11 NCAC 12 .1005 CONTINUATION OR CONVERSION

(a) Group long-term care insurance newly issued or renewed in North Carolina on or after September 1, 1990, shall provide covered individuals with a basis for continuation or conversion of coverage.

(b) As used in this Rule, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when such coverage would otherwise terminate and that is subject only to the continued timely payments of premiums when due. A group policy that lawfully restricts provisions of benefits and services to, or contains incentives to use, certain providers or facilities, may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The Commissioner 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 provider system arrangements, service availability, benefit levels, and administrative complexity.

(c) As used in this Rule, "a basis for conversion of coverage" means a policy provision that an individual:

(1) 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

(2) who has been continuously insured under the group policy, and any group policy that 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 he is covered, without evidence of insurability.

(d) As used in this Rule, "converted policy" means an individual policy 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. Where the group policy from which conversion is made lawfully restricts provision of benefits and services to, or contains incentives to use, certain providers or facilities, the commissioner, 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 provider system arrangements, service availability, benefit levels, and administrative complexity.

(e) 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 31 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 renewable annually.

(f) 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.

(g) Continuation of coverage or issuance of a converted policy is mandatory, except where:

(1) termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

(2) the terminating coverage is replaced, not later than 31 days after termination, by group coverage that is effective on the day following the termination of coverage, that provides 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 the premium for which group coverage is calculated in a manner consistent with the requirements of Paragraph (f) of this Rule.

(h) Notwithstanding any other provision of this Rule, a converted policy that is issued to an individual, who at the time of conversion is covered by another policy that provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if the benefits provided under the other policy, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund that reflects the reduction in benefit payable.

(i) 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.

(j) Notwithstanding any other provision of this Rule, any insured individual, whose eligibility for group policy coverage is based upon his relationship to another person, is entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

(k) As used in this Rule, 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.

History Note: *Authority G.S. 58-2-40(1); 58-55-30(a);*
Eff. September 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.