**Section 2012.30 Definitions**

"Accelerated Long-Term Care Benefit" means a life insurance policy, contract, rider endorsement or amendment that contains benefits providing payment from life or endowment or annuity benefits in advance of the time they would otherwise be payable at any time during the insured's lifetime as an indemnity for long-term care.

*"Applicant",* as defined in Section 351A-1 of the Illinois Insurance Code, *means*:

*in the case of an individual long-term care insurance policy, the person who seeks to contract for benefits;*

*in the case of a group long-term care insurance policy, the proposed* *certificateholder*.

*"Certificate",* as defined in Section 351A-1 of the Illinois Insurance Code, *means any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this State.*

"Chronically Ill Individual", for all long-term care policies that are marketed as "qualified" pursuant to the Internal Revenue Code of 1986, as amended (26 USC 7702B(c)(2)(A)), means any individual who has been certified by a licensed health care practitioner as:

being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity;

having a level of disability similar (as determined under regulations prescribed by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in the preceding paragraph; or

requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

The term does not include any individual otherwise meeting the requirements of this definition unless within the preceding 12-month period a licensed health care practitioner has certified that the individual meets these requirements.

"Code" means the Illinois Insurance Code [215 ILCS 5].

"Director" means the Director of the Illinois Department of Insurance.

"Exceptional Increase" means only those increases filed by an insurer as exceptional for which the Director determines the need for the premium rate increase is justified due to changes in laws or regulations applicable to long-term care coverage in this State, or to increased and unexpected utilization that affects the majority of insurers of similar products.

Except as provided in Sections 2012.112 and 2012.113, exceptional increases are subject to the same requirements as other premium rate schedule increases found in Section 2012.112 or 2012.113.

The Director may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.

The Director, in determining that the necessary basis for exceptional increase exists, shall also determine any potential offsets to higher claims costs.

*"Group Long-Term Care Insurance",* as defined in Section 351A-1 of the Code [215 ILCS 5/351A-1], *means a* *long-term care insurance policy which is delivered or issued for delivery in this State and issued to one of the following:*

*One or more employers or labor organizations, or to a trust or to the trustee(s) of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.*

*Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:*

*is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and*

*has been maintained in good faith for purposes other than obtaining insurance.*

*An association or a trust or the trustee(s) of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering such policy within this State, the association or associations, or the insurer of the association or associations, shall file evidence with the Director that the association or associations have at the outset a minimum of 100 members and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and by-laws which provide that:*

*the association or associations hold regular meetings not less than annually to further purposes of the members;*

*except for credit unions, the association or associations collect dues or solicit contributions from members; and*

*the members have voting privileges and representation on the governing board and committees.*

*Thirty days after such filing the association or associations will be deemed to satisfy such organizational requirements, unless the Director makes a finding that the association or associations do not satisfy those organizational requirements.*

*A group other than as described in subparagraphs under the definition of Group Long-Term Care Insurance, subject to a finding by the Director that:*

*the issuance of the group policy is not contrary to the best interest of the public;*

*the issuance of the group policy would result in economies of acquisition or administration; and*

*the benefits are reasonable in relation to the premiums charged.*

"Incidental", as used in Sections 2012.112(j) and 2012.113(j), means that the value of the long-term care benefit provided is less than 10% of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

"Insurer" includes insurance companies; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization.

*"Long-Term Care Insurance",* as defined in Section 351A-1 of the Code, *means any accident and health insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis 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. The term includes group and individual* *annuities and* *life insurance policies or riders which provide directly or which supplement long-term care insurance. The term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term shall also include qualified long-term care insurance contracts. Long-term care insurance may be issued by insurers,* *fraternal benefit societies,* *nonprofit health, hospital, and medical service corporations,* *prepaid health plans,* *health maintenance organizations or any similar organization*, *to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income* or related asset-*protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. Long-term care insurance may include benefits for care and treatment in accordance with the tenets and practices of any established church or religious denomination* *which* *teaches reliance on spiritual treatment through prayer for healing.*

"Maintenance or Personal Care Services", within the meaning of the Internal Revenue Code of 1986, as amended (26 USC 7702B(c)(3)), means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

*"Policy",* as defined in Section 351A-1 of the Illinois Insurance Code, *means any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this State by an insurer, fraternal benefit society, non-profit health*, *hospital, or medical service corporation, prepaid health plan, health maintenance organization or any similar organization*.

"Qualified Actuary" means a member in good standing of the American Academy of Actuaries.

"Qualified Long-Term Care Contract" has the same meaning as that for a "Qualified long-term care insurance contract" described in Section 351A-1 of the Code.

"Qualified Long-Term Care Insurance Partnership Policy" means a policy that meets all of the following requirements:

It covers an insured who was a resident of Illinois when coverage first became effective under the policy;

It is a qualified long-term care insurance policy as defined in section 7702B(b) of the Internal Revenue Code of 1986 issued not earlier than the effective date of the State plan amendment;

It meets the model regulations and requirements of the National Association of Insurance Commissioners model specified in paragraph (5) of Title VI, section 6021 of the federal Deficit Reduction Act of 2005 (42 USC 1305), and the Director of the Department of Insurance certifies it as meeting these requirements; and

If the policy is sold to an individual who:

has not attained age 61 as of the date of purchase, the policy provides compound annual inflation protection;

has attained age 61 but has not attained age 76 as of the date of purchase, the policy provides some level of inflation protection; or

has attained age 76 as of the date of purchase, the policy may, but is not required to, provide some level of inflation protection.

"Qualified Long-Term Care Services" means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitation services, and maintenance or personal care services that are required by a chronically ill individual, that are provided pursuant to a plan of care prescribed by a licensed heath care practitioner.

"Respite Service" may include, but is not limited to, temporary care for insureds aimed at relieving stress for the insureds families. Respite service shall be provided for vacation, rest, errands, family crisis or emergency.

"Similar Policy Forms" means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition of "Group Long-Term Care Insurance" found in Section 351A-1(e)(1) of the Code are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

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