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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 3. General Provisions [10232 - 10233.8] (*Article 3 added by Stats. 1988, Ch. 1342, Sec. 1.*)

10232. (a) No group long-term care insurance coverage may be offered or sold to a resident of this state under a group policy issued in another state to a group described in subdivision (d) of Section 10231.6, unless the commissioner has determined that the requirements imposed by subdivision (d) of Section 10231.6 have been met. At least 30 days in advance of advertising, marketing, or offering coverage within this state, an insurer issuing a policy to a group described in subdivision (d) of Section 10231.6 shall accomplish an informational filing with the commissioner which consists of the following materials:

- (1) A specimen master policy and certificate.
- (2) The corresponding outline of coverage.
- (3) Representative advertising materials to be used in this state.
- (4) At the option of the insurer, any other documentation which the insurer believes will provide information sufficient to allow the commissioner to determine that the requirements of subdivision (d) of Section 10231.6 have been met or which establishes that the insurance regulatory authority of another state has made a determination that the requirements have been met, or both.

(b) No group long-term care insurance coverage may be offered or sold to a resident of this state under a group policy issued in another state to a group described in subdivision (c) of Section 10231.6, unless, prior to advertising, marketing, or offering that coverage within this state, the association or associations, or the insurer of the association or associations, files evidence with the commissioner that the association or associations have at the outset a minimum of 100 persons, 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 those organizational requirements, unless the commissioner makes the finding that the association or associations do not satisfy those organizational requirements.

The association or associations, or the insurer of the association or associations, shall accompany this organizational filing with an informational filing which consists of the following materials:

- (1) A specimen master policy and certificate.
- (2) The corresponding outline of coverage.
- (3) Representative advertising materials to be used in this state.

(c) Compliance with the informational filings required to be made by this section shall also constitute compliance with the filing requirements of Section 10233.9.

(d) The materials required to be filed with the commissioner by this section shall be filed with the commissioner for informational purposes only, and not for approval purposes.

(Amended by Stats. 1992, Ch. 1132, Sec. 6. Effective January 1, 1993.)

10232.1. (a) Every policy that is intended to be a qualified long-term care insurance contract as provided by Public Law 104-191 shall be identified as such by prominently displaying and printing on page one of the policy form and the outline of coverage and in the application the following words: "This contract for long-term care insurance is intended to be a federally qualified long-term care insurance contract and may qualify you for federal and state tax benefits." Every policy that is not intended to be a qualified long-term care insurance contract as provided by Public Law 104-191 shall be identified as such by prominently displaying and printing on page one of the policy form and the outline of coverage and in the application the following words: "This contract for long-term care insurance is not intended to be a federally qualified long-term care insurance contract."

(b) Any policy or certificate in which benefits are limited to the provision of institutional care shall be called a "nursing facility and residential care facility only" policy or certificate and the words "Nursing Facility and Residential Care Facility Only" shall be prominently displayed on page one of the form and the outline of coverage. The commissioner may approve alternative wording if it is more descriptive of the benefits.

(c) Any policy or certificate in which benefits are limited to the provision of home care services, including community-based services, shall be called a "home care only" policy or certificate and the words "Home Care Only" shall be prominently displayed on page one of the form and the outline of coverage. The commissioner may approve alternative wording if it is more descriptive of the benefits.

(d) Any policy, certificate, or rider in which benefits are limited to the provision of all care settings, except nursing facility care, and that is offered under the California Partnership for Long-Term Care Program established by Section 22000 of the Welfare and Institutions Code shall be called a home care, community-based services, and residential care facility only policy, certificate, or rider and the words "Home Care, Community-Based Services, and Residential Care Facility Only" shall be prominently displayed on the first page of the form and the outline of coverage. The commissioner may approve an alternative version of those words if the alternative version is more descriptive of the benefits provided.

(e) Only those policies or certificates providing benefits for both institutional care and home care may be called "comprehensive long-term care" insurance.

(Amended by Stats. 2018, Ch. 565, Sec. 1. (SB 1248) Effective January 1, 2019.)

10232.2. (a) Every insurer that offers policies or certificates that are intended to be federally qualified long-term care insurance contracts, including riders to life insurance policies providing long-term care coverage, shall fairly and affirmatively concurrently file, offer, and market long-term care insurance policies or certificates not intended to be federally qualified, as described in subdivision (a) of Section 10232.1.

(b) All long-term care insurance contracts, including riders to life insurance contracts providing long-term care coverage, approved after the effective date of this section shall meet all of the requirements of this chapter.

(c) Until October 1, 2001, or 90 days after approval of contracts submitted for approval pursuant to subdivision (b), whichever comes first, insurers may continue to offer and market previously approved long-term care insurance contracts.

(d) Group policies issued prior to January 1, 1997, shall be allowed to remain in force and not be required to meet the requirements of this chapter, as amended during the 1997 portion of the 1997–98 Regular Session, unless those policies cease to be treated as federally qualified long-term care insurance contracts. If a policy or certificate issued on a group policy of that type ceases to be a federally qualified long-term care insurance contract under the grandfather rules issued by the United States Department of the Treasury pursuant to Section 7702B(f) of the Internal Revenue Code, the insurer shall offer the policy and certificate holders the option to convert, on a guaranteed-issue basis, to a policy or certificate that is federally tax qualified if the insurer sells tax-qualified policies.

(e) It is the intent of the Legislature that the commissioner approve by July 1, 2001, all accurate and complete contracts submitted for approval pursuant to subdivision (b). It is the further intent of the Legislature that insurers submit contracts for approval and resolve further outstanding issues pursuant to subdivision (b) in a timely manner in order for the commissioner to approve the contracts by July 1, 2001.

(Amended (as amended by Stats. 1999, Ch. 947) by Stats. 2001, Ch. 51, Sec. 3. Effective July 9, 2001.)

10232.3. (a) All applications for long-term care insurance except that which is guaranteed issue, shall contain clear, unambiguous, short, simple questions designed to ascertain the health condition of the applicant. Each health-related question shall contain only one health status inquiry and shall require only a "yes" or "no" answer, except that the application may include a request for the name of any prescribed medication and the name of a prescribing physician. If the application requests the name of any prescribed

medication or prescribing physician, then any mistake or omission shall not be used as a basis for the denial of a claim or the rescission of a policy or certificate.

(b) The following warning shall be printed conspicuously and in close conjunction with the applicant's signature block:

"Caution: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits or rescind your coverage."

(c) Every application for long-term care insurance shall include a checklist that enumerates each of the specific documents that this chapter requires be given to the applicant at the time of solicitation. The documents and notices to be listed in the checklist include, but are not limited to, the following:

(1) The outline of coverage pursuant to Section 10233.5.

(2) The HICAP notice pursuant to paragraph (8) of subdivision (a) of Section 10234.93.

(3) The long-term care insurance shoppers guide pursuant to paragraph (9) of subdivision (a) of Section 10234.93.

(4) The "Long-Term Care Insurance Personal Worksheet" pursuant to subdivision (c) of Section 10234.95.

(5) The "Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care Insurance" pursuant to Section 10235.16 if replacement is not made by direct response solicitation or Section 10235.18 if replacement is made by direct response solicitation. Unless the solicitation was made by a direct response method, the agent and applicant shall both sign at the bottom of the checklist to indicate the required documents were delivered and received.

(d) If an insurer does not complete medical underwriting and resolve all reasonable questions arising from information submitted on or with an application before issuing the policy or certificate, then the insurer may only rescind the policy or certificate or deny an otherwise valid claim, upon clear and convincing evidence of fraud or material misrepresentation of the risk by the applicant. The evidence shall:

(1) Pertain to the condition for which benefits are sought.

(2) Involve a chronic condition or involve dates of treatment before the date of application.

(3) Be material to the acceptance for coverage.

(e) No long-term care policy or certificate may be field issued.

(f) The contestability period as defined in Section 10350.2 for long-term care insurance shall be two years.

(g) A copy of the completed application shall be delivered to the insured at the time of delivery of the policy or certificate.

(h) Every insurer shall maintain a record, in accordance with Section 10508, of all policy or certificate rescissions, both state and countrywide, and shall annually furnish this information to the commissioner, which shall include the reason for rescission, the length of time the policy or certificate was in force, and the age and gender of the insured person, in a format prescribed by the commissioner.

(i) The commissioner may, in his or her discretion, make public the aggregate data collected under subdivision (h), upon request.

(Amended by Stats. 2018, Ch. 98, Sec. 2. (AB 2180) Effective January 1, 2019.)

10232.4. (a) No long-term care insurance policy or certificate other than a group policy or certificate, as described in subdivision (a) of Section 10231.6, shall use a definition of preexisting condition which is more restrictive than a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person.

(b) Every long-term care insurance policy or certificate shall cover preexisting conditions that are disclosed on the application no later than six months following the effective date of the coverage of an insured, regardless of the date the loss or confinement begins.

(c) The definition of preexisting condition does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in subdivision (b) expires. Unless a waiver or rider has been specifically approved by the commissioner, no long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in subdivision (b).

(Amended by Stats. 1999, Ch. 947, Sec. 4. Effective January 1, 2000.)

10232.5. On or after January 1, 1990, no long-term care insurance policy may be delivered or issued for delivery in this state which does any of the following:

- (a) Preconditions the availability of benefits on prior hospitalization.
- (b) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care.
- (c) Preconditions the availability of benefits for community-based care, home health care, or home care on prior institutionalization.
- (d) Conditions eligibility for noninstitutional benefits, other than those in subdivision (c), on a prior institutional stay of more than 30 days.

(Repealed and added by Stats. 1989, Ch. 1273, Sec. 4.2.)

10232.6. The commissioner may adopt regulations establishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the regulation. Any regulations adopted by the commissioner shall substantially reflect the loss ratio standards contained in Section 10 of the National Association of Insurance Commissioners Long-Term Care Insurance Model Regulations, as most recently revised.

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

10232.65. In addition to any other requirements of law, the following shall apply to a long-term care insurance policy:

- (a) The insurer shall not require an amount greater than one month's premium to be submitted with an application for the policy of insurance if interim coverage is not provided. If interim coverage is provided, the insurer shall not require an amount greater than two months' premium for that purpose. No further premiums may be collected until the policy is delivered to the applicant.
- (b) The insurer shall notify the applicant within 60 days from the date the insurer or insurer's authorized representative or producer receives the application and the amount as to whether or not the applicant will be issued a policy of insurance. If the applicant is not so notified, the insurer or insurer's authorized representative or producer shall pay interest to the applicant on the funds that the applicant submitted with the application, at the legal rate of interest on judgments as provided in Section 685.010 of the Code of Civil Procedure, from the date the insurer or insurer's authorized representative or producer received those funds until they are refunded to the applicant or are applied toward the premium.

(Added by Stats. 2001, Ch. 328, Sec. 5. Effective January 1, 2002.)

10232.7. (a) An applicant for a long-term care insurance policy or a certificate, other than an applicant for a certificate issued under a group long-term care insurance policy issued to a group as described in subdivisions (a) and (b) of Section 10231.6, shall have the right to return the policy or certificate by first-class United States mail within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

(b) The return of a policy or certificate shall void the policy or certificate from the beginning and the parties shall be in the same position as if no policy, certificate, or contract had been issued. All premiums paid and any policy fee paid for the policy shall be fully refunded directly to the applicant by the insurer within 30 days after the policy or certificate is returned.

(c) Notwithstanding Section 10276 or any other law, long-term care insurance policies or certificates to which this section applies shall have a notice prominently printed on the first page of the policy or certificate, or attached thereto, stating in substance the conditions described in subdivisions (a) and (b).

(Amended by Stats. 1989, Ch. 1273, Sec. 5.)

10232.8. (a) In every long-term care policy or certificate that is not intended to be a federally qualified long-term care insurance contract and provides home care benefits, the threshold establishing eligibility for home care benefits shall be at least as permissive as a provision that the insured will qualify if either one of two criteria are met:

- (1) Impairment in two out of seven activities of daily living.
- (2) Impairment of cognitive ability.

The policy or certificate may provide for lesser but not greater eligibility criteria. The commissioner, at his or her discretion, may approve other criteria or combinations of criteria to be substituted, if the insurer demonstrates that the interest of the insured is better served.

"Activities of daily living" in every policy or certificate that is not intended to be a federally qualified long-term care insurance contract and provides home care benefits shall include eating, bathing, dressing, ambulating, transferring, toileting, and continence; "impairment" means that the insured needs human assistance, or needs continual substantial supervision; and "impairment of cognitive ability" means deterioration or loss of intellectual capacity due to organic mental disease, including Alzheimer's disease or related illnesses, that requires continual supervision to protect oneself or others.

(b) In every long-term care policy approved or certificate issued after the effective date of the act adding this section, that is intended to be a federally qualified long-term care insurance contract as described in subdivision (a) of Section 10232.1, the threshold establishing eligibility for home care benefits shall provide that a chronically ill insured will qualify if either one of two criteria are met or if a third criterion, as provided by this subdivision, is met:

(1) Impairment in two out of six activities of daily living.

(2) Impairment of cognitive ability.

Other criteria shall be used in establishing eligibility for benefits if federal law or regulations allow other types of disability to be used applicable to eligibility for benefits under a long-term care insurance policy. If federal law or regulations allow other types of disability to be used, the commissioner shall promulgate emergency regulations to add those other criteria as a third threshold to establish eligibility for benefits. Insurers shall submit policies for approval within 60 days of the effective date of the regulations. With respect to policies previously approved, the department is authorized to review only the changes made to the policy. All new policies approved and certificates issued after the effective date of the regulation shall include the third criterion. A policy shall not be sold unless the policy includes the third criterion after one year beyond the effective date of the regulations. An insured meeting this third criterion shall be eligible for benefits regardless of whether the individual meets the impairment requirements in paragraph (1) or (2) regarding activities of daily living and cognitive ability.

(c) A licensed health care practitioner, independent of the insurer, shall certify that the insured meets the definition of "chronically ill individual" as defined under Public Law 104-191. For the purposes of long-term care insurance as defined in Section 10231.2, an insurer shall not impose a certification requirement of longer than 90 days. The policy or certificate shall explain paragraphs (1) through (5) and comply with all of the following:

(1) An insured has the option of submitting a certification to the insurer or submitting a notice of claim and requesting that the insurer conduct the assessment. If the insured requests that the insurer conduct the assessment, the insurer shall provide an independent licensed health care practitioner to conduct the assessment. If a health care practitioner makes a determination, pursuant to this section, that an insured does not meet the definition of "chronically ill individual," the insurer shall notify the insured that the insured shall be entitled to a second assessment by a licensed health care practitioner, upon request, who shall personally examine the insured. The requirement for a second assessment shall not apply if the initial assessment was performed by a practitioner who otherwise meets the requirements of this section and who personally examined the insured.

(2) The assessments conducted pursuant to this section shall be performed promptly with the certification completed as quickly as possible to ensure that an insured's benefits are not delayed. The written certification shall be renewed every 12 months.

(3) A licensed health care practitioner shall develop a written plan of care after personally examining the insured.

(4) The costs to have a licensed health care practitioner certify that an insured meets, or continues to meet, the definition of "chronically ill individual," or to prepare written plans of care shall not count against the lifetime maximum of the policy or certificate.

(5) In order to be considered "independent of the insurer," a licensed health care practitioner shall not be an employee of the insurer and shall not be compensated in any manner that is linked to the outcome of the certification.

(6) It is the intent of this subdivision that the practitioner's assessments be unhindered by financial considerations.

(7) This subdivision shall apply only to a policy or certificate intended to be a federally qualified long-term care insurance contract.

(d) "Activities of daily living" in every policy or certificate intended to be a federally qualified long-term care insurance contract as provided by Public Law 104-191 shall include eating, bathing, dressing, transferring, toileting, and continence; "impairment in activities of daily living" means the insured needs "substantial assistance" either in the form of "hands-on assistance" or "standby assistance," due to a loss of functional capacity to perform the activity; "impairment of cognitive ability" means the insured needs substantial supervision due to severe cognitive impairment; "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; and "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.

(e) Until the time that these definitions may be superseded by federal law or regulation, the terms "substantial assistance," "hands-on assistance," "standby assistance," "severe cognitive impairment," and "substantial supervision" shall be defined according to the safe-harbor definitions contained in Internal Revenue Service Notice 97-31, issued May 6, 1997.

(f) The definitions of "activities of daily living" to be used in policies and certificates that are intended to be federally qualified long-term care insurance shall be the following until the time that these definitions may be superseded by federal law or regulations:

(1) Eating, which shall mean feeding oneself by getting food in the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

(2) Bathing, which shall mean washing oneself by sponge bath or in either a tub or shower, including the act of getting into or out of a tub or shower.

(3) Continence, which shall mean the ability to maintain control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).

(4) Dressing, which shall mean putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

(5) Toileting, which shall mean getting to and from the toilet, getting on or off the toilet, and performing associated personal hygiene.

(6) Transferring, which shall mean the ability to move into or out of bed, a chair, or wheelchair.

The commissioner may approve the use of definitions of "activities of daily living" that differ from the verbatim definitions of this subdivision if these definitions would result in more policy or certificate holders qualifying for long-term care benefits than would occur by the use of the verbatim definitions of this subdivision. In addition, the following definitions may be used without the approval of the commissioner: (1) the verbatim definitions of eating, bathing, dressing, toileting, transferring, and continence in subdivision (g); or (2) the verbatim definitions of eating, bathing, dressing, toileting, and continence in this subdivision and a substitute, verbatim definition of "transferring" as follows: "transferring," which shall mean the ability to move into and out of a bed, a chair, or wheelchair, or ability to walk or move around inside or outside the home, regardless of the use of a cane, crutches, or braces.

The definitions to be used in policies and certificates for impairment in activities of daily living, "impairment in cognitive ability," and any third eligibility criterion adopted by regulation pursuant to subdivision (b) shall be the verbatim definitions of these benefit eligibility triggers allowed by federal regulations. In addition to the verbatim definitions, the commissioner may approve additional descriptive language to be added to the definitions, if the additional language is (1) warranted based on federal or state laws, federal or state regulations, or other relevant federal decision, and (2) strictly limited to that language that is necessary to ensure that the definitions required by this section are not misleading to the insured.

(g) The definitions of "activities of daily living" to be used verbatim in policies and certificates that are not intended to qualify for favorable tax treatment under Public Law 104-191 shall be the following:

(1) Eating, which shall mean reaching for, picking up, and grasping a utensil and cup; getting food on a utensil, and bringing food, utensil, and cup to mouth; manipulating food on plate; and cleaning face and hands as necessary following meals.

(2) Bathing, which shall mean cleaning the body using a tub, shower, or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, and reaching head and body parts for soaping, rinsing, and drying.

(3) Dressing, which shall mean putting on, taking off, fastening, and unfastening garments and undergarments and special devices such as back or leg braces, corsets, elastic stockings or garments, and artificial limbs or splints.

(4) Toileting, which shall mean getting on and off a toilet or commode and emptying a commode, managing clothing and wiping and cleaning the body after toileting, and using and emptying a bedpan and urinal.

(5) Transferring, which shall mean moving from one sitting or lying position to another sitting or lying position; for example, from bed to or from a wheelchair or sofa, coming to a standing position, or repositioning to promote circulation and prevent skin breakdown.

(6) Continence, which shall mean the ability to control bowel and bladder as well as use ostomy or catheter receptacles, and apply diapers and disposable barrier pads.

(7) Ambulating, which shall mean walking or moving around inside or outside the home regardless of the use of a cane, crutches, or braces.

(Amended by Stats. 2018, Ch. 98, Sec. 3. (AB 2180) Effective January 1, 2019.)

10232.81. Every long-term care policy, certificate, or rider that purports to provide benefits of home care, community-based services, and residential care facility services under the California Partnership for Long-Term Care Program established by Section 22000 of the Welfare and Institutions Code shall provide at least the following:

(a) Care in a residential care facility.

(b) Home health care.

(c) Adult day care.

(d) Personal care.

(e) Homemaker services.

(f) Hospice services.

(g) Respite care.

(Amended by Stats. 2018, Ch. 565, Sec. 2. (SB 1248) Effective January 1, 2019.)

10232.9. (a) Every long-term care policy or certificate that purports to provide benefits of home care or community-based services, shall provide at least the following:

(1) Home health care.

(2) Adult day care.

(3) Personal care.

(4) Homemaker services.

(5) Hospice services.

(6) Respite care.

(b) For purposes of this section, policy definitions of these benefits may be no more restrictive than the following:

(1) "Home health care" is skilled nursing or other professional services in the residence, including, but not limited to, part-time and intermittent skilled nursing services, home health aid services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.

(2) "Adult day care" is medical or nonmedical care on a less than 24-hour basis, provided in a licensed facility outside the residence, for persons in need of personal services, supervision, protection, or assistance in sustaining daily needs, including eating, bathing, dressing, ambulating, transferring, toileting, and taking medications.

(3) "Personal care" is assistance with the activities of daily living, including the instrumental activities of daily living, provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction. "Instrumental activities of daily living" include using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, laundry, and light housekeeping.

(4) "Homemaker services" is assistance with activities necessary to or consistent with the insured's ability to remain in his or her residence, that is provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction.

(5) "Hospice services" are outpatient services not paid by Medicare, that are designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal disease, and to provide supportive care to the primary care giver and the family. Care may be provided by a skilled or unskilled person under a plan of care developed by a physician or a multidisciplinary team under medical direction.

(6) "Respite care" is short-term care provided in an institution, in the home, or in a community-based program, that is designed to relieve a primary care giver in the home. This is a separate benefit with its own conditions for eligibility and maximum benefit levels.

(c) Home care benefits shall not be limited or excluded by any of the following:

(1) Requiring a need for care in a nursing home if home care services are not provided.

(2) Requiring that skilled nursing or therapeutic services be used before or with unskilled services.

(3) Requiring the existence of an acute condition.

(4) Limiting benefits to services provided by Medicare-certified providers or agencies.

(5) Limiting benefits to those provided by licensed or skilled personnel when other providers could provide the service, except where prior certification or licensure is required by state law.

(6) Defining an eligible provider in a manner that is more restrictive than that used to license that provider by the state where the service is provided.

(7) Requiring "medical necessity" or similar standard as a criteria for benefits.

(d) Every comprehensive long-term care policy or certificate that provides for both institutional care and home care and that sets a daily, weekly, or monthly benefit payment maximum, shall pay a maximum benefit payment for home care that is at least 50 percent of the maximum benefit payment for institutional care, and in no event shall home care benefits be paid at a rate less than fifty dollars (\$50) per day. Insurance products approved for residents in continuing care retirement communities are exempt from this provision.

Every such comprehensive long-term care policy or certificate that sets a durational maximum for institutional care, limiting the length of time that benefits may be received during the life of the policy or certificate, shall allow a similar durational maximum for home care that is at least one-half of the length of time allowed for institutional care.

(Added by renumbering Section 10232.8 by Stats. 1997, Ch. 699, Sec. 4. Effective October 6, 1997.)

10232.92. Every long-term care policy or certificate covering confinement in a nursing facility shall also include a provision with the following features:

(a) Care in a residential care facility must be covered. "Residential care facility" means a facility licensed as a residential care facility for the elderly or a residential care facility as defined in the Health and Safety Code. Outside California, eligible providers are facilities that meet applicable licensure standards, if any, and are engaged primarily in providing ongoing care and related services sufficient to support needs resulting from impairment in activities of daily living or impairment in cognitive ability and which also provide care and services on a 24-hour basis, have a trained and ready-to-respond employee on duty in the facility at all times to provide care and services, provide three meals a day and accommodate special dietary needs, have agreements to ensure that residents receive the medical care services of a physician or nurse in case of emergency, and, have appropriate methods and procedures to provide necessary assistance to residents in the management of prescribed medications.

(b) The benefit amount payable for care in a residential care facility shall be no less than 70 percent of the benefit amount payable for institutional confinement.

(c) All expenses incurred by the insured while confined in a residential care facility, for long-term care services that are necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, needed to assist the insured with the disabling conditions that cause the insured to be a chronically ill individual as authorized by Public Law 104-191 and regulations adopted pursuant thereto, shall be covered and payable, up to but not to exceed the maximum daily residential care facility benefit of the policy or certificate. There shall be no restriction on who may provide the service or the requirement that services be provided by the residential care facility, as long as the expenses are incurred while the insured is confined in a residential care facility, the reimbursement does not exceed the maximum daily residential care facility benefit of the policy or certificate, and the services do not conflict with federal law or regulation for purposes of qualifying for favorable tax consideration provided by Public Law 104-191.

(d) In policies or certificates that are not intended to be federally qualified, the threshold establishing eligibility for care in a residential care facility shall be no more restrictive than that for home care benefits, as defined in subdivision (a) of Section 10232.8, and the definitions of impairment in activities of daily living and impairment of cognitive ability shall be the same as for home care benefits, as defined in subdivisions (a) and (g) of Section 10232.8. In policies or certificates that are intended to be federally qualified, the threshold establishing eligibility for care in a residential care facility shall be no more restrictive than that for home care benefits, as defined in subdivision (b) of Section 10232.8, and the definitions of impairment in activities of daily living and impairment in cognitive ability shall be the same as those for home care benefits as defined in subdivisions (b), (c), (d), (e), and (f) of Section 10232.8.

(Repealed and added by Stats. 1999, Ch. 947, Sec. 6. Effective January 1, 2000.)

10232.93. Every long-term care policy or certificate shall define the maximum lifetime benefit as a single dollar amount that may be used interchangeably for any home- and community-based services defined in Section 10232.9, assisted living benefit defined in Section 10232.92, or institutional care covered by the policy or certificate. There shall be no limit on any specific covered benefit except for a daily, weekly, or monthly limit set for home- and community-based care and for assisted living care, and for the limits for institutional care. Nothing in this section shall be construed as prohibiting limitations for reimbursement of actual expenses and incurred expenses up to daily, weekly, and monthly limits.

(Added by Stats. 1997, Ch. 699, Sec. 6. Effective October 6, 1997.)

10232.95. Every long-term care policy or certificate that provides reimbursement for care in a nursing facility shall cover and reimburse for per diem expenses, as well as the costs of ancillary supplies and services, up to but not to exceed the maximum lifetime daily facility benefit of the policy or certificate.

(Added by Stats. 1997, Ch. 699, Sec. 6.3. Effective October 6, 1997.)

10232.96. When a policy or certificate holder of an insurance contract issued prior to December 31, 1996, requests a material modification to the contract as defined by federal law or regulations, the insurer, prior to approving such a request, shall provide written notice to the policy or certificate holder that the contract change requested may constitute a material modification that jeopardizes the federal tax status of the contract and appropriate tax advice should therefore be sought.

(Added by Stats. 1997, Ch. 699, Sec. 6.5. Effective October 6, 1997.)

10232.97. In every long-term care policy or certificate that covers care in a nursing facility, the threshold establishing eligibility for nursing facility care shall be no more restrictive than a provision that the insured will qualify if either one of two criteria are met:

- (a) Impairment in two activities of daily living.
- (b) Impairment in cognitive ability.

(Added by Stats. 1999, Ch. 947, Sec. 7. Effective January 1, 2000.)

10233. Precedent to the payment of benefits for any care covered by the terms of the policy, any insurer offering long-term care insurance as described in Section 10231.2 may obtain a written declaration by a physician, independent needs assessment agency, or any other source of independent judgment suitable to the insurer that services are necessary.

(Added by Stats. 1989, Ch. 1273, Sec. 7.)

10233.2. Long-term care insurance may not:

- (a) Be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder.
- (b) Contain a provision establishing a new waiting period in the event existing coverage is converted to, or replaced by, a new or other form within the same insurer, 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.
- (d) Provide for payment of benefits based on a standard described as "usual and customary," "reasonable and customary," or words of similar import.
- (e) Terminate a policy, certificate, or rider, or contain a provision that allows the premium for an in-force policy, certificate, or rider, to be increased due to the divorce of a policyholder or certificate holder.
- (f) Include an additional benefit for a service with a known market value other than the statutorily required home- and community-based service benefits in Section 10232.9, the assisted living benefit in Section 10232.92, or a nursing facility benefit, unless the additional benefit provides for the payment of at least five times the daily benefit and the dollar value of the additional benefit is disclosed in the schedule page of the policy.

(Amended by Stats. 1999, Ch. 947, Sec. 8. Effective January 1, 2000.)

10233.25. No long-term care policy or certificate that is issued, amended, renewed, or delivered on and after January 1, 2002, shall contain a provision that prohibits or restricts any health facilities' compliance with the requirements of Section 1262.5 of the Health and Safety Code.

(Added by Stats. 2001, Ch. 691, Sec. 7. Effective January 1, 2002.)

10233.3. If a policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods to the extent that similar exclusions have been satisfied under the original policy or certificate.

(Added by Stats. 1992, Ch. 1132, Sec. 14. Effective January 1, 1993.)

10233.4. No long-term care insurance benefits may be reduced because of out-of-pocket expenditures by the insured or on behalf of the insured by a family member of the insured or by any other individual.

(Added by Stats. 1989, Ch. 1273, Sec. 9.)

10233.5. (a) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

- (b) In the case of agent solicitations, an agent shall deliver the outline of coverage prior to the presentation of an application or enrollment form.
- (c) In the case of direct response solicitations, the outline of coverage shall be presented in conjunction with any application or enrollment form.
- (d) The outline of coverage shall be a freestanding document, using no smaller than 10-point type.
- (e) The outline of coverage shall contain no material of an advertising nature.
- (f) Use of the text and sequence of the text of the outline of coverage set forth in this section is mandatory, unless otherwise specifically indicated.
- (g) Text which is capitalized or underscored in the outline of coverage may be emphasized by other means which provide prominence equivalent to capitalization or underscoring.
- (h) The outline of coverage shall be in the following form:

“(COMPANY NAME)
(ADDRESS—CITY AND 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 jurisdiction in which group policy was issued)).

2.PURPOSE OF OUTLINE OF 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 coverage 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 does 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 those 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 care 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) (Noninstitutional 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.LIMITATIONS AND EXCLUSIONS.

(Describe:

- (a) Preexisting conditions.
- (b) Noneligible facilities/provider.

(c) Noneligible levels of care (e.g., unlicensed providers, care or treatments 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.RELATIONSHIP 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 buy 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 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 no waiver of premium provisions.

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

10.ALZHEIMER'S DISEASE, ORGANIC DISORDERS, AND RELATED MENTAL DISEASES.

(State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's Disease, organic disorders, or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision that provides preconditions to the availability of policy benefits for that 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.

13.INFORMATION AND COUNSELING. The California Department of Insurance has prepared a Consumer Guide to Long-Term Care Insurance. This guide can be obtained by calling the Department of Insurance toll-free telephone number. This number is 1-800-927-HELP. Additionally, the Health Insurance Counseling and Advocacy Program (HICAP) administered by the California Department of Aging, provides long-term care insurance counseling to California senior citizens. Call the HICAP toll-free telephone number 1-800-434-0222 for a referral to your local HICAP office."

(Amended by Stats. 1999, Ch. 947, Sec. 9. Effective January 1, 2000.)

10233.6. A certificate issued pursuant to a group long-term care insurance policy, which policy is delivered or issued for delivery in this state, shall include all of the following:

(a) A description of the principal benefits and coverage provided in the policy.

(b) A statement of the principal exclusions, reductions, and limitations contained in the policy.

(c) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premiums.

(d) A statement that the group master policy determines governing contractual provisions.

(e) An explanation of the insured's rights regarding continuation, conversion, and replacement.

(Amended by Stats. 1992, Ch. 1132, Sec. 16. Effective January 1, 1993.)

10233.7. No policy may be advertised, marketed, or offered as long-term care or nursing home insurance unless it complies with this chapter.

(Added by Stats. 1989, Ch. 1273, Sec. 12.)

10233.8. (a) A long-term care insurance policy or certificate issued, amended, renewed, or delivered on or after January 1, 2020, shall not do any of the following based solely and without any additional actuarial risks upon the status of a person as a living organ donor:

- (1) Refuse to insure, or refuse to continue to insure, the person under a long-term care insurance policy or certificate.
- (2) Limit the amount, extent, or kind of coverage available to the person under a long-term care insurance policy or certificate.
- (3) Charge the person a different rate for the same coverage under a long-term care insurance policy or certificate.
- (4) Otherwise discriminate in the offering, issuance, cancellation, amount of coverage, price, or any other condition of a long-term care insurance policy or certificate for the person.

(b) With respect to any health condition other than being a living organ donor, a person who is a living organ donor shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as persons who are not living organ donors.

(c) For purposes of this section, "living organ donor" means an individual who has donated all or part of an organ and is not deceased.

(Added by Stats. 2019, Ch. 316, Sec. 5. (AB 1223) Effective January 1, 2020.)