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INSURANCE CODE - INS

DIVISION 2. CLASSES OF INSURANCE [1880 - 12880.8] (*Division 2 enacted by Stats. 1935, Ch. 145.*)

PART 2. LIFE AND DISABILITY INSURANCE [10110 - 11549] (*Part 2 enacted by Stats. 1935, Ch. 145.*)

CHAPTER 2.6. Long-Term Care Insurance [10231 - 10237.6] (*Chapter 2.6 added by Stats. 1988, Ch. 1342, Sec. 1.*)

ARTICLE 1. Definitions [10231 - 10231.8] (*Heading of Article 1 renumbered from Article 2 by Stats. 1992, Ch. 1132, Sec. 2.*)

10231. Unless the context requires otherwise, the definitions in this article shall govern the construction of this chapter.

(*Added by Stats. 1988, Ch. 1342, Sec. 1.*)

10231.2. "Long-term care insurance" includes any insurance policy, certificate, or rider advertised, marketed, offered, solicited, or designed to provide coverage for diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services that are provided in a setting other than an acute care unit of a hospital. Long-term care insurance includes all products containing any of the following benefit types: coverage for institutional care including care in a nursing home, convalescent facility, extended care facility, custodial care facility, skilled nursing facility, or personal care home; home care coverage including home health care, personal care, homemaker services, hospice, or respite care; or community-based coverage including adult day care, hospice, or respite care. Long-term care insurance includes disability based long-term care policies but does not include insurance designed primarily to provide Medicare supplement or major medical expense coverage.

Long-term care policies, certificates, and riders shall be regulated under this chapter. The commissioner shall review and approve individual and group policies, certificates, riders, and outlines of coverage. Other applicable laws and regulations shall also apply to long-term care insurance insofar as they do not conflict with the provisions in this chapter. Long-term care benefits designed to provide coverage of 12 months or more that are contained in or amended to Medicare supplement or other disability policies and certificates shall be regulated under this chapter.

(*Amended by Stats. 2001, Ch. 159, Sec. 147. Effective January 1, 2002.*)

10231.3. (a) For the purposes of this section, the following definitions apply:

(1) An "alternate plan of care" means a plan of care that includes a specification of long-term care services, providers, or places of care that are not specifically defined as covered services, providers, or places of care under the policy. The alternate plan of care shall be developed by a licensed health care practitioner, describe the insured's needs, and specify the type, frequency, and providers of all formal and informal long-term care services that are required by the insured and the cost, if any. The services, providers, and places of care specified in an alternate plan of care shall include those that are specifically defined as covered services, providers, and places under the policy, as well as those that are not specifically defined as covered services, providers, and places under the policy.

(2) An "alternate-plan-of-care provision" means a provision in a policy, rider, endorsement, or amendment that allows benefits for services, providers, and places of care that are specified in an alternate plan of care.

(3) "Licensed health care practitioner" means a physician, registered nurse, licensed social worker, or other individual whom the United States Secretary of the Treasury may prescribe by regulation.

(4) "Plan of care" means a written description of the insured's needs and a specification of the type, frequency, and providers of all formal and informal long-term care services required by the insured and the cost, if any.

(b) An alternate-plan-of-care provision shall provide for all of the following:

(1) An alternate plan of care may be proposed by the insured or the insurer. Adoption, amendment, or replacement of an alternate plan of care shall be agreed to by the insured, the insurer, and a licensed health care practitioner that is independent of the

insurer. Consent or agreement to an alternate plan of care shall be free and mutual.

(2) The maximum benefit available under the contract shall not change based on an insured utilizing an alternate plan of care, but that benefit will be reduced by the amount of any benefits paid under an alternate plan of care.

(3) Policy benefits are payable for all services, providers, and places of care that are specified in an alternate plan of care. Coverage for services, providers, and places of care under an alternate plan of care shall be in addition to, not in lieu of, coverage for services, providers, and places of care that are specifically defined as covered services under the policy.

(4) If adopted, an alternate plan of care replaces any existing plan of care, including any previously adopted alternate plan of care. No benefits are payable for services provided pursuant to a plan of care after it is replaced by an alternate plan of care.

(5) An alternate plan of care can be replaced by a new plan of care at any time.

(A) If the new plan of care is not an alternate plan of care, the new plan of care does not need to be adopted in the manner described in paragraph (1) of this subdivision.

(B) If the new plan of care is a new or amended alternate plan of care, the new or amended alternate plan of care shall be adopted in the manner described in paragraph (1) of this subdivision.

(C) No benefits are payable for services provided pursuant to an alternate plan of care after it is replaced by a new plan of care.

(c) Nothing in this section shall be construed to require an insurer to include a provision authorizing an alternate plan of care. However, an insurer and an insured may agree to use an alternate plan of care even if there is no provision in the policy that specifically authorizes one. Nothing in this section is intended to obligate either party to negotiate an alternate plan of care. If an insurer does not accept an extra-contractual request for an alternate plan of care, the rejection is not a denial of a claim.

(d) This section shall apply to policies issued on or after January 1, 2017.

(Amended by Stats. 2018, Ch. 98, Sec. 1. (AB 2180) Effective January 1, 2019.)

10231.4. "Applicant" means either of the following:

(a) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits.

(b) In the case of a group long-term care insurance policy, the proposed certificate holder.

(Added by Stats. 1988, Ch. 1342, Sec. 1.)

10231.5. "Certificate" means any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

(Added by Stats. 1988, Ch. 1342, Sec. 1.)

10231.6. "Group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in this state and issued to any of the following:

(a) One or more employers or labor organizations, or a trust or to the trustees 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 organization.

(b) Any professional, trade, or occupational association for its members or former or retired members, or combination thereof, if that association meets both of the following:

(1) Is composed of individuals all of whom are or were actively engaged in the same profession, trade, or occupation.

(2) Has been maintained in good faith for purposes other than obtaining insurance.

(c) An association or a trust or the trustees of a fund established, created, or maintained for the benefit of members of one or more associations. Prior to advertising, marketing, or offering that policy or a certificate within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the commissioner that the association or associations have at the outset a minimum of 100 persons and have been organized and maintained in good faith for a primary purpose other than that of obtaining insurance, have been in active existence for at least one year, have a constitution and bylaws which provide all of the following, and provide evidence that the following have been consistently implemented:

(1) The association or associations hold regular meetings, not less than annually, to further purposes of the members.

(2) Except for credit unions, the association or associations collect dues or solicit contributions from members.

(3) The members have voting privileges and representation on the governing board and committees.

Thirty days after that filing the association or associations shall be deemed to satisfy these organizational requirements, unless the commissioner makes a finding that the association or associations do not satisfy those organizational requirements.

(d) A group other than as described in subdivisions (a), (b), and (c), subject to all of the following findings by the commissioner:

(1) The issuance of the group policy or certificate is not contrary to the best interest of the public.

(2) The issuance of the group policy will result in economies of acquisition or administration.

(3) The benefits are reasonable in relation to the premiums charged.

(4) The use of the true or fictitious name of the group, group master policyholder, group policy, certificate, or any trust or other entity created or used for the marketing of the group policy or certificates is not deceptive or misleading with regard to the status, character, or proprietary or representative capacity of the insurer, group, trust, or other entity.

(5) The group's main revenue source is not related to the marketing of insurance.

(6) The group's outreach method to obtain new members is not related to the solicitation of insurance.

(7) The group provides benefits or services, other than insurance, of significant value to its members. The commissioner shall investigate the percentage of members using the other services and the monetary value of those services.

(e) A life care contract provider which has received a certificate of authority in accordance with Chapter 10 (commencing with Section 1770) of Division 2 of the Health and Safety Code. Any life care contract provider which has not received the certificate of authority from the State Department of Social Services shall be subject to this chapter.

(Amended by Stats. 1992, Ch. 1132, Sec. 5. Effective January 1, 1993.)

10231.8. "Policy" means any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this state by an insurer, fraternal benefit society, nonprofit hospital service plan, or any similar organization, regulated by the commissioner.

(Added by Stats. 1988, Ch. 1342, Sec. 1.)