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

SUBCHAPTER 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~~ 400 NE 50th Street, Oklahoma City, Oklahoma ~~73112~~ 73105.

(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 hall 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 policy holder, by the signature of the policy holder 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

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 certificate holder 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. ~~The premium rate charged for such disabled person may not exceed the lowest available aged premium rate for such plan.~~

(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.

365:10-5-129.1. Guaranteed Issue for Eligible Persons

(a) **Guaranteed Issue.**

(1) Eligible persons are those individuals described in subsection (b) who apply to enroll under the policy not later than sixty-three (63) days after the date of the termination of enrollment described in subsection (b), and who submit evidence of the date of termination, disenrollment or Medicare Part D enrollment with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection (c) that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the

pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

(b) **Eligible Persons.** An eligible person is an individual described in any of the following paragraphs:

(1) **Employee welfare benefit plan.** The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all or substantially all supplemental health benefits to the individual.

(2) **Medicare Advantage.** The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

(A) The certification of the organization or has been terminated;

(B) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(C) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;

(D) The individual demonstrates, in accordance with guidelines established by the Secretary, that:

(i) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(E) The individual meets such other exceptional conditions as the Secretary may provide.

(3) **Organizations.**

(A) The individual is enrolled with:

(i) An eligible organization under a contract under Section 1876 (Medicare risk or cost);

(ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(iii) An organization under an agreement under Section 1833(a)(1)(A)

(health care prepayment plan); or

(iv) An organization under a Medicare Select Policy; and

(B) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Section 365:10-5-129.1(b)(2).

(4) **Medicare supplement.** The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(A) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or because of other involuntary termination of coverage or enrollment under the policy;

(B) The issuer of the policy substantially violated a material provision of the policy; or

(C) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

(5) **Termination of enrollment and subsequent enrollment.** The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare risk or cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act or a Medicare Select Policy; and an organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan), or a Medicare Select policy; and the subsequent enrollment under this subparagraph is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act); or

(6) **Medicare Advantage disenrollment.**

(A) The individual, upon first becoming eligible for benefit under Part A of Medicare at age 65, enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan by not later than twelve (12) months after the effective date of enrollment.

(B) An individual, under age 65, who first becomes eligible for Medicare Part B and enrolls in a Medicare Advantage plan under part C of Medicare, and disenrolls from the plan by not later than twelve (12) months after the effective date of enrollment.

(7) **Part D Benefit Enrollment.** The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in Subsection 365:10-5-129.1(e)(4).

(c) **Guaranteed issue time periods.**

(1) In the case of an individual described in Section 365:10-5-129.1(b)(1), the guaranteed issue period begins on the later of the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a

claim has been denied because of such a termination or cessation); or the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter;

(2) In the case of an individual described in Section 365:10-5-129.1(b)(2), (b)(3), (b)(5) or (b)(6) whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated;

(3) In the case of an individual described in Section 365:10-5-129.1(b)(4)(A), the guaranteed issue period begins on the earlier of the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and the date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage is terminated.

(4) In the case of an individual described in Section 365:10-5-129.1(b)(2), (b)(4)(B), (b)(4)(C), (b)(5) or (b)(6) who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date;

(5) In the case of an individual described in Subsection 365:10-5-129.1(b)(6), the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty-day (60) period immediately preceding the initial Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and

(6) In the case of an individual described in Section 365:10-5-129.1(b) but not described in the preceding provisions of this Subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three (63) days after the effective date.

(d) **Extended Medigap access for interrupted trial periods.**

(1) In the case of an individual described in Section 365:10-5-129.1(b)(5) (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in Section 365:10-5-129.1(b)(5)(A) is involuntarily terminated within the first twelve (12) months or enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in Section 365:10-5-129.1(b)(5);

(2) In the case of an individual described in Section 365:10-5-129.1(b)(6) (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in Section 365:10-5-129.1(b)(6) is involuntarily terminated with the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in Section 365:10-5-129.1(b)(6); and

(3) For purposes of Sections 365:10-5-129.1(b)(5) and (b)(6), no enrollment of an individual with an organization or provider described in Section 365:10-5-129.1(b)(5)(a), or with a plan or in a program described in Section 365:10-5-129.1(b)(6), may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

(e) **Products to which eligible persons are entitled.** The Medicare supplement policy to which eligible persons are entitled under:

(1) **Section 365:10-5-129.1(b)(1), (2), (3) and (4).** Section 365:10-5-129.1(b)(1), (2), (3) and (4) is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, F, D, G (including F or G with a high deductible), K or L offered by any issuer.

(2) **Section 365:10-5-129.1(b)(5).**

(A) Subject to subparagraph (B), Section 365:10-5-129.1(b)(5) is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Section 365:10-5-129.1(e)(1).

(B) After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in this subparagraph is: The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or at the election of the policyholder, an A, B, C, F D, G (including F or G with a high deductible, K or L policy that is offered by any issuer;

(3) **Section 365:10-5-129.1(b)(6)(A).** Section 365:10-5-129.1(b)(6)(A) shall include any Medicare supplement policy offered by any issuer.

(4) **Section 365:10-5-129.1(b)(7).** Section 365:10-5-129.1(b)(7) is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F D, G (including F or G with a high deductible, K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

(5) For individuals who meet any of the conditions identified in subsection (b) and who are under age 65 and enrolled in Medicare due to disability shall be limited to the standardized Medicare supplement plan identified by the issuer as outlined in Section 365:10-5-129 (d). Such individuals would be subject to the timeframe stated under Section 365:10-5-129.1(a)(1). ~~The premium rate charged for such disabled person may not exceed the lowest available aged premium rate for such plan.~~

(f) **Notification provisions.**

(1) At the time of an event described in Section 365:10-5-129.1(b) because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement polices under Section 365:10-5-129.1(a). Such notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in Section 365:10-5-129.1(b) because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Section 365:10-5-129.1(a). Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

APPENDIX PP. NOTICE OF APPEAL RIGHTS

NOTICE OF APPEAL RIGHTS

You have a right to appeal any decision we make that denies payment on your claim or your request for coverage of a health care service or treatment.

You may request more explanation when your claim or request for coverage of a health care service or treatment is denied or the health care service or treatment you received was not fully covered.

Contact[1] us when you:

- Do not understand the reason for the denial;
- Do not understand why the health care service or treatment was not fully covered;
- Do not understand why a request for coverage of a health care service or treatment was denied;
- Cannot find the applicable provision in your Benefit Plan Document;
- Want a copy (free of charge) of the guideline, criteria or clinical rationale that we used to make our decision; or
- Disagree with the denial or the amount not covered and you want to appeal.

If your claim was denied due to missing or incomplete information, you or your health care provider may resubmit the claim to us with the necessary information to complete the claim. [1]

Appeals: All appeals for claim denials (or any decision that does not cover expenses you believe should have been covered) must be sent to [INSERT ADDRESS OF WHERE APPEALS SHOULD BE SENT TO THE HEALTH CARRIER] within **180 days** of the date you receive our denial.[2] We will provide a full and fair review of your claim by individuals associated with us, but who were not involved in making the initial denial of your claim. You may provide us with additional information that relates to your claim and you may request copies of information that we have that pertains to your claims. We will notify you of our decision in writing. Once our internal appeal process is exhausted (or waived by us), you may be entitled to file a request for external review.[3]

External Review[3]: We have denied your request for the provision of or payment for a health care service or course of treatment. You may have a right to have our

decision reviewed by independent health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you request by submitting a request for external review within **4 months** after receipt of this notice to the Oklahoma Insurance Department, which can be contacted by mail at ~~3625 NW 56th~~ 400 NE 50th Street, Oklahoma City, OK, ~~73112-4511~~ 73105, or by phone at 800-522-0071 or 405-521-2828. For standard external review, a decision will be made within **45 days** of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an **expedited external review** of our denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational, you also may be entitled to file a request for external review of our denial. For details, please review your Benefit Plan Document, contact us or contact your state insurance department.[1]

[1] See address and telephone number on the enclosed Explanation of Benefits if you have questions about this notice.

[2] Unless your plan or any applicable state law allows you additional time.

[3] See your Benefit Plan Document for your state's appeal process and to determine if you're eligible to request an external review in your state (e.g. some state appeal processes require you to complete your insurer's appeal process before filing an external review request unless waived by your insurer; while some states do not have such a requirement).