

17. "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

18. "Transferring" means moving into or out of a bed, chair or wheelchair.

19. "Usual, customary and reasonable" shall be no more restrictive than:

i. "Usual" means the fee ordinarily charged by the provider for a particular service or supply;

ii. "Customary" means the range of usual fees charged by providers for the same service or supply under like circumstances within the geographic or socio-economic area where the service or supply is performed or furnished. The range of usual fees charged by physicians shall consider training and experience; and

iii. "Reasonable" means a fee above usual and customary which is justified by unusual complexity of the treatment required.

20. 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.

11:4-34.4 Policy practices and provisions

(a) **Renewability:** The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of N.J.A.C. 11:4-34.6 and 34.7.

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 carrier has no unilateral right to make any change in any provision of the policy while the insurance is in force, and cannot decline to renew, except that rates may be revised by the carrier 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 carrier has no right to unilaterally make any change in any provision of the policy or in the premium rate.

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

5. In addition to the other requirements of this subsection, 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 for long-term care services by type of illness, treatment, medical condition or accident, except as follows:

1. **Preexisting conditions or diseases:** The policy or certificate shall not exclude coverage for a loss or confinement which is the result of a preexisting condition if that loss or confinement begins later than six months following the effective date of coverage of an insured person.

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:**

i. **War or act of war** (whether declared or undeclared) as permitted by N.J.A.C. 11:22-6;

ii. **Participation in a riot or insurrection, or the commission of or attempt to commit a felony;**

iii. **Service in the armed forces or units auxiliary thereto** as referenced in N.J.A.C. 11:22-6;

iv. **Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;** or

v. **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. In the case of a 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; and

7. This subsection is not intended to prohibit exclusions and limitations for services provided outside of the United States.

(c) Extension of Benefits: Termination of long-term care insurance shall be without prejudice to any benefits payable for continuous loss which began while the long-term care insurance was in force and continues without interruption after termination of the long-term care insurance. Such extension of benefits beyond the period the long-term care insurance was in force may be predicated upon the insured's continuous inability to perform activities of daily living or cognitive impairment, and 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: Group long-term care insurance issued in this State on or after December 19, 2005 shall provide covered individuals with a basis for continuation or conversion of coverage.

1. For the purposes of this section, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing in force group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premiums and/or contributions when due.

2. For the purposes of this section, "a basis for conversion of coverage" means a policy provision that states that an individual whose coverage under the in force 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 conversion policy by the carrier under whose group policy he or she is or was covered, without evidence of insurability.

3. For the purposes of this section, "conversion 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.

4. Written application for the conversion policy shall be made and the first premium due, if any, shall be paid as directed by the carrier not later than 31 days after termination of coverage under the group policy. The conversion policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

5. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the conversion 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 conversion policy shall

be calculated on the basis of the insured's age at inception of coverage under the prior group policy.

6. Continuation of coverage or issuance of a conversion policy shall be mandatory, except where:

- i. Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or
- ii. The terminating coverage is replaced, not later than 31 days after termination, by group coverage effective on the day following the termination of coverage:

(1) 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

(2) The premium for which is calculated in a manner consistent with the requirements of (d)5 above.

7. The conversion policy may provide that the benefits payable under the conversion 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 in effect.

8. Notwithstanding any other provision of this section, an 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.

(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 carrier 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 carrier and premiums charged to persons under the new group policy shall not:

1. Result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

2. Vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services.

(f) The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under N.J.A.C. 11:4-34.24, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium. A reduction in benefits shall not be considered a premium change, but for purposes of the calculation required under N.J.A.C. 11:4-34.24, the initial annual premium shall be based

on the reduced benefits. The premium charged to an insured shall not increase due to either:

(g) A policy that provides coverage in addition to long-term care coverage shall separately identify the premium, rate or charge for the long-term care coverage. Where flexible premiums or charges can be applied to purchase long-term care or other coverage, the form must disclose how premiums will be applied, including any options the policyholder has for the application of these premiums and provisions for protection against unintentional lapse of one or the other coverage.

(h) Any long-term care benefit that is provided other than through acceleration of an annuity or life insurance benefit shall contain the required provisions described at N.J.S.A. 17B:26-3. N.J.S.A. 17B:26-16 will also apply to provisions respecting the matters set forth therein that are contained in individual long-term care policies. Group long-term care insurance policies shall contain the standard provisions required by N.J.S.A. 17B:27-33. Group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance shall apply the above cited provision only to the long-term care benefit.

(i) No long-term care policy or certificate shall:

1. Be cancelled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured;
2. Require, for purposes of a restoration of benefits provision, that the period between confinements be more than six months; or
3. Contain a mandatory case management provision.

(j) Annuity contracts and life insurance policies that provide directly or which supplement long-term care insurance shall comply with the statutes and regulations governing individual life insurance, group life insurance, variable contracts and annuities, as applicable.

Administrative correction.
See: 39 N.J.R. 935(a).

11:4-34.5 Unintentional lapse

(a) Each carrier offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

1. Notice before lapse or termination.
 - i. No individual long-term care policy or group certificate shall be issued until the carrier has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium or required contribution, or a written waiver dated and signed by the applicant electing not to designate an additional person to receive notice. The applicant has the right to designate at least

one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability by the third party for services provided to the insured. The form used for the written designation must provide space clearly earmarked for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance for non-payment of premium or required contribution. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate any person to receive this notice." The carrier shall notify the insured in writing in a clear and conspicuous manner of the right to change this written designation, no less often than once every two years for insureds who have not attained sixty-two and a half years and no less than annually for insureds who have attained age sixty-two and a half years of age.

ii. When the policyholder or certificate holder pays premium for long-term care insurance coverage through a payroll or pension deduction plan, the requirements contained in (a)li above need not be met until 60 days after the policyholder or certificate holder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

2. Lapse or termination for non-payment of premium. No individual long-term care policy or group certificate shall lapse or be terminated for nonpayment of premium or required contribution unless the carrier, at least 30 days before the effective date of the lapse or termination, has given written notice to the insured and to those persons designated pursuant to (a)1 above, at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until 30 days after a premium or contribution is due and unpaid. Notice shall be deemed to have been given as of five days after the date of mailing.

(b) Restoration of Coverage: In addition to the requirement in (a) above, a long-term care insurance policy or group certificate shall include a provision that provides for restoration of coverage in the event of lapse, if the carrier is provided proof that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity before a premium or contribution was required to be paid. This option shall be available to the insured if requested within five months after termination and shall allow for the collection of past due premium or contributions, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria for cognitive impairment or the loss of functional capacity contained in the policy and certificate.

11:4-34.6 Required disclosure provisions

(a) **Renewability:** Individual long-term care insurance policies shall contain a renewability provision.

1. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state that the coverage is guaranteed renewable or noncancellable. This provision shall not apply to individual life insurance policies and annuity contracts that do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the insured or owner.

2. A long-term care insurance policy, other than one where the carrier does not have the right to change the premium, shall include a statement that premium rates may change.

(b) **Riders and Endorsements:** Except for riders or endorsements by which the carrier effectuates a request made in writing by the insured under an individual long-term care insurance policy or which are required by law, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy, or that increase benefits or coverage with a concomitant increase in premium, may be rejected by the individual insured and can be added only with signed acceptance by the individual insured. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider or endorsement.

(c) **Payment of Benefits:** A long-term care insurance policy or certificate that 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 these terms and an explanation of the terms in the accompanying outline of coverage.

(d) **Preexisting Condition Limitations:** If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."

(e) **Other Limitations or Conditions on Eligibility for Benefits:** A long-term care insurance policy or certificate may contain limitations or conditions for eligibility, other than those prohibited by N.J.S.A. 17B:27E-6c(2), provided the policy or certificate describes such limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate. The policy or certificate shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

1. **Disclosure of Tax Consequences:** With regard to life insurance policies that provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy, certificate or rider and at the time the accelerated benefit payment request is submit-

ted that receipt of these accelerated benefits maybe taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or certificate and any other related documents. This subsection shall not apply to qualified long-term care insurance contracts.

(f) **Benefit Triggers:** Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be described in the policy or certificate in a separate paragraph that shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained in this section. If these triggers differ for different benefits, an explanation of the trigger shall 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 shall be specified.

(g) A qualified long-term care insurance contract shall include a disclosure statement in the policy, or certificate and in the outline of coverage as contained in item 3 in the form for outline of coverage at N.J.A.C. 11:4-34.27(a)5, that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

(h) A nonqualified long-term care insurance contract shall include a disclosure statement in the policy, or certificate and in the outline of coverage as contained in item 3 in the form for outline of coverage at N.J.A.C. 11:4-34.27(a)5, that the policy is not intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

11:4-34.7 Required disclosure of rating practices to consumers

(a) This section applies to any long-term care policy or certificate issued on or after December 19, 2005.

(b) Other than policies for which no applicable premium rate or rate schedule increases can be made, carriers shall provide all of the information listed in this subsection to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, a carrier shall provide all of the information listed below to the applicant no later than at the time of delivery of the policy or certificate.

1. A statement that the policy or certificate may be subject to rate increases in the future, including the circumstances that might lead to a rate increase. The description of circumstances shall include those factors that pose significant risk of rate increases to policyholders or certificate holders;

2. An explanation of potential premium rate revisions, and the policyholder's or certificate holder's option(s) in the