**Section 2012.50 Policy Practices and Provisions**

a) Renewability. The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care insurance policy or certificate without explanatory language in accordance with the disclosure requirements of Section 2012.62.

1) A policy issued to an individual shall not contain renewal provisions other than "guaranteed renewable" or "noncancellable".

2) The term "guaranteed renewable" 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 and when 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 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 unilaterally make any change in any provision of the insurance or in the premium rate.

4) The term "level premium" may only be used when the insurer does not have the right to change the premium.

5) In addition to the other requirements of subsection (a), a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.

b) Limitations and Exclusions. A policy may not be delivered or issued for delivery in this State as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

1) Preexisting 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 or senile dementia;

3) Alcoholism and drug addiction;

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

A) war or act of 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 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 program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or 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;

6) Expenses for services or items available or paid under another traditional long-term care insurance or health insurance policy;

7) In the case of a tax qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount;

8) This subsection (b) is not intended to prohibit exclusions and limitations by type of provider. However, no long term care issuer may deny a claim because services are provided in a state other than in the state in which the policy was issued under the following conditions:

A) When the state other than the state in which the policy was issued does not have the provider licensing, certification or registration required in the policy, but when the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification or registration; or

B) When the state other than the state in which the policy was issued licenses, certifies or registers the provider under another name.

9) This subsection (b) is not intended to prohibit 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 February 1, 1994 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 or facilities may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy. The Director 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 that an individual whose coverage under the 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 months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy the individual 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 Director to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts the provision of benefits and services, or contains incentives to use certain providers and/or facilities, the Director, in making a determination as to the substantial equivalency of benefits, 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. The converted policy offered shall be on a form that is available for general sale in this State.

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 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 guaranteed renewable.

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 of coverage or issuance of a converted policy 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 is replaced not later than 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 Director to be substantially similar 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 subsection (d)(6).

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 that 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 100% of incurred expenses. This 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 whose 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.

e) Discontinuance and Replacement

If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

1) Shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

2) Shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services.

f) The premiums charged to an insured shall not increase due to either:

1) The increasing age of the insured at ages beyond 65; or

2) The duration the insured has been covered under the policy.

g) No long-term care insurance policy shall provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

h) Electronic Enrollment for Group Policies

1) In the case of a group defined in Section 351A-1(e) of the Code, any requirement that a signature of an insured be obtained by an insurance producer or insurer shall be deemed satisfied if:

A) The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;

B) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records; and

C) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information and privileged information is maintained.

2) Upon request of the Director the insurer shall make available records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

i) Except for subsections (a)(1), (b)(8) and (9) and (g), which become effective January 1, 2009, subsections (a) through (h) become effective July 1, 2008.

j) For policies issued from July 1, 2008 through January 1, 2009, the following requirements taken from subsections (a)(1), (b)(8) and (g) apply:

1) For purposes of subsection (a), no individual long-term care insurance policy or certificate issued to an individual shall contain renewal provisions less favorable to the insured than "guaranteed renewable".

2) Subsection (b) is not intended to prohibit exclusions and limitations for payment of services provided outside the United States.

3) For purposes of subsection (g), no traditional long-term care insurance policy shall:

A) be cancelled, nonrenewed or otherwise terminated on grounds of the age or deterioration of the mental or physical health of the insured individual or certificateholder;

B) contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by new or other coverage, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder;

C) provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

4) There is no requirement for subsection (b)(9) prior to January 1, 2009.

(Source: Amended at 42 Ill. Reg. 4867, effective February 27, 2018)