TITLE 365. INSURANCE DEPARTMENT
CHAPTER 10. LIFE, ACCIDENT AND HEALTH

SUBCHAPTER 1. GENERAL PROVISIONS

PART 1. GENERAL PROVISIONS

365:10-1-17. Life, accident, and health form filings

(a) **Purpose.** The purpose of this section is to specify the procedures for submitting form filings to the Insurance Commissioner as required by Sections 3610 and 4402 of the Insurance Code.

(b) **Procedures.** Policy forms, endorsements, and revisions thereto, by insurance companies licensed in Oklahoma, shall be submitted in compliance with this section, or shall be rejected for filing, and the entity that made such submission shall be so notified.

(1) **Filing requirements.** The Insurance Code, Sections 3610 and 4402, requires that each insurer shall make its form filings by line of business directly with the Insurance Commissioner.

(2) **Filing fees.**

(A) Form filings shall be accompanied by the proper fees as specified in the Insurance Code. Fees shall not be paid in cash.

(B) Filings for groups of insurers shall be accompanied by the specified fee for each transaction, regardless of the number of members or subscribers.

(3) **Address requirements.** All filings shall be addressed as follows: Oklahoma Insurance Commissioner, 3625 NW 56th Street, Suite 100, Oklahoma City, Oklahoma 73112.

(4) **Submission.** All filings except those exempted shall be submitted through the System for Electronic Rate and Form Filing (SERFF) pursuant to the SERFF General Instructions, and shall include a description of the filing(s), all exhibits, forms, and additional information required by the Commissioner.

(5) **Effective date of filings.** The effective date of form filings and the dates of required action by the Insurance Commissioner are governed by the applicable provisions of the Insurance Code.

(6) **Notice of Insurance Commissioner action.** The Insurance Commissioner shall indicate action taken through the System for Electronic Rate and Form Filing (SERFF). Nothing in this section shall preclude the Insurance Commissioner from the use of other forms of communication to secure information from the filing entity.

(7) **Property and casualty insurance.** This section does not apply to Property and Casualty filings and such filings shall be made in accordance with the applicable provisions of the Insurance Code and Rules of the Insurance Commissioner.

(8) **Filing form and content.** All filings shall contain the following:

(A) The name of the filing entity and complete mailing address to which correspondence shall be sent.

(B) A brief description of the content and context of the filing.

(C) A list or index of the forms filed or attached thereto including the form numbers and edition date, if applicable.

(D) A complete description and full explanation of the changes made by the filing including the reasoning therefore; illustrative examples, including "John Doe"

specimen form; and a comparison of currently approved and proposed materials (side by side comparison or marked copy).

(E) A concise statement to identify the form to be replaced by the filing including the approval date in this jurisdiction and the identifying filing number of the filing containing the form to be replaced as assigned by the Insurance Department.

(F) If a form is being withdrawn or amended due to court decisions in any jurisdiction, the filing entity shall furnish the legal citation, and if from another jurisdiction, a copy of such decision or opinion with its filing.

(G) If a form is being withdrawn or amended due to a federal law or regulation of a federal agency, the filing entity shall furnish the legal citation of the pertinent provisions.

(9) **Withdrawal of pending filings.** Pending filings may be withdrawn by the filing entity upon notice to the Insurance Commissioner prior to the approval or disapproval thereof. The notice shall include the reason for the withdrawal.

(10) **Duration of filings.** All filings are in effect until withdrawn or amended by the insurer, with approval of the Insurance Commissioner or until abrogated by the Insurance Commissioner.

(11) **Group filings**. Where filings are made on behalf of more than one insurer, the filing shall list the insurer or insurers by individual name and not by Company group.

(12) **Resubmittal of filings.** All resubmissions of disapproved or rejected filings shall be presented to the Insurance Commissioner in the same manner as required by this section for an original filing. In addition the cover letter or completed transmittal forms addressed to the Insurance Commissioner shall state the full and complete history of the filing, the reason for disapproval or rejection, and the factors which distinguish the resubmittal so it warrants reconsideration.

(13) **Retroactive filings.** The Insurance Commissioner has no authority to and shall not approve filings proposing a retroactive effective date except in cases of a filing correcting an error in a previously approved filing and in cases where required or necessitated by Statute or regulation of a federal or state agency.

(14) **Delivery of policy to insured.** In any instance whereby a policy of insurance is effected the insured shall be furnished with either:

(A) The original policy;

(B) A copy of the original policy or a duplicate policy with ten point or larger type, which, at the insured's election, may be delivered to the insured electronically; or

(C) A certificate including provisions and conditions of the original policy printed with ten point or larger type.

(15) **Coverage elimination after policy issuance.** Any endorsement which eliminates or restricts coverage and which is issued during the policy term shall be identified as accepted by the ~~insured~~policyholder, by the signature of the ~~insured~~policyholder thereon, and a signed copy (original, computer generated or microfilm) of such endorsement shall be retained in the files of the insurer for one year after the expiration of the policy. Evidence of policyholder acceptance is not required if the change effected by the endorsement is mandated by applicable law.

SUBCHAPTER 5. MINIMUM STANDARDS; CONTRACT GUIDELINES

PART 13. MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

365:10-5-129. Open enrollment

(a) An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this State, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6) month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under this subsection without regard to age.

(b) If an applicant qualifies under subsection (a) or subsection (d) of this Section and submits an application during the time period referenced in said subsection (a) or subsection (d)), and

(1) as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition; or

(2) as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this subsection.

(c) Except as provided in Subsection (b) and Section 365:10-5-140, subsection (a) and subsection (d) of this Section shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective.

(d) At least one of the ten standardized Medicare supplement plans currently available from an issuer shall be made available to all applicants who qualify under this subsection by reason of disability. The issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this State because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for such policy or certificate is submitted during the six (6) month period beginning with the first month in which an individual first enrolled for benefits under Medicare Part B. <u>The premium rate charged for such disabled person may not exceed the lowest available aged premium rate for such plan.</u>

(e) In the event Social Security backdates the Medicare enrollment date, the six-month enrollment period shall be calculated from the date the individual first receives notification of approval of Medicare coverage.