

10233.5. (a) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

(b) In the case of agent solicitations, an agent shall deliver the outline of coverage prior to the presentation of an application or enrollment form.

(c) In the case of direct response solicitations, the outline of coverage shall be presented in conjunction with any application or enrollment form.

(d) The outline of coverage shall be a freestanding document, using no smaller than 10-point type.

(e) The outline of coverage shall contain no material of an advertising nature.

(f) Use of the text and sequence of the text of the outline of coverage set forth in this section is mandatory, unless otherwise specifically indicated.

(g) Text which is capitalized or underscored in the outline of coverage may be emphasized by other means which provide prominence equivalent to capitalization or underscoring.

(h) The outline of coverage shall be in the following form:

"(COMPANY NAME)

(ADDRESS--CITY AND STATE)

(TELEPHONE NUMBER)

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

(Policy Number or Group Master Policy and Certificate Number)

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. 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 those provisions, include a description of them.

4. 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.

5. 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.)

6. BENEFITS PROVIDED BY THIS POLICY.

(a) (Covered services, related deductible(s), waiting periods, elimination periods, and benefit maximums.)

(b) (Institutional benefits, by skill level.)

(c) (Noninstitutional benefits, by skill level.)

(Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should 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. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.)

7. LIMITATIONS AND EXCLUSIONS.

(Describe:

(a) Preexisting conditions.

(b) Noneligible facilities/provider.

(c) Noneligible levels of care (e.g., unlicensed providers, care or treatments provided by a family member, etc.).

(d) Exclusions/exceptions.

(e) Limitations.)

(This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in (6) above.)

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

8. 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 a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations.

(e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.)

9. TERMS UNDER WHICH THE POLICY (OR CERTIFICATE) MAY BE CONTINUED IN FORCE OR DISCONTINUED.

(a) Describe the policy renewability provisions.

(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 no waiver of premium provisions.

(d) State whether or not the company has a right to change premium, and if that right exists, describe clearly and concisely each circumstance under which the premium may change.

10. ALZHEIMER'S DISEASE, ORGANIC DISORDERS, AND RELATED MENTAL DISEASES.

(State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's Disease, organic disorders, or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision that provides preconditions to the availability of policy benefits for that insured.)

11. 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.

12. ADDITIONAL FEATURES.

(a) Indicate if medical underwriting is used.

(b) Describe other important features.

13. INFORMATION AND COUNSELING. The California Department of Insurance has prepared a Consumer Guide to Long-Term Care Insurance.

This guide can be obtained by calling the Department of Insurance toll-free telephone number. This number is 1-800-927-HELP.

Additionally, the Health Insurance Counseling and Advocacy Program (HICAP) administered by the California Department of Aging, provides long-term care insurance counseling to California senior citizens. Call the HICAP toll-free telephone number 1-800-434-0222 for a referral to your local HICAP office."