

INSURER PARTICIPATION AGREEMENT
New York State Partnership for Long Term Care
(2/2/100 Plan)

PURPOSE OF THE PROJECT

The New York State Partnership for Long Term Care ("The Partnership") was established by the State of New York to help residents plan long term care financing. The Partnership operates under the direction of the Department of Health, in consultation with the Department of Financial Services and the State Office for the Aging. Under the Partnership, agreements between the State and Participating Insurers, and the State and Participating Consumers finance the cost of long term care services.

AGREEMENT CONDITIONS

This Agreement sets forth the conditions an Insurer must satisfy under the Partnership to receive and maintain Partnership approval, and to qualify as a Participating Insurer.

I. PARTNERSHIP ENROLLMENT OF PARTICIPATING INSURERS

The Partnership requires that Participating Insurers provide benefit coverage, operational activities, and oversight that may not be applicable to long term care insurance products sold outside the Partnership.

A Participating Insurer is an Insurer that offers policy/certificate coverage approved under New York State Department of Financial Services Regulation 144, and signs this Agreement. Only Participating Insurers shall market, sell and issue Partnership policies/certificates. Participating Insurers must submit products proposed for sale as Partnership Long Term Care policies/certificates to the State Department of Financial Services for approval before the Partnership long-term care policies/certificates can be issued to insureds. Policies/certificates approved by the New York State Department of Financial Services for sale by the Participating Insurer as Partnership Long Term Care policies/certificates are hereinafter referred to as Partnership-approved policies/certificates. Participating Insurers shall also require that only Partnership Certified Agent(s)/Broker(s) shall market and sell Partnership-approved policies/certificates regardless of where the agent/broker resides and/or conducts business. Participating Insurers shall always require that at least one Partnership Certified Agent/Broker be directly involved in the marketing and sale of Partnership-approved policies/certificates. The term "Participating Insurer" shall include the Insurer's successors in interest and any third party administrators.

A Partnership Certified Agent/Broker is an agent or broker authorized to sell accident and health insurance by the New York State Department of Financial Services and who has successfully completed a Partnership-Medicaid specific training course required by the State of New York Health Department. (See ATTACHMENT 1 for current course requirements to provide proof of successful completion.)

A Participating Consumer is a consumer who has signed the Partnership Consumer Participation Agreement and has purchased long term care coverage pursuant to a Partnership-approved policy/certificate from a Participating Insurer.

Where the New York State Department of Financial Services has determined that a submitted product meets Partnership requirements set forth below, and the Insurer has signed this Insurer Participation Agreement, the Insurer shall be qualified as a Participating Insurer, and shall place the Partnership Logo on all approved policies and certificates so long as the Insurer participates in the Partnership. Upon termination of the Participating Insurer from the Partnership, or upon cessation of the Partnership, the Participating Insurer shall cease using the Partnership Logo. The Partnership Logo shall appear in all Participating Insurer advertising according to the requirements of the Partnership.

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All Partnership-approved policies/certificates issued by Participating Insurers shall contain a statement of the advantages of Medicaid Extended Coverage associated with Long Term Care policies/certificates bearing the Partnership Logo.

All Partnership-approved policies/certificates shall be tax qualified under the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104-191) and shall comply with all applicable requirements stipulated in federal regulations promulgated under HIPAA. All Partnership-approved policies/certificates shall also meet the standards required under New York State laws and regulations for favorable New York State tax qualification status.

The Partnership and Participating Insurers shall undertake a statewide joint campaign to increase public understanding of long term care financing issues and awareness of the Partnership. The joint campaign shall be directed by a Committee of State, Partnership and Participating Insurer representatives as decided by the Evolution Board. However, the Partnership shall retain full authority to approve or disapprove the form or content of any joint campaign materials. The New York State Department of Financial Services has established on behalf of the joint campaign a toll-free telephone line to provide Partnership information. However, no specific Participating Insurers shall be recommended to the public.

Participating Insurers shall issue Partnership policies/certificates to only those consumers who are Participating Consumers, having agreed to participate in the Partnership by executing the New York State Partnership for Long Term Care Consumer Participation Agreement, which includes the Participating Consumer's acknowledgement that s/he received and reviewed the Long Term Care Insurance Personal Worksheet (from the latest published *A Shopper's Guide to Long-Term Care Insurance*, National Association of Insurance Commissioners), and signed and submitted the accompanying Disclosure Statement with his/her application to purchase the insurance (see ATTACHMENT 2). The Participating Insurer shall distribute the Consumer Participation Agreement to consumer-applicants and obtain the fully executed Consumer Participation Agreement from approved applicants. As a condition of the Participating Consumer's eligibility for Medicaid Extended Coverage under the Partnership, the Participating Insurer must return the original, fully executed signature page of the Consumer Participation Agreement to the Partnership Office within thirty (30) days of execution by the Participating Consumer. Additionally, beginning April 1, 2005, the Participating Insurer must verify that the selling agent/broker is a Partnership Certified Agent/Broker and submit a written verification of the agent's/broker's status as such with the Consumer Participation Agreement. (See ATTACHMENT 3.)

II. STATUTORY AND REGULATORY COMPLIANCE

Participating Consumers who have received 24 months of nursing home insurance benefits, or its equivalent as described in Section III below, provided under Partnership-approved insurance policies/certificates shall be eligible to apply for New York State Medical Assistance ("Medicaid") without regard to the usual Medicaid resource limitations on eligibility ("Medicaid Extended Coverage"); specifically, an amount of the Participating Consumer's countable resources or assets up to the total dollar amount of the insurance benefits paid on his/her behalf ("protected resources") shall not be subject to Medicaid resource transfer or spend down rules, and shall, therefore, be exempted in determining his/her eligibility for Medicaid.

However, the Participating Consumer applying for Medicaid Extended Coverage shall remain subject to Medicaid resource transfer and spend down rules regarding his/her countable resources or assets greater than the total dollar amount of the insurance benefits paid on his/her behalf, and subject to the income limitations set forth at New York State Social Services Law Section 366. The Participating Consumer eligible for Medicaid Extended Coverage shall not be subject to Medicaid liens and recoveries against his or her protected resources for the cost of correctly paid Medical Assistance.

Participating Insurers shall offer policies/certificates approved by the New York State Department of Financial Services under Department of Financial Services Regulation 144. The State and Participating Insurers shall comply with all pertinent federal and New York State laws and regulations.

III. INSURER POLICY/CERTIFICATE COVERAGE REQUIREMENTS

1. **Basic Policy/Certificate Coverage:** All Participating Insurers must provide policy/certificate coverage which contains the following:

- **Nursing Home Care and Home- and Community-Based Care Coverage and Residential Care (RCF) Facility:**

Two (2) years of a daily benefit amount which equals the current minimum daily benefit amount set forth under New York State Department of Financial Services Regulation 144 (11NYCRR39) for the 2/2/100 plan design. A choice of higher daily benefit amount coverage may be elected at the option of the Participating Consumer. Benefits must be provided as set forth in New York State Department of Financial Services Regulation 144 and as explained in this agreement.

RCF Coverage: Includes room and board accommodations, shall be payable, provided that such care is rendered by entities set forth in Regulation 144, or by entities that fully satisfy all the following requirements:

1. The entity provides 24-hour care and services sufficient to assist residents with needs which result from the inability to perform Activities of Daily Living or from Severe Cognitive Impairment;
2. The entity has a minimum of 3 residents;
3. The entity uses aides trained or certified to provide maintenance or personal care consistent with any laws or regulations applicable to the provision of such care;
4. The entity provides 24-hour supervision of residents by a trained and awake staff;
5. The entity has formal arrangements for emergency medical care;
6. The entity maintains written records of the services provided to each resident;
7. The entity provides residents with at least 2 meals per day; AND
8. The entity has appropriate methods and procedures for the administration of prescribed drugs where allowed by law.

Where a jurisdiction has a law and/or regulation which governs whether an entity providing RCF coverage is legally operating in that jurisdiction, the requirements of the law and/or regulation in that jurisdiction shall exclusively govern whether RCF coverage is being provided by a legally operating entity.

- **Elimination Period:** A waiting period no greater than 60 days may be calculated according to service days or calendar days or any combination thereof. However, the policy/certificate must disclose to the Participating Consumer the manner in which the elimination period is calculated, as well as the effect on premium cost of using calendar days or service days or any combination thereof.
- **Inflation Protection:** Qualified policies/certificates shall provide lifetime inflation protection of three and one-half percent compounded or five percent compounded on an annual calendar or policy year basis. The insurer shall permit the covered person to choose either the three and one-half percent compounded or the five percent compounded lifetime inflation option. Inflation protection shall be mandatory except if the policy/certificate is purchased at or after age 80.
- **Notice of Eligibility to Apply for Medicaid Extended Coverage:** At least 90 days prior to a Participating Consumer meeting the durational requirement for receiving Medicaid Extended Coverage (i.e. utilizing 24 months of nursing home benefits or its equivalent under the policy/certificate,) the Participating Insurer shall send a notice to the Participating Consumer. The notice shall inform the Participating Consumer of the following: (1) the Participating Consumer's eligibility to apply for Medicaid Extended Coverage; (2) the approximate date of satisfying the durational requirement for Medicaid Extended Coverage; (3) the approximate number of remaining benefit days available before policy/certificate benefits are exhausted; (4) the total dollar amount of benefits received to date under the policy/certificate; and (5) the approximate dollar amount of remaining benefits that might be claimed under the policy/certificate. The Participating Insurer shall send the 90-day notice letter (see ATTACHMENT 4) on its letterhead to the Participating Consumer regarding this status of impending exhaustion of the minimum duration period (i.e. 24 months of nursing home benefits or its equivalent under the policy/certificate.) The Participating Insurer shall also submit a copy of this 90-day notice letter to the Partnership program office concurrent with the mailing of

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this report to the Participating Consumer. Remaining benefit days shall be measured by service in receipt at the time of notification.

- **Cumulative Report of Benefit Usage:** After a Participating Consumer has met the durational requirement for receiving Medicaid Extended Coverage (i.e. utilizing 24 months of nursing home benefits or its equivalent under the policy/certificate,) the Participating Insurer shall send a Cumulative Report of Benefit Usage (see ATTACHMENT 5), on a quarterly basis, informing the Participating Consumer of (1) the total dollar amount of benefits received to date under the policy/certificate; and (2) the approximate dollar amount of remaining benefits that might be claimed under the policy/certificate. The report shall first be sent at the close of the calendar quarter that ends following the date when the durational requirement has been met, and will continue until the issuance of the Final Policy/Certificate Benefit Report described below. The Participating Insurer shall also send a copy of each Cumulative Report of Benefits Usage to the Partnership program office concurrent with the mailing of this report to the Participating Consumer.
- **Final Policy/Certificate Benefit Report:** With respect to a Participating Consumer who has met the durational requirement for receiving Medicaid Extended Coverage, the Participating Insurer shall send a final policy/certificate benefit report (see ATTACHMENT 6) to the Participating Consumer on its letterhead within fourteen (14) business days from the date of benefit exhaustion or when the policy/certificate ceases to be in force for a reason other than the death of the policy/certificate holder, whichever occurs first. This Report will inform the Participating Consumer of the final, total dollar amount of benefits paid for qualified long-term care services under his/her policy/certificate coverage. The Participating Insurer shall also submit a copy of this Report to the Partnership program office concurrent with the mailing of this Report to the Participating Consumer.
- **Benefits Exhaustion Prior to Meeting Durational Requirement:** If a Participating Consumer is faced with a gap in coverage or benefits between the time benefits are exhausted under the terms of a Partnership insurance policy/certificate and the time that the Participating Consumer can apply for Medicaid Extended Coverage, and if this gap is caused by the receipt of any benefits under such policy/certificate other than those specified in this agreement and in New York State Department of Financial Services Regulation 144, coverage during this interim gap period will be the responsibility of the Participating Insurer.
- **Lapse Notification:** The Partnership Insurer must comply with all the Federal and State tax qualification requirements regarding notification when an insured lapses the policy/certificate.
- **Payment:** Payments made by the Participating Insurer shall only be made for services rendered on an expense-incurred basis in amounts up to the daily maximum under the contract. Where the payment made is less than the maximum benefit available, the unspent portion of the maximum benefit shall be held for the Participating Consumer's future use. The Participating Consumer's initial coverage is characterized as an account of benefit dollars equal to the contract daily benefit amount multiplied by the benefit duration. The value of the Participating Consumer's account shall be adjusted over time by the inflation protection applicable to the contract and any utilization that occurs.
- **Care Management:** Defined as care management coordination services. This benefit provides the Participating Consumer with: 1) Referral and Information Services concerning policy/certificate coverage, including but not limited to coverage, benefits, and potential resources, which shall be characterized as an expense cost; 2) Consultation Services, defined as assistance and advice in choosing and applying for long term care services, based on the personal needs of the Participating Consumer; and 3) Care Planning Services, including assessment of needs for services and the development of a plan of care. The consultation shall be given by an individual with professional training and experience in arranging and managing long term care services, and shall be offered by the Participating Insurer. The Care Planning Services shall be provided by a Licensed Health Care Practitioner as defined in Public Law 104-191, and shall be offered by the Participating Insurer. However, the Participating Consumer shall have the option to seek such services outside the Participating Insurer. Participating Consumers eligible for benefits shall receive care management benefits equal in value to two policy/certificate coverage nursing home days per calendar year or per policy/certificate year while in benefit status to pay for outside consultation services, which shall be characterized as a claims cost.

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- Policy/Certificate with Greater Duration: Additional products which exceed the basic policy/certificate basic coverage shall provide less than a 3/3/100 (3 years of nursing home coverage and 3 years of home and community-based care coverage) plan design.
2. **Optional Permissible Policy/Certificate Coverage**: All Participating Insurers must offer a basic policy/certificate product providing minimum coverage as set forth above. In addition, products may be offered with optional permissible policy/certificate coverage as set forth below in addition to the aforesaid mandatory Basic Policy/Certificate Coverage:
- Waiver of Premium: The Basic Coverage Policy/Certificate may include waiver of premium as an optional, permissible basic benefit included in coverage. If the insurer offers this benefit, each prospective insured must also be offered a 2/2/100 plan without this benefit.
 - Independent Provider: Home care benefits shall be paid for covered services rendered by an independent provider who is licensed as a health care practitioner, or certified or officially-trained as a home health care provider, without being affiliated with an entity licensed and/or certified by the New York State Department of Health, or agency exempt from licensure or certification in accordance with Article 28 and/or 36 of the Public Health Law or Section 505.14 of the Social Service Law and regulations promulgated thereunder. Home care benefits shall be paid for covered services included in a plan of care and rendered by independent providers outside of New York State, when these independent providers outside of New York State are licensed health care practitioners, or certified or officially-trained as a home health care provider in the jurisdiction where they render home care services, without being affiliated with an entity licensed and/or certified by the jurisdiction where the out-of-state independent providers render home care services. If the insurer offers this benefit, each prospective insured must also be offered a 2/2/100 plan without this benefit.
 - Non-licensed/non-certified Provider or Non-licensed/non-certified Caregiver: Home care benefits, including homemaker services, which are not arranged nor provided and supervised by a licensed and/or certified home care agency, may be payable as covered services rendered by a non-licensed/non-certified provider or non-licensed/non-certified caregiver. The terms provider and caregiver exclude members of the Participating Consumer's immediate family including spouse, parent, son, son-in-law, daughter, and daughter-in-law. The term also excludes anyone who normally lived in the policy/certificate holder's household at the time s/he became eligible for benefits.

A variety of tasks and services may be performed according to a plan of care developed by a licensed health care professional according to applicable laws and/or regulations. The Participating Consumer and/or his/her Representative must be able and willing to make an informed decision, and must agree on the receipt of services by a non-licensed/non-certified provider or non-licensed/non-certified caregiver. The Participating Consumer and/or his/her Representative must also sign the Memo of Understanding (MOU) (see ATTACHMENT 7) that specifies the responsibilities of the Participating Insurer, the Participating Consumer, and/or his/her Representative under the MOU.

If the insurer offers this benefit, each prospective insured must also be offered a 2/2/100 plan without this benefit.
- Combined Home and Community-Based Care: At the discretion of the insurer, it shall be permissible to combine home and community-based care benefit days to pay an amount in excess of the daily benefit amount set forth in the policies/certificates. In no case where home and community-based care benefit days have been combined shall the equivalent of more than 31 days of home and community-based care benefits be provided in any one-month period. If the insurer offers this payment feature, each prospective insured must also be offered a 2/2/100 plan without this payment feature.
 - Permissible Alternative Benefits: Permissible Alternative Benefits shall only be offered for products above the 2/2/100 basic policy/certificate coverage and shall be deducted from the lifetime maximum coverage of at least 24 months per covered person. Provided that benefits offered are qualified long-term care services as defined in Section 7702B(b) of the Internal Revenue Code of 1986, as amended by

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HIPAA (Public Law 104-191), and the lifetime aggregate total dollar amount per covered person is less than or equal to the contract daily benefit amount currently in effect multiplied by 25, the following may be offered:

- additional nursing home care and residential care facility reserved bed benefit,
- additional respite benefit,
- additional care management benefit,
- home modification benefit,
- informal caregiver training benefit,
- emergency response system benefit,
- therapeutic device benefit,
- supportive/durable medical equipment benefit, and
- specialized transportation benefit, such as specialized transportation to and from adult day care.

Note: Permissible alternative long-term care benefits may be added, provided such benefits are approved by the Partnership governing body, and those benefits listed above, approved by the Partnership governing body, are now permissible alternative long-term care benefits. New permissible alternative long-term care benefits may be added to this list.

3. **Other Required Product Offerings:** The Participating Insurer marketing and issuing a policy/certificate providing coverage under the 2/2/100 plan design must concurrently offer policies/certificates providing the basic 1.5/3/50 minimum plan design under regulations of the New York State Department of Financial Services and the appropriate Partnership for Long Term Care Insurer Participation Agreement.

IV. POLICY/CERTIFICATE CONVERSION

1. **Individual Policyholders:** The Participating Insurer which has previously sold individual Partnership long term care insurance approved under Section 39.3 of New York State Department of Financial Services Regulation 144, 11 NYCRR 39 shall, upon marketing new Partnership long term care insurance approved under Section 39.6 of New York State Department of Financial Services Regulation 144 11 NYCRR 39, on a one-time basis, offer to individual policyholders either 1) the Conversion or 2) the Moratorium Option set forth below.

Group Policy/Certificate holders: The Participating Insurer which has previously sold Group Partnership long term care insurance approved under Section 39.3 of New York State Department of Financial Services Regulation 144, 11 NYCRR 39 shall, upon marketing new Partnership long term care insurance approved under Section 39.6 of New York State Department of Financial Services Regulation 144 11 NYCRR 39, on a one-time basis, offer the Moratorium Option set forth below to group policy/certificate holders if the groups are employers, unions or professional associations. For all other groups, the Partnership Insurer shall comply with the section above concerning "Individual Policyholder."

1) **Conversion Option:**

- Eligibility Criteria: The option to convert to Partnership long term care insurance approved under Section 39.6 must be extended by written notification to each individual policyholder who:
 1. successfully applied for Partnership insurance under Section 39.3 during the period from ninety (90) days prior to the date of approval of the Section 39.6 product to the date of first issuance of the Section 39.6 product; and
 2. was subsequently accepted for such coverage.
- Conversion Process Period: The conversion option shall provide a thirty (30) day minimum window to convert, dating from written notification of the conversion option to the consumer.

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- **Special Underwriting Criteria:** The Participating Insurer shall approve Partnership policy applicants who satisfy the above-listed conversion eligibility criteria, and who meet underwriting criteria that shall consider no more than the following: current benefit status; current receipt of formal or informal care, at such a level as to demonstrate that the policyholder would reasonably be expected to meet the insured events criteria within one year, if the policyholder were formally assessed; current use of ambulatory devices or medical equipment that would reasonably demonstrate that the policyholder would be expected to meet the insured event criteria, if the policyholder were formally assessed.

OR

2) **Moratorium Option:** The Participating Insurer shall impose a moratorium on issuing the new long term care insurance product approved under Section 39.6 of New York State Department of Financial Services Regulation 144 during a period of ninety (90) days after the date of approval of the Section 39.6 insurance product. The Participating Insurer shall take all appropriate measures to ensure that information about the new Section 39.6 insurance product will be provided to prospective insureds contemplating the purchase of a Section 39.3 insurance product from the Participating Insurer during the ninety (90) day moratorium period applying to the Section 39.6 insurance product.

2. Replacements shall be governed by the notification and disclosure requirements set forth under New York State Department of Financial Services Regulation 62, 11 NYCRR 52, and the following requirements shall apply as pertinent to the replacement situation described:

Non-Partnership to Partnership: Commissions shall not exceed the limit set forth under New York State Department of Financial Services Regulation 62, 11 NYCRR 52; and consideration of former insured status must be acknowledged in at least one of the following ways in the case of policy/certificate replacement by the Participating Insurer for current customers:

- a) Conversion to Partnership policy/certificate coverage may be issued at an age less than the attained age of the Participating Consumer, in which case the Participating Insurer is permitted to adjust or supplement the premium for the purpose of recovering underfunding;
- b) The new Partnership policy/certificate premium shall reflect credit for prefunding under the previously held non-Partnership policy/certificate, which credit may take the form of a one-time offset against the new Partnership policy/certificate premium or a reduction over time in the premium.

Partnership to Partnership: Replacement shall be in accordance with New York State Department of Financial Services Regulation 144. If an insured with existing in-force coverage under Section 39.5 of Regulation 144 downgrades (lessens company liability in all respects except where laws, regulations and/or this agreement do not permit the insured who is downgrading to lessen company liability) to a new policy/certificate under Section 39.6 of Regulation 144, the insured shall not be subject to medical underwriting at any time. The second sentence of this paragraph applies only to downgrades with the same Participating Insurer or its successors in interest.

Partnership to Non-Partnership: The purchaser shall sign a statement acknowledging that the new policy/certificate to which conversion is made does not conform to Partnership requirements and Medicaid Extended Coverage is terminated whether or not the original policy/certificate was held by the Participating Insurer issuing the non-Partnership-approved policy/certificate.

3. Where a Participating Consumer replaces his or her Partnership policy/certificate with another Partnership policy/certificate with the same Participating Insurer and such replacement results in a more favorable rate class, or where the Participating Consumer is applying for a more favorable rate class when converting from a non-Partnership policy/certificate to a Partnership policy/certificate and would not have been subject to full underwriting except for the higher rate class, such replacement shall be considered an upgrade and the Participating Insurer may require full underwriting regardless of how long the previous policy/certificate was in force.

V. DENIAL OF BENEFIT AUTHORIZATION REQUESTS (BARs)

Denied Benefit Authorization Requests (BARs) shall be reviewed by Partnership management. The form and period of review shall depend on the general reason for denial.

Insured Event Denials: Where a request for benefits has been submitted to the Participating Insurer and denied because the Participating Insurer's assessment of the claimant indicates that he or she does not meet the insured event criteria (see Appendix A, Determination of Eligibility for Benefits and Standard for Contested Benefit Review for Tax Qualified (TQ) Partnership Policies/Certificates Intended to Be Tax Qualified under Section 7702(b) of the Internal Revenue Code), the Partnership program office shall be notified within ten (10) business days that the BAR has been denied. Notification to the Partnership program office shall include all information indicated by Appendix D, New York State Partnership for Long Term Care Benefit Authorization Request Denial Form (New York State Partnership for Long Term Care, Form Number 020). BARs denied due to failure to meet insured event status shall be processed by the Partnership management in accordance with procedures described in Appendix C, Denied Benefit Authorization Request Monitoring Process.

When the Participating Insurer notifies a Participating Consumer regarding a denied BAR due to a determination that the claimant does not meet the insured event criteria, the Participating Insurer shall include the language in ATTACHMENT 8 in a letter of notification to the claimant.

Non-Insured Event Denials: BARs denied for reasons other than failure of the Participating Consumer to meet the insured event criteria shall be reported to the Partnership program office in accordance with procedures described in Appendix C, Denied Benefit Authorization Request Monitoring Process. The Partnership program office shall examine BAR denial patterns (see Appendix C).

VI. ALTERNATIVE DISPUTE RESOLUTION (ADR)

Where a dispute regarding eligibility for benefits between the Participating Insurer and the Participating Consumer is not capable of resolution by the processes described in Appendix C, Denied Benefit Authorization Request Monitoring Process, the Partnership program office shall notify the Participating Consumer of the issues in dispute. The Participating Consumer may pursue the denied BAR through channels available under the Department of Financial Services. The establishment of Alternative Dispute Resolution (ADR) hereunder shall not be applicable to and shall not constitute precedent for any other line of business licensed for sale in the State of New York.

Where the Participating Consumer elects to enter ADR, the decision rendered thereby shall be binding on both the Participating Insurer and the Participating Consumer. Prominent notice of this option and its consequences shall be disclosed on the face page of the policy/certificate. See Appendix C, Denied Benefit Authorization Request Monitoring Process for detailed information regarding ADR.

VII. SOCIAL UNDERWRITING PROHIBITED

Social underwriting, defined as refusal to issue an insurance policy/certificate based upon non-medical primary determinants, is prohibited. However, social factors may be considered when pricing a policy/certificate for applicants, so long as a clear rationale for the pricing differential and associated premium impact is submitted to the Partnership. Non-medical factors unacceptable for use as primary determinants when refusing to issue a policy/certificate to an applicant include the applicant's: gender; marital status; living arrangements; sexual preference; presence or absence of an assumed support network (for example but not limited to family, church, community), including health status of probable caretaker spouse; current or past occupation except with respect to Group Policies or Employer-Sponsored Policies; hobbies, except recognized high risk pursuits; educational level; and geographic location.

VIII. WITHDRAWAL FROM PARTNERSHIP PARTICIPATION

The Participating Insurer may withdraw from marketing and issuing Partnership-approved policies/certificates upon not less than sixty (60) days written notice to the Partnership and the New York State Department of Health. Inforce individual Partnership-approved policies shall not be affected by Participating Insurer withdrawal. Where Participating Insurer withdrawal involves inforce group Partnership policy/certificate coverage, continuation and conversion rights of New York

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State Insurance Law, New York State Department of Financial Services Regulation 62, 16th Amendment, 11 NYCRR 52, shall apply. Willful failure to comply with the terms of this Agreement as determined by the Evolution Board (see "Oversight" below) or effective withdrawal by a Participating Insurer without requisite written notice to the Partnership shall be deemed both intent to withdraw from the Partnership and a breach of contract.

If a Participating Insurer ceases to market and issue Partnership-approved policies/certificates, all existing Partnership-approved policies/certificates issued by such Participating Insurer shall continue in force and effect, and the Participating Insurer shall continue to be bound by the terms of this Agreement, including but not limited to the data reporting requirements of Section XII, with respect to such policies/certificates. A Participating Insurer which has issued Partnership-approved policies/certificates shall not transfer its interest in such policies/certificates to another Insurer unless the subsequent Insurer and the State have entered into an Insurer Participation Agreement with respect to such policies/certificates. A Participating Insurer shall give at least thirty (30) days notice to the Partnership before transfer of its interest in Partnership policies/certificates to another Insurer.

The State may unilaterally withdraw from the Partnership or terminate the Participating Insurer upon not less than sixty (60) days written notice to the Participating Insurer, unless the State determines that an emergency exists, where Medical Assistance funding is adversely affected by the Partnership or the activities of the Participating Insurer are detrimental to the public interest to such an extent that adherence to notification requirements specified herein would severely and adversely impact other Participating Insurers, Participating Consumers, or the Partnership.

If the State elects to withdraw from the Partnership, all new sales of Partnership-approved policies/certificates shall be halted. In the event of such withdrawal and cessation of sales, the State shall honor all obligations and considerations in accordance with the State/Consumer Agreement previously entered into and signed by the State and Participating Consumers provided that the Participating Consumer maintains his or her inforce policy/certificate and complies with his or her responsibilities also contained in the State/Consumer Agreement.

IX. OVERSIGHT

1. The Partnership is overseen by the Evolution Board, (the "Board") a standing committee consisting of representatives from the State and from Participating Insurers. The State and the Participating Insurers shall possess an equal number of representative votes on the Board. The Board shall have jurisdiction of dispute resolution outside the BAR review process set forth herein at "Denial of Benefit Authorization Requests," and shall make recommendations for Partnership modification and improvement of mandated coverage, reporting requirements, and the Participating Insurer Agreements. The Board shall be chaired by the Partnership Director, who shall act as a Board member without voting power.

Composition and Voting Power of Board: The number of Participating Insurer votes on the Board shall be limited to one (1) vote for each Participating Insurer. The State shall hold that number of votes that equals the total number of Participating Insurer votes. Participating Insurers may unanimously agree to reduce the number of their board representatives through a selection process to be determined by the Participating Insurers. Upon any reduction in the number of Participating Insurer representatives, the number of State votes will be reduced correspondingly. Participating Insurer Representatives shall serve at the discretion of their companies. State Representatives shall be comprised of members of the Department of Health, Department of Financial Services, State Office for the Aging, and such other agencies, divisions or departments as may be named by the Governor of the State of New York, and shall serve at the discretion of their respective Commissioners, Directors or Superintendents. The number of State votes shall be divided equally among each agency, Division or Office representing the State.

Meetings: Attendance at all board meetings shall be mandatory to preserve the deliberative functions of the Board. Meetings shall be regularly scheduled on a quarterly basis, but special meetings may be called at the discretion of the Director. The Director shall notice all regular and special meetings and prepare the meeting agenda. The meeting agenda shall consist of any issues proposed to the Director by board representatives for consideration at the meeting. Members may also propose consideration of issues at the meeting without prior notification, however, such proposals will only be considered as time constraints within the established agenda permit.

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Quorum: A quorum consisting of one-half of the Participating Insurer representatives and three state representatives shall be required at the outset of the meeting for the conduct of business, however a quorum is not required to adjourn a meeting.

Voting: A majority of representative votes in person or by proxy in favor shall be sufficient to pass a resolution except where modification of this Agreement is proposed. All representative votes entitled to be cast thereon must be voted in person or by proxy, and a majority vote in favor shall be required for passage of a resolution to modify this Agreement. A failure to vote thereon shall be deemed an abstention. In the event of tie vote, the matter under consideration shall be tabled. Issues not involving modification of this Agreement may be submitted for vote thereon during the meeting in which they are proposed, unless a motion to table vote thereon is made and duly seconded, in which case the matter shall be tabled until the following meeting. Issues involving modification of this Agreement shall not be submitted for vote thereon during the meeting in which they are proposed, and may not be submitted for vote thereon until that meeting that follows complete consideration of the issue presented.

Financial Obligations: See ATTACHMENT 9, Conditions of Financial Responsibility between the State and Participating Insurers in the New York State Partnership for Long Term Care.

2. A Joint Technical Review Board ("JTRB") shall be established and operate pursuant to Appendix B, Joint Technical Review Board, as an independent, impartial body which shall resolve disputes that cannot be disposed of by the Partnership.

X. AGREED UPON DISCLAIMER WORDING FOR PARTNERSHIP ADVERTISEMENTS

Effective July 1, 2004, Participating Insurers must use disclaimer language agreed upon by the Evolution Board and set forth in ATTACHMENT 10 when advertising and otherwise marketing Partnership insurance policies/certificates. Such language demonstrates an acknowledgement by Participating Insurers of their obligation to comply with New York State Department of Financial Services Regulation 34 (11 NYCRR 215).

XI. MODIFICATION OF THIS AGREEMENT

Proposals for modification of this Agreement may be submitted to the Evolution Board for deliberation. Decisions of the Board disposing of modification proposals shall be binding.

XII. DATA AND REPORTING

It is necessary to collect information concerning Participating Consumers to administer the Partnership, review BARs, verify eligibility for Medicaid Extended Coverage and evaluate the success of the Partnership, including the suitability of Partnership insurance purchases in the target market according to coverage plan designs. New York is one of the few states with federal authorization to develop Partnership alternatives to long term care financing. The information collected will be combined, compared and studied to develop solutions to long term care financing that may be applied throughout the United States. To fulfill these objectives, Participating Insurers are required to compile and disclose to the Partnership program office information concerning Participating Consumers, as authorized by the Participating Consumer pursuant to the Participating Consumer Agreement. The Partnership program office shall use the information solely to evaluate Partnership objectives, shall refrain from publicly identifying a specific Participating Consumer or Participating Insurer in any communications, and shall take reasonable steps to protect Participating Consumer and Participating Insurer confidentiality.

The Participating Insurer shall comply with the data reporting and documentation requirements set forth in Appendix D, Long Term Care Insurance Uniform Data Set and New York State Partnership for Long Term Care Reporting Addendum. The Uniform Data Set has been developed collaboratively among the four Partnership states, New York, California, Connecticut, and Indiana, and in consultation with Participating Insurers. It is designed to provide important information for monitoring state programs, and utilization experience to Participating Insurers. The New York State Partnership for Long Term Care Reporting Addendum sets forth additional reporting requirements not contained in the Uniform Data Set, which are required of Participating Insurers by New York State.

XIII. NOTICES

Any notices under this Agreement shall be sent by certified mail, return receipt requested, to the parties at the following addresses:

Partnership Office:

New York State Partnership for Long-Term Care
New York State Department of Health
Corning Tower, Empire State Plaza
Albany, NY 12237

Participating Insurer: _____

XIV. GOVERNING LAW

This Agreement shall be governed by the laws of the State of New York.

Dated: _____

Participating Insurer

By: _____

Print Name

Title

Dated: _____

New York State Department of Health

By: _____

Print Name

Title

ATTACHMENT 1

CURRENT MANDATORY PARTNERSHIP COURSE REQUIREMENTS FOR PARTNERSHIP CERTIFIED AGENT/BROKER DESIGNATION

As of April 1, 2005, the New York State Health Department requires that all licensed agents and brokers authorized to sell accident and health insurance who market and sell Partnership–approved policies/certificates must successfully complete their Partnership-Medicaid training course.

In fulfilling this New York State Health Department requirement, Partnership-Certified Agents/Brokers earn six (6) continuing education (CE) credits approved by the New York State Department of Financial Services. They may apply these credits toward the biennial renewal of their insurance licenses as required by the New York State Department of Financial Services.

In order to successfully complete this course, agents and brokers must:

- Complete the Partnership E-learning self-study course module.
accessible at <http://www.nyspltc.org/training/index.htm>
- Pass an online exam based on the E-learning module.

The New York State Department of Financial Services awards six (6) CE credits for the self-study module and mandatory online exam.

Successful completion of the course will result in the Partnership awarding the agent or broker a Certificate of Completion as well as course completion documents for the six (6) credits CE online training and exam. These two (2) documents shall serve as proof of the agent's or broker's Partnership certification to market and sell Partnership-approved policies/certificates.

ATTACHMENT 2

RATIONALE FOR PARTICIPATING INSURERS AND/OR PARTICIPATING AGENTS/BROKERS DISTRIBUTING AND COLLECTING LONG TERM CARE INSURANCE PERSONAL WORKSHEET AND DISCLOSURE STATEMENT, AND STANDARDS FOR IMPLEMENTATION OF DISTRIBUTION AND COLLECTION

In accordance with purchase suitability guidelines of the NAIC Model Act and Regulation, the selling Partnership Certified Agent(s)/Broker(s) and/or Participating Insurer is/are required to examine: *(1) an applicant's ability to pay for the proposed coverage and any 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 (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 of existing insurance (if any).* To address these guidelines, the Partnership Certified Agent(s)/Broker(s) and/or the Participating Insurer must request that the applicant complete the Personal Worksheet that factors in the applicant's income, expenses, savings and investments to determine whether a Partnership policy/certificate is appropriate for him/her. Signing the Personal Worksheet Disclosure Statement serves as verification that the Participating Insurer, Partnership Certified Agent(s)/Broker(s), and Participating Consumer have disclosed and reviewed relevant information, respectively and as appropriate, prior to the purchase of Partnership insurance coverage.

If the Partnership policy/certificate application is handled by a Partnership Certified Agent/Broker, s/he must also sign the Disclosure Statement. If the policy/certificate application results from a direct mail or other type of non-agent situation, the Disclosure Statement need only be signed by the applicant prior to returning it with the application Partnership insurance coverage.

Signed Disclosure Statements are to be included in the Participating Insurer's applicant file.

ATTACHMENT 3

**PARTICIPATING INSURER'S VERIFICATION OF THE SELLING AGENT'S/BROKER'S
STATUS AS A PARTNERSHIP CERTIFIED AGENT/BROKER**

(To be submitted on company letter head and signed by the appropriate department head.)

This notice accompanying the Consumer Participation Agreement for *(name of insured here with accompanying policy/certificate number)* verifies the status of the agent and/or broker who sold a Partnership for Long-Term Care insurance product to this Participating Consumer as a Partnership Certified Agent/Broker. Copies of the agent's/broker's mandated Partnership-Medicaid training course Certificate of Completion and pertinent documents indicating the award of continuing education course credits associated with such training course are on file with this company as proof of this company's compliance with the Partnership program requirement that only Partnership Certified Agents/Brokers shall market and sell Partnership for Long-Term Care policies/certificates.

Signed _____

Date _____

Department Head

ATTACHMENT 4

90-DAY NOTICE OF QUALIFYING STATUS FOR MEDICAID EXTENDED COVERAGE

Date of Report/Notice:
Policy/Certificate Holder:
SSN:
Policy/Certificate #:

Dear _____ :

Because you are a Participating Consumer in the New York State Partnership for Long-Term Care program, we are sending you this notice to inform you that, with continued benefit use, you will meet the minimum durational requirement for Medicaid Extended Coverage in approximately 90 days. This means that when you apply for Medicaid, Medicaid will exempt an amount of your assets equivalent to the dollar amount of benefits you received under your Partnership long term care insurance policy. This amount of assets will not be subject to Medicaid’s usual transfer and spend down rules, and will not be subject to a Medicaid lien or recovery. You should provide a copy of this notice to your local Department of Social Services when you apply for Medicaid Extended Coverage.

Medicaid will disregard the dollar amount of long term care insurance benefits you have received up until the time you are found eligible for Medicaid Extended Coverage. The higher the dollar amount of benefits received under your insurance policy, the higher the amount of your assets that will be protected when you apply for Medicaid Extended Coverage. Therefore, if you still have coverage remaining under your policy at the point that you are eligible to apply for Medicaid Extended Coverage, you may want to delay applying for Medicaid Extended Coverage until you have used more benefits under your policy. On the other hand, if you will be exhausting the benefits available under your Partnership policy at the same time you meet the minimum durational requirement for Medicaid Extended Coverage, you should apply for Medicaid right away to ensure a smooth transition from private insurance coverage to Medicaid.

The number of additional benefit days that must be used under your Partnership policy to qualify for Medicaid Extended Coverage is indicated below, along with other important information that will help you decide when to submit an application for Medicaid Extended Coverage.

- Approximate date of satisfying minimum benefit duration requirement: _____
- Total Dollar Amount of Insurance Benefits Received To Date for Qualified Long Term Care Services: \$ _____
- Approximate Dollar Amount of Additional Insurance Benefits Available Under the Policy for Qualified Long Term Care Services: \$ _____
- Approximate number of benefit days available before policy/certificate benefits are exhausted: _____

At the point you have exhausted all of the benefits under your Partnership policy/certificate, we will send you a “Notice of Exhaustion of Policy/Certificate Benefits” that will indicate the final, total amount of insurance benefits paid on your behalf for qualified long-term care services. You should give a copy of this notice to the local Department of Social Services (LDSS) where you apply for Medicaid Extended Coverage.

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When you are ready to apply for Medicaid Extended Coverage, you should contact the LDSS in the county where you reside. However, if you are residing in a nursing home or an adult residential care facility, you should contact the LDSS in the county where you were residing prior to your admission. The telephone number of the appropriate LDSS office can be found in the blue pages of your telephone directory under County Government, Department of Social Services. If you live outside New York, please call the New York State Medicaid helpline with questions you may have about Medicaid Extended Coverage at 1-800-541-2831.

If you have any questions about this report, please write or call us at [*toll free number of insurer here*]. If you have any questions about the MEC application or eligibility process, please call your LDSS or the Medicaid helpline.

ATTACHMENT 5

Cumulative Report of Benefit Usage

Date of Report:
Policy/Certificate Holder:
SSN #:
Policy/Certificate #:
Quarter Reported: (MM/DD/YYYY to MM/DD/YYYY)

Dear _____ :

Because you are a Participating Consumer in the New York State Partnership for Long-Term Care program (NYSPLTC), we are providing you with this summary of benefits paid to date under your Partnership policy/certificate for qualified long-term care services. Amounts paid for qualified long-term care services are used to determine the amount of your protected assets for purposes of Medicaid Extended Coverage under the NYSPLTC.

- Total Dollar Amount of Insurance Benefits Received To Date for Qualified Long Term Care Services
\$ _____

- Approximate Dollar Amount of Additional Insurance Benefits Available Under the Policy for Qualified Long Term Care Services
\$ _____

If you have any questions about this report, please write or call us at [*toll free number of insurer here*].

ATTACHMENT 6

FINAL POLICY/CERTIFICATE BENEFIT REPORT

Date of Report:
Policy/Certificate Holder:
SSN #:
Policy/Certificate #:
Date of Benefit Exhaustion or Policy/Certificate Cancellation:

Dear _____ :

Because you are a Participating Consumer in the New York Partnership for Long-Term Care program, we are sending you this report to inform you of the final, total amount of insurance benefits paid on your behalf under your policy/certificate coverage for qualified long-term care services. Because this figure will be used in determining the amount of your protected assets under Medicaid Extended Coverage, you should give a copy of this report to the local Department of Social Services (LDSS) office where you applied or will apply for Medicaid Extended Coverage under the New York State Partnership for Long Term Care program.

- Final, Total Amount of Benefits Paid for Qualified Long Term Care Services

\$ _____

This report represents the last correspondence you will receive from us regarding your benefit payments as they pertain to Medicaid Extended Coverage.

If you have any questions about the information in this report or about your policy/certificate coverage, please write or call us at *[toll free number of insurer here]*. If you have any questions about your application or eligibility for Medicaid Extended Coverage in New York, please call your LDSS office listed in the blue pages of your telephone directory under County Government, Department of Social Services. If you live outside New York and need information or assistance about Medicaid Extended Coverage, please call the New York State Medicaid helpline at 1-800-541-2831.

ATTACHMENT 7

MEMORANDUM OF UNDERSTANDING FOR USE OF NON-LICENSED/NON-CERTIFIED PROVIDER(S) OR NON-LICENSED/NON-CERTIFIED CAREGIVER(S)

Qualified long-term care services may be provided by a non-licensed/non-certified provider or non-licensed/non-certified caregiver when the Participating Consumer and/or his/her Representative, and the Participating Insurer agree on the provision of services by such non-licensed/non-certified provider or non-licensed/non-certified caregiver. The terms provider and caregiver exclude members of the Participating Consumer's immediate family including spouse, parent, son, son-in-law, daughter and daughter-in-law. The term also excludes anyone who normally lived in the policy/certificate holder's household at the time she/he became eligible for benefits. The purpose of the provision of services by a non-licensed/non-certified provider or non-licensed/non-certified caregiver is to provide policy/certificate holders greater flexibility and freedom of choice in using their insurance benefits.

This Memorandum of Understanding (MOU) is by and between the Participating Consumer and/or his/her Representative, and the Participating Insurer. This MOU lists the responsibilities that all the parties to this agreement will assume upon execution of the MOU.

The parties hereby agree to assume the following responsibilities: The Participating Consumer and/or his/her Representative shall:

1. Be informed of the requirement, existence, and content of a Plan of Care developed and periodically updated by a licensed health care practitioner (physician, registered professional nurse, or licensed social worker);
2. Fully understand what tasks will be performed by the non-licensed/non-certified provider or non-licensed/non-certified caregiver;
3. Make an informed decision to allow/accept services by such non-licensed/non-certified provider or non-licensed/non-certified caregiver.
4. Make informed choices regarding the type and quality of services available;
5. Pursuant to the Plan of Care and in consultation with a licensed health care practitioner, recruit, hire, train, supervise, schedule, and terminate, as needed, the non-licensed/non-certified provider(s) or non-licensed/non-certified informal caregiver(s); and
6. Keep the signed MOU.

The Participating Insurer shall:

1. Ascertain that the Participating Consumer and/or his/her representative are able and willing to make informed choices regarding the type and quality of services available;
2. Provide informational support for the Consumer and/or his/her Representative to facilitate their making informed decisions;
3. Assist the Participating Consumer with recruitment and service coverage referrals, and provide informational support for the training and supervision of the non-licensed/non-certified provider(s) or non-licensed/non-certified caregiver(s);
4. Determine periodically (at least at the time of benefit recertification) that the Participating Consumer and/or his/her Representative is willing to continue receiving services by a non-licensed/non-certified provider or non-licensed/non-certified caregiver; and
5. Keep a copy of the signed MOU.

2/2/100 Plan (Ver. 12/13/12)

The Participating Consumer and/or his/her Representative, and the Participating Insurer will sign to execute this agreement.

Signatures

Participating Consumer (print name)

Participating Consumer (signature)

Date

Participating Consumer's Representative (print name)

Participating Consumer's Representative (signature)

Date

Participating Insurer (print name)

Participating Insurer (signature)

Date

ATTACHMENT 8

In a Participating Insurer's letter of denial of benefit authorization request to a policy/certificate holder, the following language must be included:

You are entitled to an independent review of your disability status through the New York State Partnership if you disagree with this denial decision. To initiate this independent review, please call the New York State Partnership for Long-Term Care, 518-474-0662, or the New York Medicaid Help Line, 1-800-541-2831 from anywhere, at your earliest convenience.

An instruction package will be mailed to you with details of the actions you must take if you choose to request an independent review. The independent assessment must be completed within 40 days of the notification of your denied benefit authorization request from this company. The complete assessment will be reviewed by the New York Partnership program office. The cost of the independent assessment is not covered by your insurance.

In addition to the inclusion of the above language, the Participating Insurer must include a notification of the Insurer's internal appeals process regarding the Insurer's review, upon request of the policy/certificate holder, regarding the latter's denied benefit authorization request. The letter must also state that the Partnership's denied BAR review process and the Participating Insurer's appeals process may occur concomitantly.

ATTACHMENT 9

**CONDITIONS OF FINANCIAL RESPONSIBILITY BETWEEN
THE STATE AND PARTICIPATING INSURERS IN THE
NEW YORK STATE PARTNERSHIP FOR LONG TERM CARE**

Under the terms outlined in the State Insurer Participation Agreement which governs the New York State Partnership for Long Term Care (Partnership), New York State (State) and Participating Insurers have joined together in a cooperative public/private effort to offer the residents of the State a method of financing long term care expenses. The activities carried out by the Evolution Board are an integral part of that effort.

The Evolution Board, as constituted under the State/Insurer Participation Agreement, meets on a quarterly basis to review Partnership activities, amend or clarify operations or policy, and, from time to time, agree on ventures that improve the operation, or further the goals, of the Partnership. This document, which was approved at the May 28, 1997 meeting of the Evolution Board, governs the financial responsibility of the State and Participating Insurers with respect to the various activities of the Evolution Board.

1. Except for situations covered under paragraph 4, the Department of Health (Department) will arrange for the site of Evolution Board meetings, and provide refreshments at such meetings.
2. Booklets, brochures, and other consumer materials produced jointly by the State and by Participating Insurers will be made available to all State and Insurer participants. It is the financial responsibility of State and Insurer participants to print and distribute such materials.
3. Generally, expenses associated with Partnership staff carrying out their duties will be borne by the Department. Such expenses may be borne by a Participating Insurer or other private entity only when: (a) the Participating Insurer or private entity has requested the participation of Partnership staff in an activity outside the staff's normally assigned duties; (b) the Department has approved the participation of Partnership staff in the activity; and (c) there is compliance with all rules of the State and of the Department governing acceptance of outside funding.
4. Ventures may be proposed at meetings of the Evolution Board. Ventures may include but are not limited to media efforts, research, or special meetings, and may be undertaken by the State and/or one or more Participating Insurers. Ventures may be undertaken only with the approval of a majority of the Evolution Board. The record of the Evolution Board meeting at which a venture is approved must contain a statement of the rationale for the venture, a statement indicating which entity or entities have accepted the responsibility for implementing the venture and for bearing the expenses associated with the venture, and an acknowledgement by such entity or entities of their responsibility. Where all Participating Insurers are to be bound by a majority vote of the Evolution Board, a record of the vote is required.
5. The Evolution Board may vote to amend or add to the conditions stated above at any time.

ATTACHMENT 10

**AGREED UPON DISCLAIMER WORDING FOR NEW YORK STATE PARTNERSHIP FOR
LONG-TERM CARE (NYSPLTC) ADVERTISEMENTS**

I. Disclaimer wording to be used when the NYSPLTC logo appears on the advertisement:

The New York State Partnership for Long Term Care Program (NYSPLTC) symbol indicates the coverage advertised complies with New York State (NYS) requirements for participation in the NYSPLTC. However, NYS and the NYSPLTC do not take part in specific insurer marketing plans, and do not endorse specific insurers or their policies/certificates.

II. Disclaimer wording to be used when the NYSPLTC logo does not appear on the advertisement:

The coverage advertised complies with New York State (NYS) requirements for participation in the NYS Partnership for Long Term Care Program (NYSPLTC). However, NYS and the NYSPLTC do not take part in specific insurer marketing plans, and do not endorse specific insurers or their policies/certificates.

APPENDIX A

**DETERMINATION OF ELIGIBILITY FOR BENEFITS
AND STANDARD FOR CONTESTED BENEFIT REVIEW FOR
PARTNERSHIP POLICIES/CERTIFICATES INTENDED TO BE TAX QUALIFIED UNDER
SECTION 7702(b) OF THE INTERNAL REVENUE CODE**

Determination of Eligibility for Benefits:

The Participating Consumer shall be eligible for benefits pursuant to Partnership-approved policies/certificates when he or she is approved for benefits authorization according to the determination of the Participating Insurer, which shall be based upon the assessment instruments, techniques, and procedures employed by the Participating Insurer.

Standard for Contested Benefit Review:

To assure use of consistent standards and criteria in eligibility determinations, the Denied Benefit Authorization Process established pursuant to Appendix C, Denied Benefit Authorization Request Monitoring Process, shall employ the INSURANCE BENEFIT AUTHORIZATION REVIEW FORM (Revised 2/00) as the independent assessment form to determine whether review of benefit authorization denials for Participating Consumers with TQ Partnership-approved policies/certificates are warranted.

A Participating Consumer or his/her representatives must request an independent assessment form, if desired, upon notification by his/her Participating Insurer that his/her BAR has been denied. Completion of the independent assessment form by a licensed health care practitioner may involve a fee which shall be the responsibility of the Participating Consumer. The required independent assessment form shall be made available to Participating Consumers through the Medicaid Help Line and through the Partnership program office number. Instructions for completing the independent assessment form, which include directions for sending the results to the Partnership program office, shall accompany the independent assessment form.

The independent assessment must be completed within forty (40) calendar days after the date of the denied benefit authorization request (BAR) and sent to the Partnership program office. The rating thresholds on which the Partnership program office shall initiate a discussional review with the Participating Insurer are included herein below.

INSURANCE BENEFIT AUTHORIZATION REVIEW FORM (Revised 2/00) Threshold Ratings for Activating a Partnership Program Office-Initiated Review with the Participating Insurer:

SECTION I - ACTIVITIES OF DAILY LIVING

A rating of at least 2 on any 2 Activities of Daily Living,

OR

SECTION II - ASSESSMENT OF COGNITIVE IMPAIRMENT

A) Severe Cognitive Impairment Test

Section II.A.1. - Three or more incorrect/non-answered questions on the Standardized Test (SPMSQ),

and

Section II.A.2. - “Yes” response,

and

Section II.A.3. - “Requires Verbal Direction” in at least 2 Intellectual Functions, OR “Requires Continual Supervision” in at least 1 Intellectual Function, OR “Individual Not Able” in at least 1 Intellectual Function,

OR

B) Safety/Health Behavior Test

“Yes” in at least 1 Safety/Health Behavior category.

APPENDIX B

JOINT TECHNICAL REVIEW BOARD

The Joint Technical Review Board ("JTRB") shall review disputed benefit authorization requests (BARs) which cannot be settled by the Partnership. The JTRB shall function as an impartial committee composed of representatives of the State and Participating Insurers as described below:

Membership: The board shall consist of five (5) members, two (2) of whom shall represent the State, and two (2) of whom shall represent the Participating Insurers. The fifth member shall be drawn alternately from the State and from Participating Insurers and shall alternate on a one calendar year basis, commencing on January first. Partnership staff may not serve as members of the JTRB. A representative of a Participating Insurer whose disputed BAR is under review by the JTRB shall recuse himself or herself from deliberation and voting on the matter while it is before the JTRB.

Members shall be drawn from a list of names maintained by the Partnership program office. Names shall be placed on the Partnership list by Participating Insurers and the State. Each Participating Insurer shall provide the Partnership program office with the name of one individual in its employ with expertise in disability review. The State shall provide the Partnership program office with the names of two health care professionals. The Partnership program office shall maintain the list and augment it with further submissions from each Participating Insurer and the State when necessary.

Members shall serve for one year, except that State members may serve longer than one year. Where matters under consideration have not been finally disposed of at the expiration of JTRB terms, the Chair shall notify the Partnership program office that membership shall be extended pending disposition of those matters. Where membership term is extended pending disposition of open matters, new matters will be tabled until such time as new members take office.

The deliberations of the JTRB shall be confidential. Members may discuss matters brought before them only in so far as they are pertinent to the administration of the JTRB or arbitration process. Individual members found to have divulged information regarding JTRB deliberations beyond the scope of communications required to perform JTRB functions shall be permanently removed from the JTRB member roster. Where the individual member is a State employee, sanctions will be made in accordance with State rules governing confidentiality. Consideration of any further actions will be referred to the Evolution Board in accordance with IX. OVERSIGHT as contained herein.

The State and Participating Insurers represented on the JTRB shall provide an appropriate substitute when an assigned member is unavailable for any reason.

Voting: A vote of a majority of the JTRB shall be necessary to make a determination on any matter under deliberation.

Leadership: The JTRB shall be chaired by a member selected upon consent of a majority of board members. The chairperson shall serve for a term of one year, and shall alternate yearly between a representative of the State and Participating Insurers. The Chairperson shall perform the following duties:

- Ensure that appropriate member resources are available for consideration of JTRB matters under deliberation;
- Ensure that Participating Insurer and State case assessment or contract records are distributed to members for review not less than five days prior to any scheduled meeting;
- Determine whether meetings may be conducted in person or by conference call;
- Ensure that cases are disposed of within fifteen (15) business days of referral from the Partnership program office, except where the case has been tabled as a new matter pending change of JTRB membership;

2/2/100 Plan (Ver. 12/13/12)

- Ensure the completion of a report on the JTRB's deliberations and recommendations in regard to each case brought before it. The report shall be forwarded to the Partnership program office with the notification of recommendation. Should the recommendation be to honor the contested BAR and the Participating Insurer continues to deny the BAR, this report shall be available to the Participating Consumer, the Participating Consumer's representative, and the Participating Consumer's Participating Insurer upon request.
- Provide the Partnership program office with written notification of JTRB case recommendations within three (3) business days of decision.

Function: It shall be the responsibility of the JTRB to review disputed BARs and to decide whether the JTRB supports or does not support the original BAR denial.

In carrying out its responsibilities, the JTRB shall have the authority to request information from the Participating Insurer and/or Participating Consumer pertinent to its deliberations including but not limited to patient assessments. All requests for such information shall be made to the Partnership program office.

Limitations: The decision making authority of the JTRB over the disposition of a disputed BAR shall be limited to supporting or not supporting the original BAR denial. Where the original BAR denial is not supported and the Participating Insurer continues to deny the BAR, the JTRB Chair shall so advise the Partnership program office. The Partnership program office shall then notify the Participating Consumer of the Participating Consumer's option to pursue arbitration.

APPENDIX C

DENIED BENEFIT REQUEST MONITORING PROCESS

Non-Insured Event Denial Monitoring:

1. The Participating Insurer shall notify the Partnership within ten (10) business days of the denial of a BAR. Notification shall be made via New York State Partnership for Long Term Care Form Number 020.
2. The submitted information shall be examined for BAR denial patterns by the Partnership program office.
3. Where a Participating Insurer's denial pattern is determined by the Partnership program office to require explanation, the Partnership program office shall contact the Participating Insurer to determine any special considerations that may affect the Participating Insurer's level of denials and account for the pattern of denials. Where no satisfactory explanation is determined, or where the Participating Insurer continues to demonstrate similar denial patterns in the future, the Partnership program office shall forward the matter to the New York State Department of Financial Services for further review of the need for remedial or regulatory action.

BARs Denied Due to Disability Determination (Insurable Event):

Partnership Review:

1. The Participating Insurer shall notify the Partnership within ten (10) business days of the denial of a BAR. Notification shall be made via New York State Partnership for Long Term Care Form Number 020.
2. Participating Consumers who experience denied BARs or their representatives must initiate the independent assessment process, have the assessment completed, and forward the results to the Partnership program office. Independent assessment requirements shall be set forth in the Consumer Participation Agreement and Partnership consumer education and publicity materials.
3. If the Participating Consumer's Insurance Benefit Authorization Review Form (Revised 2/00) rating indicates that he or she is categorized as meeting the threshold rating(s) described in Appendix A herein, the Partnership program office shall notify the Participating Insurer of the discrepancy between the Participating Consumer's disability assessment and the BAR denial. A review of the Participating Consumer's independent assessment rating and the Participating Insurer's disability assessment for BAR shall be discussed between the Partnership program office and the involved Participating Insurer.

JTRB Review:

1. The JTRB shall review the disputed BAR denial if discussion between the Partnership program office and the Participating Insurer regarding the rating of the Insurance Benefit Authorization Request Review Form (Revised 2/00) indicating incapacity likely to trigger benefits for TQ policies/certificates results in continued disagreement.
2. The JTRB shall review any information pertinent to its deliberations, including but not limited to, patient assessments which were available to the involved Participating Insurer in determining to deny the BAR, after the identities of the Participating Consumer and Participating Insurer are redacted to ensure blind review. The JTRB shall request patient assessment records through the Partnership program office. BAR denials submitted to the JTRB shall be disposed of by the JTRB within fifteen (15) business days of receipt by recommending to support or not support the original BAR denial.

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Arbitration:

1. Where the original BAR denial is not supported and the Participating Insurer continues to deny the BAR, the JTRB Chair shall so advise the Partnership program office. The Partnership program office shall then notify the Participating Consumer of the Participating Consumer's option to pursue arbitration, and provide the Participating Consumer with the New York State Partnership for Long Term Care Rules of Arbitration (hereinafter, NYSPLTC-ROA) then in effect, as adopted by the Partnership Evolution Board. If the Participating Consumer elects to pursue arbitration, such arbitration shall constitute the final course of redress for disability-related denial of a BAR within the Denied Benefit Authorization Request Monitoring Process, and shall be conducted by an independent entity approved by the Evolution Board. The Participating Consumer must file a submission for arbitration within twenty (20) days of notification by the Partnership of the option to arbitrate as specified in the NYSPLTC-ROA.
2. The Participating Insurer shall be responsible for payment of all arbitration fees as provided for in the NYSPLTC-ROA.
3. Arbitration shall be conducted and a decision issued unless otherwise agreed by the parties or specified by law, no later than thirty (30) calendar days from the date of the closing of the hearing. Arbitration shall be binding on both parties, and shall be administered by an independent entity approved by the Evolution Board under the NYSPLTC-ROA then in effect, and judgment on the decision rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof. A decision against the Participating Insurer shall include reimbursement of the cost of any independent assessments necessary for JTRB review and arbitration, as well as arbitration costs incurred by the Participating Consumer pursuant to provision number 2 above, and payment of the disputed benefit authorization retroactively to the date the Participating Consumer was determined by the arbitrator to have been eligible for benefits, after any required elimination period. It shall not be within the authority of the arbitrator to award the Participating Consumer reimbursement beyond the relief set forth hereinabove.
4. A decision against the Participating Consumer shall absolve the Participating Insurer of any liability or additional cost, excluding liability for payment of arbitration fees as stated in number 2 above.

APPENDIX D

**LONG-TERM CARE INSURANCE UNIFORM DATA SET
AND NEW YORK STATE PARTNERSHIP FOR LONG TERM CARE
REPORTING ADDENDUM**

Appendix D consists of three Attachments:

**ATTACHMENT 1 - LONG-TERM CARE INSURANCE UNIFORM DATA SET,
REPORTING REQUIREMENTS AND DOCUMENTATION**

ATTACHMENT 1 provides the complete documentation for seven fixed-format files to be reported uniformly to all Partnership states (Connecticut, California, Indiana, and New York) by Participating Insurers. This documentation is available at <http://www.opm.state.ct.us/pdpd4/ltc/insurer/uds.pdf>.

**ATTACHMENT 2 - New York State Partnership Reporting Addendum:
Files 10, File 11, and File 12.**

ATTACHMENT 2 provides reporting formats and instructions for the completion of Files 10, 11, and 12. These three files are unique to the New York Partnership:

File 10: Core Policy Benefits/Premium Information

File 11: Report on Claim Denials

File 12: Summary Report on Long Term Care Insurance Personal Worksheet

**ATTACHMENT 3 - New York State Partnership Evaluation: Carrier
Participation and Responsibilities**

**ATTACHMENT 2: NEW YORK STATE PROJECT REPORTING ADDENDUM:
FILE 10, FILE 11, AND FILE 12**

File 10: Core Policy Benefits/Premium Information

File Information

Frequency: Annually, on a calendar year basis. Hard copy reports are due January 30 of each year. The attached form, New York State LTCI Project Core Policy Form (NYS Partnership for LTC Form # 010, Rev. Jan. 10, 1994) may be used by Participating Insurers to report on core policy benefits and premiums. However, whenever a new core policy is filed with the New York State Department of Financial Services, File 10 should be submitted within 30 days after policy form approval by the New York State Department of Financial Services.

Record Definition: One record (form) for each core policy (individual, organization-sponsored, and/or group policy) sold. Each data element should be numbered and labeled.

(I) Core Policy Information

1. Report Date
2. Company Code
3. Policy Category
4. Name of Organization or Group
5. Zip-code of Organization or Group
6. Payment Type (NH)
7. Payment Type (HC)
8. Payment Type (RCF).
9. Elimination Period Type
10. Respite Service Days
11. Respite Disability Days
12. Care Management Days
13. Waiver of Premium (NH)
14. Waiver of Premium (HC)
15. Waiver of Premium (RCF)
16. Exclusion Period
17. Free-Standing Death Benefit

(II) Annualized Premiums For Core Policy, By Age

- | | | |
|------------|------------|------------|
| 15. Age 30 | 28. Age 63 | 41. Age 76 |
| 16. Age 35 | 29. Age 64 | 42. Age 77 |
| 17. Age 40 | 30. Age 65 | 43. Age 78 |
| 18. Age 45 | 31. Age 66 | 44. Age 79 |
| 19. Age 50 | 32. Age 67 | 45. Age 80 |
| 20. Age 55 | 33. Age 68 | 46. Age 81 |
| 21. Age 56 | 34. Age 69 | 47. Age 82 |
| 22. Age 57 | 35. Age 70 | 48. Age 83 |
| 23. Age 58 | 36. Age 71 | 49. Age 84 |
| 24. Age 59 | 37. Age 72 | 50. Age 85 |
| 25. Age 60 | 38. Age 73 | |
| 26. Age 61 | 39. Age 74 | |
| 27. Age 62 | 40. Age 75 | |

FILE 10: CORE POLICY BENEFITS/FEATURES/PREMIUM INFORMATION

File Definitions

(I) Core Policy Information: The Core Policy should include:

- a) Policy Duration Period: 2 years;
- b) Benefits: Nursing Home Care, Home and Community-Based Care, Residential Care Facility (RCF), and other required benefits;
- c) \$265 (for 2013) for nursing home daily benefit, home and community-based care benefit, and RCF benefit: This benefit amount will increase at 3.5% or 5% compounded annually;
- d) Inflation Protection: 3.5% or 5% compounded annually for age 79 and younger; and no inflation protection for age 80 and older;
- e) Elimination Period: 60 days;
- f) No non-forfeiture benefit; and
- g) Benefit standards stipulated in New York State Department of Financial Services Regulation 144 other than a) to e) may be provided as set forth in this agreement.

1. Report Date: MM - YY

2. Company Code: Unique, confidential company identifier issued to Participating Insurers by project staff.

3. Policy Category:

A = Tax Qualified (TQ) Individual Policy is filed as a TQ *individual* policy with the New York State Department of Financial Services and each insured receives an individual policy. Policy marketed and issued directly from the Insurer to the insured.

B = TQ Organization Sponsored Policy is filed as a TQ *individual* policy with the New York State Department of Financial Services, and each insured receives an individual policy. This category differs from the "Individual" category in that the policies are marketed to insureds through an organization (e.g., employer or association). This organizational involvement could be minimal or extensive. Such involvement might include organizational endorsement, participation in the promotion of the product, negotiation of premium discounts for members, facilitation of enrollment, payroll deductions, etc. This category of policy is sometimes referred to as "List Bill Rate" or "Franchise."

C = TQ Group Policy is filed with the New York State Department of Financial Services as a TQ "Group" policy. Group policy contracts are made with an employer or other entity (e.g. association) that covers a group of persons identified as individuals by reference to their relationship to the entity. The actual policy is held by the employer or other entity. Each insured receives a certificate under the policy, rather than an individual policy. The policy is marketed through the group.

4. Name of Organization or Group: Name of group or organization through which the partnership policy is offered.

5. Zip code of Organization or Group: Zipcode of group or organization address.

6. Payment Type (NH):

2/2/100 Plan (Ver. 12/13/12)

A = Daily Indemnity Maximum nursing home daily benefit is paid upon receipt of covered services, regardless of actual billed amount.

B = Service-based Reimbursement Nursing home benefit payments are based on actual service charges up to the maximum nursing home daily benefit. Remaining benefits are carried over.

7. Payment Type (HC/RCF):

A = Daily Indemnity Maximum home care daily benefit is paid upon receipt of covered services, regardless of actual billed amount.

B = Service-based Reimbursement Home care benefit payments are based on actual service charges up to the maximum home care daily benefit. Remaining benefits are carried over.

8. Elimination Period Type:

A = Calendar Day Elimination period is satisfied by the passage of time, regardless of the receipt of formal (paid) care by the insured.

B = Service Day Elimination period is only satisfied by the receipt of formal services provided to the insured.

C = Other

9. Respite Service Days: Maximum number of respite service days available annually to insured.

10. Respite Disability Days: Maximum number of days for which insured has to be in disability status prior to receiving respite benefit.

11. Care Management Days: Number of "care management days" available to insureds.

12a. Waiver of Premium (NH): Payment of premium is waived during a nursing home benefit period.

Y = Yes.
N = No.

12b. Waiver of Premium (HC): Payment of premium is waived during a home care or RCF benefit period.

Y = Yes.
N = No.

13. Exclusion Period (Days): Number of days after effective date of policy coverage during which insured is excluded from policy benefits. This refers to a general contract-based exclusion or probation period.

14. Free-Standing Death Benefit: Return of premium to insured's beneficiaries upon death of the insured. The death benefit must not be linked to any other type of benefit option/rider (i.e., such as a non-forfeiture option).

2/2/100 Plan (Ver. 12/13/12)

Y = Yes.
N = No.

(II) Annualized Premiums For Core Policy, By Age: Annualized premiums in dollars (including cents) for ages specified in items 15 - 50.

2/2/100 Plan 5% Inflation Protection (Ver. 12/13/12)

NEW YORK STATE PARTNERSHIP FOR LTC, CORE POLICY FORM
 (NYS Partnership for LTC, Form Number 010, Rev. April, 1998)

- (I) CORE POLICY INFORMATION _____ (Calendar Year)
1. REPORT DATE _____ (MM - YY)
2. COMPANY CODE _____
3. POLICY CATEGORY _____ (A, B, C, D, E, or F)
4. NAME OF ORGANIZATION OR GROUP _____
5. ZIP-CODE OF ORGANIZATION OR GROUP _____
6. PAYMENT TYPE (NH) _____ (A or B)
7. PAYMENT TYPE (HC) _____ (A or B)
8. ELIMINATION PERIOD TYPE _____ (A, B, or C)
9. RESPITE SERVICE DAYS _____ (014 - 365)
10. RESPITE DISABILITY DAYS _____ (000-180)
11. CARE MANAGEMENT DAYS _____ (002-365)
- 12a. WAIVER OF PREMIUM (NH) _____ (Y or N)
- 12b. WAIVER OF PREMIUM (HC/RCF) _____ (Y or N)
13. EXCLUSION PERIOD (DAYS) _____ (000-180)
14. DEATH BENEFIT (RETURN OF PREMIUM) _____ (Y or N)

(II) ANNUALIZED PREMIUMS FOR CORE POLICY, BY AGE (_____ . _____)

- | | | |
|------------------|------------------|------------------|
| 15. AGE 30 _____ | 27. AGE 62 _____ | 39. AGE 74 _____ |
| 16. AGE 35 _____ | 28. AGE 63 _____ | 40. AGE 75 _____ |
| 17. AGE 40 _____ | 29. AGE 64 _____ | 41. AGE 76 _____ |
| 18. AGE 45 _____ | 30. AGE 65 _____ | 42. AGE 77 _____ |
| 19. AGE 50 _____ | 31. AGE 66 _____ | 43. AGE 78 _____ |
| 20. AGE 55 _____ | 32. AGE 67 _____ | 44. AGE 79 _____ |
| 21. AGE 56 _____ | 33. AGE 68 _____ | 45. AGE 80 _____ |
| 22. AGE 57 _____ | 34. AGE 69 _____ | 46. AGE 81 _____ |
| 23. AGE 58 _____ | 35. AGE 70 _____ | 47. AGE 82 _____ |
| 24. AGE 59 _____ | 36. AGE 71 _____ | 48. AGE 83 _____ |
| 25. AGE 60 _____ | 37. AGE 72 _____ | 49. AGE 84 _____ |
| 26. AGE 61 _____ | 38. AGE 73 _____ | 50. AGE 85 _____ |

2/2/100 Plan 3.5% Inflation Protection (Ver. 12/13/12)

NEW YORK STATE PARTNERSHIP FOR LTC, CORE POLICY FORM
 (NYS Partnership for LTC, Form Number 010, Rev. April, 1998)

- (I) CORE POLICY INFORMATION _____ (Calendar Year)
1. REPORT DATE _____ (MM - YY)
2. COMPANY CODE _____
3. POLICY CATEGORY _____ (A, B, C, D, E, or F)
4. NAME OF ORGANIZATION OR GROUP _____
5. ZIP-CODE OF ORGANIZATION OR GROUP _____
6. PAYMENT TYPE (NH) _____ (A or B)
7. PAYMENT TYPE (HC) _____ (A or B)
8. ELIMINATION PERIOD TYPE _____ (A, B, or C)
9. RESPITE SERVICE DAYS _____ (014 - 365)
10. RESPITE DISABILITY DAYS _____ (000-180)
11. CARE MANAGEMENT DAYS _____ (002-365)
- 12a. WAIVER OF PREMIUM (NH) _____ (Y or N)
- 12b. WAIVER OF PREMIUM (HC/RCF) _____ (Y or N)
13. EXCLUSION PERIOD (DAYS) _____ (000-180)
14. DEATH BENEFIT (RETURN OF PREMIUM) _____ (Y or N)

(II) ANNUALIZED PREMIUMS FOR CORE POLICY, BY AGE (_____ . _____)

- | | | |
|------------------|------------------|------------------|
| 15. AGE 30 _____ | 27. AGE 62 _____ | 39. AGE 74 _____ |
| 16. AGE 35 _____ | 28. AGE 63 _____ | 40. AGE 75 _____ |
| 17. AGE 40 _____ | 29. AGE 64 _____ | 41. AGE 76 _____ |
| 18. AGE 45 _____ | 30. AGE 65 _____ | 42. AGE 77 _____ |
| 19. AGE 50 _____ | 31. AGE 66 _____ | 43. AGE 78 _____ |
| 20. AGE 55 _____ | 32. AGE 67 _____ | 44. AGE 79 _____ |
| 21. AGE 56 _____ | 33. AGE 68 _____ | 45. AGE 80 _____ |
| 22. AGE 57 _____ | 34. AGE 69 _____ | 46. AGE 81 _____ |
| 23. AGE 58 _____ | 35. AGE 70 _____ | 47. AGE 82 _____ |
| 24. AGE 59 _____ | 36. AGE 71 _____ | 48. AGE 83 _____ |
| 25. AGE 60 _____ | 37. AGE 72 _____ | 49. AGE 84 _____ |
| 26. AGE 61 _____ | 38. AGE 73 _____ | 50. AGE 85 _____ |

2/2/100 Plan (Ver. 12/13/12)

FILE 11. REPORT ON BENEFIT AUTHORIZATION DENIALS

File Information

Frequency: Whenever a benefit authorization request is denied. A hard copy report is due within 10 days of the denial date. The attached form New York State Partnership for LTC, Benefit Authorization Denial Form (NYS Partnership for LTC Form Number 020, Revised April, 1998) may be used by Participating Insurers to report on benefit authorization denials.

Record Definition: One record (form) per insured for each denial of a discretely identifiable request for benefit authorization/eligibility.

Trigger: Whenever a request for benefit authorization is denied.

	FIELD NAME	FIELD TYPE	FIELD DESCRIPTION
1.	Report Date	D-6	MMDDYY
2.	Company Code	N-3	ASSIGNED BY PROJECT STAFF
3.	Policy Form Number	N-8	See State Guide Book
4.	Social Security #	N-9	XXXXXXXXXXXX
5.	Original Effective Policy Date	D-8	MMDDYY
6.	Telephone # of Insured (from assessment form)	A-10	Area Code + Telephone #
7.	TYPE OF DENIAL	A-1	A=Disability (Insured Event not Met) B=Contractual (Policy Conditions)

If Field 8 = "A", go to Field 9 on the next page

If Field 8 = "B", go to Field 10 on the next page

2/2/100 Plan (Ver. 12/13/12)

9. DENIAL BASED ON DISABILITY
(i.e., insured did not meet insured event criteria)

9A.	Date of Face-to-face Assessment	D-8	MMDDYY
9B.	Date of Eligibility Decision	D-8	MMDDYY
9C.	Date of Initial Notice or Claim Submission to Carrier	D-8	MMDDYY
9D.	Location of Insured at Time of Assessment	A-1	A: Nursing Home B: Residential Care Facility C: Other Residential Facility D: Hospital E: Home F: Other
9E.	Information of Location: (If 9D is 'A', 'B', 'C', 'D', or 'F')		Name of Facility Phone Number Address

10. DENIAL BASED ON CONTRACT

Reason for Denial	A-1	A= Policyholder Inactive or Ineligible
Service		B=Coverage Not In-force on Date of
		C=Rescission
		D=Policy Exclusion
		E=Other

**NEW YORK STATE PARTNERSHIP FOR LONG TERM CARE BENEFIT AUTHORIZATION
DENIAL FORM
(NYS Partnership for LTC, Form Number 020, Rev. April 1998)**

1. REPORT DATE _____ - _____ - _____ (MMDDYY)
 2. COMPANY CODE _____
 3. POLICY FORM NUMBER _____
 4. SOCIAL SECURITY NUMBER _____ - _____ - _____
 5. ORIGINAL EFFECTIVE POLICY DATE _____ - _____ - _____ (MMDDYY)
 6. INSURED'S TELEPHONE NUMBER _____ - _____ - _____
 7. TYPE OF DENIAL _____ (A or B)
-

8. DENIAL BASED ON DISABILITY (Field 7 = "A")

(If Field 7 = "B", Go to Field 9.)

- 8A. DATE OF FACE TO FACE ASSESSMENT _____ - _____ - _____ (MMDDYY)
- 8B. DATE OF ELIGIBILITY DECISION _____ - _____ - _____ (MMDDYY)
- 8C. DATE OF INITIAL CLAIM OR NOTICE TO CARRIER _____ - _____ - _____ (MMDDYY)
- 8D. LOCATION OF INSURED AT TIME OF ASSESSMENT ? _____ (A through F)
- 8E. FACILITY NAME: _____
FACILITY PHONE: _____
FACILITY ADDRESS: _____

9. DENIAL BASED ON CONTRACT (Field 7 = "B")

_____ (A through E)

2/2/100 Plan (Ver. 12/13/12)

File 12: Summary Report on Long Term Care Insurance Personal Worksheet

File Information

Frequency: Annually, on a calendar year basis. Hard copy reports are due January 30 of each year. The attached form, New York State Partnership Suitability Data Form (NYS Partnership for LTC Form # 030) may be used by Participating Insurers to report aggregate information collected from Long Term Care Insurance Personal Worksheets.

Record Definition: One record for the **2/2/100** plan per year. Each data element should be numbered and labeled.

	FIELD NAME	FIELD TYPE	FIELD DESCRIPTION
1.	Report Year	D-4	YYYY
2.	Company Code	A-3	ASSIGNED BY PROJECT STAFF
3.	Plan Design	A-7	2/2/100
4.	Total Number of Worksheets	N-5	Total Number of Policy Purchasers
5.	Premium Payment:		
	a) From my Income	N-5	Number of Policy Purchasers
	b) From my savings/Investments	N-5	- ditto -
	c) My Family will Pay	N-5	- ditto -
6.	Annual Income:		
	a) Under \$10,000	N-5	Number of Policy Purchasers
	b) \$10,000-\$20,000	N-5	- ditto -
	c) \$20,000-\$30,000	N-5	- ditto -
	d) \$30,000-\$50,000	N-5	- ditto -
	e) Over \$50,000	N-5	- ditto -
7.	Savings and Investments, excluding Home:		
	a) Under \$20,000	N-5	Number of Policy Purchasers
	b) \$20,000-\$30,000	N-5	- ditto -
	c) \$30,000-\$50,000	N-5	- ditto -
	d) Over \$50,000	N-5	- ditto -

**NEW YORK STATE PARTNERSHIP FOR LONG TERM CARE PERSONAL WORKSHEET
SUMMARY REPORT FORM
(NYS Partnership for LTC, Form Number 030)**

- 1. REPORT YEAR _____ (YYYY)
- 2. COMPANY CODE _____
- 3. PLAN DESIGN 2/2/100
- 4. TOTAL NUMBER OF WORKSHEETS _____
- 5. PREMIUM PAYMENT:
 - A) FROM INCOME _____
 - B) FROM SAVINGS/INVESTMENTS _____
 - C) MY FAMILY WILL PAY. _____
- 6. ANNUAL INCOME
 - A) UNDER \$10,000 _____
 - B) \$10,000-\$20,000 _____
 - C) \$20,000-\$30,000 _____
 - D) \$30,000-\$50,000 _____
 - E) OVER \$50,000 _____
- 7. SAVINGS AND INVESTMENTS, EXCLUDING HOME:
 - A) UNDER \$20,000 _____
 - B) \$20,000-\$30,000 _____
 - C) \$30,000-\$50,000 _____
 - D) OVER \$50,000 _____

ATTACHMENT 3

EVALUATION OF THE NEW YORK STATE PARTNERSHIP FOR LTC: CARRIER PARTICIPATION AND RESPONSIBILITIES

The evaluation of the New York State Partnership for LTC is an integral component of the Program. The extent to which the Partnership is *effective* and/or *successful* can be defined and measured along several important dimensions. The evaluation will provide information of interest to the insurance industry, individual insurance companies, financial planners, consumers, and governmental entities. The involvement by Participating Insurers in the design and implementation of the evaluation is a necessary and appropriate Partnership activity.

At the direction of the Partnership's Evolution Board, an ad hoc Evaluation Committee comprised of Program staff and Participating Insurers will be appointed. The Committee's overall goal will be to produce an evaluation plan to measure the effectiveness of the New York State Partnership for LTC. The Committee will present its plan to the Evolution Board for formal approval.

The specific objectives of the Evaluation Committee will include the design, development, and implementation strategy for the evaluation. The Committee will determine the areas of inquiry for the evaluation, formulate the research questions to be addressed, and establish appropriate measures by which to gauge the effectiveness of the Partnership. The Committee will define the scope and nature of data collection, including, but not limited to, the provision of historical baseline data and the development and implementation of survey instruments. All Participating Insurers will be required to appoint a representative to sit on the Evaluation Committee. All Participating Insurers --whether currently or in the future-- will be required to provide data in accordance with the data collection parameters established by the Evaluation Committee. Failure to comply, without good cause, with the evaluation effort will be deemed a breach of contract.