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, 400 NE 50th Street, Oklahoma City, Oklahoma 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.

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 400 NE 50th Street, Oklahoma City, OK, 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).