy with such premiums and benefits. The assumed investment rate shall not exceed the maximum interest rate permitted under the Standard Non-forfeiture Law of this state. The method of computation may disregard incidental minimum guarantees as to the dollar amounts payable. Incidental minimum guarantees include, for example, but are not to be limited to, a guarantee that the amount payable at death or maturity shall be at least equal to the amount that otherwise would have been payable if the net investment return credited to the policy at all times from the date of issue had been equal to the assumed investment rate.

(h) The computation of values required for each variable life insurance policy may be based upon such reasonable and necessary approximations as are acceptable to the Commissioner.

(i) In determining the net investment return to be applied to the benefit base the insurer may deduct only the charges described in Rule .0438(7)(a)(i), (ii), (iv), and (v) of this Section.

(3) Mandatory Policy Provisions. Every variable life insurance policy filed for approval in this state shall contain at least the following:

(a) The cover page or pages corresponding to the cover page of each such policy shall contain:

(i) a prominent statement in either contrasting color or in boldface type at least four points larger than the type size of the largest type used in the text of any provision of that page, that the death benefit may be variable for fixed under specified conditions;

(ii) a prominent statement in either contrasting color or in boldface type at least four points larger than the type size of the largest type size used in the text of any provision on that page that cash values may increase or decrease in accordance with the experience of the separate account subject to any specified minimum guarantees;

(iii) a statement that the minimum death benefit will be at least equal to the initial face amount at the date of issue if premiums are duly paid and if there are no outstanding policy loans, partial withdrawals, or partial surrenders;

(iv) the rule, or a reference to the policy provision which describes the method for determining the variable amount of insurance payable at death;

(v) a captioned provision which provides that the policyholder may return the variable life insurance policy within 45 days of the date of the execution of the application or within 10 days of receipt of the policy by the policyholder, whichever is later, and receive a refund of all premium payments for such policy; and

(vi) such other items as are currently required for fixed benefit life insurance policies and which are not inconsistent with this Rule;

(vii) for all variable life insurance policies, which do not provide, while in force, a death benefit at least equal to the amount specified at issue or at the most recent policy change requested by the policyholder, must contain an endorsement or sticker, printed in contrasting type or color which contains sufficient cautionary languages such as: "THIS POLICY DOES NOT HAVE A MINIMUM GUARANTEED DEATH BENEFIT. THE DEATH BENEFIT IN THIS POLICY MAY BE LESS THAN OR MAY EXCEED THE PROJECTED BENEFITS REPRESENTED BY THE SOLICITING AGENT."

(b) A provision for a grace period of not less than 31 days from the premium due date which shall provide that where the premium is paid within the grace period, policy values will be the same, except for the deduction of any overdue premium, as if the premium were paid on or before the due date;

(c) A provision that the policy will be reinstated at any time within two years from the date of default upon the written application of the insured and evidence of insurability, including good health, satisfactory to the insurer, unless the cash surrender value has been paid or the period of extended insurance has expired, upon the payment of any outstanding indebtedness arising subsequent to the end of the grace period following the date of default together with accrued interest thereon to the date of reinstatement and payment of an amount not exceeding the greater of:

(i) all overdue premiums with interest at a rate not exceeding eight percent per annum compounded annually and any indebtedness in effect at the end of the grace period following the date of default with interest at a rate not exceeding eight percent per annum compounded annually; or

(ii) 110 percent of the increase in cash surrender value resulting from reinstatement plus all overdue premiums for incidental insurance benefits with interest at a rate not exceeding eight percent per annum compounded annually;

(d) A full description of the benefit base and of the method of calculation and application of any factors used to adjust variable benefits under the policy;

(e) A provision designating the separate account to be used and stating that:

(i) Such separate account shall be used to fund only variable life insurance benefits, except to the extent permitted by Sub-item (5)(c)(vi) of this Rule;

(ii) The assets of such separate account shall be available to cover the liabilities of the general account of the insurer only to the extent that the assets of the separate account exceed the liabilities of the separate account arising under the variable life insurance policies supported by the separate account; and

(iii) The assets of such separate account shall be valued at least as often as any policy benefits vary but at least monthly;

(f) A provision that at any time during the first 24 months of the variable life insurance policy, so long as premiums are duly paid, the owner may exchange the policy, or any requested increase in face amount, for a life insurance policy providing benefits that do not vary with the investment experience of a variable account. The owner shall be given the option to exchange the variable life insurance policy for a policy of permanent fixed benefit, fixed premium life insurance, or the option to exchange the variable life insurance policy for a policy of flexible benefit, flexible premium life insurance. The new policy shall be on a plan of insurance specified in the policy, provided that the new policy:

(i) shall bear the same date of issue and age at issue as the original variable life insurance policy;

(ii) is issued on a substantially comparable plan of life insurance offered in this state by the insurer or an affiliate on the date of issue of the variable life insurance policy and at the premium rates in effect on that date for the same class of insurance;

(iii) include such riders and incidental insurance benefits as were included in the original policy if such riders and incidental insurance benefits are issued with the new policy;

(iv) shall be issued subject to an equitable premium or cash value adjustment that takes appropriate account of the premiums and cash values under the original and new policies; A detailed statement of the method of computing such adjustment shall be filed with the commissioner;

(v) shall not require evidence of insurability for this exchange;

(g) A provision that the policy and any papers attached hereto by the insurer, including the application if attached, constitute the entire insurance contract;

(h) A designation of the officers of the insurer who are empowered to make an agreement or representation on behalf of the insurer and an indication that statements by the insured, or on his behalf, shall be considered as representation and not warranties;

(i) An identification of the owner of the insurance contract;

(j) A provision setting forth conditions or requirements as to the designation, or change of designation, of a beneficiary and a provision for disbursement of benefits in the absence of a beneficiary designation;

(k) A statement of any conditions or requirements concerning the assignment of the policy;

(l) A description of any adjustment in policy values to be made in the event of misstatement of age or sex of the insured;

(m) A provision that the policy shall be incontestable by the insurer after it has been in force for two years during the life time of the insured;

(n) A provision stating that the investment policy of the separate account shall not be changed without the approval of the insurance commissioner of the state of domicile of the insurer, and that the approval process is on file with the Commissioner of this state;

(o) A provision that payment of variable death benefits in excess of the minimum death benefits, cash values, policy loans, or partial withdrawals (except when used to pay premiums) or partial surrenders may be deferred:

(i) for up to six months from the date of request, if such payments are based on policy values which do not depend on the investment performance of the separate account; or

(ii) otherwise, for any period during which the New York Stock Exchange is closed for trading (except for normal holiday closing) or when the Securities and Exchange Commission has determined that a state of emergency exists which may make such payment impractical;

(p) A description of the basis for computing the cash surrender value under the policy shall be included; Such surrender value may be expressed as either:

(i) a schedule of cash value amounts per one thousand dollars ($1,000) of variable face amount at each attained age or policy year for at least 20 years from issue, or for the premium paying period, if less than 20 years; or

(ii) one cash value schedule as described in Sub-item (3)(p)(i) of this Rule for the death benefit, or for each one thousand dollars ($1,000) of death benefit, which would be in effect if the net investment return is always equal to the assumed investment rate and a second schedule applicable to any adjustments to the death benefit (disregarding the minimum death benefit guarantee and term insurance amounts) if the net investment return does not equal the assumed investment rate at each age for at least 20 years from issue, or for the premium paying period if it is less than 20 years;

(q) Premiums for incidental insurance benefits shall be stated separately;

(r) Any other policy provisions required by this Rule;

(s) Such other items as are currently required for fixed benefit life insurance policies and are not inconsistent with this Rule.

(4) Non-forfeiture, Partial Withdrawal, Policy Loan and Partial Surrender Provisions. Every variable life insurance policy delivered or issued for delivery in this state shall contain provisions which are not less favorable to the policyholders than the following:

(a) a provision for non-forfeiture insurance benefits so that at least one such benefit is offered on a fixed basis from the due date of the premium in default:

(i) Variable extended term insurance may not be offered;

(ii) A given non-forfeiture option need not be offered on both a fixed and a variable basis;

(iii) The insurer may establish a reasonable minimum cash surrender value below which any such non-forfeiture insurance options will not be available;

(b) a provision for policy loans (which may at the option of the insurer be entitled and referred to as a partial withdrawal provision) not less favorable to the policyholder than the following:

(i) Up to 75 percent but if the loan is made from the general account not more than 90 percent of the policy's cash value may be borrowed;

(ii) The amount borrowed, or any repayment thereof, shall not affect the amount of the premium payable under the policy;

(iii) The amount borrowed shall bear interest at a rate not to exceed eight percent per year compounded annually;

(iv) Any indebtedness shall be deducted from the proceeds payable on death;

(v) Any indebtedness shall be deducted from the cash value upon surrender or in determining any non-forfeiture benefit;

(vi) Whenever the indebtedness exceeds the cash value, the insurer shall give notice of intent to cancel the policy if the excess indebtedness is not repaid within 31 days after the date of mailing of such notice;

(vii) The policy may provide that if, at any time, so long as premiums are duly paid, the variable death benefit is less than it would have been if no loan or withdrawal had ever been made, the policy holder may increase such variable death benefit up to what it would have been if there had been no loan or withdrawal by paying an amount not exceeding 110 percent of the corresponding increase in cash value and by furnishing such evidence of insurability as the insurer may request;

(viii) The policy may specify a reasonable minimum amount which may be borrowed at any time but such minimum shall not apply to any automatic premium loan provision;

(ix) No policy loan provision is required if the policy is under the extended insurance non-forfeiture option;

(x) In addition to the foregoing, the policy may contain partial surrender provision; however, any such provision shall provide that the policyholder may request part of the cash value and both the variable and minimum death benefits will be reduced in proportion to the percentage of the cash value received by the

policyholder and the premium for the remaining amount of insurance will also be reduced to the appropriate rates for the reduced amount of insurance. The policy may provide that a partial surrender provision shall not require the insurer to reduce the amount of the minimum death benefit to less than the lowest amount of minimum death benefit which would have been issued to the insured under the insurance plans of the insurer at the time the policy was issued. The policy must clearly provide that the policyholder has the option of electing to exercise the cash value privileges of the policy loan or partial withdrawal provision rather than the partial surrender provision;

(xi) All policy loan, partial withdrawal, or partial surrender provisions shall be constructed so that variable life insurance policyholders who have not exercised such provision are not disadvantaged by the exercise thereof;

(xii) Monies paid to the policyholders upon the exercise of any policy loan, partial withdrawal, or partial surrender provision shall be withdrawn from the separate account and shall be returned to the separate account upon repayment except that a stock insurer may provide the monies for policy loans from the general account.

(5) Other Policy Provisions. The following provisions may in substance be included in a variable life insurance policy or related form delivered or issued for delivery in this state:

(a) An exclusion for suicide within two years of the policy issue date;

(b) Incidental insurance benefits may be offered on a fixed basis only;

(c) Policies issued on a participating basis shall offer to pay dividend amounts in cash. In addition, such policies may offer the following dividend options.

(i) The amount of the dividend may be credited against premium payments;

(ii) The amount of the dividend may be applied to provide paid-up amounts of additional fixed benefit whole life insurance;

(iii) The amount of the dividend may be applied to provide paid-up amounts of additional variable life insurance;

(iv) The amount of the dividend may be deposited in the general account at a specified minimum rate of interest;

(v) The amount of the dividend may be applied to provide paid-up amounts of fixed benefit one-year term insurance;

(vi) The amount of the dividend may be deposited as a variable deposit in the separate account if the separate account is exempt pursuant to Section 3(c)(11) of the Investment Company Act of 1940;

(d) A provision allowing the policyholder to elect in writing in the application for the policy or thereafter an automatic premium loan on a basis not less favorable than that required of policy loans or partial withdrawals under Item (4) of this Rule except that a restriction that no more than two consecutive premiums can be paid under this provision may be imposed.

History Note: *Authority G.S. 58-2-40; 58-7-95;*
Eff. January 1, 1978;
Readopted Eff. September 26, 1978;
Amended Eff. February 1, 1996; September 1, 1994; April 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0437 RESERVE LIABILITIES FOR VARIABLE LIFE INSURANCE

(a) Reserve liabilities for variable life insurance policies shall be established pursuant to G.S. 58-58-50 accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

(b) Reserve liabilities for the guaranteed minimum death benefit shall be the reserve needed to provide for the contingency of death occurring when the guaranteed minimum death benefit exceeds the death benefit that would be paid in the absence of the guarantee, and shall be maintained in the general account of the insurer and shall be not less than the greater of the following minimum reserves:

(1) The aggregate total of the term costs, if any, covering a period of one full year from the valuation date, of the guarantee on each variable life insurance contract, assuming an immediate one-third depreciation in the current value of the assets of the separate account followed by a net investment return equal to the assumed investment rate; or

(2) The aggregate total of the "attained age level" reserves on each variable life insurance contract. The "attained age level" reserve on each variable life insurance contract shall not be less than zero and shall equal the "residue," as described in (A) of this Subsection of the prior year's "attained age level" reserve on the contract, with any such "residue" increased or decreased by a payment computed on an attained age basis as described in (B) of this Subsection:

(A) The residue of the prior year's "attained age level" reserve on each variable life insurance contract shall not be less than zero and shall be determined by adding interest at the valuation interest rate to such prior year's reserve, deducting the tabular claims based on the "excess," if any, of the guaranteed minimum death benefit over the death benefit that would be payable in the absence of such guarantee, and dividing the net result by the tabular probability of survival. The "excess" referred to in the preceding sentence shall be based on the actual level of death benefits that would have been in effect during the preceding year in the absence of the guarantee, taking appropriate account of the reserve assumptions regarding the distribution of death claim payments over the year.

(B) The payment referred to in this Subsection (b)(2) shall be computed so that the present value of a level payment of that amount each year over the future premium paying period of the contract is equal to "A" minus "B" minus "C" where "A" is the present value of the future guaranteed minimum death benefits, "B" is present value of the future death benefits that would be payable in the absence of such guarantee, and "C" is any "residue," as described in (A) of this Subsection of the prior year's "attained age level" reserve on such variable life insurance contract. If the contract is paid-up, the payment shall equal "A" minus "B" minus "C". The amounts of future death benefits referred to in "B" shall be computed assuming a net investment return of the separate account which may differ from the assumed investment rate and/or the valuation interest rate but in no event may exceed the maximum interest rate permitted for the valuation of life insurance contracts;

(3) The valuation interest rate and mortality table used in computing the two minimum reserves described in (1) and (2) of this Subsection shall conform to permissible standards for the valuation of life insurance contracts. In determining such minimum reserve, the company may employ suitable approximations and estimates, including but not limited to groupings and averages.

(c) Reserve liabilities for all fixed incidental insurance benefits shall be maintained in the general account in amounts determined in accordance with the actuarial procedures appropriate to such benefit.

History Note: *Authority G.S. 58-2-40(1); 58-7-95;*
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Amended Eff. April 8, 2002;
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11 NCAC 12 .0438 SEPARATE ACCOUNTS

The following requirements apply to the establishment and administration of variable life insurance separate accounts:

(1) Establishment and Administration of Separate Accounts. An insurer issuing variable life insurance in this state shall establish one or more separate accounts pursuant to G.S. 58-7-95 of the insurance laws of this state:

(a) If no law or other regulation provides for the custody of separate account assets and if the insurer itself is not the custodian of such assets, all contracts for such custody shall be in writing and the commissioner of the insurer's state of domicile shall approve of both the terms of any such contract and the proposed custodian prior to the transfer of custody.

(b) An insurer shall not without the prior written approval of the commissioner employ in any material connection with the handling of separate account assets any person who:

(i) within the last 10 years has been convicted of any felony or a misdemeanor arising out of such person's conduct involving embezzlement, fraudulent conversion, or misappropriation of funds or securities or involving violation of Sections 1341 to 1343 of Title 18, United States Code; or

(ii) within the last 10 years has been found by any state regulatory authority to have violated or has acknowledged violation of any provision of any state insurance law involving fraud, deceit, or knowing misrepresentation; or

(iii) within the last 10 years has been found by federal or state regulatory authorities to have violated or has acknowledged violation of any provision of federal or state securities laws involving fraud, deceit, or knowing misrepresentation.

(c) All persons with access to the cash, securities, or other assets of the separate account shall be under good and sufficient bond.

(d) If an insurer establishes more than one separate account for variable life insurance, justification for the establishment of each additional separate account shall also be filed with the commissioner and shall be subject to his approval.

(e) The assets of such separate accounts established for variable life insurance policies shall be valued at least as often as variable benefits are determined but in any event at least monthly.

(f) A separate account exempt pursuant to Section 3(c)(11) of the Investment Company Act of 1940 because of the tax qualified status of the policies funded thereby shall not be used to fund other variable life insurance policies.

(g) Except for separate accounts exempt pursuant to Section 3(c)(11) of the Investment Company Act of 1940, variable life insurance separate accounts shall not be used for variable annuities or for the investment of funds corresponding to dividend accumulations or other policyholder liabilities not involving life contingencies.

(2) Amounts in the Separate Account

(a) The insurer shall maintain in each variable life insurance separate account assets with a fair market value at least equal to the greater of the valuation reserves for the variable portion of the variable life insurance policies or the benefit base for such policies.

(b) The benefit base of any variable life insurance policy as of the beginning of any valuation period shall not be less than the sum of the following factors after deducting amounts of any indebtedness pursuant to .0436(4)(b) of this Section:

(i) the valuation net premium for such period for the variable portion of the policy minus the discounted cost of term insurance for such period, based on the tabular mortality and interest rates used in determining valuation reserves; and

(ii) the valuation terminal reserve, for the variable portion of the policy, at the end of the immediately preceding valuation period adjusted for the net investment return of such preceding period.

(c) In lieu of the minimum benefit base requirement specified in (2)(b) of this Rule, an insurer may otherwise qualify if it can be demonstrated, to the satisfaction of the commissioner, that the policy benefits obtained over a 20-year period from the date of issue by the use of the insurer's benefit base are at least substantially equivalent in value to the benefits obtained by the use of the minimum benefit base. The commissioner may specify the range of net investment return to be used in this demonstration.

(d) Notwithstanding the actual reserve basis used for policies that do not meet standard underwriting requirements, the benefit base for such policies may be the same as for corresponding policies which do meet standard underwriting requirements.

(3) Investments by the Separate Account

(a) No sale, exchange, or other transfer of assets may be made by an insurer or any of its affiliates between any other investment account and one or more of its separate accounts unless:

(i) in case of a transfer into a separate account, such transfer is made solely to establish the account or to support the operation of the policies with respect to the separate account to which the transfer is made; and

(ii) such transfer, whether into or from a separate account, is made by a transfer of cash; but other assets may be transferred if approved by the commissioner in advance.

(b) Assets allocated to a variable life insurance separate account shall be held in cash or investments having a reasonably ascertainable market price. For purposes of this Rule, only the following shall be considered "investments having a reasonable ascertainable market price":

(i) liens in favor of the insurer against separate account policy reserves resulting from use by policyholders of cash values;

(ii) securities listed and traded on the New York Stock Exchange, the American Stock Exchange, or regional stock exchanges or successors to such exchanges having the same or similar qualifications;

(iii) securities listed on the NASDAQ System;

(iv) shares of an investment company registered pursuant to the Investment Company Act of 1940; Where such an investment company issues book shares in lieu of share certificates, such book shares shall be deemed to be adequate evidence of ownership;

(v) obligations of or guaranteed by the United States government, the Canadian government, any state, or municipality or governmental subdivision of a state;

(vi) commercial paper issued by business corporations when the total of such paper issued by the corporation does not exceed in value a guaranteed short line of credit by a bank;

(vii) certificates of deposit issued by financial institutions the deposits of which are insured by the FDIC or FSLIC; and

(viii) new bond or debt issued which may reasonably be expected to be listed on an exchange regulated by the Securities Exchange Act of 1934.

(c) Notwithstanding any other provision of law or the provisions of (b) of this Subsection, assets allocated to a variable life insurance separate account shall not be invested in:

(i) commodities or commodity contracts;

(ii) put and call options or combinations of such options;

(iii) short sales;

(iv) purchases on margins;

(v) letter or restrict stock;

(vi) units or other evidences of ownership of a separate account of another, except those registered under the Investment Company Act of 1940; or

(vii) real estate other than shares of a real estate investment trust listed as described in (b)(ii) of this Subsection.

(4) Limitations on Ownership

(a) A variable life insurance separate account shall not purchase or otherwise acquire the securities of any issuer, other than securities issued or guaranteed as to principal and interest by the United States, if immediately after such purchase or acquisition the value of such investment, together with prior investments of such separate account in such security valued as required by these regulations, would exceed 10 percent of the value of the assets of the separate account. The commissioner may waive this limitation in writing if he believes such waiver will not render the operation of the separate account hazardous to the public or the policyholders in this state.

(b) No separate account shall purchase or otherwise acquire the voting securities of any issuer and its separate accounts, in the aggregate, will own more than 10 percent of the total issued and outstanding voting securities of such issuer. The commissioner may waive this limitation in writing if he believes such waiver will not render the operation of the separate account hazardous to the public or the policyholders in this state or jeopardize the independent operation of the issuer of such securities.

(c) The percentage limitation specified in (a) of this Subsection shall not be construed to preclude the investment of the assets of separate accounts in shares of investment companies registered pursuant to the Investment Company Act of 1940 if the investments

and investment policies of such investment companies comply substantially with provisions of (3) of this Rule and other applicable portions of this Regulation.

(5) Valuation of Assets of a Variable Life Insurance Separate Account

(a) Investments of the separate account shall be valued at their market value on the date of valuation:

(i) Market value for investments traded on the recognized exchanges means the last reported sale price on the date of valuation. If there has been no sale on that date, the market value means the last reported bid quotation on the date of valuation.

(ii) Market value for investments listed on the NASDAQ System means the last representative bid quotation on the valuation date. If an investment ceases to be listed but continues to be traded over the counter, it shall be valued at the lowest bid quotation as it appears on the National Quotation Bureau sheets.

(iii) If the valuation date referred to in (i) and (ii) of this Subsection is a day when the exchange or the NASDAQ System is not open for business, the valuation date shall be the last date when the exchange of the NASDAQ System was open for business.

(b) If an investment ceases to be traded, it shall be valued at fair value as determined in good faith by or at the direction of the committee of the separate account, or, if there is no such committee, the Board of directors of the insurer but not in excess of the last reported bid quotation. Within 30 days notification of cessation of trading of any investment shall be reported by the insurer to the insurance commissioner of the state of domicile of the insurer. Such commissioner shall within a reasonable period of time determine the method of valuation or disposition of such investment.

(6) Separate Account Investment Policy

(a) The investment policy of a separate account operated by a domestic insurer filed under .0435(2)(e) of this Section shall not be changed without the approval of the insurance commissioner and any approval of variable life insurance policyholders that may be required under the Investment Company Act of 1940.

(b) With respect to changes of investment policy for which the commissioner must give his approval, the following regulations shall apply:

(i) Such approval shall be deemed to be given 60 days after the date the request for approval was filed with the commissioner, unless he notifies the insurer before the end of such 60 day period of his determination that the proposed change is a material change in the investment policy.

(ii) If the change is deemed material by the commissioner, he shall approve such change only if he determines that the change does not appear detrimental to the interest of the policyholders of the insurer or adverse to the operations of the insurer.

(iii) If a proposed change of investment policy is deemed material by the commissioner, any policyholder objecting to such change shall be given the right to request that, within 60 days of the effective date of the change, his policy be converted without evidence of insurability, under one of the following options, to a fixed benefit life insurance policy issued by the insurer or an affiliate:

(A) If the policy is in force on a premium paying basis, either:

(I) conversion as of the original issue age to a substantially comparable permanent form of fixed benefit life insurance, based on the insurer's premium rates for fixed benefit life insurance at the original issue age, for an amount of insurance not exceeding the death benefit of the variable life insurance policy on the date of conversion; or

(II) conversion as of the attained age to a substantially comparable permanent form of fixed benefit life insurance for an amount of insurance not exceeding the excess of the death benefit of the variable life insurance policy on the date of conversion

over its cash value on the date of conversion if the policyholder elects to surrender the variable life policy for its cash value, or the death benefit payable under any paid-up insurance option if the policyholder elects such nonforfeiture option under the variable life policy.

(B) If the policy is in force as paid-up variable life insurance, then conversion will be to a substantially comparable paid-up fixed benefit life insurance policy for an amount of insurance not exceeding the death benefit of the variable life insurance policy on the date of conversion. If conversion is made pursuant to (A)(I) or (II) of this Subsection, then there will be an equitable premium or cash value adjustment that takes appropriate account of the premiums and cash values under the original and new policies. A detailed statement of the method of computing such adjustment shall be filed with the commissioner.

(7) Charges Against a Variable Life Insurance Separate Account

(a) The insurer may deduct only the following from the separate account:

(i) taxes or reserves for taxes attributable to investment gains and income of the separate account;

(ii) actual cost of reasonable brokerage fees and similar direct acquisition and sales costs incurred in the purchase or sale of separate account assets;

(iii) actuarially determined costs of insurance (tabular costs) and the release of reserves and benefit base consistent with the release of separate account liabilities;

(iv) charges for investment management expenses, including internal costs attributable to the investment management of assets of the separate account at a rate not in excess of that stated in the policy;

(v) charges for mortality and expense guarantees at a rate not in excess of that stated in the policy;

(vi) any amounts in excess of those required to be held in the separate account.

(b) Any charges against the separate account made by either an affiliate of the insurer or an unaffiliated fund shall be considered part of the charges limited by (a)(iv) and (v) of this Subsection. Any charge against the separate account, excluding taxes, shall not vary in accordance with the difference between the investment performance of the separate account and any index of securities prices or other measure of investment performance.

(8) Standards of Conduct. Every insurer seeking approval to enter into the variable life insurance business in this state shall adopt by formal action of its board of directors and file with the commissioner a written statement specifying the standards of conduct of the insurer, its officers, directors, employees, and affiliates with respect to investments of variable life insurance separate accounts and variable life insurance operations. Such standards of conduct shall be binding on the insurer and those to whom it refers.

(9) Conflicts of Interest

(a) Rules under any provision of the insurance laws of this state or any regulation applicable to the officers and directors of insurance companies with respect to conflicts of interest shall also apply to members of any separate account's committee or other similar body. No officer or director of such company nor any member of any managing committee or body of a separate account shall receive directly or indirectly any commission or any other compensation with respect to the purchase or sale of assets of such separate account.

(b) No provision of this Regulation shall be construed to prohibit:

(i) the investment of separate account assets in securities issued by one or more investment companies registered pursuant to the Investment Company Act of 1940 which is sponsored or managed by the insurer or an affiliate, and the payment of investment management or advisory fees on such assets;

(ii) an insurer or an affiliate to act as a broker or dealer in connection with the sale of securities to or by such separate account;

(iii) the rendering of investment management or investment advisory services by an insurer or affiliate, for a fee, subject to the provisions of this Regulation.

(10) Investment Advisory Services to a Separate Account

(a) An insurer shall not enter into a contract under which any person undertakes, for a fee, to regularly furnish investment advice to such insurer with respect to any of its separate accounts maintained for variable life insurance policies unless:

(i) the person providing such advice is registered as an investment adviser under the Investment Advisers Act of 1940; or

(ii) the person providing such advice is an investment manager under the Employee Retirement Income Security Act of 1974 with respect to the assets of each employee benefit plan allocated to the separate account; or

(iii) the insurer has filed with the commissioner and continues to file annually the following information and statements concerning the proposed adviser:

(A) the name and form of organization, state of organization, and its principal place of business;

(B) the names and addresses of its partners, officers, directors, and persons performing similar functions or, if such an investment adviser by an individual, of such individual;

(C) a written standard of conduct complying in substance with the requirements of (9) of this Rule which has been adopted by the investment adviser and is applicable to the investment adviser, its officers, directors, and affiliates;

(D) a statement provided by the proposed adviser as to whether the adviser or any person associated therewith:

(I) has been convicted within 10 years of any felony or misdemeanor arising out of such person's conduct as an employee, salesman, officer or director of an insurance company, a bank, an insurance agent, a securities broker or an investment adviser; involving embezzlement, fraudulent conversion, or misappropriation of funds or securities, or involving the violation of Sections 1341, 1342, or 1343 or Title 18 of the United States Code;

(II) has been permanently or temporarily enjoined by order, judgment, or decree of any court of competent jurisdiction from acting as an investment adviser, underwriter, broker, or dealer, or as an affiliated person or as an employee of any investment company, bank, or insurance company, or from engaging in or continuing any conduct or practice in connection with any such activity;

(III) has been found by federal or state regulatory authorities to have willfully violated or has acknowledged willful violation of any provision of federal or state securities laws or state insurance laws or of any such laws; or

(IV) has been censured, denied an investment adviser registration, had a registration as an investment adviser revoked or suspended, or been barred or suspended from being associated with an investment adviser by order of federal or state regulatory authorities.

(b) The commissioner may, after notice and opportunity for hearing, by order require such investment advisory contract to be terminated if he deems continued operation thereunder to be hazardous to the public or the insurer's policyholders.

History Note: *Authority G.S. 58-2-40(1); 58-7-95;*
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Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0439 INFORMATION FURNISHED TO APPLICANTS

An insurer delivering or issuing for delivery in this state any variable life insurance policies shall deliver to the applicant for the policy, and obtain a written acknowledgment of receipt from such applicant coincident with or prior to the execution of the application, a prospectus included in a registration statement relating to the policies which satisfied the requirements of the Securities Act of 1933 and which was declared effective by the Securities and Exchange Commission, or if the policies are exempted from the registration requirements of such act by section 3(a)(2) thereof, the insurer shall furnish all information and reports required by the Employee Retirement Income Security Act of 1974.

History Note: *Authority G.S. 58-2-40(1); 58-7-95;*
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Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0440 APPLICATIONS

The application for a variable life insurance policy shall contain:

(1) a prominent statement that the death benefit may be variable or fixed under specified conditions;
(2) a prominent statement that cash values may increase or decrease in accordance with the experience of the separate account (subject to any specified minimum guarantees);
(3) questions designed to elicit information which enables the insurer to determine the suitability of variable life insurance for the applicant.

History Note: *Authority G.S. 58-2-40(1); 58-7-95;*
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Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0441 REPORTS TO POLICYHOLDERS

Any insurer delivering or issuing for delivery in this state any variable life insurance policies shall mail to each variable life insurance policyholder at his or her last known address the following reports:

(1) within 30 days after each anniversary of the policy, a statement or statements of the cash surrender value, death benefit, any partial withdrawal or policy loan, any interest charge, and any optional payments allowed pursuant to .0436(4) of this Section under the policy computed as of the policy anniversary date; provided, however, that such statement may be furnished within 30 days after a specified date in each policy year so long as the information contained therein is computed as of a date not more than 45 days prior to the mailing of such notice; This statement shall state in contrasting color or distinctive type that, in accordance with the investment experience of the separate account, the cash values and the variable death benefit may increase or decrease, and shall prominently identify any value described therein which may be recomputed prior to the next statement required by this Rule. If the policy guarantees that the variable death benefit on the next policy anniversary date will not be less than the variable death benefit specified in such statement, the statement shall be modified to so indicate;
(2) annually, if not already required by the Securities and Exchange Commission, a statement or statements including:
    (a) a summary of the financial statement of the separate account based on the annual statement last filed with the commissioner;
    (b) the net investment return of the separate account for the last year and, for each year after the first, a comparison of the investment rate of the separate account during the last year with the investment rate during prior years, up to a total of five years where available;
    (c) a list of investments held by the separate account as of a date not earlier than the end of the last year for which an annual statement was filed with the commissioner;

(d) any charges, taxes, and brokerage fees determined on an accrual basis payable by the separate account during the previous year, each expressed as a dollar amount and a percentage and the total expressed as a dollar amount and as a percentage of the assets of the separate account;

(e) a statement of the portfolio turnover rate as defined herein during the preceding fiscal year of investments allocated to the separate account:

(i) The rate shall be calculated by dividing "A," the lesser of purchases or sales of portfolio securities for the particular fiscal year, by "B," the monthly average of the value of the portfolio securities owned by the separate account during the particular fiscal year. Such monthly average shall be calculated by totaling the values of the portfolio securities as of the beginning and end of the first month of the particular fiscal year and as the end of each of the succeeding 11 months, and dividing the sum by 13, except that the average value of securities for which market quotations are not available may be based upon the value of such securities as of the end of the preceding fiscal quarters.

(ii) For the purposes of this Rule, there shall be excluded from both the numerator and the denominator all U.S. Government securities (short-term and long-term) and all other securities whose maturities at the time of acquisition were one year or less. Purchases shall also include any cash paid upon the conversion of one portfolio security into another. Purchases shall also include the cost of rights or warrants purchased. Sales shall include the net proceeds of the sale of rights or warrants. Sales shall also include the net proceeds of redemptions of portfolio securities by call or maturity.

(iii) The insurer shall show, in addition to the calculated portfolio turnover rate, both the amount of the purchases and the amount of the sales [calculated as prescribed in (2)(e)(ii) of this Rule] and the monthly average (but not the individual monthly figures) of the value of the portfolio securities owned by the separate account during the fiscal year.

(iv) The insurer may, if it wishes, make any statement or explanation with respect to any significant variations in the portfolio turnover rate during the three fiscal years next preceding.

(f) a statement of any change, since the last report, in the investment objective and orientation of the separate account, in any investment restriction or material quantitative or qualitative investment requirement applicable to the separate account, or in the investment adviser or the separate account;

(g) the name of each broker or dealer handling portfolio transactions on behalf of the separate account in which the insurer or an affiliate has any material direct or indirect interest and the nature of such transactions and the amount of compensation received by each such broker or dealer from business originating with the separate account during the preceding fiscal year;

(h) the names and principal occupations of each principal executive officer and each director of the insurer; and

(i) the names of all parents of the insurer and the basis of control of the insurer, and the name of any person who is known to own, of record or beneficially, 10 percent or more of the outstanding voting securities of the company

(3) monthly, a report which describes the value of the insured's death benefits to policyholders whose policies, while in force do not provide a death benefit at least equal to the amount specified at issue or at the most recent policy change requested by the policyholder.

History Note: *Authority G.S. 58-2-40(1); 58-7-95;*
Eff. January 1, 1978;
Readopted Eff. September 26, 1978;
Amended Eff. April 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0442 FOREIGN COMPANIES

If the law or regulation in the place of domicile of a foreign company provides a degree of protection to the policyholders and the public which is substantially equal to that provided by these regulations, the commissioner, to the extent deemed appropriate by him in his discretion may consider compliance with such law or regulation as compliance with the regulations.

History Note: *Authority G.S. 58-2-40(1); 58-7-95;*
Eff. January 1, 1978;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0443 QUALIFICATION: FOR THE SALE OF VARIABLE LIFE INSURANCE

(a) Qualifications to Sell Variable Life Insurance

(1) No person may sell or offer for sale in this state any variable life insurance policy unless such person is an agent and has filed with the commissioner, in a form satisfactory to the commissioner, evidence that such person holds any license or authorization which may be required for the solicitation or sale of variable life insurance by any federal or state securities law.

(2) Any examination administered by the department for the purpose of determining the eligibility of any person for licensing as an agent shall, after the effective date of this Regulation, include such questions concerning the history, purpose, regulation, and sale of variable life insurance as the commissioner deems appropriate.

(b) Reports of Disciplinary Actions. Any person qualified in this state under this article to sell or offer to sell variable life insurance shall immediately report to the commissioner:

(1) any suspension or revocation of his agent's license in any other state or territory of the United States;

(2) the imposition of any disciplinary sanction, including suspension or expulsion from membership, suspension, or revocation of or denial of registration, imposed upon him by any national securities exchange, or national securities association, or any federal, state, or territorial agency with jurisdiction over securities or variable life insurance;

(3) any judgment or injunction entered against him on the basis of conduct deemed to have involved fraud, deceit, misrepresentation, or violation of any insurance or securities law or regulation.

(c) Refusal to Qualify Agent to Sell Variable Life Insurance; Suspension, Revocation, or Nonrenewal of Qualification. The commissioner may reject any application or suspend or revoke or refuse to renew any agent's qualification to sell or offer to sell variable life insurance upon any ground that would bar such applicant or such agent from being licensed to sell other life insurance contracts in this state. The rules governing any proceeding relating to the suspension or revocation or an agent's license shall also govern any proceeding for suspension or revocation of an agent's qualification to sell or offer to sell variable life insurance.

History Note: *Authority G.S. 58-2-40(1); 58-7-95;*
Eff. January 1, 1978;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0444 SEPARABILITY ARTICLE

History Note: *Authority G.S. 58-9(1); 58-79.2;*
Eff. January 1, 1978;
Readopted Eff. September 26, 1978;
Repealed Eff. July 1, 1988.

11 NCAC 12 .0445 INTEREST CHARGES ON MISSTATEMENT OF AGE OR SEX

Interests on overpayments made by an insurer because of misstatement of age or sex shall not be charged unless an equal rate of interest is paid by the insurer for under payments.

History Note: *Authority G.S. 58-2-40; 58-58-1;*
Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0446 SOUND HEALTH

No policy of life insurance shall contain a provision that the policy will be voided if the insured is not in sound or good health on the effective date of the policy, or date of reinstatement unless such provision contains the following:

(1) The burden of proof as to whether the condition was material lies solely with the insurer;
(2) If voided, there will be a full refund of premium;
(3) Reference to such condition was not contained in the written application.

History Note: *Authority G.S. 58-2-40; 58-58-1;*
Eff. September 26, 1978;
Amended Eff. April 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0447 FREE LOOK PROVISION

(a) An insurer, prior to the time that any individual life insurance or annuity policy is issued for delivery or delivered, shall ensure that a "Ten Day Free Look" provision is displayed by sticker or printed on the face of each life insurance or annuity policy.

(b) The free look provision required by this Rule shall afford the policyholder a period of time, following receipt of the policy, during which the policy may be returned to the company for a prompt refund of the premium paid. This Rule also applies to any group life insurance or annuity policy or certificate that contains a free look provision.

History Note: *Authority G.S. 58-2-40; 58-58-1;*
Eff. September 26, 1978;
Amended Eff. August 1, 2004; February 1, 1992; April 1, 1989; July 1, 1982;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0448 WAITING PERIODS ON LIFE INSURANCE RIDERS

On all life insurance riders providing additional benefits, attached subsequent to the date of the policy, a sticker shall be attached in a prominent place on the rider stating, when appropriate, substantially the following: "PLEASE READ THIS RIDER CAREFULLY".

THE WAITING PERIODS IN THE SUICIDE AND/OR INCONTESTABILITY PROVISIONS ARE DIFFERENT FROM THOSE IN THE POLICY AND BEGIN ON THE EFFECTIVE DATE OF THE RIDER.

History Note: *Authority G.S. 58-2-40; 58-58-1;*
Eff. September 26, 1978;
Amended Eff. February 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0449 LIMITED INITIAL DEATH BENEFIT

No policy or certificate of life insurance which provides a limited death benefit for a stated initial period shall be issued except on a guaranteed issue basis. Such policy shall have printed on the face in bold type Graded Death Benefit.

History Note: *Authority G.S. 58-2-40; 58-3-150; 58-58-1;*
Eff. September 26, 1978;
Amended Eff. February 1, 1996; July 1, 1986;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0450 REQUIREMENT FOR MODIFIED PREMIUM LIFE INSURANCE

The application for a modified premium life insurance policy which has a higher first year premium shall contain an acknowledgment, signed by the applicant, stating that he understands:

(1) He is paying a higher first year premium; and

(2) If he discontinues the coverage, the only benefits available to him are those set forth in the non-forfeiture provision, regardless of the money paid in.

History Note: *Authority G.S. 58-2-40; 58-58-1;*
Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0451 POLICY LOAN INTEREST RATES

History Note: *Authority G.S. 58-9; 58-195;*
Eff. September 26, 1978;
Repealed Eff. July 1, 1988.

11 NCAC 12 .0452 LIFE INSURANCE SOLICITATION: GENERAL
11 NCAC 12 .0453 LIFE INSURANCE SOLICITATION: DEFINITIONS
11 NCAC 12 .0454 LIFE INSURANCE SOLICITATION: DISCLOSURE
11 NCAC 12 .0455 LIFE INSURANCE SOLICITATION: GENERAL RULES
11 NCAC 12 .0456 LIFE INSURANCE SOLICITATION: OTHER

History Note: *Authority G.S. 58-9; 58-25.1; 58-26; 58-33; 58-42; 58-42.1; 58-54.4; 58-195; 58-198; 58-199;*
Eff. April 26, 1979;
Repealed Eff. June 16, 1979.

11 NCAC 12 .0457 CREDIT INSURANCE: AUTOMOBILE LEASES

History Note: *Authority G.S. 58-9;*
Eff. July 1, 1986;
Repealed Eff. April 1, 1989.

11 NCAC 12 .0458 RESERVED FOR FUTURE CODIFICATION

11 NCAC 12 .0459 RESERVED FOR FUTURE CODIFICATION

11 NCAC 12 .0460 PREARRANGEMENT INSURANCE DISCLOSURE

History Note: *Authority G.S. 58-2-40; 58-58-1; 58-60-35;*
Eff. February 1, 1992;
Repealed Eff. February 1, 1996.

11 NCAC 12 .0461 USE OF SENIOR-SPECIFIC CERTIFICATIONS AND PROFESSIONAL DESIGNATIONS

(a) This Rule applies to the solicitation, sale, or purchase of, or advice made in connection with the solicitation, sale or purchase of a life insurance or annuity product.

(b) The NAIC Model Regulation on the Use of Senior-Specific Certifications and Professional Designations ("Model Regulation"), as adopted by the National Association of Insurance Commissioners at the Fall National Meeting of 2008, including subsequent amendments and editions, is hereby incorporated by reference. Copies of the Model Regulation are available free of charge from the Life and Health Division by email at l&hinbox@ncdoi.gov or the Department of Insurance Website at www.ncdoi.com.

(c) As used in the Model Regulation, "reference to State unfair trade practices act" means Article 63 of Chapter 58 of the General Statutes and "insert reference to enabling legislation" means G.S. 58-63-75.

History Note: *Authority G.S. 58-2-40; 58-63-75;*
Eff. February 1, 2010;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0462 SUITABILITY IN ANNUITY TRANSACTIONS

(a) The NAIC Suitability in Annuity Transactions Model Regulation (#275) ("NAIC Model Regulation #275"), as adopted by the National Association of Insurance Commissioners at the Spring National Meeting of 2020, including subsequent amendments and editions, is hereby incorporated by reference. Copies of the Model Regulation are available free of charge from the Life and Health Division by email at l&hinbox@ncdoi.gov, the Department of Insurance website at www.ncdoi.com, or the NAIC Model Law website at https://content.naic.org/model-laws.

(b) As used in NAIC Model Regulation #275, "insert reference to enabling legislation" means S.L. 2017-136.

History Note: *Authority G.S. 58-2-40; S.L. 2017-136;*
Eff. January 1, 2023.

SECTION .0500 - ACCIDENT AND HEALTH: GENERAL NATURE

11 NCAC 12 .0501 ACCIDENT AND HEALTH: GENERAL NATURE

History Note: *Authority G.S. 57-4; 57-7; 58-9;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Repealed Eff. July 1, 1988.

11 NCAC 12 .0502 RATE INCREASES FOR INDIVIDUAL AND BLANKET POLICIES

History Note: *Authority G.S. 58-251.2;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Repealed Eff. April 1, 1989.

11 NCAC 12 .0503 WAITING PERIOD

(a) If a sickness or disease first manifests itself during the waiting period, it must be covered at the end of said waiting period.

(b) If the company can prove that the condition existed prior to the effective date of coverage, the company will not be required to pay benefits until the end of the time period prescribed in part b of "Time Limit on Certain Defenses."

(c) If the policy is issued to an individual over age 65, any condition not specifically excluded must be covered at the end of the waiting period.

History Note: *Authority G.S. 58-2-40; 58-51-1; 58-51-60; 58-65-1; 58-65-40;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0504 APPROVAL OF FILING: 90 DAY DEEMER NOT IN EFFECT

History Note: *Authority G.S. 58-254.7; 58-370(a);*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. April 1, 1989;
Repealed Eff. February 1, 1992.

11 NCAC 12 .0505 MAIL ORDER APPLICATION: ACCIDENT AND HEALTH

History Note: *Authority G.S. 58-257;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Repealed Eff. July 1, 1986.

11 NCAC 12 .0506 MASS MARKETING APPLICATION

Applications used in the solicitation for accident and health insurance on a mass marketing basis may not require information on pre-existing conditions dating back further than five years prior to the date of the application.

History Note: *Authority G.S. 58-2-40(1);*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0507 FRATERNAL ORDERS: SOCIETIES AND ASSOCIATIONS

History Note: *Authority G.S. 58-9(1);*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Repealed Eff. March 1, 1992.

11 NCAC 12 .0508 ACCIDENT AND HEALTH TRAVEL: NEWSPAPER SUBSCRIPTIONS

Travel insurance procured in connection with newspaper subscriptions must comply with the following procedures:

(1) All advertising matters shall be published over the name of the regularly licensed agent.
(2) The policies shall be offered to all readers of the newspaper and not restricted to subscribers only and a subscription to the paper shall not be a prerequisite to obtaining these policies.

History Note: *Authority G.S. 58-2-40(1); 58-51-1;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0509 ACCIDENT AND HEALTH INSURANCE: NATURAL DEATH BENEFIT

No policy of accident and health insurance may be issued in North Carolina which contains a provision wherein the company promises to pay a funeral benefit, a fatal sickness benefit, a natural death benefit or other additional benefit, the payment of which is contingent upon the natural death of the insured. Provided, industrial weekly or monthly premium or assessment policies containing provision for payment of weekly indemnity on account of sickness and accident, and in addition to natural death benefit not in excess of one hundred fifty dollars ($150.00) are exempt from this ruling if such policies clearly set forth the additional premium or assessment (or proportion thereof) to be charged for continuation of the natural death benefit after termination of the accident and health provisions.

History Note: *Authority G.S. 58-2-40(1); 58-51-1;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0510 ACCIDENT AND HEALTH INSURANCE: TOTAL TEMPORARY DISABILITY

Accident and health policies providing total temporary disability benefits must provide for the payment of at least three months benefits if the insured is prevented from performing the duties of his occupation.

History Note: *Authority G.S. 58-2-40(1); 58-51-1;*

Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0511 GROUP ACCIDENT AND HEALTH INSURANCE: EXCLUSIONS

Individual accident and health certificates issued under a group accident and health policy must contain all exclusions that are set out in the master policy.

History Note: *Authority G.S. 58-2-40(1); 58-51-1;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0512 ACCIDENT AND HEALTH INSURANCE: EFFECTIVE DATE

The effective date of an accident and health policy shall be the date of issue when the premium or policy fee is paid in advance. This does not prevent the policy from containing some provision that coverage on the policy does not begin because of sickness for a certain period after the effective date, neither does it intend to interfere with provisions for the elimination of benefits for the first specified days of accident or illness.

History Note: *Authority G.S. 58-2-40(1); 58-51-1;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0513 ACCIDENT AND HEALTH: RIDER OR ELIMINATION ENDORSEMENT

All companies writing non-group accident, health or hospitalization insurance policies shall print in bold type on the face of the policy a notification that a rider or elimination endorsement has been attached. The requirement shall be waived for individual health riders when the applicant signs the rider.

History Note: *Authority G.S. 58-2-40; 58-65-1; 58-65-40;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0514 COORDINATION: GROUP A/H CONTRACT BENEFITS: GROUP COVERAGES

Purpose. In order to promote consistency in liability for claims and claims determination for group accident and health coverage, when a person has more than one type of group insurance and there is a basis for a claim under two or more group insurance plans, each group accident and health policy and any accident and health certificates issued under a group accident and health policy shall contain uniform order of benefit determination provisions as outlined in this Rule.

(1) Applicability:
  (a) These Coordination of Benefits ("COB") provisions apply when an employee or the employee's covered dependent has health care coverage under This Plan and one or more other Health Plans as defined in Sub-item (2)(a) of these provisions and when there is a basis for a claim under This Plan and the other Health Plan(s).
  (b) If these COB provisions apply, whether This Plan is the Primary Plan or the Secondary Plan is determined pursuant Item (3) of these provisions.
  (c) When This Plan is a Primary Plan, its benefits shall be determined before those of the other Secondary Plan(s) and without considering the Secondary Plan's benefits. When there are more than two other Health Plans covering the person, This Plan may be a

Primary Plan as to one or more other Health Plans and may be a Secondary Plan as to a different Health Plan or Health Plans.

(d) When This Plan is a Secondary Plan, its benefits shall be determined without considering the benefits of the Primary Plan or any other Secondary Plan and it shall credit to the deductible any amount that would otherwise be credited to it in the absence of coverage by another Health Plan. When This Plan is a Secondary Plan, any amount of those benefits paid for any Allowable Expense may be reduced to the amount of the Allowable Expense that is unpaid by the Primary Plan to prevent the payment of benefits under more than one Health Plan that would total more than 100 percent of the total expense for that claim.

(e) The benefits of This Plan:

(i) Shall not be reduced when, pursuant to Item (3) of these provisions, it is determined to be the Primary Plan; but

(ii) May be reduced when, pursuant to Item (3) of these provisions, it is determined to be the Secondary Plan.

(2) Definitions:

(a) "Allowable Expense" means any health care expense, including coinsurance or copayments, without reduction for an applicable deductible, that is covered in full or in part by any of the Health Plans covering the person. When a Health Plan provides benefits in the form of medical services, the reasonable cash value of each service rendered shall be considered both an allowable expense and a benefit paid.

(b) "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

(c) "Health Plan" means a plan which provides benefits or services for, or because of, medical or dental care or treatment:

(i) True group insurance. This includes prepayment, group practice or individual practice coverage. It does not include accident and health coverage for students, blanket, franchise individual, automobile and homeowner coverage.

(ii) Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.

Each coverage under Sub-items (2)(a)(i) or (ii) of these provisions is a separate Health Plan. Also, if there is more than one schedule of benefits, and COB provisions apply only to one, each of the schedule of benefits is a separate Health Plan.

(d) "Primary Plan" means a Health Plan whose benefits for a person's health care coverage has been determined to be the first claim payor taking the existence of any other Health Plan into consideration, pursuant to Item (3) of these provisions.

(e) "Secondary Plan" means a Health Plan that is not a Primary Plan.

(f) "This Plan" means this group accident and health policy.

(3) Order of Benefit Determination:

(a) When there is a basis for a claim under This Plan and another Health Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Health Plan, unless:

(i) the other Health Plan has provisions coordinating its benefits with those of This Plan; and

(ii) both the other Health Plan's provisions and This Plan's provisions in Sub-item (3)(b) of these provisions, require that This Plan's benefits be determined before those of the other Health Plan.

(b) This Plan determines its order of benefits using the first of the following rules which applies:

(i) Non-dependent/Dependent. The benefits of the Health Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent)

are determined before those of the Health Plan which covers the person as a dependent.

(ii) Dependent Child/Parents Not Separated or Divorced. Except as stated in Sub-item (3)(b)(iii) of these provisions, when This Plan and another Health Plan cover the same child as a dependent of different persons, called "parents":

(A) the benefits of the Health Plan of the parent whose birthday falls earlier in a year are determined before those of the Health Plan of the parent whose birthday falls later in that year; but

(B) if both parents have the same birthday, the benefits of the Health Plan that has covered a parent for a longer period of time are determined before those of the Health Plan that covered the other parent for a shorter period of time.

However, if the other Health Plan does not have the provision described in Sub-item (3)(b)(ii)(A) of these provisions, but instead has a provision based upon the gender of the parent, and if, as a result, the Health Plans do not agree on the order of benefits, the provision in the other Health Plan will determine the order of benefits.

(iii) Dependent Child/Separated or Divorced Parents. If two or more Health Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(A) first, the Health Plan of the parent with custody of the child;

(B) then, the Health Plan of the spouse of the parent with custody of the child; and

(C) finally, the Health Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the healthcare expenses or healthcare coverage and the Health Plan of the parent has actual knowledge of those terms, the benefits of that Health Plan are determined first. Sub-item (3)(b)(iii)(C) of these provisions does not apply with respect to any Claim Determination Period or plan-year during which any benefits are actually paid or provided before the Health Plan has that actual knowledge.

(iv) Active Inactive Employee. The benefits of a Health Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Health Plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other Health Plan does not have a provision like Sub-item (3)(b)(iv), and if, as a result, the Health Plans do not agree on the order of benefits, Sub-item (3)(b)(iv) is ignored.

(v) Longer/Shorter Length of Coverage. If none of the other provisions of Item (3) determine the order of benefits, the benefits of the Health Plan which covered an employee, member or subscriber longer are determined before those of the Health Plan which covered that person for the shorter time.

History Note: *Authority G.S. 58-2-40; 58-51-1; 58-51-80; 58-51-81; 58-65-1; 58-65-40;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. February 1, 1992; April 1, 1989; July 1, 1986;
Readopted Eff. July 1, 2020.

11 NCAC 12 .0515 COUNTERSIGNATURE BY AGENT

History Note: *Authority G.S. 58-9(1); 58-44;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Repealed Eff. April 1, 1989.

11 NCAC 12 .0516 ACCIDENT AND HEALTH ADVERTISING: RESPONSIBILITY OF INSURER

Every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All such advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer whose policies are so advertised. Such advertisements shall be made in accordance with the provisions of 11 NCAC 12 .0516 to .0536.

History Note: *Authority G.S. 58-2-40(1); 58-63-15;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0517 ACCIDENT AND HEALTH ADVERTISING: DEFINITIONS

The following definitions are applicable to accident and health advertising Rules 11 NCAC 12 .0516 to .0536 only:

(1) "Advertisement" is defined as:
  (a) printed and published material, audio visual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio scripts, TV scripts, billboards and similar displays; and
  (b) descriptive literature and sales aids of all kinds issued by an insurer, agent or broker for presentation to members of the insurance buying public, including but not limited to circulars, leaflets, booklets, depictions, illustrations, and form letters; and
  (c) prepared sales talks, presentations and material for use by agents, brokers and solicitors.

(2) "Policy" is defined as any policy, plan, certificate, contract, agreement, statement of coverage, rider or endorsement which provides long term care, Medicare supplement, accident or sickness benefits or medical, surgical or hospital expense benefits, whether on an indemnity, reimbursement, service or prepaid basis, except when issued in connection with another kind of insurance other than life and except disability, waiver of premium and double indemnity benefits included in life insurance and annuity contracts.

(3) "Insurer" is defined as any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyd's, fraternal benefit society, health maintenance organization, and any other legal entity which is defined as an "insurer" in the insurance code of this state and is engaged in the advertisement of a policy as "policy" is herein defined.

(4) "Exception" is defined as any provision in a policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy.

(5) "Reduction" is defined as any provision which reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction not been used.

(6) "Limitation" is defined as any provision which restricts coverage under the policy other than an exception or a reduction.

(7) "Institutional advertisement" is defined as an advertisement having as its sole purpose the promotion of the reader's or viewer's interest in the concept of accident and sickness insurance, or the promotion of the insurer.

(8) "Invitation to inquire" is defined as advertisement having as its objective the creation of a desire to inquire further about the product and which is limited to a brief description of the loss for which the benefit is payable, and which may contain:
  (a) the dollar amount of benefits payable; and
  (b) the period of time during which the benefits are payable; provided the advertisement does not refer to cost; An advertisement which specified either the dollar amount of benefit payable or the period of time during which the benefit is payable shall contain a provision in effect as follows:

"For costs and further details of the coverage, including exclusions, any reductions or limitations and terms under which the policy may be continued in force, see your agent or write to the company."

(9) "Invitation to contract" is defined as an advertisement which is neither an invitation to inquire nor an institutional advertisement.

History Note: *Authority G.S. 58-2-40; 58-54-10; 58-54-25; 58-54-35; 58-55-30; 58-63-15; 58-65-1; 58-65-40; 58-67-50; 58-67-150;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. February 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0518 ADVERTISING: DISCLOSURE OF REQUIRED INFORMATION

All information required to be disclosed shall be set out conspicuously and in close conjunction with the statements to which such information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisement so as to be confusing or misleading.

History Note: *Authority G.S. 58-2-40(1); 58-63-15;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0519 ACCIDENT AND HEALTH ADVERTISING: FORM AND CONTENT

The format and content of an advertisement of an accident or sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the commissioner, from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence, within the segment of the public to which it is directed.

Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used.

History Note: *Authority G.S. 58-2-40(1); 58-63-15;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0520 ACCIDENT AND HEALTH ADVERTISING: PROHIBITIONS

No advertisement shall omit information or use words, phrases, statements, references or illustrations if the omission of such information or use of such words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.

No advertisement shall contain or use words or phrases such as, "all"; "full"; "complete"; "comprehensive"; "unlimited"; "up to"; "as high as"; "this policy will help fill some of the gaps that Medicare and your present insurance leave out"; "this policy will help to replace your income" (when used to express loss of time benefits); or similar words and phrases, in a manner which exaggerates any benefits beyond the terms of the policy.

An advertisement shall not contain descriptions of a policy limitation, exception, or reduction, worded in a positive manner to imply that it is a benefit, such as, describing a waiting period as a "benefit builder," or stating "even pre-existing conditions are covered after two years." Words and phrases used in an advertisement to describe such policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of such limitations, exceptions and reductions of the policy offered.

No advertisement of a benefit for which payment is conditional upon confinement in a hospital or similar facility shall use words or phrases such as "tax free"; "extra income"; "extra pay"; or substantially similar words or phrases because such words and phrases have the capacity, tendency or effect to mislead the public into believing that the policy advertised will, in some way, enable them to make a profit from being hospitalized.

No advertisement of a hospital or other similar facility confinement benefit shall advertise that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is based upon a daily pro rata basis relating to the number of days of confinement unless such statement of such monthly or weekly benefit amounts are followed immediately by equally prominent statements of benefit payable on a daily basis. When the policy contains a limit on the number of days of coverage provided, such limit must appear in the advertisement.

No advertisement of a policy covering only one disease or a list of specified diseases shall imply coverage beyond the terms of the policy. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact.

An advertisement for a policy providing benefits for specified illnesses only, such as cancer, or for specified accidents only, such as automobile accidents, shall clearly and conspicuously in prominent type state the limited nature of the policy. The statement shall be worded in language identical to, or substantially similar to the following: "this is a limited policy"; "this is a cancer only policy"; "this is an automobile accident only policy."

An advertisement of a direct response insurance product shall not imply that because "no insurance agent will call and no commissions will be paid to agents" that it is "a low cost plan" or use other similar words or phrases because the cost of advertising and servicing such policies is a substantial cost in the marketing of a direct response insurance product.

History Note: *Authority G.S. 58-2-40(1); 58-63-15;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0521 ACCIDENT: HEALTH ADVERTISING: EXCEPTIONS AND LIMITATIONS

When an advertisement which is an invitation to contract refers to either a dollar amount, or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, it shall also disclose those exceptions, reductions and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity or tendency to mislead or deceive.

When a policy contains a waiting, elimination, probationary or similar time period between the effective date of the policy and the effective date of coverage under the policy or at a time period between the date a loss occurs and the date benefits begin to accrue for such loss, an advertisement which is subject to the requirements of the preceding Paragraph shall disclose the existence of such periods.

An advertisement shall not use the words "only"; "just"; "merely"; "minimum" or similar words or phrases to describe the applicability of any exceptions and reductions, such as: "This policy is subject to the following minimum exceptions and reductions."

History Note: *Authority G.S. 58-2-40(1); 58-63-15;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0522 ACCIDENT AND HEALTH ADVERTISING: PRE-EXISTING CONDITIONS

An advertisement which is subject to the requirements of 11 NCAC 12 .0521 shall, in negative terms, disclose the extent to which any loss is not covered if the cause of such loss is traceable to a condition existing prior to the effective date of the policy. The use of the term "pre-existing condition" without an appropriate definition or description shall not be used.

When a policy does not cover losses resulting from pre-existing conditions, no advertisement of the policy shall state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim thereunder. This Rule prohibits the use of the phrase "no medical examination required" and phrases of similar import, but does not prohibit explaining "automatic issue." If an insurer requires a medical examination for a specified policy, the advertisement, if it is an invitation to contract, shall disclose that a medical examination is required.

When an advertisement contains an application form to be completed by the applicant and returned by mail for a direct response insurance product, such application form shall contain a question or statement which reflects the

pre-existing condition provision of the policy immediately preceding the blank space for the applicant's signature. For example, such an application form shall contain a question or statement substantially as follows:
Do you understand that this policy will not pay benefits during the first _____year(s) after the issue date for a disease or physical condition which you now have or have had in the past?_____YES.
Or substantially the following statement:
I understand that the policy applied for will not pay benefits for any loss incurred during the first _____year(s) after the issue date on account of disease or physical condition which I now have or have had in the past.

History Note: *Authority G.S. 58-2-40(1); 58-63-15;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0523 ADVERTISING: RENEWABILITY AND TERMINATION

When an advertisement which is an invitation to contract refers to either a dollar amount or a period of time for which any benefit is payable, or the cost of the policy, or the loss for which such benefit is payable, it shall disclose the provisions relating to renewability, cancellability and termination and any modification of benefits, losses covered or premiums because of age or for other reasons, in a manner which shall not minimize or render obscure the qualifying conditions.

History Note: *Authority G.S. 58-2-40(1); 58-63-15;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0524 ACCIDENT AND HEALTH ADVERTISING: TESTIMONIALS

Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer, in using a testimonial, makes as its own all of the statements contained therein and the advertisement including such statements, is subject to all the provisions of these Rules.
If the person making a testimonial, an endorsement or an appraisal has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or otherwise, such fact shall be disclosed in the advertisement. If a person is compensated for making a testimonial, endorsement or appraisal, such fact shall be disclosed in the advertisement by language substantially as follows: "Paid Endorsement." This Rule does not require disclosure of union "scale" wages required by union rules if the payment is actually for such "scale" for TV or radio performances. The payment of substantial amounts, directly or indirectly, for "travel and entertainment" for filming or recording of TV or radio advertisements remove the filming or recording from the category of an unsolicited testimonial and require disclosure of such compensation. This Rule does not apply to an institutional advertisement which has as its sole purpose the promotion of the insurer.
An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by any individual or group of individuals, society, association or other organizations, unless such is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, such fact shall be disclosed in the advertisement.
When a testimonial refers to benefits received under a policy, the specific claim data, including claim number, date of loss, and other pertinent information shall be retained by the insurer for inspection for a period of four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

History Note: *Authority G.S. 58-2-40(1); 58-63-15;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0525 ACCIDENT AND HEALTH ADVERTISING: USE OF STATISTICS

An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not use irrelevant facts, and shall not be used unless it accurately reflects all of the relevant facts. Such an advertisement shall not imply that such statistics are derived from the policy advertised unless such is the fact, and when applicable to other policies or plans shall specifically so state.

An advertisement shall not represent or imply that claim settlements by the insurer are "liberal" or "generous," or use words of similar import, or that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for a unique claim for the policy advertised is misleading and shall not be used.

The source of any statistics used in an advertisement shall be identified in such advertisement.

History Note: *Authority G.S. 58-2-40(1); 58-63-15;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0526 ACCIDENT AND HEALTH ADVERTISING OF PLAN OR POLICIES

When a choice of the amount of benefits is referred to, an advertisement which is an invitation to contract shall disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of the benefits selected.

When an advertisement refers to various benefits which may be contained in two or more policies, other than group master policies, the advertisement shall disclose that such benefits are provided only through a combination of such policies.

History Note: *Authority G.S. 58-2-40; 58-63-15;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. February 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0527 ACCIDENT AND HEALTH ADVERTISING: COMPARISONS: STATEMENTS

History Note: *Authority G.S. 58-9(1); 58-54.4;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Repealed Eff. February 1, 1992.

11 NCAC 12 .0528 ACCIDENT AND HEALTH ADVERTISING: LICENSING AND STATUS

An advertisement which is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

An advertisement shall not create the impression directly or indirectly that the insurer, its financial condition or status, or the payment of its claims, or the merits, desirability, or advisability of its policy forms or kinds or plans of insurance are approved, endorsed, or accredited by any division or agency of this state or the United States Government.

History Note: *Authority G.S. 58-2-40(1); 58-63-15;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0529 ACCIDENT AND HEALTH ADVERTISING: IDENTITY OF INSURER

The name of the actual insurer shall be stated in all of its advertisements and the form number of the policy advertised shall be stated in an advertisement which is an invitation to contract. An advertisement shall not use a trade name, any insurance group designation, name of the parent company of the insurer, name of a particular

division of the insurer, service mark, slogan, symbol or other device which without disclosing the name of the actual insurer would have the capacity and tendency to mislead or deceive as to the true identity of the insurer.
No advertisement shall use any combination of words, symbols, or physical materials which by their content, phraseology, shape, color or other characteristics are so similar to combinations of words, symbols, or physical materials used by agencies of the federal government or of this state, or otherwise appear to be of such a nature that it tends to confuse or mislead prospective insureds into believing that the solicitation is in some manner connected with an agency of the municipal, state, or federal government.

History Note: *Authority G.S. 58-2-40(1); 58-63-15;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0530 ACCIDENT AND HEALTH ADVERTISING: GROUP IMPLICATIONS
An advertisement of a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and as such enjoy special rates or underwriting privileges, unless such is the fact.

History Note: *Authority G.S. 58-2-40(1); 58-63-15;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0531 ADVERTISING: INTRODUCTORY OR SPECIAL OFFERS
An advertisement of an individual policy shall not directly or by implication represent that a contract or combination of contracts is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such is the fact.
An advertisement shall not contain phrases describing an enrollment period as "special," "limited," or similar words or phrases when the insurer uses such enrollment periods as the usual method of advertising accident and sickness insurance.
An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this state unless there has been a lapse of not less than three months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period with the number of enrollment periods being limited to no more than two in any one calendar year for a particular insurance product. The advertisement shall indicate the date by which the applicant must mail the application, which shall be not less than 10 days and not more than 40 days from the date that such enrollment period is advertised for the first time. This Rule applies to all advertising media, i.e., mail, newspapers, radio, television, magazines and periodicals, by any one insurer. It is inapplicable to solicitations of employees or members of a particular group or association which otherwise would be eligible under specific provisions of the insurance code for group, blanket or franchise insurance. The phrase "any one insurer" includes all the affiliated companies of a group of insurance companies under common management or control.
This Rule prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless such is the fact.
The phrase "a particular insurance product" in the second paragraph of this Rule means an insurance policy which provides substantially different benefits than those contained in any other policy. Different terms of renewability; an increase in the dollar amounts of benefits; an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product being offered as a different product eligible for concurrent or overlapping enrollment periods.
An advertisement shall not offer a policy which utilizes a reduced initial premium rate in a manner which overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more

prominently than the renewal premium, and both the initial reduced and the renewal premium must be stated in juxtaposition in each portion of the advertisement where the initial reduced premium appears.
Special awards, such as a "safe drivers' award" shall not be used in connection with advertisements of accident or accident and sickness insurance.

History Note: *Authority G.S. 58-2-40(1); 58-63-15;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0532 ACCIDENT: HEALTH ADVERTISING: STATEMENT ABOUT AN INSURER
An advertisement shall not contain statements which are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by a commercial rating system unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendation.

History Note: *Authority G.S. 58-2-40(1); 58-63-15;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0533 ACCIDENT AND HEALTH ADVERTISING: ADVERTISING FILE
Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its individual policies and typical printed, published or prepared advertisements of its blanket, franchise and group policies hereafter disseminated in this or any other state, whether or not licensed in such other state, with a notation attached to each such advertisement which shall indicate the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to regular and periodical inspection by this department. All such advertisements shall be maintained in said file for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

History Note: *Authority G.S. 58-2-40(1); 58-63-15;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0534 ACCIDENT AND HEALTH ADVERTISING: CERTIFICATE OF COMPLIANCE
Each insurer required to file an annual statement which is now or which hereafter becomes subject to the provisions of these rules must file with this department, with its annual statement, a certificate of compliance executed by an authorized officer of the insurer wherein it is stated that, to the best of his knowledge, information and belief, the advertisements which were disseminated by the insurer during the preceding statement year complied or were made to comply in all respects with the provisions of these Rules and insurance laws of this state as implemented and interpreted by these Rules.

History Note: *Authority G.S. 58-2-40(1); 58-63-15;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0535 ACCIDENT AND HEALTH ADVERTISING: ADVERTISING EXPENSE

Total advertising expense incurred by the insurer or by an affiliated corporation on behalf of the insurer for the purposes of solicitation and conservation of accident and health insurance business shall be included as line items in the expense exhibits of all statutory financial statements filed by a licensed insurer with the Department.

History Note: *Authority G.S. 58-2-40(1); 58-63-15;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0536 ACCIDENT AND HEALTH ADVERTISING: PRIOR REVIEW OR APPROVAL

The commissioner may, when in his discretion he deems it in the public interest, require the filing of all or any part of the advertising material of an insurer with this department for review prior to its use. All advertising material subject to review prior to its use shall be filed with this department 30 days prior to its intended use. In instances where charges are pending against an insurer, the commissioner may, during the period such charges are pending but not to exceed 30 days unless extended by consent order, by order require all or any part of the advertising material be filed for review prior to its use or for prior approval. The commissioner may within his discretion refuse to approve all or any part of the advertising material so filed. All advertising material subject to prior approval shall be filed with this department 60 days prior to its intended use. When it has been determined by the commissioner after notice and hearing that an insurer has violated any of the insurance laws of this state or Rules of the commissioner, the commissioner may in his discretion, by order require that all or any part of the advertising material be filed with this department for review prior to its use or for prior approval. The commissioner may within his discretion refuse to approve all or any part of the advertising material so filed. In any case where review prior to its use or prior approval is required, a shorter period of time may be allowed by the commissioner.

History Note: *Authority G.S. 58-2-40(1); 58-63-15;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0537 PRE-EXISTING CONDITIONS: INSURED'S AGE OVER 65

History Note: *Authority G.S. 58-251.1; 58-252;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Repealed Eff. February 1, 1992.

11 NCAC 12 .0538 ACCIDENT: HEALTH PROMOTIONAL MATERIAL: STICKERS REQUIRED

For all accident and health insurance promotional material of all kinds for presentation in person, by mail or otherwise by an insurer, or its representative to the insurance buying public, including but not limited to circulars, leaflets and booklets, the same procedure as outlined in 11 NCAC 12 .0543 and .0544 shall be used and similar wording such as that required by these rules and be placed in a prominent place on all of such material.

History Note: *Authority G.S. 58-2-40; 58-63-15; 58-65-1; 58-65-40;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0539 NOTICE FOR REVISION OF RATES FOR NON-PROFIT SERVICE CORP

Notice of a public hearing on the revision of an existing schedule of rates or establishment of a new schedule of rates for a non-profit hospital, medical or dental service corporation shall be published once a week for two consecutive weeks, with the last publication date not more than 10 days before the date of the hearing, in the major morning newspapers in the Cities of Wilmington, Raleigh, Greensboro, Charlotte and Asheville, North Carolina and the cities wherein the principal office of the corporation is located, if other than the aforementioned.

The notice shall be in the form designated as 11 NCAC 12 .0204.

History Note: *Authority G.S. 58-2-40; 58-65-45;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0540 BLANKET AND FRANCHISE POLICIES
A group disability policy as interpreted under G.S. 58-14-5(4) does not include blanket and franchise policies.

History Note: *Authority G.S. 58-2-40; 58-14-5(4);*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. April 8, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0541 NOTICE OF CLAIM: CREDIT INSURANCE
The claimant shall have a minimum of 30 days to give written notice of claim.

History Note: *Authority G.S. 58-2-40; 58-57-25;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0542 ACCIDENT AND HEALTH APPLICATION: GUARANTEED ISSUE
When an accident and health policy is sold on a guaranteed issue basis, the application for such insurance used in the solicitation may not contain health questions on the application.

History Note: *Authority G.S. 58-2-40;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0543 POLICIES CONTAINING A PRE-EXISTING CONDITION EXCLUSION
All individual or franchise insurance policy forms and group certificates containing an exclusion for pre-existing conditions, or other language substantially similar to that set forth in form 11 NCAC 12 .0201, shall display a sticker or printed notice on the face of the policy and the outline of coverage. Such sticker shall be in red bold face type the size of which shall not be less than 14 point. The use of a rubber stamp will not satisfy this requirement.
Laser printed policies may be excused from this red print requirement provided the notice is in bold face print. Companies must certify that policy forms are produced by laser print in order to exercise this excuse.

History Note: *Authority G.S. 58-2-40; 58-51-1; 58-65-1; 58-65-40;*
Eff. September 26, 1978;
Amended Eff. April 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0544 POLICIES RENEWABLE AT THE OPTION OF THE COMPANY
All individual or franchise insurance policy forms and group certificates that are renewable at the option of the company or other language substantially similar to that set forth in form 11 NCAC 12 .0201 shall display a sticker or printed notice on the face of the policy and the outline of coverage. Such sticker or notice shall be in red bold face type the size of which shall not be less than 14 point. The use of a rubber stamp will not satisfy this requirement.

Laser printed policies may be excused from this red print requirement provided the notice is in bold face print. Companies must certify that policy forms are produced by laser print in order to exercise this excuse.

History Note: *Authority G.S. 58-2-40; 58-51-1; 58-65-1; 58-65-40;*
Eff. September 26, 1978;
Amended Eff. April 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0545 OFFSET OF INCREASED SOCIAL SECURITY: GROUP DISABILITY

History Note: *Authority G.S. 58-2-40; 58-51-1; 58-65-1; 58-65-40;*
Eff. September 26, 1978;
Repealed Eff. July 1, 2012.

11 NCAC 12 .0546 DIAGNOSIS OF CANCER

No insurer shall exclude a clinical diagnosis of cancer if, in the opinion of the attending physician, a positive diagnosis can not otherwise be made without jeopardizing the life of the claimant. The insurer may require that there be definitive treatment for cancer. The insurer may require confirmation of the diagnosis, at the insurer's expense, by a physician not associated with the attending physician.

History Note: *Authority G.S. 58-2-40; 58-51-1; 58-51-95; 58-65-40;*
Eff. September 26, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0547 WAITING PERIOD

History Note: *Authority G.S. 57-1; 57-4; 58-249; 58-252;*
Eff. September 26, 1978;
Repealed Eff. April 1, 1989.

11 NCAC 12 .0548 INSURANCE FOR MEDICARE ELIGIBLE

(a) Direct response insurers providing accident and health insurance to persons eligible for Medicare by reason of age shall:

(1) guarantee to the policyholder an unconditional 30 day right to return the policy for a full refund of premium; and

(2) alert prospective policyholders, in advertisements or direct mail solicitations, of their right to obtain a copy of the NAIC-HHS Guide to Health Insurance for People with Medicare prior to sale.

(b) All insurers providing accident and health insurance to persons eligible for Medicare by reason of age shall annually report to the Commissioner the number of written complaints or inquiries received from these policyholders who are eligible for Medicare.

History Note: *Authority G.S. 58-2-40; 58-2-190; 58-2-195; 58-3-100; 58-3-115; 58-3-150; 58-51-1; 58-51-15; 58-51-60; 58-51-85; 58-51-95; 58-54-1; 58-63-15; 58-65-1; 58-65-4; 58-65-105;*
Eff. October 24, 1981;
Temporary Amendment Eff. October 16, 1991 for a period of 180 days to expire on April 13, 1992;
Amended Eff. May 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0549 CONVERSION POLICIES: HOSPITAL ROOM RATES

The dollar amount for the maximum hospital room and board daily expense benefit for Plan A of conversion policies required by G.S. 58-53-90 shall be one hundred seventy dollars ($170.00).

History Note: *Authority G.S. 58-2-40; 58-53-90; 58-53-115;*
Eff. February 1, 1982;
Amended Eff. February 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0550 ORTHODONTIC COVERAGE LIMITATIONS

No insurer providing benefits for orthodontic services and supplies shall condition receipt of those benefits upon a determination of the class of malocclusion or any measurement of the position of the teeth or jaws, but shall rely upon the opinion of an orthodontist who has examined the patient.

History Note: *Authority G.S. 58-2-40; 58-3-120; 58-3-150; 58-51-1; 58-51-95; 58-63-15; 58-65-40; 58-67-50;*
Eff. April 1, 1982;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0551 CANCER INSURANCE REQUIREMENTS

Cancer policy requirements. Cancer policies approved in this State shall comply with the following:

(1) The policy shall have a pre-existing conditions sticker that complies with 11 NCAC 12 .0543 and reads as follows: NO RECOVERY FOR PRE-EXISTING DIAGNOSED CANCER - READ CAREFULLY No benefits will be provided during the first 12 months of the policy for cancer diagnosed before the 30th day after the effective date shown in the policy schedule.

(2) In the definition of cancer, clinical diagnosis of cancer shall be accepted as evidence that cancer exists in an insured when a pathological diagnosis cannot be made, provided the medical evidence substantially documents the diagnosis of cancer and the insured received definitive treatment for cancer. If the requisite pathological clinical diagnosis can only be made postmortem, liability shall be assumed retroactively beginning with the date of the terminal admission to the hospital for not less than 45 days before the date of death.

(3) A cancer policy shall not have a waiting period any longer than 30 days after the effective date.

(4) Benefits shall be provided for unrelated cancers diagnosed after the effective date of the policy.

(5) Under the benefits provisions of the policy, provided the contract offers these benefits, the minimum standards are as follows:

  (a) Benefits for blood and plasma shall cover actual charges incurred, including fees for administering the blood.

  (b) The term "In-patient" shall precede the words "drugs" and "medicines" if the policy is an in-hospital indemnity contract or does not provide out-patient benefits.

  (c) Ambulance benefits shall include transportation from one medical facility to another.

  (d) First diagnosed or first occurrence cancer benefits shall be no less favorable than other generally offered cancer benefits and shall be offered in addition to core benefits.

(6) Cancer coverage may include other diseases or conditions; provided, however, it shall be properly labeled -- CANCER AND SPECIFIED DISEASE(S).

(7) Cancer and dread disease policies are defined as "Medical Expense" policies for the purposes of loss ratio requirements as set forth in the NAIC guidelines.

History Note: *Authority G.S. 58-2-40; 58-51-1; 58-51-95;*
Eff. July 1, 1986;
Amended Eff. April 1, 1997; April 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0552 TEMPOROMANDIBULAR JOINT DYSFUNCTION

History Note: *Authority G.S. 58-2-40; 58-51-1; 58-51-95; 58-65-85;*
Eff. July 1, 1986;
Repealed Eff. February 1, 1996.

11 NCAC 12 .0553 EXCESS INSURANCE: NON-DUPLICATION OF COVERAGE

(a) An accident and health policy with a nonduplication of coverage benefit may be permitted, if it contains the following sticker on the face in red:

EXCESS INSURANCE

This policy is not intended to be issued where other medical insurance exists. If other medical insurance does exist at the time of the claim, then the amounts of benefit payable by such other medical insurance will become the deductible amount of this policy if such benefits exceed the deductible amount shown in the Schedule of Benefits.

Such sticker shall be in red bold face type the size of which shall not be less than 12 points. The use of a rubber stamp will not satisfy this requirement. The use of laser print shall exempt the use of red print.

(b) A non-duplication of coverage benefit in blanket insurance shall be permitted when premiums are non-contributory and 100 percent of the participants are covered.

History Note: *Authority G.S. 58-2-40; 58-51-1; 58-65-1; 58-65-40;*
Eff. July 1, 1986;
Amended Eff. February 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0554 STOP-LOSS COVERAGE - REQUIREMENTS

History Note: *Authority G.S. 58-9; 58-249; 58-254.7;*
Eff. April 1, 1989;
Repealed Eff. February 1, 1992.

11 NCAC 12 .0555 LONG-TERM CARE POLICY REQUIREMENTS

(a) Definitions:

(1) Long-Term Care Insurance is defined as any contract of insurance offering institutional or noninstitutional support in order to restore deteriorating health and to maintain functional independence. Such services for an acute or chronic physical or mental impairment, or short term illness or injury, include but are not limited to assistance with daily living, medical or rehabilitative care, and home health care.

(2) In regard to Skilled, Intermediate, Custodial, or Home Health Care, when the insured receives definitive treatment for these services regardless of the type of facility or setting the insured is confined in, benefits are payable for the service receive based on the benefits of the contract for that service.

(b) The following provisions are required:

(1) Long-term care insurance policies must provide benefits for at least three levels of care and provide the same duration for each level of care for a minimum of 12 months.

(2) Coordination or non-duplication of benefits is permitted between true group long-term care policies only.

(3) The loss ratio is required to be at least 60 percent for individual policies and at least 75 percent for group policies.

(4) Custodial care that is administered for assistance of the patient in performing the activities of daily living shall not be denied based on the type of facility in which the care is received; but rather must be provided as long as the insured is confined as an inpatient in any facility licensed by the State, regardless of whether or not that facility is commonly understood to be or is defined as a long-term care facility.

(5) No long-term care policy, contract, or certificate may use waivers to exclude, limit, or reduce benefits for specifically named or described pre-existing diseases or physical conditions.

History Note: *Authority G.S. 58-2-40; 58-51-1; 58-51-95; 58-55-30;*
Eff. April 1, 1989;
Amended Eff. February 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0556 HOME HEALTH CARE POLICY REQUIREMENT

All Home Health Care Policies shall have the notice printed in contrasting type or color on the face of the policy as follows: "This Is Not A Long-Term Care Policy - This Policy Provides Home Health Care Benefits Only - Read Carefully". Home health care policies must comply with G.S. 58-51-60 and the following items:

(1) Prior hospitalization or skilled nursing home confinement shall not be required to satisfy eligibility for benefits.

(2) Benefits shall be provided without a physician certification that the insured or claimant would need medical care in a skilled nursing facility or hospital setting.

(3) Home health benefits shall not be limited to acute conditions.

History Note: *Authority G.S. 58-2-40; 58-51-1; 58-51-95;*
Eff. April 1, 1989;
Amended Eff. February 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0557 POLICIES CONTAINING A TERMINATION OR CANCELLATION PROVISION

(a) Any policy or certificate of insurance that may be terminated for reasons other than non-payment of premium or the insured's stated age must be affixed with a notice referring the insured to the renewal provision. Such notice must appear in 12 point bold red print and read as follows: Important Cancellation Information - Please Read The Provision Entitled, ".....", Found On Page "...".

(b) Laser printed policies are not subject to the red print requirement in Paragraph (a) of this Rule if the notice is in bold face print and if the insurer certifies that its policy forms are produced by laser print.

History Note: *Authority G.S. 58-2-40; 58-51-1;*
Eff. April 1, 1989;
Amended Eff. February 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0558 PREMIUM REVISION

History Note: *Authority G.S. 58-9; 58-249; 58-254.7;*
Eff. April 1, 1989;
Repealed Eff. February 1, 1992.

11 NCAC 12 .0559 PRECERTIFICATION

Policies requiring precertification must contain a disclosure of penalties for benefits and services that are not precertified.

History Note: *Authority G.S. 58-2-40; 58-50-60;*
Eff. February 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0560 UNIFORM CLAIM FORMS

History Note: *Authority G.S. 58-2-40; 58-3-171;*
Filed as a Temporary Adoption Eff. January 1, 1994 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Eff. April 1, 1994;
Repealed Eff. July 1, 2012.

11 NCAC 12 .0561 DEDUCTIBLES AND COPAYMENTS BASED ON REAL COST

(a) As used in this Rule:

(1) "Health benefit plan" means any accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement.

(2) "Health care provider" includes any person who, under Chapter 90 of the General Statutes is licensed, registered, or certified to engage in the practice of or performs duties associated with any of the following: medicine, surgery, dentistry, pharmacy, optometry, midwifery, osteopathy, podiatry, chiropractic, radiology, nursing, physiotherapy, pathology, anesthesiology, anesthesia, laboratory analysis, rendering assistance to a physician, dental hygiene, psychiatry, psychology; or a hospital as defined by G.S. 131E-76(3); or a nursing home as defined by G.S. 131E-101(6).

(3) "Health insurer" means any health insurance company subject to Articles 1 through 63 of Chapter 58, including a multiple employer welfare arrangement; any preferred provider plan; and any corporation subject to Articles 65 and 67 of Chapter 58; that provides a health benefit plan.

(b) If health insurers enter into contracts with health care providers for the provision of health care services at discounted rates of payment (including capitated and other alternative negotiated rates), and applicable deductibles or copayments paid by insureds are to be based upon a percentage of the fees for services rendered, the amounts of deductibles and copayments shall be computed based on such rates for the services rendered when such rates are less than the provider's ordinary charges for the services rendered.

(c) The following are deemed to be unfair and deceptive acts and practices in the business of insurance:

(1) Attempting to settle a claim or attempting to charge or to collect or charging or collecting copayments in amounts greater than those calculated in accordance with this Rule.

(2) Attempting to pay or settle or paying or settling a claim based upon the calculation of a deductible that is not calculated in accordance with this Rule.

(3) Attempting to calculate or calculating an annual, calendar, or lifetime maximum amount payable on any amounts other than as set forth in this Rule.

(4) Attempting to settle a claim involved in coordination of benefits in any manner not in accordance with this Rule.

(5) Attempting to collect a claim against a stop-loss or excess health insurer in any manner inconsistent with this Rule.

(d) Negotiating discounts with health care providers based upon the total volume of services and that is settled on a retrospective basis in which the discounts are not attributed to individual claimants, is not deemed to be an unfair and deceptive act or practice in the business of insurance.

History Note: *Authority G.S. 58-2-40; 58-50-55; 58-63-65; 58-65-1; 58-65-40; 58-65-140; 58-67-150;*
Eff. January 1, 1995;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0562 UNEARNED PREMIUM

As used in this Rule, "unearned premium" means that portion of the premium representing the unexpired portion of the policy term. All insurers of individual health or accident and health insurance shall in the event of cancellation or the death of the insured return any portion of unearned premium.

History Note: *Authority G.S. 58-2-40(1);*
Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0563 WEIGHTED AVERAGE: MENTAL ILLNESS BENEFITS COVERAGE

(a) The definitions contained in G.S. 58-3-220(h) are incorporated into this rule by reference.

(b) To exercise the option under G.S. 58-3-220(f), at the time of submission for approval of a group health benefit plan policy form, certificate, or rider containing mental illness benefits, the insurer shall include in the submission a certification of compliance with this rule signed by a qualified actuary, as defined in 11 NCAC 16 .0401(17). The certification of compliance shall include a statement that:

(1) No more than 70 percent of the entire plan's actuarial value is contained in the selected physical illness and injury benefits that are subject to any limit.
(2) The weighted average calculation was performed and calculated as prescribed in paragraph (c) of this rule.

(c) The weighted average calculation shall be performed on a benefit-by-benefit basis. The weighted average for a limit shall be calculated by summing the product of the expected value of each physical illness and injury benefit and its applicable limit, and then dividing that summation by the sum of the expected values of each physical illness and injury benefit.

(d) An insurer shall make the information, documentation, and actuarial calculations described in this rule available to the Commissioner upon request.

History Note: *Authority G.S. 58-2-40; 58-3-220;*
Eff. July 1, 2008;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

SECTION .0600 - REPLACEMENT REGULATIONS

11 NCAC 12 .0601 PURPOSE AND SCOPE

The purpose of the rules in this Section are:

(1) To regulate the activities of insurers and producers with respect to the replacement of existing life insurance and annuities.
(2) To protect the interests of life insurance and annuity purchasers by establishing minimum standards of conduct to be observed in replacement or financed purchase transactions that will:
  (a) assure that purchasers receive information with which a decision can be made in their own best interest;
  (b) reduce the opportunity for misrepresentation and incomplete disclosures; and
  (c) establish penalties for failure to comply with requirements of the rules in this section.

History Note: *Authority G.S. 58-2-40; 58-3-115; 58-58-1; 58-58-40;*
Eff. October 1, 1985;
Amended Eff. August 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0602 DEFINITION OF REPLACEMENT

When used in the rules in this Section, "replacement" means a transaction in which a new policy or contract is to be purchased, and it is known or should be known to the proposing producer, or to the proposing insurer if there is no producer, that by reason of the transaction, an existing policy or contract has been or is to be:

(1) lapsed, forfeited, surrendered, or partially surrendered, assigned to the replacing insurer or otherwise terminated;
(2) converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;
(3) amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;
(4) reissued with any reduction in cash value; or
(5) used in a financed purchase.

History Note: *Authority G.S. 58-2-40; 58-3-115; 58-58-1; 58-58-40;*
Eff. October 1, 1985;
Amended Eff. August 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0603 OTHER DEFINITIONS

When used in the rules in this Section:

(1) "Direct-response solicitation" means a solicitation through a sponsoring or endorsing entity, or individually, solely through mails, telephone, the Internet or other mass communication media.

(2) "Existing insurer" means the insurance company whose policy or contract is or will be changed or affected in a manner described within the definition of "replacement" in 11 NCAC 12 .0602.

(3) "Existing policy or contract" means an individual life insurance policy (policy) or annuity contract (contract) in force, including a policy under a binding or conditional receipt or a policy or contract that is within an unconditional refund period.

(4) "Financed purchase" means the purchase of a new policy involving the actual or intended use of funds obtained by the withdrawal or surrender of, or by borrowing from values of an existing policy to pay all or part of any premium due on the new policy. For purposes of a regulatory review of an individual transaction only, if a withdrawal, surrender or borrowing involving the policy values of an existing policy is used to pay premiums on a new policy owned by the same policyholder and issued by the same company within four months before or 13 months after the effective date of the new policy, it shall be deemed prima facie evidence of the policyholder's intent to finance the purchase of the new policy with existing policy values. This prima facie standard is not intended to increase or decrease the monitoring obligations contained in 11 NCAC 12 .0607(1)(e).

(5) "Illustration" means a presentation or depiction that includes non-guaranteed elements of a policy of life insurance over a period of years as defined in 11 NCAC 04 .0501(b)(8).

(6) "Policy summary" means:

(a) For policies or contracts other than universal life policies, a written statement regarding a policy or contract which contains, to the extent applicable, the following information:

(i) current death benefit;

(ii) annual contract premium;

(iii) current cash surrender value;

(iv) current dividend;

(v) application of current dividend; and

(vi) amount of outstanding loan.

(b) For universal life policies, a written statement that contains the following information:

(i) the beginning and end date of the current report period;

(ii) the policy value at the end of the previous report period and at the end of the current report period;

(iii) the total amounts that have been credited or debited to the policy value during the current report period, identifying each by type (e.g., interest, mortality, expense and riders);

(iv) the current death benefit at the end of the current report period on each life covered by the policy;

(v) the net cash surrender value of the policy as of the end of the current report period; and

(vi) the amount of outstanding loans, if any, as of the end of the current report period.

(7) "Producer" includes duly licensed agents and brokers as defined by G.S. 58-33-10(7).

(8) "Replacing insurer" means the insurance company that issues or proposes to issue a new policy or contract that replaces an existing policy or contract or is a financed purchase.

(9) "Registered contract" means a variable annuity contract or variable life insurance policy subject to the prospectus delivery requirements of the Securities Act of 1933.

(10) "Sales material" means a sales illustration and any other written, printed or electronically presented information created, or completed or provided by the company or producer and used in the presentation to the policy or contract owner related to the policy or contract purchased.

History Note: *Authority G.S. 58-2-40; 58-3-115; 58-58-1; 58-58-40;*
Eff. October 1, 1985;
Amended Eff. August 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0604 EXEMPTIONS

(a) Unless otherwise stated in Chapter 58 of the North Carolina General Statutes, this Section shall not apply to transactions involving:

(1) Credit life insurance;

(2) Group life insurance or group annuities where there is no direct solicitation of individuals by an insurance producer. Direct solicitation does not include any group meeting held by an insurance producer solely for the purpose of educating or enrolling individuals or, when initiated by an individual member of the group, assisting with the selection of investment options offered by a single insurer in connection with enrolling that individual. Group life insurance or group annuity certificates marketed through direct response solicitation is subject to the provisions of 11 NCAC 12 .0608;

(3) Group life insurance and annuities used to fund prearranged funeral contracts;

(4) An application to the existing insurer that issued the existing policy or contract when a contractual change or a conversion privilege is being exercised; or, when the existing policy or contract is being replaced by the same insurer pursuant to a program filed with and approved by the Commissioner; or, when a term conversion privilege is exercised among corporate affiliates;

(5) Proposed life insurance that is to replace life insurance under a binding or conditional receipt issued by the same company;

(6) Policies or contracts used to fund:

(A) An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA);

(B) A plan described by Sections 401(a), 401(k) or 403(b) of the Internal Revenue Code, where the plan, for purposes of ERISA, is established or maintained by an employer;

(C) A governmental or church plan defined in Section 414 of the Internal Revenue Code, a governmental or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under Section 457 of the Internal Revenue Code; or

(D) As described in the Internal Revenue Code, a nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor.

(7) Where new coverage is provided under a life insurance policy or annuity contract and the cost is borne wholly by the insured's employer or by an association of which the insured is a member;

(8) Existing life insurance that is a non-convertible term life insurance policy that will expire in five years or less and cannot be renewed;

(9) Immediate annuities that are purchased with proceeds from an existing contract. Immediate annuities purchased with proceeds from an existing policy are not exempt from the rules in this Section; or

(10) Structured settlements.

(b) Notwithstanding 11 NCAC 12 .0604(a)(6), the rules in this Section apply to policies or contracts used to fund any plan or arrangement that is funded solely by contributions an employee elects to make, whether on a pre-tax or after tax-basis, and where the insurer has been notified that plan participants may chose from among two or more insurers and there is a direct solicitation of an individual employee by an insurance producer for the purchase of a contract or policy. As used in this Paragraph, direct solicitation does not include any group meeting held by an insurance producer solely for the purpose of educating individuals about the plan or arrangement or enrolling individuals in the plan or arrangement, or when initiated by an individual employee, assisting with the selection of investment options offered by a single insurer in connection with enrolling that individual employee.

(c) Registered contracts are exempt from the requirements of 11 NCAC 12 .0606(2) and 12 .0612(a)(2) with respect to the provision of illustrations or policy summaries; however, premium or contract contribution amounts and identification of the appropriate prospectus or offering circular are required instead.

History Note: *Authority G.S. 58-2-40; 58-3-115; 58-58-1; 58-58-40;*
Eff. October 1, 1985;
Amended Eff. February 1, 2008; August 1, 2004; April 8, 2002; November 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0605 DUTIES OF PRODUCERS

(a) A producer who initiates an application shall submit to the insurer, with or as part of the application, a statement signed by both the applicant and the producer as to whether the applicant has existing policies or contracts. Electronic capture of signature is acceptable in accordance with The Uniform Electronic Transactions Act, G.S. 66, Article 40. If the answer is "no," the producer's duties with respect to replacement are complete.
(b) If the applicant answered "yes" to the question regarding existing coverage referred to in Paragraph (a) of this Rule, the producer shall present and read to the applicant, not later than at the time of taking the application, a notice regarding replacements in the format required by 11 NCAC 12 .0611. The notice shall be signed by both the applicant and the producer attesting that the notice has been read aloud by the producer or that the applicant did not wish the notice to be read aloud (in which case the producer need not have read the notice aloud) and left with the applicant. If the notice and any required signatures are captured electronically, the notice shall be delivered to the applicant within two business days of receipt by the home office of the insurer.
(c) The notice shall list all life insurance policies or annuities proposed to be replaced, identified by name of insurer, the insured or annuitant, and policy or contract number if available; and shall include a statement as to whether each policy or contract will be replaced or whether a policy will be used as a source of financing for the new policy or contract. If a policy or contract number has not been issued by the existing insurer, alternative identification, such as an application or receipt number, shall be listed.
(d) In connection with a replacement transaction, the producer shall leave with the applicant at the time an application for a new policy or contract is completed the original or a copy of all sales material. With respect to electronically presented sales material, it shall be provided to the policy or contract owner in printed form no later than at the time of policy or contract delivery.
(e) Except as provided in 11 NCAC 12 .0612(c), in connection with a replacement transaction the producer shall submit to the insurer to which an application for a policy or contract is presented, a copy of each document required by this Section, a statement identifying any preprinted or electronically presented company approved sales materials used, and copies of any individualized sales materials, including any illustrations related to the specific policy or contract purchased.

History Note: *Authority G.S. 58-2-40; 58-3-115; 58-58-1; 58-58-40;*
Eff. October 1, 1985;
Amended Eff. August 1, 2004; October 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0606 DUTIES OF THE EXISTING INSURER

Where a replacement is involved in the transaction, the existing insurer shall:

(1) Retain and be able to produce all replacement notifications received, indexed by replacing insurer, for at least five years or until the conclusion of the next regular examination conducted by the Insurance Department of its state of domicile, whichever is later.

(2) Send a letter to the policy or contract owner of the right to receive information regarding the existing policy or contract values including, if available, an in force illustration. If an in force illustration cannot be produced within five business days after receipt of a notice that an existing policy or contract is being replaced, the insurer shall provide a policy summary. The information shall be provided within five business days after receipt of the request from the policy or contract owner.

(3) Upon receipt of a request to borrow, surrender or withdraw any policy values, send a notice advising the policy owner that the release of policy values may affect the guaranteed elements, non-guaranteed elements, face amount or surrender value of the policy from which the values are released. The notice shall be sent separate from the check if the check is sent to anyone other than the policy owner. When consecutive automatic premium loans are made, the insurer is only required to send the notice at the time of the first loan.

History Note: *Authority G.S. 58-2-40; 58-3-115; 58-58-1; 58-58-40;*
Eff. October 1, 1985;
Amended Eff. August 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0607 DUTIES OF INSURERS THAT USE PRODUCERS

Each insurer shall:

(1) Maintain a system of supervision and control to insure compliance with the requirements of the rules in this section that shall include the following:

(a) Information to its producers of the requirements of the rules in this section and incorporation of the requirements of the rules in this Section into all relevant producer training manuals prepared by the insurer;

(b) Provision to each producer of a written statement of the company's position with respect to the acceptability of replacements providing guidance to its producer as to the appropriateness of these transactions;

(c) A system to review the appropriateness of each replacement transaction that the producer does not indicate is in accord with Sub-item (1)(b) of this Rule.

(d) Procedures to confirm that the requirements of the rules in this Section have been met; and

(e) Procedures to detect transactions that are replacements of existing policies or contracts by the existing insurer, but that have not been reported as such by the applicant or producer. Compliance may include systematic customer surveys, interviews, confirmation letters, or programs of internal monitoring;

(2) Have the capacity to monitor each producer's life insurance policy and annuity contract replacements for that insurer, and shall produce, upon request, and make such records available to the Department. The capacity to monitor shall include the ability to produce records for each producer's:

(a) Life replacements, including financed purchases, as a percentage of the producer's total annual sales for life insurance;

(b) Number of lapses of policies by the producer as a percentage of the producer's total annual sales for life insurance;

(c) Annuity contract replacements as a percentage of the producer's total annual annuity contract sales;

(d) Number of transactions that are unreported replacements of existing policies or contracts by the existing insurer detected by the company's monitoring system as required by Sub-item (1)(e) of this Rule; and

(e) Replacements, indexed by replacing producer and existing insurer.

(3) Require with or as a part of each application for life insurance or an annuity a signed statement by both the applicant and the producer as to whether the applicant has existing policies or contracts;

(4) Require with each application for life insurance or an annuity that indicates an existing policy or contract, a completed notice regarding replacements as required in 11 NCAC 12 .0611;

(5) When the applicant has existing policies or contracts, be able to produce copies of any sales material required by 11 NCAC 12 .0605(e), the basic illustration and any supplemental illustrations related to the specific policy or contract that is purchased, and the producer's and applicant's signed statements with respect to financing and replacement for at least five years after the termination or expiration of the proposed policy or contract;

(6) Ascertain that the sales material and illustrations required by 11 NCAC 12 .0605(e) meet the requirements of the rules in this Section and are complete and accurate for the proposed policy or contract;

(7) If an application does not meet the requirements of the rules in this Section, notify the producer and applicant and fulfill the outstanding requirements; and

(8) Maintain records in paper, photograph, micro process, magnetic, mechanical or electronic media or by any process that accurately reproduces the actual document.

History Note: *Authority G.S. 58-2-40; 58-3-115; 58-58-1; 58-58-40;*
Eff. October 1, 1985;
Amended Eff. August 1, 2004; April 8, 2002; November 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0608 DUTIES OF INSURERS WITH RESPECT TO DIRECT RESPONSE SOLICITATIONS

(a) In the case of an application that is initiated as a result of a direct response solicitation, the insurer shall require, with or as part of each completed application for a policy or contract, a statement asking whether the applicant, by applying for the proposed policy or contract, intends to replace, discontinue, or change an existing policy or contract. If the applicant indicates a replacement or change is not intended or if the applicant fails to respond to the statement, the insurer shall send the applicant, with the policy or contract, a notice regarding replacement as required in 11 NCAC 12 .0611.

(b) If the insurer has proposed the replacement or if the applicant indicates a replacement is intended and the insurer continues with the replacement, the insurer shall:

(1) Provide to applicants or prospective applicants with the policy or contract a notice, as required in 11 NCAC 12 .0611. In these instances, the insurer may delete the reference to producer, including the producer's signature, and references not applicable to the product being sold or replaced, without having to obtain approval of the form from the Commissioner. The insurer's obligation to obtain the applicant's signature shall be satisfied if it can demonstrate that it has made a diligent effort to secure a signed copy of the notice referred to in this Paragraph. The requirement to make a diligent effort shall be deemed satisfied if the insurer includes in the mailing a self-addressed postage prepaid envelope with instructions for the return of the signed notice referred to in this Section; and

(2) Comply with the requirements of 11 NCAC 12 .0612(a)(2), if the applicant furnishes the names of the existing insurers, and the requirements of 11 NCAC 12 .0612(a)(3), 12 .0612(a)(4), and 12 .0612(b).

History Note: *Authority G.S. 58-2-40; 58-3-115; 58-58-1; 58-58-40;*
Eff. October 1, 1985;
Amended Eff. August 1, 2004; October 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0609 VIOLATIONS AND PENALTIES

(a) Any failure to comply with the rules in this Section shall be considered a violation of G.S. 58-63-15(1). Violations include:

(1) Any deceptive or misleading information set forth in sales material;

(2) Failing to ask the applicant in completing the application the pertinent questions regarding the possibility of financing or replacement;

(3) The intentional incorrect recording of an answer;

(4) Advising an applicant to respond negatively to any question regarding replacement in order to prevent notice to the existing insurer; or

(5) Advising a policy or contract owner to write directly to the company in such a way as to attempt to obscure the identity of the replacing producer or company.

(b) Policy and contract owners may replace existing life insurance policies or annuity contracts after indicating in or as a part of applications for new coverage that replacement is not their intention; however, patterns of such action by policy or contract owners of the same producer shall be deemed prima facie evidence of the producer's knowledge that replacement was intended in connection with the identified transactions, and these patterns of action shall be deemed prima facie evidence of the producer's intent to violate the rules in this Section.

(c) Where it is determined that the requirements of the rules in this Section have not been met, the replacing insurer shall provide to the policy owner:

(1) Either:

(A) An in force illustration if available; or

(B) A policy summary for the replacement policy; or

(C) An available disclosure document for the replacement contract; and

(2) The appropriate notice regarding replacements as required in 11 NCAC 12 .0611.

(d) Violations of the rules in this Section shall subject the violators to penalties that may include the revocation or suspension of a producer's or company's license, monetary fines and the forfeiture of any commissions or compensation paid to a producer as a result of the transaction in connection with which the violations occurred.

History Note: *Authority G.S. 58-2-40; 58-3-100; 58-3-115; 58-33-45; 58-33-75; 58-58-1; 58-58-40; 58-63-65;*
Eff. October 1, 1985;
Amended Eff. August 1, 2004; October 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0610 SEVERABILITY

If any rule or portion of a rule of this Section, or the applicability thereof to any person or circumstance, is held invalid by a court, the remainder of this Section, or the applicability of such provision to other persons, shall not be affected thereby.

History Note: *Authority G.S. 58-2-40; 58-3-115; 58-58-1; 58-58-40;*
Eff. October 1, 1985;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0611 NOTICE REGARDING REPLACEMENT

Notice regarding replacement shall be the most current format adopted by the NAIC Life Insurance and Annuities Replacement Model Regulation. A copy of the notice may be obtained at the Department's website: http//www.ncdoi.com/Industry/Life/LAH/RateFilings/Annuity/AppendixABC.pdf or in writing from the Life and Health Division of the North Carolina Department of Insurance at 1201 Mail Service Center, Raleigh, NC 27699-1201.

History Note: *Authority G.S. 58-2-40; 58-3-115; 58-58-1; 58-58-40;*
Eff. October 1, 1985;
Amended Eff. August 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0612 DUTIES OF REPLACING INSURERS THAT USE PRODUCERS

(a) Where a replacement is involved in a transaction, the replacing insurer shall:

(1) Verify that the required forms are received and are in compliance with the rules in this section.

(2) Notify any other existing insurer that may be affected by the proposed replacement within five business days of receipt of a completed application indicating replacement or when the replacement is identified if not indicated on the application, and mail a copy of the available illustration or policy summary for the proposed policy or available disclosure document for the proposed contract within five business days of a request from an existing insurer;

(3) Be able to produce copies of the notification regarding replacement required in 11 NCAC 12 .0605(b), indexed by producer, for at least five years or until the next regular examination by the insurance department of a company's state of domicile, whichever is later; and

(4) Provide to the policy or contract owner notice of the right to return the policy or contract within 30 days of the delivery of the contract and receive an unconditional full refund of all premiums or considerations paid on it, including any policy fees or charges; or, in the case of a variable or market value adjustment policy or contract, a payment of the cash surrender value provided under the policy or contract plus the fees and other charges deducted from the gross premiums or considerations, or imposed under such policy or contract; such notice may be included in the notice required by 11 NCAC 12 .0611.

(b) In transactions where the replacing insurer and the existing insurer are the same or subsidiaries or affiliates under common ownership or control, the replacing insurer shall allow credit for the period of time that has elapsed under the replaced policy's or contract's incontestability and suicide periods up to the face amount of the existing policy or contract. With regard to financed purchases, the credit may be limited to the amount the face amount of the existing policy is reduced by the use of existing policy values to fund the new policy or contract.

(c) If an insurer prohibits the use of sales material other than that approved by the company, as an alternative to the requirements made of an insurer pursuant to 11 NCAC 12 .0605(e), the insurer may:

(1) Require with each application a statement signed by the producer that:

(A) Represents that the producer used only company-approved sales material; and

(B) States that copies of all sales material were left with the applicant in accordance with 11 NCAC 12 .0605(d); and

(2) Within 10 days of the issuance of the policy or contract:

(A) Notify the applicant by sending a letter or by verbal communication with the applicant by a person whose duties are separate from the marketing area of the insurer, that the producer has represented that copies of all sales material have been left with the applicant in accordance with 11 NCAC 12 .0605(d);

(B) Provide the applicant with a toll free number to contact the company; and

(C) Stress the importance of retaining copies of the sales material for future reference.

(d) An insurer shall retain and be able to produce a copy of the letter or other verification referenced in Part (c)(2)(A) of this Rule in the policy or contract file for at least five years after the termination or expiration of the policy or contract.

History Note: *Authority G.S. 58-2-40; 58-3-100; 58-3-115; 58-33-45; 58-33-75; 58-58-1; 58-58-40;*
Eff. August 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

SECTION .0700 - CREDIT INSURANCE AND CREDIT LIFE:ACCIDENT AND HEALTH INSURANCE

11 NCAC 12 .0701 LIMITATION ON AMNT OF CR LIFE/CR ACCIDENT/HEALTH INS WRITTEN

The amount of Credit Life and/or Credit Accident and Health insurance to be written by an insurer may be limited by its underwriting practices.

History Note: *Authority G.S. 58-2-40; 58-57-15;*
Eff. May 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0702 INSURER LIABILITY: PREMIUM ACCEPTED FROM INELIGIBLE DEBTOR

If any premium is received for Credit Life and Credit Accident and Health insurance on an insured debtor who is not eligible under the terms of the policy, or for excess insurance not covered by the policy, the liability of the insurer may be limited to a refund of the premium or excess premium to the creditor policyholder or the insured debtor. Such refund shall be promptly paid or credited to the person entitled thereto, and the insured debtor shall be notified of such refund and termination of such excess or ineligible insurance; provided, however, that the insurer shall be liable for any valid claims arising prior to such refund of premium and notification to the insured debtor.

History Note: *Authority G.S. 58-2-40; 58-57-15;*
Eff. May 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0703 CALCULATION - UNEARNED PREMIUM REFUNDS: CREDIT LIFE & CREDIT ACCIDENT/HEALTH INSURANCE

For the purpose of calculating refunds on Credit Life and Credit Accident and Health insurance no charge for credit insurance may be made for the first 15 days of a loan month and a full may be charged for 16 days or more of a loan month; or a refund may be made on a pro rate basis for each day within the loan month.

History Note: *Authority G.S. 58-2-40; 58-57-50;*
Eff. May 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0704 MISSTATEMENT OF AGE: CREDIT LIFE AND HEALTH INSURANCE

The provision on misstatement of age is subject to the incontestible period of the policy.

History Note: *Authority G.S. 58-2-40; 58-57-25;*
Eff. April 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0705 REFUND OF UNEARNED PREMIUM AT DEATH: CREDIT LIFE/CREDIT ACCIDENT/HEALTH INSURANCE

History Note: *Authority G.S. 58-2-40; 58-57-50;*
Eff. May 1, 1989;
Amended Eff. April 8, 2002;
Repealed Eff. September 1, 2009.

11 NCAC 12 .0706 SUICIDE: CREDIT LIFE INSURANCE

In the event of the suicide of the insured debtor or the joint insured debtor, if any, sane or insane, within one year after the effective date of this certificate, the insurer shall have no liability with respect to such death except for a refund of the premium paid, provided, that in the event of joint life coverage a refund of premiums shall be forty percent of the premium paid.

History Note: *Authority G.S. 58-2-40; 58-57-40;*
Eff. April 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0707 NOTICE OF CLAIM: CREDIT LIFE/CREDIT ACCIDENT/HEALTH INSURANCE

The claimant under a Credit Life or Credit Accident and Health certificate or policy shall have a minimum of 30 days to give written notice of claim.

History Note: *Authority G.S. 58-2-40; 58-57-25;*
Eff. May 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0708 AMOUNT/CREDIT LIFE INSURANCE/TRANSACTIONS OF GREATER THAN 120 MONTHS DURATION

For transactions of greater than 120 months in duration, the initial amount of credit life insurance shall not exceed the amount of contractural indebtedness.

History Note: *Authority G.S. 58-2-40; 58-57-15;*
Eff. May 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0709 UNIFORM DECREASING COVERAGE: CREDIT LIFE

No policy written, on transactions of 60 months or greater in duration, shall incorporate a schedule of benefits which does not follow an amortization schedule.

History Note: *Authority G.S. 58-2-40; 58-57-15;*
Eff. April 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0710 ACTUARIALLY EQUIVALENT: CREDIT LIFE

With respect to G.S. 58-57-40 entitled "Credit Life Insurance Rate Standards", for credit life insurance on a basis other than the foregoing, premiums charged shall be actuarially equivalent, is interpreted by the department to mean that the actuarially equivalent rates must maintain a sixty percent loss ration and must exhibit a composite rate equal to the appropriate prima facie rate. The loss ratio shall be calculated by dividing the present value of future benefits by the present value of future premiums. In calculating the present value both interest and mortality rate used should reflect anticipated company experience.

History Note: *Authority G.S. 58-2-40; 58-57-40;*
Eff. April 1, 1989;
Amended Eff. April 8, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0711 MOTOR VEHICLE LEASES

(a) A motor vehicle lease is eligible for Credit Life and Credit Accident and Health insurance if:

(1) the lessee's has assumed a contractural obligation to make payments as compensation for use of the leased vehicle,

(2) the total of all payments which the lesses is contractually obligated to make for such use either exceeds or is substantially equal to the value of the property when leased, and

(3) the term of the lease does not exceed 15 years.

(b) Where the lessee's contractural obligation includes paying or guaranteeing a lump sum (the "residual amount") at the end of the periodic payment schedule, the insurance may cover the sum of all periodic payments plus the residual amount. The residual amount will be included in determining the total of all payments for purposes of (a) - (b) in this Rule.

(c) Where upon the lessee's death the lessee's estate is obligated to purchase the leased vehicle at a price stated in or determinable under the lease, Credit Life insurance may written to provide a death benefit equal to:

(1) the sum of all remaining periodic payments required under the lease plus any residual amount stated in or determinable under the lease; or

(2) the purchase price at the time of the lessee's death as stated in or determinable under the lease. The sum of all periodic payments together with any lump sum residual amount will be included in determining with the total of purposes of (a) - (b) in this Rule.

(d) Where neither the lessee's not the lessee's estate has any obligation with regard to purchase of the leased vehicle or payment or guarantee of any residual amount, Credit Life insurance may be written to provide a death benefit which is equal to the sum of all remaining periodic installments required under the terms of the lease.

(e) Credit Accident and Health insurance may be written to cover only the periodic payments required under the lease.

(f) In addition to all other applicable requirements for Credit Life insurance and Credit Accident and Health insurance, and subject to (a) - (e) in this Rule, the following information must be fully disclosed in the certificate or the policy of insurance and the lease contract when Credit Life or Credit Accident and Health insurance is provided in connection with a leasing contract:

(1) the identity of the lessee, designated as such;

(2) the identity of any co-lessee, designated as such;

(3) the identity of the lessor, designated as such;

(4) the amount of the periodic lease payment being insured;

(5) the residual amount, if any, insured for Credit Life insurance;

(6) the premium for Credit Life insurance on periodic payments under the lease (if provided);

(7) the premium for Credit Life insurance on any residual amount (if provided);

(8) the premium, if any, for Credit Accident and Health insurance under the lease (if provided).

(g) Whenever a Credit Life insurance certificate or policy provides or may provide Credit Life insurance applicable to a residual amount, such policy or certificate shall include a disclosure as to whether Credit Life insurance is or is not applicable to the residual amount or a statement describing the conditions under which Credit Life insurance will apply to the residual amount.

History Note: *Authority G.S. 58-2-40; 58-57-1; 58-57-5;*
Eff. April 1, 1989;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0712 TRUNCATED COVERAGE NOTICE

The following notice must appear in bold print on the face of the individual policy or certificate of truncated credit insurance:

NOTICE: The death benefit in this policy may not completely pay off your loan. If the term of your loan is longer than the term of this insurance, the death benefit is only payable if death occurs during the term of the insurance. Total disability benefits will not be paid for any period of total disability continuing after the termination date shown in the schedule.

History Note: *Authority G.S. 58-2-40; 58-57-20; 58-57-70;*
Eff. January 1, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0713 REVOLVING OR OPEN-END CREDIT INSURANCE

The following notice must appear in bold print on the face of an individual policy or certificate of credit insurance written under G.S. 58-57-105 to address the effective date and termination date of coverage:

NOTICE: Coverage will begin when your account has an open balance and will continue, subject to other provisions in this policy, as long as your account has an open balance. No premium will be charged when your account does not have an open balance. Premium charges will automatically resume when your account has another open balance, subject to the termination provisions in this policy.

History Note: *Authority G.S. 58-2-40; 58-57-70; 58-57-105;*
Eff. January 1, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .0714 REFUND OF UNEARNED PREMIUM FOR CREDIT INSURANCE

If credit life insurance coverage is sold together with any other credit insurance coverage, such as accident and health, and death occurs, then as of the date of death the credit life insurance premium is deemed to be fully earned, but the other credit insurance coverage(s) shall provide for a refund of unearned premium. Such refund shall be made in accordance with the provisions of G.S. 58-57-50.

History Note: *Authority G.S. 58-2-40; 58-57-50;*
Eff. July 1, 2010;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

SECTION .0800 - MEDICARE SUPPLEMENT INSURANCE

11 NCAC 12 .0813 FILING REQUIREMENTS FOR ADVERTISING
11 NCAC 12 .0814 FORMS

History Note: *Filed as a Temporary Repeal Eff. June 13, 1990, for a period of 180 days to expire on December 10, 1990;*
Filed as a Temporary Rule Eff. August 31, 1989 for a period of 180 days to expire on February 26, 1990;
Authority G.S. 58-9; 58-710; 58-711; 58-712; 58-713; 58-714; 58-715; 58-717;
Eff. February 1, 1990;
Repealed Eff. December 1, 1990.

11 NCAC 12 .0815 PURPOSE AND DEFINITIONS
11 NCAC 12 .0816 APPLICABILITY AND SCOPE

History Note: *Authority G.S. 58-2-40; 58-54-5; 58-54-10; 58-54-15; 58-54-25; 58-54-50;*
Temporary Adoption Eff. June 13, 1990, for a period of 180 days to expire on December 10, 1990;
Eff. December 1, 1990;
Temporary Amendment Eff. October 16, 1991 for a period of 180 days to expire on April 13, 1992;
Amended Eff. March 1, 1992;
Temporary Amendment Eff. February 1, 2002;
Amended Eff. April 1, 2003;
Repealed Eff. December 31, 2005.

11 NCAC 12 .0817 DEFINITIONS

History Note: *Filed as a Temporary Adoption Eff. June 13, 1990, for a period of 180 days to expire on December 10, 1990;*
ARRC Objection Lodged July 19, 1990;
Authority G.S. 58-2-40; 58-54-1;
Expired on December 10, 1990.

11 NCAC 12 .0818 POLICY DEFINITIONS AND TERMS
11 NCAC 12 .0819 POLICY PROVISIONS
11 NCAC 12 .0820 MINIMUM BENEFIT STANDARDS BEFORE JANUARY 1, 1992
11 NCAC 12 .0821 STANDARDS FOR CLAIMS PAYMENT
11 NCAC 12 .0822 LOSS RATIO STANDARDS AND REFUND OR CREDIT OF PREMIUM

History Note: *Authority G.S. 58-2-40; 58-54-5; 58-54-10; 58-54-15; 58-54-50;*
Temporary Adoption Eff. June13, 1990 for a period of 180 days to expire on December 10, 1990;
Eff. December 1, 1990;
Temporary Amendment Eff. October 16, 1991 for a period of 180 days to expire on April 13, 1992;
Amended Eff. August 3, 1992; March 1, 1992;
Temporary Amended Eff. February 1, 2002;
Amended Eff. April 1, 2003;
Repealed Eff. December 31, 2005.

11 NCAC 12 .0823 FILING REQUIREMENTS FOR OUT-OF-STATE GROUP POLICIES

History Note: *Filed as a Temporary Repeal Eff. October 16, 1991 for a period of 180 days to expire on April 13, 1992;*
Filed as a Temporary Adoption Eff. June 13, 1990, for a period of 180 days to expire on December 10, 1990;
Authority G.S. 58-2-40; 58-54-20;
Eff. December 1, 1990;

Repealed Eff. March 1, 1992.

11 NCAC 12 .0824 REQUIRED DISCLOSURE PROVISIONS
11 NCAC 12 .0825 REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE
11 NCAC 12 .0826 FILING REQUIREMENTS FOR ADVERTISING
11 NCAC 12 .0827 STANDARDS FOR MARKETING
11 NCAC 12 .0828 APPROPRIATENESS OF RECOMMENDED PURCHASE/EXCESSIVE INSURANCE
11 NCAC 12 .0829 REPORTING OF MULTIPLE POLICIES
11 NCAC 12 .0830 PROHIBITIONS IN REPLACEMENT POLICIES OR CERTIFICATES

History Note: *Authority G.S. 58-2-40, 58-54-25; 58-54-35;*
Temporary Adoption Eff. June 13, 1990 for a period of 180 days to expire on December 10, 1990;
Eff. December 1, 1990;
Temporary Amendment Eff. October 16, 1991 for a period of 180 days to expire on April 13, 1992;
Amended Eff. February 1, 1996; August 3, 1992; March 1, 1992;
Repealed Eff. December 31, 2005.

11 NCAC 12 .0831 MEDICARE SUPPLEMENT ANNUAL REPORT
11 NCAC 12 .0832 NOTICE FORMS
11 NCAC 12 .0833 BENEFIT CONVERSION REQUIREMENTS DURING TRANSITION

History Note: *Filed as a Temporary Repeal Eff. October 16, 1991 for a period of 180 days to expire on April 13, 1992;*
Filed as a Temporary Adoption Eff. June 13, 1990, for a period of 180 days to expire on December 10, 1990;
Authority G.S. 58-2-40; 58-54-10; 58-54-15; 58-54-25; 58-54-35;
Eff. December 1, 1990;
Repealed Eff. March 1, 1992.

11 NCAC 12 .0834 PERMITTED COMPENSATION ARRANGEMENTS

History Note: *Authority G.S. 58-2-40; 58-54-15;*
Temporary Rule Eff. August 17, 1990, for a period of 180 days to expire on February 13, 1991;
Eff. February 1, 1991;
Temporary Amendment Eff. October 16, 1991 for a period of 180 days to expire on April 13, 1992;
Amended Eff. March 1, 1992;
Repealed Eff. December 31, 2005.

11 NCAC 12 .0835 MINIMUM BENEFIT STANDARDS ON OR AFTER JANUARY 1, 1992
11 NCAC 12 .0836 STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS
11 NCAC 12 .0837 OPEN ENROLLMENT
11 NCAC 12 .0838 FILING AND APPROVAL OF POLICIES/CERTIFICATES AND PREMIUM RATES

History Note: *Authority G.S. 58-2-40; 58-54-10; 58-54-15; 58-54-20; 58-54-50;*
Temporary Adoption Eff. October 16, 1991 for a period of 180 days to expire on April 13, 1992;
Eff. March 1, 1992;
Amended Eff. February 1, 1996;
Temporary Amendment Eff. February 1, 2002;
Amended Eff. April 1, 2003;
Repealed Eff. December 31, 2005.

11 NCAC 12 .0839 MEDICARE SELECT POLICIES AND CERTIFICATES

History Note: Authority G.S. 58-2-40; 58-54-10; 58-54-15; 58-54-25;
Eff. February 1, 1996;
Repealed Eff. December 31, 2005.

11 NCAC 12 .0840 HIGH DEDUCTIBLE PLANS
11 NCAC 12 .0841 CREDITABLE COVERAGE
11 NCAC 12 .0842 GUARANTEED ISSUE FOR ELIGIBLE PERSONS

History Note: Authority G.S. 58-2-40; 58-54-10; 58-54-15; 58-54-25; 58-54-50;
Temporary Adoption Eff. August 1, 1998;
Eff. April 1, 1999;
Temporary Amendment Eff. February 1, 2002;
Amended Eff. April 1, 2003;
Repealed Eff. December 31, 2005.

11 NCAC 12 .0843 NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

(a) The North Carolina Department of Insurance incorporates by reference, including subsequent amendments and editions, the National Association of Insurance Commissioners Medicare Supplement Insurance Minimum Standards Model Act, Model No. 651. Copies of this Act may be obtained from: The National Association of Insurance Commissioners, 2301 McGee Street, Kansas City, MO 64108-1662; the North Carolina Department of Insurance, Life & Health Division, 1201 Mail Service Center, Raleigh, NC 27699-1201; and from the Department of Insurance web page: http://www.ncdoi.com/.

(b) Section 7 of Model No. 651 shall apply to policies or certificates issued for delivery in North Carolina before January 1, 1992.

(c) Section 8 of Model No. 651 shall apply to policies or certificates issued for delivery in North Carolina on or after January 1, 1992.

(d) For purposes of this rule, Section 8A(7)(c) of Model No. 651 shall read as follows:

Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period effective as of the date of termination of enrollment in the group health plan.

(e) The applicable effective dates for Section 14B(3) of Model No. 651 are October 16, 1991, December 1, 1995, and May 31, 1997.

(f) Insurers shall use the Appendices of Model No. 651 for reporting and disclosure formats.

(g) This Rule applies to policies issued, renewed, or reinstated on or after January 1, 2006.

History Note: Authority G.S. 58-2-40; 58-54-10; 58-54-15; 58-54-25; 58-54-50;
Eff. August 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

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SECTION .0900 - UTILIZATION REVIEW

11 NCAC 12 .0901 ORGANIZATIONAL STRUCTURE

History Note: *Authority G.S. 58-2-40(1); 58-50-60;*
Eff. June 1, 1996;
Repealed Eff. January 1, 1998 pursuant to S.L. 1997-5 s. 4.4.

11 NCAC 12 .0902 DEFINITIONS
11 NCAC 12 .0903 APPLICATION TO AND COMPLIANCE BY PAYERS

History Note: *Authority G.S. 58-2-40(1); 58-50-60;*
Eff. February 1, 1991;
Repealed Eff. January 1, 1998 pursuant to S.L. 1997-5 s. 4.4.

11 NCAC 12 .0904 REQUIREMENTS FOR UTILIZATION REVIEW

History Note: *Authority G.S. 58-2-40(1); 58-50-60;*
Eff. March 1, 1991;
Repealed Eff. January 1, 1998 pursuant to S.L. 1997-5 s. 4.4.

11 NCAC 12 .0905 UTILIZATION REVIEW PLAN
11 NCAC 12 .0906 MINIMUM STANDARDS FOR UTILIZATION REVIEW ENTITIES
11 NCAC 12 .0907 ACCESSIBILITY
11 NCAC 12 .0908 STANDARD DATA ELEMENTS
11 NCAC 12 .0909 MEDICAL CRITERIA
11 NCAC 12 .0910 NONCERTIFICATION
11 NCAC 12 .0911 EMERGENCIES; WAIVERS; EXTENSIONS; CONFIDENTIALITY
11 NCAC 12 .0912 EDUCATION OF INSUREDS ABOUT REVIEW REQUIREMENTS
11 NCAC 12 .0913 IDENTIFICATION CARDS, CERTIFICATES, AND BOOKLETS
11 NCAC 12 .0914 APPEALS OF NONCERTIFICATION
11 NCAC 12 .0915 RECORDS; EXAMINATIONS; TELEPHONE AUDITS
11 NCAC 12 .0916 PROHIBITED ACTS
11 NCAC 12 .0917 REPORT ON UTILIZATION REVIEW EXPERIENCE

History Note: *Authority G.S. 58-2-40(1); 58-50-60;*
Eff. February 1, 1991;
Repealed Eff. January 1, 1998 pursuant to S.L. 1997-5 s. 4.4.

11 NCAC 12 .0918 WRITTEN UTILIZATION REVIEW PLAN
11 NCAC 12 .0919 TELEPHONE ACCESSIBILITY STANDARDS

History Note: *Authority G.S. 58-2-40(1); 58-50-60;*
Eff. June 1, 1996;
Repealed Eff. January 1, 1998 pursuant to S.L. 1997-5 s. 4.4.

SECTION .1000 - LONG-TERM CARE INSURANCE

11 NCAC 12 .1001 APPLICABILITY AND SCOPE

History Note: *Authority G.S. 58-2-40(1); 58-55-30(a);*
Eff. September 1, 1990;
Repealed Eff. April 1, 1995.

11 NCAC 12 .1002 DEFINITIONS

(a) As used in this Section, "insurer" means an entity licensed under G.S. 58 that writes long-term care insurance.

(b) As used in this Section, "exceptional increase" means only those increases filed by an insurer as exceptional for which the Commissioner determines the need for the premium rate increase is justified: due to changes in laws or rules applicable to long-term care coverage in this state; or due to increased and unexpected utilization that affects the majority of insurers of similar products. Except as provided in 11 NCAC 12 .1028, exceptional increases are

subject to the same requirements as other premium rate schedule increases. The Commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase. The Commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claim costs.
(c) As used in 11 NCAC 12 .1028(k), "incidental" means that the value of the long-term care benefits provided is less than ten percent of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.
(d) As used in this Section, "qualified actuary" means a member in good standing of the American Academy of Actuaries.
(e) As used in this Section, "similar policy forms" means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in G.S. 58-55-20(3)a. are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.
(f) The definitions contained in G.S. 58-1-5 and in G.S. 58-55-20 are incorporated in this Section by reference.

History Note: *Authority G.S. 58-2-40(1); 58-55-30(a);*
Eff. September 1, 1990;
Amended Eff. February 1, 1996; December 1, 1993; December 1, 1992;
Amended Eff. August 1, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1003 POLICY DEFINITIONS; APPEALS
(a) Unless otherwise required by federal law or regulation, no policy issued or issued for delivery in this State shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

(1) "Activities of daily living" means at least bathing, continence, dressing, eating, toileting, and transferring.
(2) "Acute condition" means that the individual is medically unstable and requires frequent monitoring by a medical doctor or registered nurse.
(3) "Bathing" means washing oneself by sponge bath, or in a tub or shower, including the task of getting into and out of the tub or shower.
(4) "Cognitive impairment" means a deficiency in a person's short or long-term memory; orientation as to person, place, and time; deductive or abstract reasoning; or judgment as it relates to safety awareness.
(5) "Continence" means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
(6) "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
(7) "Eating" means feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table); or by feeding tube or intravenously.
(8) "Hands-on-assistance" means physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the activity of daily living.
(9) "Medicare" means the "Health Insurance for the Aged Act", Title XVIII of the Social Security Amendments of 1965, as amended.
(10) "Mental of nervous disorder" shall not be defined to include mroe than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.
(11) "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.
(12) "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
(13) "Transferring" means moving into our out of a bed, chair, or wheelchair.

(14) "Skilled nursing care," "intermediate care," "personal care," home care," and other services shall be defined in relation to the level of skill required, the nature of the care, and the setting in which care must be delivered.

(b) The definitions contained in G.S. 58-55-20 and G.S. 58-55-35(a) are incorporated by reference into this Section.

(c) A policy may condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment as long as those conditions are defined in the policy. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as medical doctors, nurses, or social workers. Policies shall include a description of the procedures for appealing and resolving benefit determinations.

History Note: *Authority G.S. 58-2-40(1); 58-55-30(a);*
Eff. September 1, 1990;
Amended Eff. April 1, 1999;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1004 POLICY PRACTICES AND PROVISIONS

(a) The terms "guaranteed renewable" or "noncancellable" may not be used in any individual policy without further explanatory language in accordance with the disclosure requirements of 11 NCAC 12 .1006. No such policy issued to an individual shall contain renewal provisions other than "guaranteed renewable" or "noncancellable".

(b) The term "guaranteed renewable" may be used only when the insured has the right to continue the policy in force by timely payments of premiums; during which period the insurer has no unilateral right to make any change in any provision of the policy while the policy is in force and can not refuse to renew: Provided that rates may be revised by the insurer on a class basis.

(c) The term "level premium" may be used only when the insurer does not have the right to change the premium.

(d) The word "noncancellable" may be used only when the insured has the right to continue the policy in force by timely payments of premiums and during which period the insurer has no right to unilaterally make any change in any provision of the policy or in the premium rate.

(e) No policy may limit or exclude coverage by type of illness, treatment, medical condition, or accident, except as follows:

(1) preexisting conditions as specified in G.S. 58-55-30;
(2) mental or nervous disorders, except for Alzheimer's Disease;
(3) alcoholism and drug addiction;
(4) illness, treatment, or medical condition arising out of:
    (A) war or act of war (whether declared or undeclared);
    (B) participation in a felony, riot, or insurrection;
    (C) service in the armed forces or units auxiliary thereto;
    (D) suicide, attempted suicide, or intentionally self-inflicted injury; or
    (E) aviation activity as a nonfare-paying passenger;
(5) treatment provided in a government facility (unless otherwise required by law); services for which benefits are available under Medicare (unless otherwise required by law), under any other governmental program (except Medicaid), or under any state or federal workers' compensation, employer's liability, or occupational disease law; services provided by the insured's parents, spouse, children or siblings; and services for which no charge is normally made in the absence of insurance;
(6) exclusions and limitations for payment for services provided outside the United States; and
(7) legitimate variations in benefit levels to reflect differences in provider rates.

(f) Termination of a policy shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while the policy was in force and continues without interruption after termination. Such extension of benefits beyond the period during which the policy was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits; and may be subject to any policy waiting period and all other applicable provisions of the policy.

History Note: *Authority G.S. 58-2-40(1); 58-55-30(a);*
Eff. September 1, 1990;
Amended Eff. February 1, 1996; December 1, 1993; December 1, 1992;

Amended Eff. August 1, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1005 CONTINUATION OR CONVERSION

(a) Group long-term care insurance newly issued or renewed in North Carolina on or after September 1, 1990, shall provide covered individuals with a basis for continuation or conversion of coverage.

(b) As used in this Rule, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when such coverage would otherwise terminate and that is subject only to the continued timely payments of premiums when due. A group policy that lawfully restricts provisions of benefits and services to, or contains incentives to use, certain providers or facilities, may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The Commissioner shall make a determination as to the substantial equivalency of benefits; and in doing so shall take into consideration the differences between managed care and non-managed care plans, including provider system arrangements, service availability, benefit levels, and administrative complexity.

(c) As used in this Rule, "a basis for conversion of coverage" means a policy provision that an individual:

(1) whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class; and

(2) who has been continuously insured under the group policy, and any group policy that it replaced, for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he is covered, without evidence of insurability.

(d) As used in this Rule, "converted policy" means an individual policy 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 from which conversion is made. Where the group policy from which conversion is made lawfully restricts provision of benefits and services to, or contains incentives to use, certain providers or facilities, the commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including provider system arrangements, service availability, benefit levels, and administrative complexity.

(e) Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than 31 days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy; and shall be renewable annually.

(f) Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

(g) Continuation of coverage or issuance of a converted policy is mandatory, except where:

(1) termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

(2) the terminating coverage is replaced, not later than 31 days after termination, by group coverage that is effective on the day following the termination of coverage, that provides benefits identical to, or benefits determined by the commissioner to be substantially equivalent to or in excess of, those provided by the terminating coverage, and the premium for which group coverage is calculated in a manner consistent with the requirements of Paragraph (f) of this Rule.

(h) Notwithstanding any other provision of this Rule, a converted policy that is issued to an individual, who at the time of conversion is covered by another policy that provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if the benefits provided under the other policy, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund that reflects the reduction in benefit payable.

(i) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

(j) Notwithstanding any other provision of this Rule, any insured individual, whose eligibility for group policy coverage is based upon his relationship to another person, is entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.
(k) As used in this Rule, a "managed care plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management, or use of specific provider networks.

History Note: *Authority G.S. 58-2-40(1); 58-55-30(a);*
Eff. September 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1006 REQUIRED DISCLOSURE PROVISIONS

(a) Renewability. Individual long-term care insurance policies shall contain a renewability provision. This provision shall be prominently displayed, shall appear on the first page of the policy, and shall clearly state that the coverage is guaranteed renewable or noncancellable. This provision does not apply to long-term care policies which are part of or combined with life insurance policies.
(b) Premium Rate Changes. A long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that premium rates may change.
(c) Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if 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 charge shall be set forth in the policy, rider or endorsement.
(d) Payment of Benefits. A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of these terms and an explanation of the terms in its accompanying outline of coverage.
(e) Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."
(f) Other Limitations or Conditions on Eligibility for Benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in 11 NCAC 12 .1008 and G.S. 58-55-30 shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."
(g) Disclosure of Tax Consequences. With regard to life insurance policies that provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This Paragraph shall not apply to tax qualified long-term care insurance contracts.
(h) Benefit Triggers. Activities of daily living and cognitive impairment shall be used to measure an insured's need for long term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained in this section. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.
(i) Tax Qualified. A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in 11 NCAC 12 .1015(e) that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.
(j) Tax Non-Qualified. A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in 11 NCAC 12 .1015(e) that the policy is not intended to be a qualified long-term care insurance contract.

History Note: *Authority G.S. 58-2-40(1); 58-55-30(a);*
Eff. September 1, 1990;
Amended Eff. August 1, 2002; December 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1007 PROHIBITION OF POST-CLAIMS UNDERWRITING

(a) All applications for policies except those that are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

(b) If an application for a policy contains a questions that asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

(c) If, at the time of the application, the medications listed in the application were known or should have been known by the insurer or by the insurer's agent or representative to be directly related to a medical condition for which coverage would otherwise be limited or denied, the policy shall not be rescinded nor shall coverage be denied or limited for that condition.

(d) Except for policies that are guaranteed issue:

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

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

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

"Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, [name of company] has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises. If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]"

(3) Prior to issuance of a policy to an applicant age 80 years or older, the insurer shall obtain one of the following: A report of a physical examination; an assessment of functional capacity; an attending physician's statements; or copies of medical records.

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

(f) Every insurer selling or issuing policies shall maintain a record of all policy rescissions, both in North Carolina and countrywide, except those that insureds voluntarily effectuated; and shall annually furnish this information to the commissioner in the format prescribed by the National Association of Insurance Commissioners.

History Note: *Authority G.S. 58-2-40(1); 58-55-30(a);*
Eff. September 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1008 MINIMUM STANDARDS FOR HOME HEALTH CARE BENEFITS

(a) A policy providing benefits for home health care services may not limit or exclude benefits by:

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

(2) requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services in a home or community setting before home health care services are covered;

(3) limiting eligible services to services provided by registered nurses or licensed practical nurses;

(4) requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide or by another licensed or certified home care worker acting within the scope of his or her licensure or certification.

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

(6) limiting benefits to services provided by Medicare-certified agencies or providers; or

(7) excluding coverage for adult day care services.

(b) Home health care coverage may be applied to the non-home health care benefits provided in the policy when determining maximum coverage under the terms of the policy. Home health care benefits shall be offered in an amount of not less than twenty-five dollars ($25.00) per day.

History Note: *Authority G.S. 58-2-40(1); 58-55-30(a);*
Eff. September 1, 1990;
Amended Eff. December 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1009 REQUIREMENT TO OFFER INFLATION PROTECTION

(a) No insurer may offer a policy unless the insurer also offers to the applicant the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations that are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each applicant, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

(1) Increases benefit levels annually, in a manner so that the increases are compounded annually at a minimum of 5 percent;

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

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

(b) Where the policy is issued to a group, the required offer in Paragraph (a) of this Rule shall be made to the group policyholder; except, if the policy is issued to a group defined in G.S. 58-55-20(3)d other than to a continuing care facility, the offering shall be made to each proposed certificate holder.

(c) The offer in Paragraph (a) of this Rule is not required of life insurance policies or riders containing accelerated long-term care benefits.

(d) Insurers shall include the following information in or with the outline of coverage:

(1) a graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period.

(2) any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at ages 75 and 85 for benefit increases. An insurer may use a reasonable hypothetical or a graphic demonstration for the purposes of this disclosure.

(3) Inflation protection benefit increases under a policy that contains such benefits shall continue throughout the period of coverage without regard to an insured's age, an insured's claim status or claim history, or the length of time an insured has been covered under the policy.

(4) An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium that the insurer expects to remain constant. This offer shall disclose in bold faced print that the premium may change in the future unless the premium is guaranteed to remain constant.

(e) Inflation protection provided in this Rule shall be included in a policy unless an insurer obtains a rejection of inflation protection, signed by the applicant, as follows:

(1) The rejection shall be considered a part of the application by addendum or supplement to the application; and

(2) The rejection notice shall state:

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

History Note: *Authority G.S. 58-2-40(1); 58-55-30(a);*

Eff. September 1, 1990;
Amended Eff. December 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1010 REQUIREMENTS FOR REPLACEMENT

(a) Individual and direct response solicited long-term care insurance application forms shall include a question designed to elicit information as to whether the proposed policy is intended to replace any other accident and health or long-term care insurance policy presently in force. A supplementary applicant or other form to be signed by the applicant containing such a question may be used.

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

"NOTICE TO APPLICANT REGARDING REPLACEMENT
OF INDIVIDUAL ACCIDENT AND HEALTH OR LONG-TERM CARE INSURANCE

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

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

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

1. Health conditions that you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, 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 pre-existing conditions or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions or probationary periods in the new policy or certificate for similar benefits to the extent such time was spent under the original plan.
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 health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

_____

(Signature of Agent, Broker or Other Representative)

The above Notice to Applicant was delivered to me on:

_____

(Date)

_____
(Applicant's Signature) "

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

"NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND HEALTH OR LONG-TERM CARE INSURANCE

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

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.
1. Health conditions that you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, 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 pre-existing conditions or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions or probationary periods in the new coverage for similar benefits to the extent such time was spent 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 still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

_____
(Company Name)"

(d) When replacement is intended, the replacing insurer shall give written notice of the proposed replacement to the existing insurer. The existing policy shall be identified by the insurer, name of the insured, and policy number or address, including zip code. This notice shall be made within five business days after the date the application is received by the insurer or the date the policy is issued, whichever date is sooner.
(e) The application shall include questions designed to elicit information as to whether or not another policy is intended to be replaced.

History Note: *Authority G.S. 58-2-40(1); 58-55-30(a);*
Eff. September 1, 1990;
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11 NCAC 12 .1011 DISCRETIONARY POWERS OF COMMISSIONER

The Commissioner may, upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this Section with respect to a specific policy upon a written finding that:

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

History Note: *Authority G.S. 58-2-40(1); 58-55-30(a);*
Eff. September 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1012 RESERVE STANDARDS

(a) When long-term care benefits are provided through the acceleration of benefits under group or individual life insurance policies or riders to such policies, policy reserves for such benefits shall be determined in accordance with G.S. 58-58-50. Claim reserves must also be established in the case when such policy or rider is in claim status.
(b) Reserves for policies and riders subject to this Rule shall be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.
(c) In the development and calculation of reserves for policies and riders subject to this Rule, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures, and all other considerations that have an effect on projected claim costs, including the following: definition of insured events; covered long-term care facilities; existence of home convalescence care coverage; definition of facilities; existence or absence of barriers to eligibility; premium waiver provision; renewability; ability to raise premiums; marketing method; underwriting procedures; claims adjustment procedures; waiting period; maximum benefit; availability of eligible facilities; margins in claim costs; optional nature of benefit; delay in eligibility for benefit; inflation protection provisions; and guaranteed insurability option.
(d) Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.
(e) When long-term care benefits are provided other than as in Paragraphs (a) through (d) of this Rule, reserves shall be determined in accordance with 11 NCAC 11F .0200.

History Note: *Authority G.S. 58-2-40(1); 58-55-30(a);*
Eff. September 1, 1990;
Amended Eff. August 1, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1013 LOSS RATIO

(a) This Rule shall apply to all long-term care insurance policies except those subject to 11 NCAC 12 .1014 and .1028. Further, 11 NCAC 12 .0555(b)(3) shall not apply to policies or certificates covered under 11 NCAC 12 .1014 and .1028.
(b) Benefits under long-term care insurance policies shall be deemed to be reasonable in relation to premiums, provided that the expected loss ratio is at least 60 percent for individual policies and 75 percent for group policies, and is calculated in a manner that provides for reserving of the long-term care insurance risk. In evaluating the expected loss ratio, consideration shall be given to all relevant factors, including:

(1) statistical credibility of incurred claims experience and earned premiums;
(2) the period for which rates are computed to provide coverage;
(3) experienced and projected trends;
(4) concentration of experience within early policy duration;
(5) expected claim fluctuation;
(6) experience refunds, adjustments, or dividends;
(7) renewability features;
(8) expense factors;
(9) interest;
(10) experimental nature of the coverage;
(11) policy reserves;
(12) mix of business by risk classification; and
(13) product features such as long elimination periods, high deductibles, and high maximum limits.

(c) Paragraph (b) of this Rule shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

(1) The interest credited internally to determine cash value accumulations, including long-term care, if any, is guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
(2) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of G.S. 58-58-55;
(3) The policy meets the disclosure requirements of G.S. 58-55-30;
(4) Any policy illustration meets the applicable requirements of 11 NCAC 04 .0500; and
(5) An actuarial memorandum is filed with the Commissioner that includes:
    (A) A description of the basis on which the long-term care rates were determined;
    (B) A description of the basis for the reserves;
    (C) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
    (D) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;
    (E) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
    (F) The estimated average annual premium per policy and the average issue age;
    (G) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
    (H) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

History Note: *Authority G.S. 58-2-40(1); 58-55-30(a);*
Eff. September 1, 1990;
Amended Eff. August 1, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1014 FILING REQUIREMENT

(a) Before an insurer offers a group policy to a resident of North Carolina pursuant to G.S. 58-55-25, it shall file with the Commissioner evidence that the group policy has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those of North Carolina.

(b) This Rule applies to any long-term care policy issued in this state on or after February 1, 2003. An insurer shall provide the information listed in this paragraph to the commissioner 45 days prior to making a long-term care insurance form available for sale.

(1) A copy of the disclosure documents required in 11 NCAC 12 .1027, and

(2) An actuarial certification consisting of at least the following:

(A) 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 form with no future premium increases anticipated;

(B) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

(C) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

(D) A complete description of the basis for contract reserves that are anticipated to be held under the form to include:

(i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts 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 rating where permitted); 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 the situations where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship. If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration based on a standard age distribution; and

(E) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or a comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

(c) The Commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences; relevant and credible data from other studies; or both.

(d) In the event the Commissioner asks for additional information under this provision, the period in Paragraph (b) of this Rule does not include the period during which the insurer is preparing the requested information.

History Note: *Authority G.S. 58-2-40(1); 58-55-30(a);*
Eff. September 1, 1990;
Amended Eff. August 1, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1015 STANDARD FORMAT OUTLINE OF COVERAGE

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

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

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

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

(e) Format for outline of coverage:

[COMPANY NAME]

[ADDRESS - CITY & STATE]
[TELEPHONE NUMBER]
LONG-TERM CARE INSURANCE
OUTLINE OF COVERAGE
[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

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

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. FEDERAL TAX CONSEQUENCES.

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

OR

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

4. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.
   (a) [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:

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

      (2) [Policies and certificates that are noncancellable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to

increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

(b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]

(c) [Describe waiver of premium provisions or state that there are not such provisions.]

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

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

6. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [Provide a brief description of the right to return–"free look" provision of the policy.]

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

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

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

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

8. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

9. BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductibles, waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Non-institutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and 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, explanation of the triggers must accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.]

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Non-eligible facilities and provider;

(c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) Exclusions and exceptions;

(e) Limitations.]

[This section must provide a brief specific description of any policy provisions that limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in Number 6 above.]

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

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:
(a) That the benefit level will not increase over time;
(b) Any automatic benefit adjustment provisions;
(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;
(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any restrictions or limitations;
(e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

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

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

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

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

15. CONTACT THE NORTH CAROLINA SENIORS' HEALTH INSURANCE INFORMATION PROGRAM (SHIIP) IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

History Note: *Authority G.S. 58-2-40(1); 58-55-30(a);*
Eff. September 1, 1990;
Amended Eff. August 1, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1016 PERMITTED COMPENSATION ARRANGEMENTS

(a) As used in this Rule:
(1) "Compensation" means consideration or remuneration of any kind relating to the sale or renewal of a policy, including but not limited to commissions, bonuses, gifts, prizes, or awards.
(2) "Policy" includes a certificate.
(3) "Representative" includes an agent, general agent, manager, broker, or other producer.

(b) If a policy is replaced, no person shall provide and no representative shall receive compensation greater than that payable by the replacing insurer on renewal policies. This Paragraph does not apply if the benefits of the replacement policy are clearly and substantially greater than the benefits of the replaced policy.

(c) Each insurer shall establish marketing procedures that set forth a mechanism or formula for determining whether replacement policies contain benefits clearly and substantially greater than the benefits of replaced policies.

History Note: *Authority G.S. 58-2-40; 58-54-15;*
Temporary Rule Eff. August 17, 1990 for a period of 180 days to expire on February 13, 1991;
Eff. February 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1017 REQUIREMENTS FOR ADVERTISING

Every insurer, health care service plan or other entity providing long-term care insurance or benefits in this State shall provide a copy of any long-term care insurance advertisement intended for use, whether through written, radio or television medium, to the Commissioner for approval. In addition, all advertisements shall be retained by the insurer, health care service plan or other entity for at least three years from the date the advertisement was first used.

History Note: *Authority G.S. 58-2-40(1); 58-55-30(a); 58-55-30(j);*
Eff. December 1, 1992;
Amended Eff. August 1, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1018 STANDARDS FOR MARKETING

(a) Every insurer, health care service plan or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

(1) Establish marketing procedures and agent training requirements to assure that:
  (A) Any marketing activities, including any comparison of policies, by its agents or other producers will be fair and accurate; and
  (B) Excessive insurance is not sold or issued.

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

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

(3) Provide copies of the disclosure forms required in 11 NCAC 12 .1027(d) to the applicant.

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance, except that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required.

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

(6) Every insurer providing long-term care insurance in this State shall at the time of solicitation provide the address and toll-free telephone number of the North Carolina Seniors' Health Insurance Information Program (SHIIP).

(7) For long-term care health insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to this Section.

(8) Provide an explanation of contingent benefit upon lapse as provided for in 11 NCAC 12 .1026.

(b) In addition to the practices prohibited in G.S. 58, Article 63, the following acts and practices are prohibited:

(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy or to take out a policy of insurance with another insurer.

(2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue influence. As used in this Subparagraph, "undue influence" means a fraudulent influence

over the mind and will of another to the extent that the professed action is not freely done but is in truth the act of the one who procures the result.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

(4) Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

(c) With respect to the obligations set forth in this Rule, the primary responsibility of an association, as defined in G.S. 58-55-20(3)(c), when endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold. The insurer shall file with the Commissioner the following material:

(1) The policy and certificate,

(2) A corresponding outline of coverage, and

(3) All advertisements requested by the Commissioner.

(d) The association shall disclose in any long-term care insurance solicitation:

(1) The specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and

(2) A brief description of the process under which the policies and the insurer issuing the policies were selected.

(3) If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

(4) The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.

(e) The association shall also:

(1) At the time of the association's decision to endorse, engage the services of a long term care insurance expert who is not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates and update the examination thereafter in the event of material change;

(2) Monitor the marketing efforts of the insurer and its agents; and

(3) Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.

(4) Paragraphs (e)(1) through (e)(3) of this Rule shall not apply to qualified long-term care insurance contracts.

(f) No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the Commissioner the information required in this Rule.

(g) The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in this rule.

(h) Failure to comply with the filing and certification requirements of this rule constitutes an unfair trade practice in violation of G.S. 58, Article 63.

History Note: *Authority G.S. 58-2-40(1); 58-55-30(a); 58-63-15(9);*
Eff. December 1, 1992;
Amended Eff. August 1, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1019 REPLACEMENT POLICIES

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

History Note: *Authority G.S. 58-2-40(1); 58-55-30(a);*
Eff. December 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1020 SHOPPER'S GUIDE

Every insurer providing long-term care insurance in this State shall, before sale, deliver a shopper's guide to every applicant. The guide shall be in the format developed by the NAIC.

History Note: *Authority G.S. 58-2-40(1); 58-55-30(a);*
Eff. December 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1021 REPORTING

Each insurer shall on a statewide basis:

(1) Maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales.

(2) Maintain records of the amount of lapses of long-term care insurance policies sold by agents as a percent of the agent's total annual sales.

(3) Report annually by June 30th the 10 percent of its agents with the greatest percentages of lapses and replacements.

(4) Report annually by June 30th the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.

(5) Report annually by June 30th the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.

History Note: *Authority G.S. 58-2-40(1); 58-55-30(a); 58-2-195(a);*
Eff. December 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1022 PROTECTION AGAINST UNINTENTIONAL LAPSE

(a) No individual policy shall be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy for nonpayment of premium; or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. Every applicant has the right to so designate at least one person. Designation does not constitute acceptance of any liability on the part of the designated person or persons for services provided to the insured. The form used for the designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. If an applicant elects not to designate any person, a written, signed waiver shall state:

"Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate any person to receive such notice."

The insurer shall notify the insured of the right to change this written designation no less often than once every two years.

(b) When a policyholder pays premium for a policy through a payroll or pension deduction plan, the requirements contained in Paragraph (a) of this Rule need not be met until 60 days after the policyholder is no longer on such a payment plan. The application or enrollment form for such policies shall clearly indicate the payment plan selected by the applicant.

(c) No individual policy shall lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to any person or persons designated under Paragraph (a) of this Rule, at the addresses provided by the insured. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of five days after the date of mailing.
(d) In addition to the requirement in Paragraph (a) of this Rule, each policy shall provide for reinstatement of coverage if the insurer is furnished proof of cognitive impairment or the loss of functional capacity of the insured. This option is available to the insured if requested within five months after lapse or termination; and the insurer may require payment of past due premium before reinstatement, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity, if any, contained in the policy.

History Note: *Authority G.S. 58-2-40(1); 58-55-30(a);*
Eff. December 1, 1993;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1023 INCONTESTABILITY PERIOD
(a) For a policy that has been in force for less than six months, an insurer may rescind the policy or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation by the insured that is material to the acceptance for coverage.
(b) For a policy that has been in force for at least six months but less than two years, an insurer may rescind the policy or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation by the insured that is both material to the acceptance for coverage and that pertains to the condition for which benefits are sought.
(c) After a policy has been in force for two years, the policy is not contestable upon the grounds of misrepresentation alone; that policy may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.
(d) No policy may be field issued based on medical or health status. For purposes of this Paragraph, "field issued" means a policy or certificate issued by an agent or a third-party administrator pursuant to the underwriting authority granted to the agent or third party administrator by an insurer.
(e) If an insurer has paid benefits under a policy, the benefit payments may not be recovered by the insurer if the policy is rescinded.

History Note: *Authority G.S. 58-2-40(1); 58-55-30(a);*
Eff. December 1, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1024 PROHIBITED POLICY PRACTICE
(a) No insurer may increase the rate or premium charged to an insured for a policy because of:
(1) the increasing age of the insured at ages beyond 65; or
(2) the amount of time the insured has been covered under a policy.
(b) This Rule applies only to policies newly issued on and after December 1, 1994.

History Note: *Authority G.S. 58-2-40(1); 58-55-30(a);*
Eff. December 1, 1994;
Amended Eff. April 1, 1995;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1025 SUITABILITY
(a) Each insurer, except an insurer issuing life insurance that accelerates benefits for long-term care, shall:
(1) Train its agents in the use of its suitability standards.
(2) Maintain a copy of its suitability standards and make them available for inspection upon request by the Division.

(b) To determine whether the applicant meets the standards developed by the insurer, the agent and insurer shall develop procedures that take the following into consideration:

(1) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage.

(2) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals of needs.

(3) The values, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.

(c) The sale or dissemination of information obtained through the personal long-term care insurance worksheet referred to in G.S. 58-55-31(c)(1) by an insurer or an agent to any person outside of the insurance company or insurance agency is prohibited.

(d) Each year the insurer shall report to the Division the total number of applications received from residents of this State, the number of applicants who declined to provide information on the worksheet, the number of applicants who did not meet the suitability standards, the number of those who chose to confirm after receiving a suitability letter.

(e) An insurer may issue a policy to an applicant that does not meet the financial suitability standards if the applicant signs a waiver acknowledging the suitability results.

History Note: *Authority G.S. 58-2-40(1); 58-55-30(a); 58-55-31;*
Eff. April 1, 1999;
Amended Eff. November 1, 1999;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1026 NONFORFEITURE BENEFIT REQUIREMENTS

(a) This Rule does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(b) To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of G.S. 58-55-31:

(1) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in Paragraph (g) of this Rule; and

(2) The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

(c) If the offer required to be made under G.S. 58-55-31 is rejected, the insurer shall provide the contingent benefit upon lapse described in this Rule.

(d) In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificate-holder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(e) The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in this Paragraph based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least 45 days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%

63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

(f) On or before the effective date of a substantial premium increase as defined in Paragraph (e) of this Rule, the insurer shall:

(1) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(2) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of Paragraph (g) of this Rule. This option may be elected at any time during the 120-day period; and

(3) Notify the policyholder or certificate-holder that a default or lapse at any time during the 120-day period shall be deemed to be the election of the offer to convert.

(g) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, shall satisfy the following criteria:

(1) For purposes of this Paragraph, attained age rating is defined as a schedule of premiums starting from the issue date increases at least one percent per year prior to age 50 and at least three percent per year beyond age 50.

(2) For purposes of this Paragraph, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in Paragraph (g)(3) of this Rule.

(3) The standard nonforfeiture credit will be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of Paragraph (i) of this Rule.

(4) The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three

years as well as thereafter. For a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of: the end of the tenth year following the policy or certificate issue date; or the end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(h) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

(i) All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status.

(j) There shall be no difference in the minimum nonforfeiture benefits as required under this Rule for group and individual policies.

(k) The requirements set forth in this Rule shall become effective August 1, 2003, and shall apply as follows:

(1) Except as provided for in Paragraph (k)(2) of this Rule, the provisions of this Rule apply to any long-term care policy issued in this state on or after August 1, 2002.

(2) For certificates issued on or after August 1, 2002, under a group long-term care insurance policy as defined in G.S. 58-55-20(3), which policy was in force at the time this Rule became effective, the provisions of this Rule shall not apply.

(l) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of 11 NCAC 12 .1013 treating the policy as a whole.

(m) To determine whether contingent nonforfeiture upon lapse provisions are triggered under Paragraph (e) of this Rule, a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

(n) A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

(1) The nonforfeiture provision shall be disclosed;

(2) The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as 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

(3) The nonforfeiture provision shall provide at least one of the following:

(A) Reduced paid-up insurance; or

(B) Extended term insurance; or

(C) Shortened benefit period.

History Note: *Authority G.S. 58-2-40(1); 58-55-30(a); 58-55-31;*
Eff. April 1, 1999;
Amended Eff. August 1, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1027 REQUIRED DISCLOSURE OF RATING PRACTICES TO CONSUMERS

(a) This Rule shall apply as follows:

(1) To any long-term care policy or certificate issued in this state on or after February 1, 2003, except as provided in Paragraph (a)(2) of this Rule.

(2) For certificates issued on or after August 1, 2002 under a group long-term care insurance policy as defined in G.S. 58-55-20(3), which policy was in force at the time this Rule became effective, the provisions of this Rule shall apply on the policy anniversary following July 1, 2003.

(b) Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this Paragraph to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all required disclosure to the applicant no later than at the time of delivery of the policy or certificate. Required disclosure is as follows:

(1) A statement that the policy may be subject to rate increases in the future;

(2) An explanation of potential future premium rate revisions, and the policyholder's or certificate-holder's option in the event of a premium rate revision;
(3) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;
(4) A general explanation for applying premium rate or rate schedule adjustments that shall include:
  (A) A description of when premium rate or rate schedule adjustments will be effective on either the next anniversary date or the next billing date; and
  (B) The right to a revised premium rate or rate schedule as provided if the premium rate or rate schedule is changed;
(5) Information regarding history of rate increases:
  (A) Information regarding each premium rate increase on this policy form or similar policy forms over the past 10 years for this state or any other state that, at a minimum, identifies:
    (i) The policy forms for which premium rates have been increased;
    (ii) The calendar years when the form was available for purchase; and
    (iii) The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics;
  (B) An insurer shall have the right to exclude from the disclosure premium rate increases that apply only to blocks of business acquired from other non-affiliated insurers or the long-term care policies acquired from other non-affiliated insurers when those increases occurred prior to the acquisition;
  (C) If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from non-affiliated insurers on or before August 1, 2002 or the end of a 24 month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with this Rule; and
  (D) If the acquiring insurer referenced in Paragraph (b)(5)(C) of this Rule files for a subsequent rate increase, even within the 24-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in Paragraph (b)(5)(C) of this Rule, the acquiring insurer must make all disclosures required by this Rule, including disclosure of the earlier rate increase.

(c) An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under this Rule. If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.
(d) An insurer shall use the NAIC Long-Term Care Insurance Model Regulation forms identified as Appendices B and F to comply with the requirements of Paragraphs (b) and (c) of this Rule.
(e) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate-holders, if applicable, at least 45 days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required under this Rule when the rate increase is implemented.

History Note: *Authority G.S. 58-2-40(1); 58-55-30(a); 58-63-15(9);*
Eff. August 1, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1028 PREMIUM RATE SCHEDULE INCREASES

(a) This Rule shall apply as follows:
(1) Except as provided in Paragraph (a)(2) of this Rule, this Rule applies to any long-term care policy or certificate issued in this state on or after February 1, 2003; and
(2) For certificates issued on or after August 1, 2002, under a group long-term care insurance policy as defined in G.S. 58-55-20(3), which policy was in force at the time this Rule became effective, the provisions of this Rule shall apply on the policy anniversary following August 1, 2003.

(b) An insurer shall request approval of a pending premium rate schedule increase, including an exceptional increase, from the Commissioner at least 90 days prior to the notice to the policyholders and shall include:

(1) Information required by 11 NCAC 12 .1027;

(2) Certification by an actuary who is a member in good standing with the American Academy of Actuaries that:

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

(B) The premium rate filing is in compliance with the provisions of this Rule;

(3) An actuarial memorandum justifying the rate schedule change request that includes:

(A) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale:

(i) Annual values for the five years preceding and the three years following the valuation date shall be provided separately;

(ii) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(iii) The projections shall demonstrate compliance with Paragraph (c) of this Rule; and

(iv) For exceptional increases:

(I) The projected experience shall be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(II) In the event the Commissioner determines, as provided in 11 NCAC 12 .1002 that offsets may exist, the insurer shall use net projected experience;

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

(C) Disclosure of the analysis performed to determine why a rate adjustment 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;

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

(E) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates;

(4) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, or underwriting criteria; and

(5) All projected premium rate schedule increases shall be filed with the Commissioner for review and approval under G.S. 58-51-95.

(c) All premium rate schedule increases shall be determined in accordance with the following requirements:

(1) Exceptional increases shall provide that 70 percent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(2) Premium rate schedule increases shall be 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 the following:

(A) The accumulated value of the initial earned premium times 58 percent;

(B) 85 percent of the accumulated value of prior premium rate schedule increases on an earned basis;

(C) The present value of future projected initial earned premiums times 58 percent; and

(D) 85 percent of the present value of future projected premiums not in Part (c)(2)(C) of this Rule on an earned basis;

(3) In the event that a policy form has both exceptional and other increases, the values in Subparagraphs (c)(2)(B) and (D) of this Rule will also include 70 percent for exceptional rate increase amounts; and

(4) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in 11 NCAC 11F .0207(c). The actuary shall disclose as part of the actuarial memorandum the use of any actuarially appropriate averages.

(d) For each rate increase that is implemented, the insurer shall file for review and approval under G.S. 58-51-95 by the Commissioner the updated projections, as defined in Part (b)(3)(A) of this Rule, annually for the next three years and include a comparison of actual results to projected values. The Commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in Paragraph (l) of this Rule, the projections required by this Paragraph shall be provided to the policyholder in lieu of filing with the Commissioner.

(e) If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in Part (b)(3)(A) of this Rule, shall be filed for review and approval under G.S. 58-51-95 by the Commissioner every five years following the end of the required period in Paragraph (d) of this Rule. For group insurance policies that meet the conditions in Paragraph (l) of this Rule, the projections required by this Rule shall be provided to the policyholder in lieu of filing with the Commissioner.

(f) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in Paragraph (c) of this Rule, the Commissioner may require the insurer to implement any of the following:

(1) Premium rate schedule adjustments; or

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

It is to be expected that the actual experience will not exactly match the insurer's projections. During the period that projections are monitored as described in Paragraphs (d) and (e) of this Rule, the Commissioner shall determine that there is not an adequate match if the differences in earned premiums and incurred claims are not in the same direction (both actual values higher or lower than projections) or the difference as a percentage of the projected is not of the same order. In determining whether the actual experience adequately matches the projected experience, consideration shall be given to Part (b)(3)(E) of this Rule, if applicable.

(g) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

(1) A plan, subject to the Commissioner's approval under G.S. 58-51-95 for improved administration or claims processing, or both, designed to eliminate the potential for further deterioration of the policy form requiring further premium rate increases; otherwise the Commissioner may impose the condition in Paragraph (i) of this Rule; and

(2) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to Paragraph (c) of this Rule had the greater of the original anticipated lifetime loss ratio or 58 percent been used in the calculations described in Parts (c)(2)(A) and (C) of this Rule.

(h) For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if adverse lapsation has occurred or is anticipated:

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

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

(3) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(i) In the event adverse lapsation has occurred, 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 in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

(1) The offer shall:

(A) Be subject to the approval under G.S. 58-51-95 of the Commissioner;

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

(C) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy;

(2) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

(A) The maximum rate increase determined based on the combined experience; or

(B) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus 10 percent.

(j) If the Commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the Commissioner may, in addition to the provisions of Paragraph (i) of this Rule, prohibit the insurer from either of the following:

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

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

A premium rate is inadequate if the rate is unreasonably low for the insurance provided and the use or continued use of the rate by the insurer has had or will have the effect of endangering the solvency of the insurer; destroying competition; creating a monopoly; or violating actuarial principles, practices, or soundness.

(k) Paragraphs (a) through (j) of this Rule shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in 11 NCAC 12 .1002, if the policy complies with all of the following provisions:

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

(2) The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following: G.S.58-58-55; 58-58-60; and 11 NCAC 12 .0436.

(3) The policy meets the disclosure requirements of 11 NCAC 12 .1006 and 11 NCAC 12 .1206;

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

(A) Policy illustrations as required by 11 NCAC 04 .0500;

(B) Disclosure requirements in 11 NCAC 12 .1212;

(C) Disclosure requirements in 11 NCAC 12 .0420 and 12 .0422;

(D) Disclosure requirements in G.S. 58-7-95; and

(E) Disclosure requirements in G.S. 58-60-15;

(5) An actuarial memorandum is filed with the Commissioner that includes:

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

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

(C) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(D) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

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

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

(G) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

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

(l) Paragraphs (f) and (h) of this Rule shall not apply to group insurance policies as defined in G.S. 58-55-20(3) where:

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

(2) The policyholder, and not the certificate-holders, pays a material portion of the premium, which shall not be less than 20 percent of the total premium for the group in the calendar year prior to the year a rate increase is filed.

History Note: *Authority G.S. 58-2-40; 58-51-95(f);*
Eff. August 1, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1029 SCOPE AND APPLICATION

(a) Except as otherwise specifically provided, this Section applies to all long-term care insurance policies and life insurance policies that accelerate benefits for long-term care delivered or issued for delivery in this state on or after the effective date by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations, prepaid health plans; health maintenance organizations and all similar organizations.

(b) This Section applies to 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; or

(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 Social Security's normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

History Note: *Authority G.S. 58-2-40; 58-2-210;*
Eff. August 1, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1030 LONG-TERM CARE PARTNERSHIP STANDARDS

(a) As used in this Rule:

(1) "Consumer Price Index" means the measure of the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services as determined by the Bureau of Labor Statistics of the U. S. Department of Labor.

(2) "Qualified Policy" has the same meaning as in G.S. 58-55-55(6) and includes a certificate issued under a group policy as specified in G.S. 58-55-60.

(b) Inflation protections:

(1) A qualified policy that is sold to an individual who has not attained the age of 61 as of the date of purchase shall provide compound annual inflation benefit increase equal to:

(A) at least three percent; or

(B) the changes in the Consumer Price Index.

(2) A qualified policy that is sold to an individual who has attained the age of 61 but has not attained the age of 76 as of the date of purchase shall provide a level of inflation protection that:

(A) shall be disclosed to the applicant or enrollee at the time of application or enrollment; and

(B) meets the requirements of 58-55-60(5)(b).

(c) The disclosures required by G.S. 58-55-60 and G.S. 58-55-70 shall be provided by the insurer to the insured or applicant and to the additional person designated pursuant to 11 NCAC 12 .1022 at the last known address on record with the insurer within 30 calendar days of the day the insurer receives notification of the requested change from the insured that results in the status of a qualified policy changing to unqualified policy status.

History Note: *Authority G.S. 58-2-40; 58-51-5; 58-51-95; 58-55-30; 58-55-55; 58-55-60; 58-55-65; 58-55-70;*
Eff. February 1, 2011;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

SECTION .1100 - MORTGAGE INSURANCE CONSOLIDATIONS

11 NCAC 12 .1101 APPLICATION

This Section applies to:

(1) All consolidations, whether the old coverage is provided under an individual or a group policy; and

(2) All mortgage insurance offered, issued, or delivered in this State, through the mail or otherwise, in connection with consolidations.

History Note: *Authority G.S. 58-2-40; 58-2-210;*
Eff. February 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1102 DEFINITIONS

In this Section, unless the context clearly indicates otherwise:

(1) "Consolidation" means any transaction in which a financial institution or servicer makes its premium collection services available to its mortgage debtors in connection with a particular insurer's ("new insurer") offer of mortgage insurance, which offer is made to debtors who, immediately prior to the offer, had mortgage insurance with another insurer ("old insurer") and were paying premiums for that insurance with their monthly mortgage payments.

(2) "Financial institution" or "servicer" means any entity or organization that services mortgage loans by collecting and accounting for monthly mortgage payments.

(3) "Loan transfer" means a transaction in which the servicing of a block of mortgage loans is transferred from one servicer to another. This includes, but is not limited to, a transfer of servicing to a new servicing location that occurs within a financial institution following, and as a result of, a merger or acquisition.

(4) "Loan transfer consolidation" means a consolidation involving debtors whose mortgage loans have been transferred from one servicer to another.

(5) "Mortgage" or "mortgage loan" means an indebtedness that is secured by real estate and that is not subject to Article 57 of General Statute Chapter 58.

(6) "Mortgage insurance" means group or individual life, individual accidental death, or individual disability insurance, or any combination thereof, designed to pay all or part of a mortgage loan in the event of the insured's death or disability. Group mortgage life insurance can only be written with contracts issued in North Carolina. Trust arrangements are not allowed for use for group mortgage life insurance.

(7) "New coverage" or "new plan" means the mortgage insurance coverage or mortgage insurance plan for which the financial institution collects premiums beginning on the effective date of a consolidation.

(8) "Old coverage" or "old plan" means the mortgage insurance coverage or mortgage insurance plan the financial institution collected premiums for immediately prior to the consolidation.

History Note: *Authority G.S. 58-2-40; 58-2-210;*
Eff. February 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1103 GENERAL REQUIREMENTS

No insurer shall participate in any consolidation unless it complies with the following requirements:

(1) The offer of new coverage must be made on a timely basis:

(a) In a loan transfer consolidation, the offer of new coverage to the prospective insured must be made as soon as reasonably possible. If the offer of new coverage is not made at least 30 days before the proposed effective date of the new coverage, the insurer shall notify the debtor, in writing, that he has the right to an unconditional refund of all premiums

paid since the transfer date provided he exercises the right, in writing, within 30 days after the date of the notification.

(b) In all other consolidations, the offer of new coverage shall be made to the prospective insured at least 30 days before the proposed effective date of the new coverage.

(2) A group certificate or individual policy shall be delivered to each debtor insured under the new plan. In addition to all other applicable requirements of General Statute Chapter 58, the group certificate or individual policy shall include the following information:

(a) The name or names of the single or joint insureds;

(b) Identification of the insured mortgage;

(c) The amount of insurance under the new plan;

(d) The premium for the new coverage;

(e) The effective date of the new coverage; and

(f) The beneficiary for the new coverage. If the insured had the right to name a beneficiary under the old contract, the insured shall retain this right under the new contract.

(3) No group certificate or individual policy evidencing the new coverage shall include a contestability clause or, in the case of mortgage life insurance, a provision excluding suicide.

(4) All group mortgage life insurance certificates issued in connection with any consolidation shall include a conversion privilege permitting an insured debtor to convert, without evidence of insurability, to an individual policy of decreasing term insurance within 30 days after the date the insured debtor's group coverage is terminated for reasons other than the nonpayment of premiums. The initial amount of coverage under the individual policy shall be an amount equal to the amount of coverage terminated under the group policy and shall decrease over a term that corresponds with the scheduled term of the insured debtor's mortgage loan. The premium for the individual policy shall be the same premium the insured debtor was paying under the group policy.

(5) Except for offers of new coverage made pursuant to 11 NCAC 12 .1104 and .1106, the new coverage shall be effectuated for the prospective insured only after the new insurer receives an application that has been signed by the prospective insured.

(6) Except as provided in 11 NCAC 12 .1104 and .1105, the new insurer must calculate premiums for the new coverage on the basis of its own rates, the prospective insured's then attained age, if applicable, and the amount of insurance offered.

History Note: *Authority G.S. 58-2-40; 58-2-210;*
Eff. February 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1104 SPECIFIC REQUIREMENTS FOR CERTAIN OFFERS

(a) The offer of new coverage may be based on the same premium the prospective insured was paying for his old coverage, and a signed application need not be obtained, if the new insurer complies with all applicable requirements of this Section and General Statute Chapter 58, and the following conditions are met:

(1) The old coverage is accidental death insurance, disability insurance, or group mortgage life insurance.

(2) The amount of insurance provided by the new plan must be the same or greater than provided by the old plan.

(3) All of the benefits provided by the old plan, including but not limited to accidental death riders and waiver-of-premium benefits, must be provided by the new plan.

(b) Individual policies of mortgage life insurance may only be consolidated pursuant to 11 NCAC 12 .0600.

History Note: *Authority G.S. 58-2-40; 58-2-210;*
Eff. February 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1105 DISCLOSURE REQUIREMENTS

In conjunction with any offer of new coverage made in any consolidation, the new insurer shall disclose in writing to each debtor the following:

(1) That the insured may have the right to continue or convert his old coverage by paying premium directly to the old insurer;
(2) That the new coverage is not conditioned upon either the termination or replacement of the old coverage;
(3) The name and address of the old and new insurer;
(4) The effective date of the new coverage;
(5) The beneficiary of the new coverage;
(6) Amount of coverage for both the new and old plans. If the amount of coverage for the old plan is not known, a statement that the amount may be scheduled and it may be less than or greater than the amount of the loan and the insured should check his old policy schedule for an exact amount of coverage;
(7) Material differences, if any, between the new plan and the old plan;
(8) A statement as to whether the old plan was an individual or group plan and a statement as to whether the new plan is an individual or a group policy.
(9) Cautionary language shall be affixed in sticker form in bold type upon the face or insert page of any policy/certificate issued pursuant to 11 NCAC 12 .1104 and .1106 with language substantially as follows:

IMPORTANT NOTICE

This certificate/policy is issued to you in connection with a mortgage insurance consolidation. It is the intention of the insurer to provide you coverage that is equal to or better than the coverage you had before. To the extent the benefits provided or the provisions of your prior certificate/policy are more liberal than those under this certificate/policy, the provisions of your prior certificate will control. This certificate/policy shall be incontestable from its date of issue.

History Note: *Authority G.S. 58-2-40; 58-2-210;*
Eff. February 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1106 DISABILITY INSURANCE PLANS

If the financial institution sponsors a mortgage life insurance plan and a disability insurance plan that are underwritten by the same insurer, and if the new insurer consolidates the mortgage life plan pursuant to 11 NCAC 12 .1104 by offering the same coverage at the old premium, the new insurer must also consolidate the disability insurance plan by offering the same coverage at the old premium.

History Note: *Authority G.S. 58-2-40; 58-2-210;*
Eff. February 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1107 DISCLOSURE OF CONSOLIDATION TO THE DEPARTMENT

(a) Except for loan transfer consolidations, the new insurer shall notify the Department of the intent to execute a mortgage insurance consolidation involving North Carolina financial institutions at least 30 days before the proposed effective date of the new coverage.
(b) If the consolidation is pursuant to a loan transfer, the Department shall be notified as soon as reasonably possible, but no later than 30 days after the date that the insurance company is notified by the financial institution that the loan transfer has occurred. Notifications required under this Rule shall be in writing and sent to:
North Carolina Department of Insurance
Life and Health Division
Post Office Box 26387
Raleigh, NC 27611
(c) Notifications required under this Rule shall contain the following information:
(1) Identification of financial institution(s) involved;
(2) Reason for transfer, i.e., loan transfer or other type of consolidation;

(3) Proposed effective date of the consolidation;
(4) Identification of the insurance companies whose coverages are being consolidated;
(5) A listing of the new insurer's form numbers to be used; and
(6) The approximate number of North Carolina insureds whose mortgages will be consolidated.

History Note: *Authority G.S. 58-2-40; 58-2-210;*
Eff. February 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

SECTION .1200 - ACCELERATED BENEFITS

11 NCAC 12 .1201 PURPOSE AND APPLICATION

The purpose of this Section is to regulate accelerated benefit provisions of individual and group life insurance policies and annuities and to provide required standards of disclosure. This Section applies to all accelerated benefits provisions of individual and group life insurance policies and annuities, except those subject to Article 55 of General Statute Chapter 58, that are issued or delivered in this State on or after the effective date of this Section.

History Note: *Authority G.S. 58-2-40; 58-3-150; 58-7-15(1); 58-58-1;*
Eff. March 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1202 DEFINITIONS

(a) "Accelerated benefits" covered under this Section are benefits are payable under a life insurance or annuity contract:

(1) To a policyowner or certificateholder, during the lifetime of the insured, in anticipation of death or upon the occurrence of specified life-threatening or catastrophic conditions as defined by the policy or rider; and
(2) That reduce the death benefit otherwise payable under the life insurance or annuity contract; and
(3) That are payable upon the occurrence of a single qualifying event that results in the payment of a benefit amount fixed at the time of acceleration.

(b) "Qualifying event" means one or more of the following:

(1) A medical condition that a duly licensed health care provider predicts would result in a drastically limited life span as specified in the contract; or
(2) A medical condition that has required or requires extraordinary medical intervention, including a major organ transplant or continuous artificial life support, without which the insured would die; or
(3) Any condition that usually requires continuous confinement in an eligible institution as defined in the contract if the insured is expected to remain there for the rest of his or her life; or
(4) A medical condition that medical evidence indicates would, in the absence of extensive or extraordinary medical treatment, result in a drastically limited life span. Such condition may include one or more of the following:
    (A) Coronary artery disease resulting in an acute infarction or requiring surgery;
    (B) Permanent neurological deficit resulting from cerebral vascular accident;
    (C) End stage renal failure; or
    (D) Acquired Immune Deficiency Syndrome.

History Note: *Authority G.S. 58-2-40; 58-3-150; 58-7-15(1); 58-58-1;*
Eff. March 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1203 TYPE OF PRODUCT

Accelerated benefit riders and life insurance policies and annuities with accelerated benefit provisions are primarily deemed to be mortality risks rather than morbidity risks.

History Note: *Authority G.S. 58-2-40; 58-3-150; 58-7-15(1); 58-58-1;*
Eff. March 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1204 ASSIGNEE/BENEFICIARY

Before the payment of any accelerated benefit, the insurer shall obtain from any assignee or irrevocable beneficiary a signed acknowledgement of concurrence for payment. If the insurer paying the accelerated benefit is the assignee under the policy, no such acknowledgement is required.

History Note: *Authority G.S. 58-2-40; 58-3-150; 58-7-15(1); 58-58-1;*
Eff. March 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1205 CRITERIA FOR PAYMENT

(a) Lump Sum Settlement Option Required. Contract payment options shall include the option to take the benefit as a lump sum. The benefit shall not be made available as an annuity that is contingent upon the life of the insured.
(b) Restrictions on Use of Proceeds. No restrictions by the insurer are permitted on the use of the proceeds by the insured.
(c) Accidental Death Benefit Provisions. If any death benefit remains after payment of an accelerated benefit, any accidental death benefit provision in the policy or rider shall not be affected by the payment of the accelerated benefit.

History Note: *Authority G.S. 58-2-40; 58-3-150; 58-7-15(1); 58-58-1;*
Eff. March 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1206 DISCLOSURES

(a) Descriptive Title. The term "accelerated benefit" shall be included in the descriptive title printed on the first page of the policy or rider. Products regulated under this Section shall not be described or marketed as long-term care insurance or as providing long-term care benefits.
(b) Tax Consequences. A disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted, which statement shall advise that receipt of accelerated benefits may be taxable and that assistance should be sought from a personal tax advisor. The statement shall be prominently displayed on the first page of the policy or rider and on any other related documents.
(c) Solicitation:

(1) A written disclosure including, but not limited to, a brief description of the accelerated benefit and definitions of the conditions or occurrences triggering payment of the benefits shall be given to the applicant. The description shall include an explanation of any effect of the payment of a benefit on the policy's cash value, accumulation account, death benefit, premium, policy loans and policy liens:
    (A) In the case of agent solicited insurance, the agent shall provide the disclosure form to the applicant prior to or concurrently with the application. Acknowledgement of the disclosure shall be signed by the applicant and writing agent.
    (B) In the case of a solicitation by direct response methods, the insurer shall incorporate the disclosure in the application or attach a disclosure form thereto.
    (C) In the case of group insurance policies, the disclosure form shall be contained as part of the certificate of coverage or any related document furnished by the insurer for the certificate holder.
(2) If there is a premium or cost of insurance charge, the insurer shall give the applicant a generic illustration numerically demonstrating any effect of the payment of a benefit on the policy's cash value, accumulation account, death benefit, premium, policy loans and policy liens:

(A) In the case of agent solicited insurance, the agent shall provide the illustration to the applicant prior to or concurrently with the application.

(B) In the case of a solicitation by direct response methods, the insurer shall provide the illustration to the applicant at the time the policy is delivered.

(C) In the case of group insurance policies, the disclosure form shall be contained as part of the certificate of coverage or any related document furnished by the insurer for the certificate holder.

(3) Disclosure of Premium Charge:

(A) Insurers with financing options other than those described in 11 NCAC 12 .1210(a)(2) shall disclose to the policy owner any premium or cost of insurance charge for the accelerated benefit. Each insurer shall make a reasonable effort to assure that the certificate holder is aware of any additional premium or cost of insurance charge if the certificate holder is required to pay such charge.

(B) Each insurer shall furnish an actuarial demonstration to the Department when filing a policy form containing an accelerated benefit, which demonstration shall disclose the method of arriving at the insurer's cost for the accelerated benefit.

(4) Disclosure of Administrative Expense Charge. Each insurer shall disclose to each policy owner any administrative expense charge. Each insurer shall make a reasonable effort to assure that each certificate holder is aware of any administrative expense charge if the certificate holder is required to pay such charge.

(d) Effect of the Benefit Payment. When a policy owner or certificate holder requests an acceleration, the insurer shall send a statement to the policy owner or certificate holder and irrevocable beneficiary showing any effect that the payment of the accelerated benefit will have on the policy's cash value, accumulation account, death benefit, premium, policy loans and policy liens. The statement shall disclose that:

(1) receipt of accelerated benefit payments may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlement; and that

(2) receipt of an accelerated benefit payment may be taxable and assistance should be sought from a personal tax advisor.

Each time an accelerated benefit option is exercised the policy owner and certificate holder shall be given an endorsement, rider or schedule page that reflects any revisions to cash values, death benefits, accumulation accounts, premiums, policy loans, policy liens and any other values that change as a result of the payment or payments. When a previous disclosure statement becomes invalid as a result of an acceleration of the death benefit, the insurer shall send a revised disclosure statement to the policy owner or certificate holder and irrevocable beneficiary. When the insurer agrees to accelerate death benefits, the insurer shall issue an amended schedule page to the policyholder or notify the certificate holder under a group policy to reflect any new, reduced in-force face amount of the contract.

History Note: *Authority G.S. 58-2-40; 58-3-150; 58-7-15(1); 58-58-1;*
Eff. March 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1207 EFFECTIVE DATE OF THE ACCELERATED BENEFITS

An accelerated benefit provision shall be effective for qualifying events that occur on or after the effective date of the policy or rider. The accelerated benefit provision shall be effective for illness no more than 30 days after the effective date of the policy or rider.

History Note: *Authority G.S. 58-2-40; 58-3-150; 58-7-15(1); 58-58-1;*
Eff. March 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1208 WAIVER OF PREMIUMS

The insurer may offer a waiver of premium for the accelerated benefit provision in the absence of a regular waiver of premium provision being in effect. At the time the benefit is claimed, the insurer shall explain any continuing premium requirement to keep the policy in force.

History Note: *Authority G.S. 58-2-40; 58-3-150; 58-7-15(1); 58-58-1;*
Eff. March 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1209 DISCRIMINATION

In addition to the requirements of G.S. 58-58-35 and G.S. 58-63-15(7)a, insurers shall not apply any additional conditions on the payment of the accelerated benefits other than those conditions specified in the policy or rider.

History Note: *Authority G.S. 58-2-40; 58-3-120; 58-3-150; 58-7-15(1); 58-58-1; 58-58-35; 58-63-15(7);*
Eff. March 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1210 ACTUARIAL STANDARDS

(a) Financing Options:

(1) The insurer may require a premium charge or cost of insurance charge for the accelerated benefit. These charges shall be based on sound actuarial principles. In the case of group insurance, the additional cost may also be reflected in experience rating.

(2) The insurer may pay a present value of the face amount. The calculation shall be based on any applicable actuarial discount appropriate to the policy design. The interest rate or interest rate methodology used in the calculation shall be based on sound actuarial principles and disclosed in the contract or actuarial memorandum. The maximum interest rate used shall be no more than the greater of:

(A) The current yield on 90 day treasury bills; or

(B) The current maximum statutory adjustable policy loan interest rate.

(3) The insurer may accrue an interest charge on the amount of the accelerated benefits. The interest rate or interest rate methodology used in the calculation shall be based on sound actuarial principles and disclosed in the contract or actuarial memorandum. The maximum interest rate used shall be no more than the greater of:

(A) The current yield on 90 day treasury bills; or

(B) The current maximum statutory adjustable policy loan interest rate.

The interest rate on the portion of the lien that is equal in amount to the cash value of the contract at the time of the benefit acceleration shall be no more than the policy loan interest rate stated in the contract.

(b) Effect on Cash Value:

(1) Except as provided in Subparagraph (b)(2) of this Rule, when an accelerated benefit is payable, there shall be no more than a pro rata reduction in the cash value based on the percentage of death benefits accelerated to produce the accelerated benefit payment.

(2) Alternatively, the payment of accelerated benefits, any administrative expense charges, any future premiums and any accrued interest can be considered a lien against the death benefit of the policy or rider and the access to the cash value may be restricted to any excess of the cash value over the sum of any other outstanding loans and the liens. Future access to additional policy loans may also be limited to any excess of the cash value over the sum of the lien and any other outstanding policy loans.

(c) Effect of Any Outstanding Policy Loans on Accelerated Death Benefit Payment. When payment of an accelerated benefit results in a pro rata reduction in the cash value, the payment may not be applied toward repaying an amount greater than a pro rata portion of any outstanding policy loans.

History Note: *Authority G.S. 58-2-40; 58-3-150; 58-7-15(1); 58-58-1;*
Eff. March 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1211 ACTUARIAL DISCLOSURE AND RESERVES

(a) Actuarial Memorandum. A qualified actuary shall describe the accelerated benefits, the risks, the expected costs and the calculation of statutory reserves in an actuarial memorandum accompanying each filing with the

Commissioner. The insurer shall maintain in its files descriptions of the bases and procedures used to calculate benefits payable under these provisions. These descriptions shall be made available for examination by the Commissioner or a designee upon request.

(b) Reserves:

(1) When benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves shall be determined in accordance with G.S. 58-58-50. All valuation assumptions used in constructing the reserves shall be determined as appropriate for statutory valuation purposes by a member in good standing of the American Academy of Actuaries. Mortality tables and interest rates currently recognized for life insurance reserves by the NAIC may be used as well as appropriate assumptions for the other provisions incorporated in the policy form. The actuary must follow both actuarial standards and certification for good and sufficient reserves. Reserves in the aggregate should be sufficient to cover:

(A) Policies upon which no claim has yet arisen.

(B) Policies upon which an accelerated claim has arisen.

(2) For policies and certificates that provide actuarially equivalent benefits, no additional reserves need to be established.

(3) Policy liens and policy loans, including accrued interest, represent assets of the insurer for statutory reporting purposes. For any policy on which the policy lien exceeds the policy's statutory reserve liability such excess must be held as a non-admitted asset.

History Note: *Authority G.S. 58-2-40; 58-3-150; 58-7-15(1); 58-58-1;*
Eff. March 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1212 LONG-TERM CARE BENEFITS ACCELERATION

(a) An insurer that issues life insurance policies that accelerate benefits for long-term care shall comply with 11 NCAC 12 .1010 if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with 11 NCAC 12 .0611. If a life insurance policy that accelerates benefits for long-term care is replaced by another life insurance policy that accelerates benefits for long-term care, the replacing insurer shall comply with 11 NCAC 12 .1010 AND 11 NCAC 12 .0611

(b) 11 NCAC 12 .1013 does not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

(1) The interest credited internally to determine cash value accumulations, including long-term care, in any, are guaranteed interest rate for cash value accumulations without long-term care set forth in the policy.

(2) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of G.S. 58-58-30.

(3) The policy meets the disclosure requirements of G.S. 58-55-30.

(4) Any policy illustration that meets the applicable requirements of 11 NCAC 04. 0501

(5) An actuarial memorandum is filed with the Division that includes:

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

(B) A description of the basis for the reserves.

(C) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance.

(D) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any.

(E) A description and a table of the anticipated policy reserves and additional reserves held in each future year for active lives.

(F) The estimated average annual premium per policy and the average issue age.

(G) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or assessment underwriting. For a group policy, the

statement shall indicate whether the enrollee or any dependent will be underwritten and when that underwriting occurs.

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

History Note: *Authority G.S. 58-2-40(1); 58-55-30(a); 58-58-1; 58-58-40;*
Eff. April 1, 1999;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

SECTION .1300 - SMALL EMPLOYER GROUP HEALTH COVERAGE

11 NCAC 12 .1301 DEFINITIONS

(a) As used in this Section, unless the context clearly indicates otherwise:

(1) "Act" means the North Carolina Small Employer Group Health Coverage Reform Act described in G.S. 58-50-100.

(2) "Carrier" means a small employer carrier.

(3) "Extra eligible" means an individual who is not an eligible employee or a dependent of an eligible employee who is insured under the health benefit plan of a small employer.

(4) "New entrant" means an eligible employee, or the dependent of an eligible employee, who becomes part of an employer group after the initial period for enrollment in a health benefit plan.

(5) "Nonstatutory plan" means any health benefit plan subject to the Act other than the statutory plans.

(6) "Policy anniversary" or "plan anniversary" means the annual anniversary of the issuance of a health benefit plan. If a plan is issued through a multiple employer trust, "policy anniversary" or "plan anniversary" means the annual anniversary of the issuance of the health benefit plan to the small employer.

(7) "Previously declined group" means a group whose application for coverage was declined for any reason by a carrier after January 1, 1992, and before August 14, 1992.

(8) "Previously declined individual" means an individual whose application for coverage for a health benefit plan was declined by a carrier before August 14, 1992.

(9) "Producer" means an insurance agent or insurance broker licensed under Article 33 of G.S. Chapter 58.

(10) "Statutory plan" means the basic or standard health care plan.

(b) The definitions contained in G.S. 58-50-110 are incorporated into this Section by reference.

History Note: *Authority G.S. 58-2-40(1);*
Temporary Adoption Eff. December 21, 1992 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Eff. April 1, 1993;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1302 SCOPE

(a) Any health benefit plan is subject to the Act if it is a health benefit plan under G.S. 58-50-115(a)(1) or (2) and is not excluded from the Act by G.S. 58-50-110(11).

(b) This Section does not apply to individual health insurance policies that are not subject to G.S. 58-50-115.

(c) The Act and this Section apply to a health benefit plan provided to a small employer or to the employees of a small employer without regard to whether the health benefit plan is offered under or provided through a group policy or trust arrangement.

History Note: *Authority G.S. 58-2-40(1); 58-50-110(5); 58-50-113(a)(3); 58-50-115;*
Temporary Adoption Eff. December 21, 1992 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Eff. April 1, 1993;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1303 POLICY FORMS AND APPROVALS

All carriers must file all health benefit plan policy forms with the Department for approval before they may be used. The following procedures apply to filing those policy forms:

(1) The filing cover letter shall include a certification by the carrier that specifies that the health benefit plan will be marketed to small employers. Each health benefit plan that will be marketed with payroll deduction shall include this certification.

(2) Carriers are not required to file new health benefit plan policy forms. Existing policy forms may be brought into compliance with the Act by means of amendments or variable language.

History Note: *Authority G.S. 58-2-40(1); 58-50-125(b); 58-51-1;*
Temporary Adoption Eff. December 21, 1992 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Eff. April 1, 1993;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1304 COMPLIANCE

(a) Each carrier and third party administrator shall file a report on North Carolina small employer group insurance activity annually on or before March 15, which report shall describe case characteristics and numbers of health benefit plans in various categories marketed or issued to small employers. The report shall be in a format prescribed by the Commissioner.

(b) Each carrier shall provide the same health benefit plan to eligible employees and dependents; provided, however, under G.S. 58-67-35(a)(5) and (a)(6)b. and c., an HMO may offer its approved small employer health benefit plan in conjunction with an approved indemnity benefit plan to eligible employees and dependents, and the two plans must be of similar value in that the deductibles, copayments, and covered benefits must be comparable.

(c) A carrier shall not set contribution and participation requirements for the statutory plans that are more restrictive than those for the carrier's nonstatutory plans.

(d) If any eligible employee or dependent has qualifying existing coverage, as defined in G.S. 58-50-130(a)(5), and therefore does not participate in the employer's health benefit plan, a carrier is not required to issue or renew the employer's plan unless either:

(1) at least two eligible employees in a group of seven or less elect to participate; or

(2) at least 25 percent of eligible employees in a group of more than seven elect to participate.

(e) Each carrier shall offer both statutory plans to any small employer upon request or if the carrier is unable to issue a nonstatutory plan to the small employer applicant.

(f) A carrier shall provide an extension of benefits to any insured who is a hospital inpatient until the insured is released by the hospital if the insured's existing coverage would end during the insured's hospital stay and if replacement coverage is not available to the insured, subject to the continued payment of monthly premiums or dues by the insured.

(g) New business applications submitted to a carrier on and after September 1, 1992, shall be accompanied by a statement signed by the producer and the small employer applicant that certifies that the employer understands that the firm may elect coverage under the statutory plans. The disclosure form shall be made part of such statement. A copy of the signed statement and disclosure form must be provided to the small employer applicant. The disclosure form shall be in a form prescribed by the Commissioner.

(h) If a carrier establishes more than one class of business under G.S. 58-50-113, the carrier shall maintain at least one basic and standard health care plan in each class of business so established. Nothing in this Section prevents a carrier from offering the statutory plans through an association or multiple employer trust.

History Note: *Authority G.S. 58-2-40(1); 58-50-105; 58-50-113; 58-50-120(c)(4); 58-50-120(c)(6); 58-50-125(d); 58-50-130(a)(2); 58-50-130(a)(5); 58-50-130(d); 58-50-130(f);*
Temporary Adoption Eff. December 21, 1992 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Eff. April 1, 1993;

Temporary Amendment Eff. October 11, 1993 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Amended Eff. October 1, 1994; February 1, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1305 PROHIBITED ACTS

(a) A carrier shall not unilaterally change a small employer group from one health benefit plan to another. A carrier shall not require an in-force health benefit plan risk to replace existing coverage with the basic or standard health care plans.

(b) No carrier, its agents or field representatives, a broker, nor a small employer shall discourage any employee or dependent from applying for coverage so that the small employer can be issued a more favorable premium rate or benefit package.

(c) No carrier shall set classes of employees in such a way as to exclude any employees who are eligible for insurance by definition. This Paragraph does not prevent a carrier from classifying ineligible employees or "extra-eligibles".

History Note: *Authority G.S. 58-2-40(1); 58-50-125(d); 58-50-130(a)(3);*
Temporary Adoption Eff. December 21, 1992 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Eff. April 1, 1993;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1306 REINSURANCE POOL

History Note: *Authority G.S. 58-2-40(1); 58-50-130(b)(4); 58-50-150(a); 58-50-150(f)(5); 58-50-150(g);*
Filed as a Temporary Adoption Eff. December 21, 1992 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Eff. April 1, 1993;
Filed as a Temporary Amendment Eff. October 11, 1993 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Amended Eff. February 1, 1994;
Repealed Eff. July 1, 2012.

11 NCAC 12 .1307 GUARANTEED ISSUE AND RENEWAL

(a) No carrier shall decline an application for coverage under the statutory plans. A carrier may continue to issue health benefit plans other than the statutory plans.

(b) If an eligible employee commits fraud or makes material misrepresentation to a carrier, the carrier may rescind coverage for that employee. If the small employer commits fraud or makes a material misrepresentation to a carrier, the carrier may rescind coverage for that entire small employer group.

(c) The late enrollee provision in G.S. 58-50-130(a)(4) applies to all health benefit plans subject to the Act.

(d) Any health benefit plan covering an employer that by definition becomes a small employer is not subject to the Act until the next anniversary date of that plan.

(e) Any health benefit plan covering a small employer that by definition loses its status as a small employer is subject to the Act until the next anniversary date of that plan. At that time, the carrier shall determine if the employer is by definition a small employer. If the employer is not a small employer, the carrier may terminate the plan. If the carrier does not terminate the plan, the carrier shall amend the plan with riders or
endorsements to comply with requirements of statutes and rules that were not reflected in the plan before the anniversary date.

(f) Before a plan anniversary date, a small employer may request that coverage be changed from one statutory plan to another statutory plan.

(g) Previously declined individuals are not late enrollees unless they fail to enroll during their initial enrollment periods.

(h) On the next health benefit plan anniversary date that falls on or after August 14, 1992, a carrier shall remove all exclusionary riders or conditional modifications on any health benefit plan that is subject to the Act.

(i) A carrier may base termination on nonpayment of premium; and shall apply termination decisions uniformly to all of the carrier's small employer group business.
(j) A carrier is not required to issue a statutory plan to a small employer if within the prior 12 months the carrier terminated a health benefit plan of the small employer because the employer:

(1) failed to pay the premium;
(2) committed fraud or materially misrepresented information necessary to determine the group size, group participation rate, or the group premium rate; or
(3) failed to materially comply with a health benefit plan provision, including carrier requirements for employee group premium contributions.

(k) All health benefit plans subject to the Act that were delivered, issued for delivery, renewed, or continued in this State or covering persons residing in this State on or after January 1, 1992, must be guaranteed renewable, except for the reasons listed in G.S. 58-50-130(a)(3).
(l) Each carrier shall provide an open enrollment period for a new entrant to be added to the health benefit plan. The open enrollment period shall be at least 30 days in length. A new entrant who is a new eligible employee shall be added to the plan within 90 days of his or her employment. A new entrant who is a dependent shall have an open enrollment period of at least 30 days, beginning on the date he or she becomes a dependent of an eligible employee, if the eligible employee has coverage. If a new entrant does not apply for coverage by the end of the open enrollment period, he or she is a late enrollee unless he or she meets the requirements of G.S. 58-50-110(14)a, b, or c.

History Note: *Authority G.S. 58-2-40(1); 58-50-105; 58-50-125(d); 58-50-125(e)(1); 58-50-130(a); 58-50-130(h);*
Temporary Adoption Eff. December 21, 1992 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Eff. April 1, 1993;
Temporary Amendment Eff. October 11, 1993 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Amended Eff. February 1, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1308 ELECTIONS BY CARRIERS

(a) If an election to be a risk assuming carrier is disapproved by the Commissioner, the carrier shall be considered a reinsuring carrier as of the date of the disapproval, unless the carrier is already so considered.
(b) An insurer that has previously notified the Commissioner that it is not a small employer carrier may enter the small employer group health insurance market upon notification to the Commissioner and the Commissioner's approval of the carrier's statutory health benefit plans; and that carrier shall be a reinsuring carrier.

History Note: *Authority G.S. 58-2-40(1); 58-50-135(a); 58-50-135(c); 58-50-150(a);*
Temporary Adoption Eff. December 21, 1992 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Eff. April 1, 1993;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1309 FAIR MARKETING STANDARDS

(a) A carrier may select those agents with whom it chooses to contract. If a carrier chooses to contract with an agent, the carrier may not terminate or refuse to renew the agency contract for any reason related to the health status, claims experience, occupation, or geographic location of the small employer groups placed by the agent with the carrier. If the agent is directing statutory plan business to the carrier, the carrier may terminate the agency contract.
(b) No carrier shall, directly or indirectly, enter into any contract, agreement, or arrangement with an agent that provides for or results in any consideration provided to an agent for the issuance or renewal of a health benefit plan to vary on account of the health status, claims experience, industry, occupation, or geographic location of a small employer group covered by the plan.
(c) Each carrier shall provide all small employers in the same class of business an equal opportunity to obtain coverage under the statutory plans.

(d) No carrier shall apply more stringent application or informational requirements for enrollment for the statutory plans than are applied for other health benefit plans offered by the carrier.
(e) No carrier shall limit or discourage any producer marketing the statutory plans.
(f) A carrier shall provide a price quote to a small employer, directly or through an authorized producer, within seven business days after receiving a request for a quote and such information necessary to provide that quote. If additional information is necessary for the quote, a carrier shall notify a small employer, directly or through an authorized producer, within five business days after receiving the additional information.

History Note: *Authority G.S. 58-2-40(1); 58-50-120(c)(7); 58-50-125(f);*
Temporary Adoption Eff. December 21, 1992 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Eff. April 1, 1993;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

SECTION .1400 - HMO: POINT-OF-SERVICE

11 NCAC 12 .1401 APPLICABILITY AND SCOPE

This Section applies to any HMO that, under G.S. 58-67-35(a)(6)d, offers coverage to its enrollees for health care services that are received, other than in an emergency, from:

(1) Providers who are not employed by, under contract with, or otherwise affiliated with the HMO; or
(2) Providers who are employed by, under contract with, or otherwise affiliated with the HMO in instances when such services are not received in compliance with the HMO's health care plan requirements.

History Note: *Authority G.S. 58-2-40; 58-67-35; 58-67-150;*
Eff. January 1, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1402 DEFINITIONS

In this Section, unless the context clearly indicates otherwise:

(1) "Coinsurance" means the percentage of an allowed charge or expense for a covered health care service that an enrollee must pay.
(2) "Copayment" means a fixed dollar amount that an enrollee must pay each time a covered health care service is provided.
(3) "Deductible" means a specified amount of covered health care services, expressed in dollars, that must be incurred by an enrollee before the HMO will assume any financial liability for all or part of covered health care services.
(4) "In-plan covered services" means covered health care services that are received according to the rules of the health care plan from providers employed by, under contract with, or approved in advance by the HMO; and means emergency health care services.
(5) "Out-of-plan covered services" means non-emergency, medically necessary covered health care services that are not received according to the rules of the health care plan, including services from affiliated providers that are received without the approval of the HMO.
(6) "Out-of-pocket expense" means a specified dollar amount of coinsurance incurred and payable by an enrollee for covered health care services in a specified period; but does not include deductible amounts, copayment amounts, charges in excess of the amount allowed by the HMO, amounts exceeding the maximum benefits, nor any disallowed or noncovered expenses under the rules of the health care plan.
(7) "Point-of-service product" means a feature in a health care plan that provides benefits for both in-plan covered services and out-of-plan covered services.
(8) The definitions contained in G.S. 58-67-5 are incorporated into this Section by reference.

History Note: *Authority G.S. 58-2-40; 58-67-35; 58-67-150;*
Eff. January 1, 1994;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1403 GENERAL REQUIREMENTS

No HMO shall provide any point-of-service product unless it complies with the following requirements and with G.S. 58-67-10(d)(1):

(1) Where the covered benefits of a point-of-service product include coinsurance, the difference in coinsurance rates between in-plan covered services and out-of-plan covered services shall not exceed 30 percentage points.

(2) If the schedule of benefits for a point-of-service product imposes a deductible for in-plan covered services, the amount of any annual deductible per enrollee or per family for out-of-plan covered services may not exceed five times the amount of the corresponding annual deductible applied to in-plan covered services.

(3) If the schedule of benefits for a point-of-service product does not include an annual deductible for in-plan covered services, the annual deductibles for out-of-plan covered services shall not exceed two thousand dollars ($2000) per enrollee and the family deductible may not exceed three times the amount of the corresponding annual deductible for the enrollee.

(4) The portion of any charge for out-of-plan covered services to be applied to an annual deductible may be based on the amount the HMO would have recognized as an allowable charge had the service been rendered as an in-plan covered service.

(5) If there is a lifetime maximum benefit for in-plan covered services, the amount of any annual and lifetime maximum limits for out-of-plan covered services shall not be less than one-half of the amount of any annual and lifetime maximum limits for in-plan covered services.

(6) If a point-of-service product includes copayments for both in-plan covered services and out-of-plan covered services, the amount of the copayment for an out-of-plan covered service shall not exceed the copayment for an in-plan covered service by more than fifty dollars ($50.00) or 100%, whichever is greater.

(7) A point-of-service product shall make all mandated benefits available in the form of in-plan covered services.

(8) Point-of-service products shall provide incentives, including financial incentives, for enrollees to use in-plan covered services.

(9) Any offered out-of-plan covered service must be available on an in-plan covered service basis.

(10) A HMO offering a point-of-service product may exclude coverage for preventive health care services provided on an out-of-plan basis.

(11) Point-of-service products shall give enrollees the option to choose in-plan covered services or out-of-plan covered services each time such covered services are authorized, obtained, or rendered.

History Note: *Authority G.S. 58-2-40; 58-67-35; 58-67-150;*
Eff. January 1, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1404 DISCLOSURE REQUIREMENTS

(a) Every explanation of benefits shall contain an explanation of coverage for out-of-plan covered services that allows each enrollee to determine his or her obligations with respect to such services.

(b) Marketing materials, evidences of coverage, enrollee handbooks, and other materials given to enrollees by an HMO that offers a point-of-service product shall contain an explanation of the point-of-service product. The explanation shall include:

(1) the method of reimbursement;

(2) applicable copayment and deductible amounts;

(3) any other uncovered costs or charges;

(4) the covered health care services that an enrollee may receive on an out-of-plan basis; and

(5) instructions for submittal of claims for out-of-plan covered services.

History Note: *Authority G.S. 58-2-40; 58-67-35; 58-67-150;*

Eff. January 1, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

SECTION .1500 - UNIFORM CLAIM FORMS

11 NCAC 12 .1501 DEFINITIONS

In this Section, unless the context indicates otherwise:

(1) "CPT-4 Codes" means the Physician Current Procedural Terminology published by the American Medical Association.

(2) "Current ADA Dental Claim Form" means the most recent health insurance claim form published by the American Dental Association.

(3) "Ethnic origin code" is the established Ethnic (Race) Code as used by the Economics and Statistics Administration, Bureau of Labor Statistics, U.S. Department of Commerce.

(4) "CMS" means Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

(5) "CMS Form 1450 (UB-04)" means the health insurance claim form published by the CMS for use by institutional health care providers.

(6) "CMS Form 1500" means the health insurance claim form published by the CMS for use by individual health care providers.

(7) "HCPCS" means Healthcare Common Procedure Coding System, a coding system that describes products, supplies, procedures, and health care provider services; and includes the CPT-4 Codes, alphanumeric codes, and related modifiers. HCPCS includes:

  (a) "HCPCS Level I Codes", which are the CPT-4 codes and modifiers for professional services and procedures;

  (b) "HCPCS Level II Codes", which are national alphanumeric codes and modifiers for health care products and suppliers, as well as some codes for professional services not included in the CPT-4 Codes;

  (c) "HCPCS Level III Codes", which are local alphanumeric codes and modifiers for items and services not included in HCPCS Level I or HCPCS Level II.

(8) "ICD-9-CM Codes" means the diagnosis and procedure codes in the International Classification of Diseases, Clinical Modifications, published by the U.S. Department of Health and Human Services.

(9) "Individual health care provider" includes any individual, who under Chapter 90 of the General Statutes is licensed, registered, or certified to engage in the practice of or performs duties associated with any of the following: medicine, surgery, dentistry, pharmacy, optometry, midwifery, osteopathy, podiatry, chiropractic, radiology, nursing, physiotherapy, pathology, anesthesiology, anesthesia, laboratory analysis, rendering assistance to a physician, dental hygiene, psychiatry, or psychology.

(10) "Institutional health care provider" includes:

  (a) a hospital defined under G.S. 131E-176(13);

  (b) an ambulatory surgical facility defined under G.S. 131E-176(1b);

  (c) a health service facility defined under G.S. 131E-176(9b);

  (d) a home health agency defined under G.S. 131E-176(12);

  (e) any of the entities listed in G.S. 58-55-35.

(11) "Payor" means an entity that provides a "health benefit plan", as defined in G.S. 58-3-171(c).

(12) "Standard claim form" means the CMS Form 1450 (UB-04), CMS Form 1500, or the current ADA Dental Claim Form.

History Note: *Authority G.S. 58-2-40; 58-3-171;*
Eff. October 1, 1994;
Readopted Eff. May 1, 2020.

11 NCAC 12 .1502 REQUIREMENTS FOR USE OF CMS FORM 1450 (UB-04)

(a) The CMS Form 1450 (UB-04) shall be the standard claim form for all manual billing by institutional health care providers, and the CMS Form 1450 shall be accepted by all payors conducting business in this State.

(b) The cause of injury code shall be located in form locator 72. This code shall be required on all CMS Form 1450 (UB-04) claims generated by institutional health care providers for claims of inpatients and of patients treated in emergency rooms or trauma centers; and where the diagnosis includes an injury diagnosis, which means a diagnostic code in the range or 800-999 as defined in the ICD-10 coding manual.
(c) Payors may require institutional health care providers to use only the following coding systems for the filing of claims for health care services:

(1) Codes to report all diagnoses, reasons for encounters, and procedures based upon code level changes made effective October 1 of each year or other effective date designated by the CMS.
(2) HCPCS Level I and II Codes based upon code level changes made effective October 1 of each year or other effective date designated by the CMS.
(3) CPT-4 Codes based upon code level changes made effective January 1 of each year or other effective date designated by the CMS.

(d) When there is no applicable HCPCS Level I or Level II Code or modifier, the payor may establish its own code or modifier. A complete list of all codes and modifiers established by payors shall be published by and available upon request from payors.

History Note: *Authority G.S. 58-2-40; 58-3-171;*
Eff. October 1, 1994;
Amended Eff. March 1, 1995;
Readopted Eff. May 1, 2020.

11 NCAC 12 .1503 REQUIREMENTS FOR USE OF CMS FORM 1500

(a) The CMS Form 1500 shall be the standard claim form for all manual individual health care provider billing, and the CMS Form 1500 shall be accepted by all payors conducting business in this State.
(b) Payors may require individual health care providers to use only the following coding system for the filing of claims for health care services:

(1) ICD-9-CM Codes to report all diagnoses, reasons for encounters, and procedures based upon code level changes made effective October 1 of each year or other effective date designated by the CMS.
(2) HCPCS Level I and Level II Codes based upon code level changes made effective October 1 of each year or other effective date designated by the CMS.
(3) CPT-4 Codes based upon code level changes made effective January 1 of each year or other effective date designated by the CMS.

(c) When there is no applicable HCPCS Level I or Level II Code or modifier, the payor shall establish its own code or modifier. A complete list of all codes and modifiers established by payors shall be published by and available upon request from payors.
(d) Type of service codes may not be used.
(e) Place of service codes and descriptions shall be recognized by all payors processing claims for services rendered in North Carolina.
(f) CMS physician and specialty codes shall be recognized by payors processing claims for services rendered in North Carolina.

History Note: *Authority G.S. 58-2-40; 58-3-171;*
Eff. October 1, 1994;
Amended Eff. February 1, 1995;
Readopted Eff. May 1, 2020.

11 NCAC 12 .1504 REQUIREMENTS FOR USE OF THE CURRENT ADA DENTAL CLAIM FORM

Dentists shall use the current ADA Dental Claim Form and instructions for all manual claims filing with payors. The ADA Dental Claim Form is hereby incorporated by reference, including subsequent amendments and additions, and is available at no cost at https://www.ada.org/en/publications/cdt/ada-dental-claim-form.

History Note: *Authority G.S. 58-2-40; 58-3-171;*
Eff. October 1, 1994;
Amended Eff. February 1, 1995;
Readopted Eff. May 1, 2020.

11 NCAC 12 .1505 MANAGED CARE FORMS

(a) As used in this Rule, "managed care plan" includes a health maintenance organization or a preferred provider organization.

(b) The following managed care forms may be used by managed care plans, but shall not be a part of the standard claim form:

(1) An "out-of-network" justification form shall be used by patients filing claims with their managed care plans when they have to justify the reasons they sought out-of-network health care services. This form shall be standardized, and the managed care plan industry shall develop and file this form with the Commissioner.

(2) A "patient encounter form and electronic format" shall be used by managed care plans to record and report encounter information. This form shall provide information similar to the CMS Form 1450 (UB-04) and CMS Form 1500 and shall include information on patient identification, dates of services provided, types of services provided, and identities of health care providers. This form and electronic formats shall be standardized, and the managed care plan industry shall develop and file these with the Commissioner.

History Note: *Authority G.S. 58-2-40; 58-3-171;*
Eff. October 1, 1994;
Readopted Eff. May 1, 2020.

11 NCAC 12 .1506 ELECTRONIC FORMAT STANDARDS

(a) As used in this Rule, "ASC X12 Standard Format" means the standards for electronic data interchange within the health care provider industry developed by the Accredited Standards Committee X12 Insurance Subcommittee of the American National Standards Institute.

(b) Payors and health care providers that receive or generate claims or send payments by electronic means shall accept or generate the appropriate ASC X12 Standard Format for their health care claims submission and remittance transactions.

History Note: *Authority G.S. 58-2-40; 58-3-171;*
Eff. October 1, 1994;
Readopted Eff. May 1, 2020.

11 NCAC 12 .1507 ATTACHMENT FORM OR FORMAT

(a) As used in this Rule, "attachment form or format" means a form, document, or communication of any kind used by a payor to request additional information, other than that contained on the standard claim form, from a health care provider in connection with processing a claim for payment.

(b) Payors shall not require the submission of information already contained in the standard claim form.

History Note: *Authority G.S. 58-2-40; 58-3-171;*
Eff. October 1, 1994;
Readopted Eff. May 1, 2020.

11 NCAC 12 .1508 MEDICARE SUPPLEMENT PAYORS

Medicare supplement insurance payors shall electronically interface claims data with the Medicare Section of CMS.

History Note: *Authority G.S. 58-2-40; 58-3-171;*
Eff. October 1, 1994;
Readopted Eff. May 1, 2020.

11 NCAC 12 .1509 PATIENT SUBMITTED CLAIM FORMS

The health care provider shall provide a patient the CMS-1500 and UB-04 (CMS-1450) standard claim forms, if the patient must submit a claim to a payor. The standard claim form shall be provided as the initial bill for payment of services and shall be used by the patient to request reimbursement from a payor. Health care providers shall also continue to provide patients billing statements for subsequent billing of the same services. A payor shall not require any additional documentation from a patient to support a claim for reimbursement payment by a patient if the

information required is already contained on the standard claim form. No payor shall require any patient to submit claims or other information in an electronic format.

History Note: *Authority G.S. 58-2-40; 58-3-171;*
Eff. October 1, 1994;
Readopted Eff. May 1, 2020.

SECTION .1600 - RETAINED ASSET ACCOUNTS

11 NCAC 12 .1601 DEFINITIONS

As used in this Section:

(1) "Policy" means any policy or certificate of insurance that provides a death benefit.

(2) "Retained asset account" or "account" means any mechanism whereby the settlement of proceeds payable under an insurance policy is accomplished through the use of a temporary repository of proceeds into a checking or draft account.

History Note: *Authority G.S. 58-2-40; 58-3-150; 58-7-15; 58-58-1; 58-58-110;*
Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1602 GENERAL REQUIREMENTS

No insurer shall offer retained asset accounts as a mode of settlement of proceeds unless the insurer complies with the following:

(1) The retained asset account shall be specifically identified as a settlement option within the terms of the claim form in conjunction with any other mode of settlement.

(2) The policy owner shall be provided the contractual right of selection from all available optional modes of settlement before death or death of the insured if the insured is not the policy owner.

(3) The insurer shall provide the beneficiary with information that clearly discloses the rights and obligations of both the beneficiary and the insurer with respect to the mode of settlement.

History Note: *Authority G.S. 58-2-40; 58-3-150; 58-7-15; 58-58-1; 58-58-110;*
Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1603 DISCLOSURE REQUIREMENTS

In conjunction with the use of a retained asset account as a mode of settlement, the insurer shall disclose the following, in writing, to any beneficiary or, in the case of a group contract, to the policy owner:

(1) Any other settlement options available under the policy.

(2) Any interest being paid under other options.

(3) Whether the retained asset account is the equivalent of a checking or draft account.

(4) An explanation of the account's features, including:

  (a) What banking services are provided to the account holder.

  (b) Which services are provided at no charge and which services involve a fee and the amount of the fee.

  (c) The nature and frequency of account statements.

  (d) A telephone number and address where the beneficiary can obtain additional information regarding the account.

  (e) Any minimum or maximum benefit payment requirements under the account.

  (f) The number of withdrawals permitted within any time period.

(5) That payment of the total proceeds is accomplished by delivery of a "checkbook kit" or "draft kit" to the beneficiary.

(6) That one check or draft can be written to access the entire proceeds and that other settlement options are preserved until the entire balance is withdrawn or the balance drops below the insurer's minimum payment requirements.

(7) Any time delays the beneficiary should expect to encounter in completing any authorized transaction under a retained asset account and the anticipated amount of such time delay.

(8) That interest earned on the account may be taxable and the beneficiary should consult a tax advisor.

(9) The methodology used to determine the interest rate being paid under the retained asset account.

History Note: *Authority G.S. 58-2-40; 58-3-150; 58-58-1; 58-58-110;*
Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1604 ACCOUNTING

Funds necessary to cover liabilities under retained asset accounts shall be reported on the annual statement.

History Note: *Authority G.S. 58-2-40; 58-2-165; 58-58-1; 58-58-110;*
Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

SECTION .1700 - VIATICAL SETTLEMENTS

11 NCAC 12 .1701 DEFINITIONS
11 NCAC 12 .1702 VIATICAL SETTLEMENT PROVIDERS
11 NCAC 12 .1703 VIATICAL SETTLEMENT BROKERS AND REPRESENTATIVES
11 NCAC 12 .1704 STANDARDS FOR EVALUATION OF REASONABLE PAYMENTS
11 NCAC 12 .1705 REPORTING
11 NCAC 12 .1706 CONTRACTS AND PAYMENT OF PROCEEDS
11 NCAC 12 .1707 SOLICITATION
11 NCAC 12 .1708 ADVERTISING STANDARDS
11 NCAC 12 .1709 DISCLOSURE

History Note: *Authority G.S. 58-2-40; 58-16-30; 58-58-42; 58-58-42(e); 58-58-42(j); 58-63-15; 58-63-65;*
Eff. February 1, 1996;
Amended Eff. January 1, 1998; May 1, 1997;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Temporary Repeal Eff. April 1, 2002;
Repealed Eff. April 1, 2003.

11 NCAC 12 .1710 DEFINITIONS

(a) The definitions contained in G.S. 58-58-205 apply to this Section.

(b) The following definitions shall apply to this Section:

(1) "Division" means the Life and Health Division of the Department of Insurance.

(2) "Insured" means the person covered under the policy being considered for viatication.

(3) "Life expectancy" means the mean of the number of months the individual insured under the life insurance policy to be viaticated can be expected to live as determined by the viatical settlement provider considering medical records and appropriate experiential data.

(4) "Net death benefit" means the amount of the life insurance policy or certificate to be viaticated less any outstanding debts or liens.

(5) "Patient identifying information" includes an insured's name, address, telephone number, facsimile number, electronic mail address, photograph or likeness, employer, employment status, or social security number.

History Note: *Authority G.S. 58-2-40; 58-58-300;*
Temporary Adoption Eff. April 1, 2002;
Eff. April 1, 2003;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1711 LICENSE REQUIREMENTS

(a) In addition to the information required by G.S. 58-58-210, applicants for provider licenses shall submit the following:

(1) A plan of operation, including the manner in which the provider proposes to operate in North Carolina and the type or types of insurance policies or contracts it intends to viaticate.

(2) The provider's plan of operation shall be a narrative overview of the provider's business and shall include the following information:

(A) A certified copy of the provider's charter and by-laws, if a corporation or limited liability company, and a copy of the partnership agreement, if a partnership.

(B) A chart showing the relationship of the provider to any parent, affiliated, or subsidiary corporation.

(C) A description of the provider's marketing techniques, including a description of training programs for those individuals who will have direct contact with viators.

(D) A list of the names of the provider's directors and management personnel, including job titles and descriptions of the job duties.

(E) A schedule listing the names of financial institutions with which the provider has escrow trust agreements.

(F) A description of what steps through which the viator will have access to funds, including the source that will make such funds available.

(G) A financing plan.

(H) A statement disclosing the identities of all stockholders holding 10% or more of the provider, and all partners, directors, officers and members of the provider, depending on whether the provider is a partnership, corporation, or limited liability company.

(I) An antifraud plan, as specified in G.S. 58-58-268(b).

(3) Each provider shall notify the Division of any change in the items listed in Paragraph (a)(2) of this Rule within 30 business days after the change.

(4) Every nonresident provider shall file a power of attorney designating the Commissioner as the provider's agent for service of legal process in accordance with G.S. 58-58-210(g).

(b) A provider license may be renewed yearly by payment of the applicable fee, a notarized certification from the company's president attesting there has been no change to information on file required by G.S. 58-58-210 and this Rule, and a copy of a letter of good standing obtained from the provider's domiciliary regulator.

(c) If a provider's license expires under G.S. 58-58-210(c) and the provider has, on the license renewal date, viatical settlements where the insured has not died, it shall do one of the following:

(1) Renew or maintain its current license status until the earlier of the following events:

(A) The date the provider properly assigns, sells or otherwise transfers the viatical settlements where the insured has not died; or

(B) The date that the last insured covered by viatical settlement transaction has died; or

(2) Appoint, in writing, the broker who received commissions from the viatical settlement, if applicable, or any other provider or broker licensed in this State to make all inquiries to the viator, or the viator's designee, regarding health status of the viator or any other matters.

History Note: *Authority G.S. 58-2-40; 58-58-210; 58-58-300;*
Temporary Adoption Eff. April 1, 2002;
Eff. April 1, 2003;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1712 VIATICAL SETTLEMENT BROKERS

(a) Applications for broker licenses shall be made with the Agent Services Division of the Department of Insurance.

(b) A broker shall not, without the written agreement of the viator obtained before performing any services in connection with a viatical settlement, seek or obtain any compensation from the viator.

History Note: *Authority G.S. 58-2-40; 58-16-30; 58-58-300;*

Temporary Adoption Eff. April 1, 2002;
Eff. April 1, 2003;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1713 STANDARDS FOR EVALUATION OF REASONABLE PAYMENTS

(a) Insureds who are terminally or chronically ill shall receive no less than the following payouts for viaticating a policy. The percentage may be reduced by 5% for viaticating a policy written by an insurer rated less than the highest four categories by A.M. Best, or a comparable rating by another rating agency.

Insured's Life Expectancy	Minimum Percentage of Face Value Less Outstanding Loans Received by Viator
Less than 6 months	[80%]
At least 6 but less than 12 months	[70%]
At least 12 but less than 18 months	[65%]
At least 18 but less than 25 months	[60%]
25 months or more	Viator must receive at least the greater of the cash surrender value or accelerated death benefit for the policy

(b) Insureds who are not terminally or chronically ill shall receive at least the cash surrender value of the policy.

History Note: *Authority G.S. 58-2-40; 58-58-300;*
Temporary Adoption Eff. April 1, 2002;
Eff. April 1, 2003;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1714 REPORTING REQUIREMENTS

(a) On June 1 of each calendar year, each licensed provider shall make a report of all viatical settlement transactions in which the viators are residents of this State. The report shall contain the following information for the previous calendar year:

(1) For each viatical settlement entered into during the reporting period:
- (A) Date of viatical settlement contract;
- (B) Viator's state of residence at the time of the contract;
- (C) Life expectancy of the insured at the time of contract in months;
- (D) Face amount of policy viaticated;
- (E) Net death benefit viaticated;
- (F) Estimated total premiums to keep policy in force for mean life expectancy;
- (G) Net amount paid to viator;
- (H) Source of policy (B-Broker; D-Direct Purchase; O-Purchased from individual or entity other than the original viator);
- (I) Type of coverage (I-Individual or G-Group);
- (J) Whether or not the viatical settlement was entered into during the policy's contestable or suicide period, or both;
- (K) Classification of the viator's or insured's diseases or injuries:
  - (i) Cardiovascular diseases;
  - (ii) Diseases of the central nervous system;
  - (iii) Diseases of the peripheral nervous system;
  - (iv) Elders with nonspecific disease processes;
  - (v) Infectious diseases and autoimmune diseases;
  - (vi) Liver and renal diseases;
  - (vii) Neoplasms;
  - (viii) Non-neoplastic pulmonary diseases;
- (L) Type of funding (P-purchaser; L-licensee; I-accredited investor; F-financing entity; S-special purpose entity; R-related provider trust); and

(M) Rating of insurer that issued the policy at the time the policy was viaticated.

(2) For viatical settlements where death has occurred during the reporting period:
- (A) Date of viatical settlement contract;
- (B) Viator's state of residence at the time of the contract;
- (C) Life expectancy of the insured at the time of contract in months;
- (D) Net death benefit collected;
- (E) Total premiums paid to maintain the policy (WP-Waiver of Premium; NA-Not Applicable);
- (F) Net amount paid to viator;
- (G) Classification of the viator's or insured's diseases or injuries:
  - (i) Cardiovascular diseases;
  - (ii) Diseases of the central nervous system;
  - (iii) Diseases of the peripheral nervous system;
  - (iv) Elders with nonspecific disease processes;
  - (v) Infectious diseases and autoimmune diseases;
  - (vi) Liver and renal diseases;
  - (vii) Neoplasms;
  - (viii) Non-neoplastic pulmonary diseases;
- (H) Date of death;
- (I) Amount of time between date of contract and date of death in months;
- (J) Difference between the number of months that passed between the date of contract and the date of death and the mean life expectancy in months as determined by the reporting company;
- (K) Type of coverage (I-Individual or G-Group); and
- (L) Whether or not the viatical settlement was entered into during the policy's contestable or suicide period, or both;

(3) Name and address of each viatical settlement broker through whom the reporting provider purchased a policy from a viator who resided in this State at the time of contract; and

(4) Number of policies purchased from an individual or entity other than the original viator as a percentage of total policies purchased.

(b) On June 1 of each calendar year, each licensed broker shall make an annual report of all viatical settlement transactions during the previous calendar year in which the viators are residents of this State. The report shall be in the format prescribed by the NAIC in Appendix D of the model regulation. A copy of the format may be obtained from the Division.

History Note: *Authority G.S. 58-2-40; 58-58-225; 58-58-300;*
Temporary Adoption Eff. April 1, 2002;
Eff. April 1, 2003;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1715 GENERAL RULES

(a) With respect to a policy containing a provision for double or additional indemnity for accidental death, the additional payment shall remain payable to the beneficiary last named by the viator before entering into the viatical settlement contract, or to such other beneficiary, other than the provider, as the viator may thereafter designate, or in the absence of a beneficiary, to the estate of the viator.

(b) Payment of the proceeds of a viatical settlement under G.S. 58-58-250(i) shall be by means of wire transfer to the account of the viator or by certified check or cashier's check.

(c) Payment of the proceeds to the viator under a viatical settlement shall be made in a lump sum except where the provider has purchased an annuity or similar financial instrument issued by a licensed insurance company or bank, or an affiliate of either. Retention of a portion of the proceeds by the provider or escrow agent is not permissible.

(d) A provider or broker shall not pay or offer to pay any finder's fee, commission, or other compensation to any insured's physician, or to an attorney, accountant or other person providing medical, legal, or financial planning services to the viator, or to any other person acting as an agent of the viator, other than a broker, with respect to the viatical settlement.

(e) A provider shall not knowingly solicit purchasers who have treated or have been asked to treat the illness of the insured whose coverage would be the subject of the investment.
(f) If a provider enters into a viatical settlement that allows the viator to retain an interest in the policy, the viatical settlement contract shall contain the following provisions;

(1) A provision that the provider shall effect the transfer of the amount of the death benefit only to the extent or portion of the amount viaticated. The insurance company shall pay benefits in excess of the amount viaticated directly to the viator's beneficiary;
(2) A provision that the provider will, upon acknowledgment of the perfection of the transfer, either:
    (A) Advise the insured, in writing, that the insurance company has confirmed the viator's interest in the policy; or
    (B) Send a copy of the instrument sent from the insurance company to the viatical settlement provider that acknowledges the viator's interest in the policy; and
(3) A provision that apportions the premiums to be paid by the provider and the viator. It is permissible for the viatical settlement contract to specify that all premiums shall be paid by the provider. The contract may also require that the viator reimburse the provider for the premiums attributable to the retained interest.

History Note: *Authority G.S. 58-2-40; 58-58-250; 58-58-300;*
Temporary Adoption Eff. April 1, 2002;
Eff. April 1, 2003;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1716 CONTRACTS AND PAYMENT OF PROCEEDS

(a) Two specimen copies of each contract, application, brochure, and proposal shall be filed with the Division for approval under G.S. 58-58-220.
(b) In addition to the requirements in G.S. 58-58-250, every contract shall include the following provisions:

(1) If the viator elects the right to rescind the contract, the provider's rights or interest in the policy will terminate immediately upon the viator giving notice of the rescission and tendering of the settlement proceeds together with any escrow interest received by the viator.
(2) The amount of the fee or fees to be paid by the viator to the provider in conjunction with the contract shall be clearly stated, along with any conditions of payment or receipt of the fee or fees.
(3) The contract together with the application constitutes the entire agreement between the parties.
(4) If the contract provides for the payment of an additional settlement amount to the viator upon the exercise of a guaranteed insurability option by the viator, the contract shall disclose the amount of the additional settlement and the terms upon which it shall be payable.
(5) If the policy to be viaticated provides a guaranteed insurability option, the option may only be exercised for the benefit of a person who has an insurable interest in the life to be insured.

(c) Every application for a contract shall:

(1) Contain the viator's printed name and signature;
(2) Be witnessed and notarized by a person who does not have a financial interest in the policy or viatical settlement contract; and
(3) Provide for an acknowledgment by the viator of receipt of the information booklet required by G.S. 58-58-245(a)(8).

History Note: *Authority G.S. 58-2-40; 58-58-220; 58-58-300;*
Temporary Adoption Eff. April 1, 2002;
Eff. April 1, 2003;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1717 ADVERTISING MATERIAL

History Note: *Authority G.S. 58-2-40; 58-58-220; 58-58-300;*
Temporary Adoption Eff. April 1, 2002;
Temporary Adoption Expired December 27, 2002.

11 NCAC 12 .1718 DISCLOSURE

(a) The provider, upon receipt of an application to viaticate and after determining the value to be offered in return for the assignment or transfer of the death benefit or ownership of a policy to the provider, shall deliver a proposal to the viator before the contract is to be signed. The proposal shall disclose the following information:

(1) Amount of death benefit to be viaticated;
(2) Policy cash value before deducting any loan;
(3) Policy net cash value after deducting any loan;
(4) Policy death benefit less net cash value;
(5) Amount offered to viator;
(6) Whether any supplemental benefit or benefits including the following benefits, are present, will be continued and, if so, the source of premium payment and the beneficiary of the proceeds of such supplemental benefit, and the provider's interest in each benefit:
    (A) Accidental death and dismemberment benefit, including the amount of the benefit;
    (B) Disability income;
    (C) Waiver of premium or of monthly deduction waiver;
    (D) Guaranteed insurability options; or
    (E) Children or spouse coverage;
(7) Name of the insurer, and whether the insurer does or does not have an accelerated death benefit program for which the viator qualifies;

(b) The provider shall disclose on the application or in the brochure that the identity of the viator will not be disclosed except under the conditions set forth in G.S. 58-58-225 or as otherwise allowed or required by law. The provider shall provide an explanation of the conditions in G.S. 58-58-225 to the viator.

History Note: *Authority G.S. 58-2-40; 58-58-225; 58-58-245; 58-58-300;*
Temporary Adoption Eff. April 1, 2002;
Eff. April 1, 2003;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1719 PROHIBITED PRACTICES

(a) A provider or broker shall obtain from a person that is provided with patient identifying information a signed affirmation that the person or entity will not further divulge the information without procuring the express, written consent of the insured for the disclosure.

(b) If a provider or broker is compelled by a court of competent jurisdiction by order or subpoena to produce records containing patient identifying information, the provider or broker shall notify the viator and the insured in writing at their last known addresses within five business days after receiving notice of the court's order or subpoena.

(c) A provider shall not act as a broker and provider in the same viatical settlement contract.

(d) A viatical settlement provider shall not use a longer life expectancy than is reasonable, based on all medical and actuarial information available at the time of a viatical settlement transaction, in order to reduce the payout to which the viator is entitled. A life expectancy that is determined by a trained life underwriter, or an independent company in the business of providing life expectancy estimates and which may be determined, in part, by reference to proprietary financial or actuarial models, shall be deemed to be "reasonable" for the purpose of this Rule.

History Note: *Authority G.S. 58-2-40; 58-58-225; 58-58-245; 58-58-300;*
Temporary Adoption Eff. April 1, 2002;
Eff. April 1, 2003;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1720 INSURANCE COMPANY PRACTICES

(a) Every life insurance company licensed in this State shall respond to a request for verification of coverage from a provider or a broker within 30 calendar days after the date a request is received. The insurer shall inform the provider or broker whether the insurer intends to pursue an investigation regarding possible fraud or the validity of the insurance contract. The following items shall accompany the request for verification of coverage:

(1) A current authorization signed by the insured;
(2) If the policy to be viaticated is an individual policy, a verification of coverage form, completed by the provider or broker, substantially similar to the format prescribed by the NAIC in Appendix B of the NAIC Viatical Settlements Model Regulation; and
(3) If the viatication involves a group insurance certificate, a verification of coverage form, completed by the provider or the broker, substantially similar to the format prescribed by the NAIC in Appendix C of the NAIC Viatical Settlements Model Regulation.

(b) A life insurance company shall not charge a fee for responding to a request for information from a provider or broker in accordance with this rule in excess of any usual and customary charges to insureds for similar services.

(c) A life insurance company may send an acknowledgment of receipt of the request for verification of coverage to the viator and, where the viator is not the insured, also to the insured. The acknowledgment shall contain a description of any accelerated death benefit that is available under a provision of or rider to the policy.

(d) Copies of the formats described in this Rule are on file at the Division.

History Note: *Authority G.S. 58-2-40; 58-6-6; 58-58-250; 58-58-300;*
Temporary Adoption Eff. April 1, 2002;
Eff. April 1, 2003;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

SECTION .1800 - PPO BENEFIT PLAN PRODUCT LIMITATIONS

11 NCAC 12 .1801 APPLICABILITY

This Section applies to any insurer or service corporation that, under G.S. 58-50-56, offers a preferred provider benefit plan.

History Note: *Authority G.S. 58-2-40; 58-50-56;*
Temporary Adoption Eff. January 1, 1998;
Eff. August 1, 1998;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1802 DEFINITIONS

The definitions contained in G.S. 58-50-56(a) are incorporated into this Section by reference and as used in this Section, the following terms have the meanings ascribed to them:

(1) "Coinsurance" means the percentage of an allowed charge or expense, or usual and customary charge for a covered health care service that an enrollee must pay.
(2) "Copayment" means a fixed dollar amount that an enrollee must pay each time a covered health care service is provided.
(3) "Deductible" means a specified amount of covered health care services, expressed in dollars, that must be incurred by an enrollee before the insurer will assume any financial liability for all or part of covered health care services.
(4) "Emergency health care services" means those services as defined and delivered in accordance with G.S. 58-3-190.
(5) "Enrollee" means an individual who is covered by a PPO benefit plan.
(6) "In-network covered services" means covered health care services that are received according to the rules of the health benefit plan from providers employed by, under contract with, or approved in advance by the insurer; and means emergency health care services regardless of the status or affiliation of the provider of such services.
(7) "Out-of-network covered services" means non-emergency, medically necessary covered health care services that are not received according to the rules of the health benefit plan, including services from affiliated providers that are received without the approval of the insurer.
(8) "Out-of-pocket expense" means a specified dollar amount of coinsurance incurred and payable by an enrollee for covered health care services in a specified period. Out-of-pocket expense may or may not include deductible amounts, copayment amounts, charges in excess of the amount

allowed by the insurer, amounts exceeding the maximum benefits, or any other disallowed or noncovered expenses under the rules of the health benefit plan.

(9) "PPO benefit plan" has the same meaning as "preferred provider benefit plan" in G.S. 58-50-56(a)(3).

History Note: *Authority G.S. 58-2-40; 58-50-56;*
Temporary Adoption Eff. January 1, 1998;
Eff. August 1, 1998;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1803 GENERAL REQUIREMENTS

No insurer shall provide any PPO benefit plan unless it complies with the following:

(1) Where the covered benefits of a PPO benefit plan include coinsurance, the difference in coinsurance rates between in-network covered services and out-of-network covered services shall not exceed 30 percentage points.

(2) If the schedule of benefits for a PPO benefit plan imposes a deductible for in-network covered services, the amount of any separate annual deductible per enrollee or per family for out-of-network covered services may not exceed two times the amount of the annual per enrollee or per family deductible applied to in-network covered services.

(3) If the schedule of benefits for a PPO benefit plan does not include an annual deductible for in-network covered services, the annual deductibles for out-of-network covered services shall not exceed two hundred and fifty dollars ($250.00) per enrollee and the family deductible may not exceed seven hundred and fifty dollars ($750.00).

(4) The portion of any charge for out-of-network covered services to be applied to an annual deductible may be based on actual charges or the insurer's usual and customary charges.

(5) If there are benefit maximums for in-network covered services, the amount of any annual and lifetime maximum limits for out-of-network covered services shall not be less than one-half of the amount of any annual and lifetime maximum limits for in-network covered services.

(6) If a PPO benefit plan includes copayments for both in-network covered services and out-of-network covered services, the amount of the copayment for an out-of-network covered service shall not exceed the copayment for an in-network covered service by more than twenty dollars ($20.00) or 100%, whichever is greater.

(7) If the schedule of benefits for a PPO benefit plan limits the annual out-of-pocket expenses of enrollees to a maximum amount for in-network covered services, the amount of any separate annual out-of-pocket maximum for out-of-network covered services may not exceed two times the maximum amount for in-network covered services.

(8) If the schedule of benefits for a PPO benefit plan does not include an annual maximum limit on out-of-pocket expenses for in-network covered services, the maximum limit on out-of-pocket expenses for out-of-network covered services shall not exceed one thousand two hundred and fifty dollars ($1,250) per enrollee or three thousand seven hundred and fifty dollars ($3,750) per family.

(9) An insurer offering a PPO benefit plan may limit coverage for annual physicals and health screenings performed for preventative purposes to those services provided on an in-network basis, except that services provided in connection with mandated benefits must be available on both an in-network and out-of-network basis. An insurer shall provide coverage on both an in-network and out-of-network basis for all other covered services.

(10) PPO benefit plans shall give enrollees the option to choose in-network covered services or out-of-network covered services each time those covered services are authorized, obtained, or rendered; and shall not require enrollees to obtain insurer approval to exercise that option.

(11) An insurer offering a PPO benefit plan shall not impose different medical management requirements, including utilization review criteria or prior approval requirements, for out-of-network covered services than are imposed on in-network covered services. Those medical management requirements shall not restrict enrollees' abilities to seek covered services on out-of-network bases.

History Note: *Authority G.S. 58-2-40; 58-50-56;*

Temporary Adoption Eff. January 1, 1998;
Eff. August 1, 1998;
Readopted Eff. May 1, 2020.

11 NCAC 12 .1804 DISCLOSURE REQUIREMENTS

(a) If an enrollee utilizes out-of-network covered services, the explanation of benefits shall contain an explanation of coverage for out-of-network covered services that allows each enrollee to determine his or her obligations with respect to those services.

(b) Marketing materials, evidences of coverage, enrollee handbooks, and other materials given to enrollees by an insurer that offers a PPO benefit plan shall contain a clear and comprehensive explanation of the PPO benefit plan. The explanation shall include the following information:

(1) the method of reimbursement, including whether actual charges or usual and customary charges are used in making all benefit calculations;
(2) applicable coinsurance, copayment, and deductible amounts;
(3) any other uncovered costs or charges;
(4) the covered health care services that an enrollee may receive on an out-of-network basis, including whether or not annual physicals and health screenings are available out-of-network; and
(5) instructions for submittal of claims for out-of-network covered services.

History Note: *Authority G.S. 58-2-40; 58-3-191(b); 58-50-56;*
Temporary Adoption Eff. January 1, 1998;
Eff. August 1, 1998;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

SECTION .1900 – DOMESTIC VIOLENCE – PROHIBITED ACTS

11 NCAC 12 .1901 DEFINITIONS

As used in this Section, the following terms have the meanings ascribed to them:

(1) "Abuse" means the occurrence of one or more of the following acts by a current or former family member, household member, intimate partner or caretaker:
    (a) Attempting to cause or intentionally, knowingly or recklessly causing another person bodily injury, physical harm, severe emotional distress, psychological trauma, rape, sexual assault or involuntary sexual intercourse;
    (b) Knowingly engaging in a course of conduct or repeatedly committing acts toward another person, including following the person or minor child, under circumstances that place the person or minor child in reasonable fear of bodily injury or physical harm;
    (c) Subjecting another person to false imprisonment; or
    (d) Attempting to cause or intentionally, knowingly, or recklessly causing damage to property so as to intimidate or attempt to control the behavior of another person.
(2) "Abuse-related medical condition" means a medical condition sustained by a subject of abuse that arises in whole or part out of an act or pattern of abuse.
(3) "Abuse status" means the fact or perception that a person is, has been, or may be a subject of abuse, irrespective of whether the person has sustained abuse-related medical conditions.
(4) "Health benefit plan" or "plan" means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; a plan provided by a Professional Employer Organization; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. "Health benefit plan" includes accident only, credit health, dental, vision, Medicare supplement or long-term care insurance, coverage issued as a supplement to liability insurance, short-term and catastrophic health insurance, coverage only for a specified disease or illness, hospital indemnity or other fixed indemnity insurance, disability income insurance, and a policy that pays on a cost-incurred basis. "Health benefit plan" does not mean the N.C. State Health Plan, workers'

compensation insurance or any plan implemented or administered by the North Carolina or United States Department of Health and Human Services, or any successor agency, or its representatives.

(5) "Insurance professional" means an agent, broker, or adjuster as defined in G.S. 58-33-10 or a third party administrator as defined in G.S. 58-56-2.

(6) "Insurer" means an insurance company subject to Chapter 58 of the General Statutes, a service corporation organized under Article 65 of Chapter 58 of the General Statutes, a health maintenance organization organized under Article 67 of Chapter 58 of the General Statutes, a multiple employer welfare arrangement subject to Article 49 of Chapter 58 of the General Statutes, the North Carolina Health Insurance Risk Pool subject to Part 6 of Article 50 of Chapter 58 of the General Statutes, and a Professional Employee Organization subject to Article 89A of Chapter 58 of the General Statutes.

(7) "Insured" means a party named on a health benefit plan as the person with legal rights to the benefits provided by the health benefit plan. For group plans, "insured" includes a person who is a beneficiary covered by a group health benefit plan.

(8) "Subject of abuse" means a person against whom an act of abuse has been directed; who has current or prior injuries, illnesses or disorders that resulted from abuse; who seeks, may have sought, or had reason to seek medical or psychological treatment for abuse; or protection, court-ordered protection or shelter from abuse.

History Note: *Authority G.S. 58-2-40; 58-63-65;*
Eff. April 1, 2010;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1902 UNFAIR OR DECEPTIVE ACTS OR PRACTICES

(a) The following are unfair or deceptive acts or practices in the business of insurance:

(1) To deny, refuse to issue, renew or reissue, cancel or otherwise terminate a health benefit plan, or restrict or exclude health benefit plan coverage or add a premium differential to any health benefit plan on the basis of the applicant's or insured's abuse status;

(2) To exclude or limit coverage for losses or deny a claim incurred by an insured on the basis of the insured's abuse status;

(3) To request information relating to acts of abuse or an applicant's or insured's abuse status, or make use of that information, however obtained, except for the limited purposes of complying with legal obligations or verifying a person's claim to be a subject of abuse; or

(4) To terminate group coverage for a subject of abuse because coverage was originally issued in the name of the abuser and the abuser has divorced, separated from, or lost custody of the subject of abuse, or the abuser's coverage has terminated voluntarily or involuntarily. Nothing in this Rule prohibits the insurer or insurance professional from requiring the subject of abuse to pay the full premium for coverage under the health benefit plan or from requiring as a condition of coverage that the subject of abuse reside or work within the insurer's service area, if the requirements are applied to all insureds of the insurer or insurance professional. The health carrier or insurance professional may terminate group coverage after the continuation coverage required by this subsection has been in force for 18 months, if it offers conversion to an individual plan as provided in Part 2 of Article 53 of Chapter 58 of the General Statutes. The continuation coverage required by this section shall be satisfied by coverage required under P.L. 99-272, the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, or under state continuation coverage required under Part 1 of Article 53 of Chapter 58 of the General Statutes, and is not intended to be in addition to coverage provided under COBRA or state continuation. Nothing in this Subparagraph is intended to supersede or interfere with the provisions of G.S. 58-68-60 when the subject of abuse is an "eligible individual" as defined in G.S. 58-68-60(b).

(b) Subparagraph (a)(3) of this Rule does not prohibit an insurer or insurance professional from asking about a medical condition or from using medical information to underwrite or to carry out its duties under the policy, even if the medical information is related to a medical condition that the insurer or insurance professional knows or has reason to know is abuse-related, to the extent otherwise permitted under this Rule and other applicable law.

History Note: *Authority G.S. 58-2-40; 58-53-5; 58-63-65; 58-68-60;*

Eff. April 1, 2010;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.

11 NCAC 12 .1903 JUSTIFICATION OF ADVERSE INSURANCE DECISIONS

An insurer or insurance professional that takes an action that adversely affects an applicant or insured on the basis of a medical condition that the health insurer or insurance professional knows or has reason to know is abuse-related shall explain the reason for its action to the applicant or insured in writing and shall be able to demonstrate that its action, and any applicable plan provision:

(1) Does not have the purpose or effect of treating abuse status as a medical condition or underwriting criterion;

(2) Is not based upon any actual or perceived correlation between a medical condition and abuse;

(3) Is otherwise permissible by law and applies in the same manner and to the same extent to all applicants and insureds with a similar medical condition without regard to whether the condition or claim is abuse-related; and

(4) Except for claim actions, is based on a determination, made in conformance with sound actuarial principles and supported by actual or reasonably anticipated experience, that there is a correlation between the medical condition and a material increase in insurance risk.

History Note: *Authority G.S. 58-2-40; 58-63-65;*
Eff. April 1, 2010;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.