ARKANSAS REGISTER

Transmittal Sheet

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W. J. "BILL" McCUEN
SECRETARY OF STATE

By _____

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Secretary of State
State Capitol
Little Rock, Arkansas 72201-1094

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Name of Agency Arkansas Insurance Department

Department Legal Division

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Statutory Authority for Promulgating Rules ACT 642 of 1989,

Ark. Code Ann. §§ 23-61-108 and 25-15-202.

Intended Effective Date		Date
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CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted In Compliance With Act 434 of 1967 As Amended.

Don Taylor
SIGNATURE

Insurance Commissioner
TITLE

8-23-90
DATE

RULE AND REGULATION 13

LONG-TERM CARE INSURANCE

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SECTION 1. PURPOSE

The purposes of this Regulation are to implement Act 642 of 1989, to promote the public interest, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages, and to facilitate flexibility and innovation in the development of long-term care insurance.

SECTION 2. AUTHORITY

This Regulation is issued pursuant to the authority vested in the Commissioner under Act 642 of 1989, and Ark. Code Ann. §§23-61-108, and 25-15-202, et seq.

SECTION 3. APPLICABILITY AND SCOPE

Except as otherwise specifically provided, this Regulation applies to all long-term care insurance policies, contracts, certificates, riders or other evidence of coverage issued, delivered or issued for delivery, advertised, marketed or offered in this State on or after the effective date hereof, by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations; and all similar organizations.

SECTION 4. DEFINITIONS

For the purpose of this Regulation, the terms "long-term care insurance", "group long-term care insurance", "Commissioner", "applicant", "policy" and "certificate" shall have the meanings set forth in Section 4 of Act 642 of 1989.

SECTION 5. POLICY DEFINITIONS

No long-term care insurance policy issued, delivered or issued for delivery in this State shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

A. "Medicare" shall be defined as "The Health Insurance for the Aged Act, Titled XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended", or "Titled I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof", or words of similar import.

B. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

C. "Skilled nursing care", "intermediate care", "personal care", "home care", and other services shall be defined in relation to the level of skills required, the nature of the care, and the setting in which care must be delivered.

D. All providers of services, including but not limited to "skilled nursing facility", "extended care facility", "intermediate care facility", convalescent nursing home", "personal care facility", and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

SECTION 6. POLICY PRACTICES AND PROVISIONS

A. Renewability. The terms "guaranteed renewable" and "nonconcellable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of Section 7 and of this Regulation.

(1) No such policy issued to an individual shall contain renewal provisions less favorable to the insured than "guaranteed renewable". However, the Commissioner may authorize nonrenewal on a statewide basis, on terms and conditions deemed necessary by the Commissioner, to best protect the interests of the insureds, if the insurer demonstrates:

(a) That renewal will jeopardize the insurer's solvency; or

(b) That:

(i) The actual paid claims and expenses have substantially exceeded the premium and investment income associated with the policies; and

(ii) The policies will continue to experience substantial and unexpected losses over their lifetime; and

(iii) The projected loss experience of the policies cannot be significantly improved or mitigated through reasonable rate adjustments or other reasonable methods; and

(iv) The insurer has made repeated and good faith attempts to stabilize loss experience of the policies, including the timely filing for rate adjustments.

(2) The term "guaranteed renewable" may be used only when: (a) the insured has the right to continue the long-term care insurance in force by the timely payment of premiums, and (b) the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and (c) the insurer cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(3) The term "noncancellable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums, during which period the insurer has no right to make any unilateral change in any

provision of the insurance policy or in the premium rate.

B. Limitations and Exclusions. No policy may be delivered or issued for delivery in this State as long-term care insurance if such policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

(1) Pre-existing conditions or diseases;

(2) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;

(3) Alcoholism and drug addiction;

(4) Illness, treatment or medical condition arising out of:

(a) War or act war (whether declared or undeclared);

(b) Participation in a felony, riot or insurrection;

(c) Service in the armed forces or units auxiliary thereto;

(d) Suicide (sane or insane), attempted suicide or an intentionally self-inflicted injury; or

(e) Aviation (this exclusion applies only to non-fare-paying passengers);

(5) Treatment provided in a government facility (unless otherwise required by law); services for which benefits are available under Medicare or other governmental programs (except Medicaid); any state or federal workers' compensation, employer's liability or occupational disease law; any motor vehicle no-fault law; services provided by a member of the covered person's immediate family; and services for which no charge is normally made in the absence of insurance; and

(6) Subsection B. is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

C. Extension of Benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits, and may be subject to any policy waiting period, and all other applicable provisions of the policy.

D. Continuation or Conversion

(1) Group long-term care insurance issued in this State on or after the effective date of this Rule shall provide covered individuals with a basis for continuation or conversion of coverage.

(2) For the purposes of this Section, "a basis for continuation of coverage" means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies which restrict provision of benefits and services to, or contain incentives to use certain providers and/or facilities may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy. However, the individual may request lower benefits if he so desires. The Commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(3) For the purposes of this Section, "a basis for conversion of coverage" means a policy provision under which an individual, whose coverage under a group policy would otherwise terminate or has been terminated for any reason (including discontinuance of the group policy in its entirety or with respect to an insured class) and who has been continuously insured under the group policy (and any group policy which it replaced) for at least six (6)

months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

(4) For the purposes of this Section, "converted policy" means an individual policy of long-term care insurance providing benefits identical to, or benefits determined by the Commissioner to be substantially equivalent to, or in excess of those provided under the group policy from which conversion is made or benefits, as requested by the individual, which are lower than those provided under the group policy. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers and/or facilities, the Commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed and non-managed care plans including, but not limited to, providers system arrangements, service availability, benefit levels and administrative complexity.

(5) Written application for the converted policy shall be made, and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

(6) Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

(7) Continuation or conversion of coverage shall be mandatory, except where:

(a) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

(b) The terminating coverage resulted not later than thirty-one (31) days after termination by group coverage effective on the day following the termination of coverage:

(i) Providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and

(ii) The premium for which is calculated in a manner consistent with the requirements of Paragraph (6) of this Section.

(8) Notwithstanding any other provision of this Section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than one hundred percent (100%) of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

(9) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

(10) Notwithstanding any other provision of this Section, any insured individual, who eligibility for group long-term care coverage is based upon his or her relationship to another person, shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

(11) For the purposes of this Section: a "Managed-Care Plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

SECTION 7. REQUIRED DISCLOSURE PROVISIONS

A. Renewability. Individual long-term care insurance policies shall contain a renewability provision. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. This provision shall not apply to policies which do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

B. Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under the individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issuance, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.

C. Payment of Benefits. A long-term care insurance policy which provides for the payment of benefits based on standards described as "usual and customary", "reasonable and customary", or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

D. Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to pre-existing conditions, such limitations shall appear as a separate paragraph of the policy or certificate

and shall be labeled as "Pre-existing Condition Limitations."

E. Other Limitations or Conditions on Eligibility for Benefits. Effective March 17, 1990, a long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in Act 642 of 1989, Act Section 6 (d) (2), shall set forth a description of such limitations or conditions, including any required number of days of confinement, in a separate paragraph "Limitations or Conditions on Eligibility for Benefits."

SECTION 8. REQUIREMENTS FOR REPLACEMENT

A. Questions Concerning Replacement. Individual and direct response solicited long-term care insurance application forms shall include a question designed to elicit information as to whether the proposed insurance policy is intended to replace any other disability or long-term care insurance policy presently in force. A suppplementary application or other form to be signed by the applicant containing such a question may be used.

B. Solicitations Other than Direct Response. Upon determining that a sale will involve replacement, an insurer other than an insurer using direct response solicitation methods, or its agent shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of disability or long-term care coverage. One (1) copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be the language stated in Appendix 1 of this Rule.

C. Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of disability or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be the language stated in Appendix 2 to this Rule.

SECTION 9. DISCRETIONARY POWERS OF COMMISSIONER

The Commissioner may, upon written request and after an administrative hearing, issue on order to modify or suspend a specific provision or provisions of this Regulation with respect to a specific long-term care insurance policy or certificate upon a written finding that:

A. The modification or suspension would be in the best interest of the insureds; and

B. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

C. (1) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or

(2) The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or

(3) The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

SECTION 10. RESERVE STANDARDS

A. When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for such benefits shall be determined in accordance with Ark. Code Ann. §§23-84-101--111. Claims reserves must also be established in the case when such policy or rider is in claim status. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

B. When long-term care benefits are provided other than as in Subsection A. above, whether issued on an individual or group policy basis, reserves shall be determined in accordance with all appropriate provisions of Rule and Regulation 22, "Reserve Standards for Valuation Of Individual Disability Policies" including, but not necessarily limited to, Sections 2.1, 2.3(c) (5), 2.7, and 3.1 and 3.3 thereof.

SECTION 11. LOSS RATIO

Benefits under individual long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%) calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

A. Statistical credibility of incurred claims experience and earned premiums;

B. The period for which rates are computed to provide coverage;

C. Experience and projected trends;

D. Concentration of experience within early policy duration;

E. Expected claim fluctuation;

F. Experience refunds, adjustments or dividends;

G. Renewability features;

H. All appropriate expense factors;

I. Interest;

J. Experimental nature of the coverage;

K. Policy reserves;

L. Mix of business by risk classification; and

M. Product features such as long elimination periods, high deductibles and high maximum limits.

SECTION 12. FILING REQUIREMENT

Prior to an insurer or similar organization offering group long-term care insurance to a resident of this State pursuant to Section 5 of the Long-Term Care Minimum Standards Act, it shall file with the Commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this State.

SECTION 13. STANDARD FORMAT OUTLINE OF COVERAGE

This Section of the Regulation implements, interprets and incorporates the provisions of Section 6(g) (1) (A) of Act 642 of 1989 in prescribing a standard format and the content of an outline of coverage.

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

B. The outline of coverage shall contain no material of an advertising nature.

C. Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.

D. Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

E. Format for outline of coverage shall be the language stated in Appendix 3 to this Rule.

SECTION 14. EFFECTIVE DATE

This Regulation shall be effective October 1, 1990.

SECTION 15. SEVERABILITY.

Any Section or provision of this Rule held by a court to be invalid or unconstitutional will not affect the validity of any other Section or provision.

Ron Taylor
Insurance Commissioner

8-23-90
Date

APPENDIX 1

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF INDIVIDUAL DISABILITY OR LONG-TERM CARE INSURANCE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing disability or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of the seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding the propose replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____
(Date)

_____
(Applicant's Signature)

APPENDIX 2

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF DISABILITY OR LONG-TERM CARE INSURANCE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing disability or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3. [To be included only if the application to attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to you new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

_____

(Company Name)

APPENDIX 3

FORMAT FOR OUTLINE
OF COVERAGE

[COMPANY NAME]

[ADDRESS - CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

1. This policy is [an individual policy of insurance] [a group policy] which was issued in the [indicate jurisidiction in which group policy was issued].

2. PURPOSE OF OUTLINE COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverages for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

   (a) [Provide a brief description of the right to return--"free look" provision of the policy.]

   (b) [Include a statement that the policy either does or not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

4. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company

(a) [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

5. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

6. BENEFITS PROVIDED BY THIS POLICY.

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

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

(c) [Non-institutional benefits, by skill level.]

[Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.]

7. LIMITATION AND EXCLUSIONS.

[Describe:

(a) Pre-existing conditions;

(b) Non-eligible facilities/providers;

(c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) Exclusions/exceptions;

(e) Limitations.]

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

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

8. RELATION OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted.

[As applicable, indicate the following:

(a) That the benefit level will not increase over time;

(b) Any automatic benefit adjustment provisions;

(c) Whether the insured will be guaranteed the option to but additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

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

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

(a) Describe the policy renewability provisions;

(b) For group coverage, specifically describe continuation/ conversion provisions applicable to the certificate and group policy;

(c) Describe waiver of premium provisions or state that there are not such provisions;

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

10. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

11. PREMIUM.

[(a) State the total annual premium for the policy;

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

12. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]