WEST VIRGINIA
SECRETARY OF STATE
KEN HECHLER
ADMINISTRATIVE LAW DIVISION

Form #6

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FILED

APR 30 3 12 PM '99

OFFICE OF WEST VIRGINIA SECRETARY OF STATE

NOTICE OF FINAL FILING AND ADOPTION OF A LEGISLATIVE RULE AUTHORIZED BY THE WEST VIRGINIA LEGISLATURE.

AGENCY: Insurance Commission TITLE NUMBER: 114

AMENDMENT TO AN EXISTING RULE: YES X, NO ___

IF YES, SERIES NUMBER OF RULE BEING AMENDED: 12

TITLE OF RULE BEING AMENDED: Individual Accident and Sickness Insurance Minimum Standards

IF NO, SERIES NUMBER OF NEW RULE BEING PROPOSED: ___

TITLE OF RULE BEING PROPOSED: ___

THE ABOVE RULE HAS BEEN AUTHORIZED BY THE WEST VIRGINIA LEGISLATURE.

AUTHORIZATION IS CITED IN (house or senate bill number) HB 2570

SECTION 64-7-3(a), PASSED ON March 10, 1999.

THIS RULE IS FILED WITH THE SECRETARY OF STATE. THIS RULE BECOMES EFFECTIVE ON THE FOLLOWING DATE: April 30, 1999

Donna L. Lucenberg
Associate Counsel

AUTHORIZED SIGNATURE

$6.60

STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner
Legal Division

CECIL H. UNDERWOOD
Governor

HANLEY C. CLARK
Insurance Commissioner

April 30, 1999

HAND DELIVERED

Ms. Judy Cooper, Director
Administrative Law Division
Office of Secretary of State
State Capitol Complex
Charleston, WV

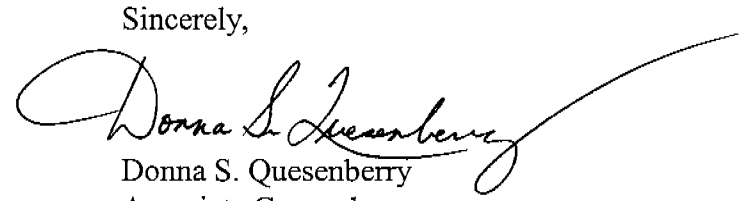
Dear Ms. Cooper:

Attached for filing with your office is the "final filing" form for the rule Series 12 titled "Individual Accident and Sickness Insurance Minimum Standards." This rule was authorized in House Bill 2570 and passed by the Legislature on March 10, 1999.

We are also providing your office with a computer disk containing the aforementioned rule and a hard copy of the promulgation history of that rule. The filing date and effective date have already been inserted onto the computer disk.

If you have any questions about the enclosed forms or the computer disk, please do not hesitate to call me.

Sincerely,



Donna S. Quesenberry
Associate Counsel

DSQ/ksb

Enclosures

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CECIL H. UNDERWOOD
GOVERNOR

STATE OF WEST VIRGINIA
DEPARTMENT OF TAX AND REVENUE
Charleston, West Virginia
P. O. Box 963
Charleston, WV 25324-0963
Ph. (304) 558-0211 - Fax (304) 558-2324

ROBIN C. CAPEHART
SECRETARY

CONSENT TO PROPOSAL OF RULE

To Whom It May Concern:

Pursuant to West Virginia Code §5F-2-2(a)(12), the undersigned hereby grants consent to the proposal of the following rule proposed by the Insurance Commissioner of the State of West Virginia: Title 114, Series 12, relating to Individual Accident and Sickness Insurance Minimum Standards.

Dated this 26th day of June, 1997.

Robin C. Capehart

Robin Capehart
Secretary of Tax and Revenue

PROMULGATION HISTORY

WEST VIRGINIA INSURANCE COMMISSION

INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS

TITLE 114, SERIES 12

06/03/98	Notice of Comment Period Filed
07/06/98	Last Date Comments Were Received
07/30/98	Agency Approved Legislative Rule Filed
09/23/98	Date Reviewed by Legislative Rule-Making Review Committee
12/13/98	Date Authorized to Promulgate Legislative Rule as Originally Filed
04/30/99	Filing Date
04/30/99	Effective Date

114CSR12

TITLE 114
LEGISLATIVE RULE
INSURANCE COMMISSIONER

SERIES 12
INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS

Section

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APPENDIX B. BASIC MEDICAL-SURGICAL EXPENSE COVERAGE, OUTLINE OF COVERAGE

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FILED
APR 30 3 12 PM '99
OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

114CSR12

TITLE 114
LEGISLATIVE RULE
INSURANCE COMMISSIONER

SERIES 12
INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS

§114-12-1. General

1.1. Scope. -- The purpose of this legislative rule is to provide reasonable standardization of coverage and simplification of terms and benefits of individual accident and sickness insurance policies; to facilitate public understanding and comparison of such policies and contracts; to eliminate provisions contained in such policies and contracts which may be misleading or confusing in connection with either their purchase or the settlement of claims; and to provide for full disclosure in the sale of such policies and contracts. This rule applies to all individual accident and sickness insurance policies and all individual subscriber contracts of hospital, medical, dental and health service corporations, health care corporations, fraternal benefit societies, and all individual enrollee agreements of health maintenance organizations delivered or issued for delivery in this State on and after the effective date of this rule, except that it does not apply to:

a. Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the group or individual policy or contract includes provisions which are inconsistent with the requirements of this rule;

b. Credit accident and sickness insurance subject to WV 114 CSR 6 "Regulation of Credit Life Insurance and Credit Accident and Sickness Insurance";

c. Medicare supplement insurance policies subject to WV 114 CSR 24 "Medicare Supplement Insurance";

d. Long-term care insurance policies subject to WV 114 CSR 32 "Long-Term Care Insurance";

e. Coverage under the West Virginia Public Employees Insurance Act (West Virginia Code §5-16-1 et seq.);

f. Coverage under Medicare or Medicaid; and

g. Coverage under any automobile no-fault, workers' compensation, employer's liability, occupational disease or similar law.

The requirements contained in this rule are in addition to any other applicable rules previously or subsequently promulgated.

1.2. Authority. -- West Virginia Code §§33-2-10, 33-28-4, 33-28-5 and 33-28-6.

1.3. Filing Date. -- April 30, 1999

1.4. Effective Date. – April 30, 1999

§114-12-2. Definitions

As used in this legislative rule:

2.1. "Applicant" means a person who seeks to contract for insurance coverage.

2.2. "Certificate" means any certificate delivered or issued for delivery in this State under a policy subject to this rule.

2.3. "Commissioner" means the Insurance Commissioner of the State of West Virginia.

2.4. "Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

a. A group health plan;

b. Accident and sickness insurance coverage;

c. Part A or Part B of Title XVIII of the Social Security Act [42 U.S.C. §301 et seq.];

d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;

e. Chapter 55 [10 U.S.C. §1071 et seq.] of Title 10 of the United States Code;

f. A medical care program of the Indian Health Service or of a tribal organization;

g. A state health benefits risk pool;

h. A health plan offered under Chapter 89 [5 U.S.C. §8901 et seq.] of Title 5 of the United States Code;

i. A public health plan (as defined in federal regulations); or

j. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

2.5. "Direct response insurance product" means a policy, the sale of which is effected through direct contact between an insurer and an individual insured, without employing the intermediary services of an agent, broker or solicitor.

2.6. "Excepted benefits" means benefits under one or more(or any combination) of the following:

a. Coverage only for accident, or disability income insurance, or any combination thereof;

b. Coverage issued as a supplement to liability insurance;

c. Liability insurance, including general liability insurance and automobile liability insurance;

d. Workers' compensation or similar insurance;

e. Automobile medical payment insurance;

f. Credit-only insurance;

g. Coverage for on-site medical clinics;

h. Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance;

i. If provided under a separate policy, certificate or contract of insurance:

1. Limited scope dental or vision benefits;

2. Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof;

3. Coverage for only a specified disease or illness;

4. Hospital indemnity or other fixed indemnity insurance; and

5. Medicare supplement insurance (as defined under 1882 (g)(1) of the Social Security Act [42 U.S.C. §301 et seq.]), coverage supplemental to the coverage provided under chapter 55 [10 U.S.C. §1071 et seq.] of title 10, United States Code and similar supplemental coverage provided under group accident and sickness insurance.

2.7. "Eligible individual" means an individual:

a. For whom, as of the date on which the individual seeks coverage, the aggregate period of creditable coverage is eighteen months or more and whose most recent prior creditable coverage was under a group health plan, governmental plan (as defined in section 3(32) of the Employee Retirement Income Security Act of 1974), church plan (as defined in section 3(33) of the Employee Retirement Income Security Act of 1974), or accident and sickness insurance coverage offered in connection with any such plan;

b. Who is not eligible for coverage under a group health plan, part A or part B of Title XVIII of the Social Security Act, or state plan under Title XIX of such act (or any successor program), and does not have other accident and sickness insurance coverage;

c. With respect to whom the most recent prior creditable coverage was not terminated as a result of fraud, intentional misrepresentation of material fact under the terms of the coverage, or nonpayment of premium;

d. Who did not turn down an offer of continuation of coverage under a COBRA continuation provision or under a similar state program if it was offered; and

e. Who, if the individual elected such continuation coverage, has exhausted that coverage under the COBRA continuation provision or similar state program.

2.8. A "home health care agency" is:

a. An agency approved under Title XVIII of the Social Security Act (42 U.S.C. § 1395 et seq.) (Medicare); or

b. An agency certified to provide home health care in this State.

2.9. "Individual market" means the market for accident and sickness insurance coverage offered to individuals other than in connection with a group health plan.

2.10. "Insurer" means any of the following entities that holds a valid certificate of authority from the commissioner: An insurance company authorized to transact accident and sickness insurance; fraternal benefit society organized pursuant to West Virginia Code §33-23-1 et seq.; a hospital, medical, dental or health service corporation organized pursuant to West Virginia Code §33-24-1 et seq.; a health care corporation organized pursuant to West Virginia Code §33-25-1 et seq.; or a health maintenance organization organized pursuant to West Virginia Code §33-25A-1 et seq.

2.11. "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

2.12. "Medicare supplement policy" means a policy of accident and sickness insurance or a subscriber contract of a hospital, medical, dental or health service corporation, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.) or an issued policy under a demonstration project specified in 42 U.S.C. §1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

2.13. "Policy" means any policy, plan, contract, agreement, provision, rider or endorsement delivered or issued for delivery in this State by an insurer subject to this rule.

2.14. "Premium" means the consideration for insurance, by whatever name called.

2.15. "Preexisting condition exclusion" means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date.

§114-12-3. Policy Definitions

3.1. Except as provided in this rule, no policy or certificate subject to this rule may be advertised, solicited, delivered or issued for delivery in this State unless the policy or certificate contains definitions or terms which conform to the requirements of this section.

3.2. "Accident", "accidental injury", or "accidental means" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

a. The definition may not be more restrictive than the following: "Injury or injuries, for which benefits are provided" means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while the insurance coverage is in force.

b. The definition may provide that the term "injuries" excludes injuries for which benefits are provided or available under any motor vehicle no-fault, workers' compensation, employer's liability, occupational disease or similar law, unless prohibited by law.

3.3. "Convalescent nursing home", "extended care facility," "intermediate care facility," or "skilled nursing facility" shall be defined in relation to its status, facilities and available services.

a. A definition of such home or facility may not be more restrictive than one requiring that it:

1. Be operated pursuant to law;

2. Be approved for payment of Medicare benefits or be qualified to receive approval if requested;

3. Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

4. Provide continuous twenty-four-hour-a-day nursing services by or under the supervision of a registered graduate professional nurse (R.N.); and

5. Maintain a daily medical record of each patient.

b. The definition of such home or facility may provide that the term excludes:

1. Any home, facility or part of a home or facility used primarily for rest;

2. A home or facility for the aged or for the care of drug addicts or alcoholics; or

3. A home or facility primarily used for the care and treatment of mental diseases or disorders, or custodial or educational care.

3.4. "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals.

a. The definition of "hospital" may not be more restrictive than one requiring that the hospital:

1. Be an institution operated pursuant to law;

2. Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and

3. Provide twenty-four-hour (24-hour) nursing services by or under the supervision of registered graduate professional nurses (R.N.'s).

b. The definition of "hospital" may state that the term excludes:

1. Any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for the services: Provided, That no policy providing hospital indemnity coverage may exclude coverage because of confinement in a hospital operated by the federal or state government.

2. Convalescent homes, convalescent, rest or nursing facilities; or

3. Facilities for the aged, drug addicts or alcoholics and those primarily affording custodial, educational or rehabilitory care.

3.5. "Medicare" shall be defined as "the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I Of Public Law 89-97 as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

3.6. "Mental or nervous disorder" may not be defined more restrictively than a definition including neurosis, psycho-neurosis, psychosis, or mental or emotional disease or disorder of any kind.

3.7. "Nurse" may be defined so that the description of nurse is restricted to a type of nurse, such as registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the words "nurse," "trained nurse," "registered nurse" or "nurse-midwife" are used without specific instruction, then the use of the terms requires the insurer to recognize the services of any individual who qualifies under that terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of this State.

3.8. "One (1) period of confinement" means consecutive days of in-hospital service received as an in-patient, or successive confinements when discharge from and readmission to the hospital occur within a period of time not more than ninety (90) days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of one hundred eighty (180) days.

3.9. "Partial disability" shall be defined in relation to the individual's inability to perform one or more but not all of the "major," "important," or "essential" duties of employment or occupation, or may be related to a percentage of time worked or to a specified number of hours or to compensation. Where a policy provides total disability benefits and partial disability benefits, only one (1) elimination period may be required.

3.10. "Physician" may be defined by including words such as "duly qualified physician" or "duly licensed physician." The use of these terms requires an insurer to recognize and to accept, to the extent of its obligation under the policy, all providers of medical care and treatment when the services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

3.11. "Preexisting condition" may not be defined to be more restrictive than the following: "Preexisting condition" means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a two-year (2-year) period preceding the effective date of the policy; or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a two-year (2-year) period preceding the effective date of the policy.

3.12. "Residual disability" shall be defined in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major," "important" or "essential duties" of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. A policy which provides for residual disability benefits may require a qualification period, during which the insured shall be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term "residual disability," the insurer may use "proportionate disability" or another term of similar import which, in the opinion of the Commissioner, adequately and fairly describes the benefit.

3.13. "Sickness" may not be defined to be more restrictive than the following: "Sickness" means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force. The definition may be further modified to exclude sicknesses or diseases for which benefits are provided or available under any workers' compensation, occupational disease, employer's liability or similar law.

3.14. "Total disability" may not be defined more restrictively than a disability requiring that the individual who is totally disabled not be engaged in any employment or occupation for which he or she is or becomes qualified by reason of education, training or experience, and in fact not be engaged in any employment or occupation for wage or profit.

a. Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual's inability to:

1. Perform "any occupation whatsoever," "any occupational duty," or "any and every duty of his or her occupation"; or

2. Engage in any training or rehabilitation program.

b. An insurer may specify the requirement of the complete inability of the person to perform all of the substantial and material duties of his or her regular occupation, or words of similar import. An insurer may require care by a physician (other than the insured or a member of the insured's immediate family).

§114-12-4. Prohibited Policy Provisions

4.1. No policy may utilize an initial premium which is less than a pro rata portion of the applicable annual premium.

4.2. No policy may contain a provision establishing a probationary or waiting period during which no coverage is provided under the policy: Provided, That a policy may contain a probationary or waiting period not to exceed ninety (90) days for specified diseases or conditions. Accident policies may not contain probationary or waiting periods.

a. An insurer offering accident and sickness insurance coverage, other than excepted benefits, in the individual market may not, with respect to an eligible individual desiring to enroll in individual accident and sickness insurance coverage, impose any preexisting condition exclusion with respect to such coverage.

4.3. No policies or riders for additional coverage may be issued as a dividend, unless an equivalent cash payment is offered to the policyholder as an alternative to the dividend policy or rider. No dividend policy or rider may be issued for an initial term of less than six (6) months.

4.4. No policy may exclude coverage for a loss due to a preexisting condition for a period greater than twelve (12) months following issuance of the policy. Provided, That an insurer offering accident and sickness insurance coverage, other than excepted benefits, in the individual market may not, with respect to an eligible individual desiring to enroll in individual accident and sickness coverage, impose any preexisting condition with respect to such coverage.

4.5. A disability income policy may contain a "return of premium" or "cash value benefit" so long as:

a. The return of premium or cash value benefit is not reduced by an amount greater than the aggregate of any claims paid under the policy; and

b. The insurer demonstrates that the reserve basis for the policies is adequate.

4.6. Policies providing hospital confinement indemnity coverage may not contain provisions excluding coverage because of confinement in a hospital operated by the state or federal government.

4.7. Except as otherwise prohibited by West Virginia Code §33-15-2b, this rule does not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical conditions or extra-hazardous activity. Where waivers are required as a condition of policy issuance, renewal or reinstatement, signed acceptance by the insured is required unless on initial issuance of the policy, the full text of the waiver is contained either on the first page or the specification page.

4.8. Policy provisions expressly precluded in this section shall in no way be construed as a limitation on the authority of the Commissioner to disapprove other policy provisions including, but not limited to, provisions respecting limitations, exceptions, reductions or eliminations of coverage, not otherwise specifically authorized by statute or rule, which policy provisions are considered by the Commissioner to be unjust, unfair, unreasonable or unfairly discriminatory either to the policyholder, subscriber, beneficiary or any person insured under the policy.

§114-12-5. Minimum Standards for Benefits

5.1. General. -- The following minimum standards for benefits are prescribed for the categories of coverage noted in this section. No policy or certificate subject to this rule may be delivered or issued for delivery in this State which does not meet the required minimum standards for the specified categories, unless the Commissioner finds that policies or certificates containing less than the prescribed minimum standards for benefits, which are filed for approval, will be in the public interest and otherwise meet the requirements set forth in West Virginia Code §33-6-9. Nothing in this section precludes the issuance of any policy combining two (2) or more categories of coverage set forth in West Virginia Code §33-28-5(a)(1) through (6), inclusive.

a. An insurer providing inpatient benefits in connection with childbirth must meet all requirements of West Virginia Code §33-15-4e with respect to both the mother and her newborn.

b. A "noncancellable," "guaranteed renewable" or "noncancellable and guaranteed renewable" policy may not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. The policy shall provide that in the event of the insured's death, the spouse of the insured, if covered under the policy, shall become the insured.

c. The terms "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" may not be used without further explanatory language in accordance with the disclosure requirements of subsection 6.1 of this rule. The terms "noncancellable" or "noncancellable and guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of sixty-five (65) or to eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force. Except as provided in this subdivision, the term "guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums until the age of sixty-five (65) or to eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.

d. In a family policy covering both husband and wife, the age of the younger spouse shall be used as the basis for meeting the age and durational requirements of the definitions of "noncancellable" and "guaranteed renewable." However, this requirement may not prevent termination of coverage of the older spouse upon attainment of the stated age limit, e.g., age sixty-five (65), so long as the policy may be continued in force as to the younger spouse to the age or for the durational period as specified in the definition.

e. When accidental death and dismemberment coverage is part of the insurance coverage offered under the policy, the insured shall have the option to include all insureds under the policy and not just the principal insured.

f. If a policy contains a status-type military service exclusion which suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to an insured in military service on a pro rata basis.

g. In the event the insurer cancels or refuses to renew, policies providing pregnancy benefits shall provide for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.

h. Policies providing convalescent or extended care benefits following hospitalization may not condition such benefits upon admission to the convalescent or extended care facility within a period of less than fourteen (14) days after discharge from the hospital.

i. Any policy which provides coverage of a dependent child may not terminate coverage for the dependent child if, upon attainment of any limiting age set forth in the policy, the child is and continues to be both incapable of self-sustaining employment due to mental retardation or physical handicap on the date that the child's coverage would otherwise terminate under the policy due to the attainment of the specified limiting age; and chiefly dependent on the policyholder for support and maintenance. The policy may require that within thirty-one (31) days of such date, the insurer receive due proof of the incapacity in order for the insured to elect to continue the policy in force with respect to the dependent child. As an alternative to this requirement, a separate converted policy may be issued to the child at the option of the insured or policyholder.

j. Any policy providing coverage for the recipient in a transplant operation shall also provide for the reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.

k. A policy may contain a provision relating to recurrent disabilities: Provided, That no such provision may specify that a recurrent disability be separated by a period greater than six (6) months from the last previous occurrence of the disability.

l. Accidental death and dismemberment benefits shall be payable if the loss occurs within ninety (90) days from the date of the accident, irrespective of total disability. Disability income benefits, if provided, may not require the loss to commence less than thirty (30) days after the date of accident, nor may any policy which the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the policy was in force.

m. Specific dismemberment benefits may not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.

n. Termination of the policy by the insurer shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period the policy was in force may be predicated upon the continuous disability of the insured or limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

5.2. "Basic Hospital Expense Coverage" is a policy of accident and sickness insurance which provides coverage for a period of not less than thirty-one (31) days during any continuous hospital confinement for each person insured under the policy, for expenses incurred for necessary treatment and services rendered as a result of accident or sickness for at least the following:

a. Daily hospital room and board in an amount not less than the lesser of the average semi-private room rate of the confining hospital or thirty dollars ($30) per day;

b. Miscellaneous hospital service for expenses incurred for the charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during the period of confinement in an amount not less than either eighty percent (80%) of the charges incurred up to at least one thousand dollars ($1,000) or ten (10) times the daily hospital room and board benefits; and

c. Hospital outpatient services in an amount not less than fifty dollars ($50) for hospital services rendered to an insured as an outpatient for any one accident or sickness.

d. Benefits provided under subdivisions a and b of this subsection may be provided subject to a combined deductible amount not in excess of one hundred dollars ($100).

5.3. "Basic Medical-Surgical Expense Coverage" is a policy of accident and sickness insurance which provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for at least the following:

a. Surgical services:

1. In amounts not less than those provided on a fee schedule based on an acceptable relative value scale of surgical procedures, up to a maximum of at least five hundred dollars ($500) for any one procedure; or

2. Not less than eighty percent (80%) of the reasonable charges.

b. Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical services rendered by a physician other than the physician (or his or her assistant) performing the surgical services:

1. In an amount not less than eighty percent (80%) of the reasonable charges; or

2. Fifteen percent (15%) of the surgical service benefit.

c. In-hospital medical services, consisting of physicians' services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than eighty percent (80%) of the reasonable charges, or five dollars ($5) per call, one (1) call per day, for at least twenty-one (21) such calls during one (1) period of confinement.

5.4. "Hospital Confinement Indemnity Coverage" is a policy of accident and sickness insurance which provides daily benefits for hospital confinement on an indemnity basis in an amount not less than thirty dollars ($30) per day and for a period of not less than thirty-one (31) days during any one (1) period of confinement for each person insured under the policy.

5.5. "Major medical expense coverage" is a policy which provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than ten thousand dollars ($10,000); copayment by the covered person not to exceed twenty-five percent (25%) of covered charges; and a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of such bases not to exceed five per cent (5%) of the aggregate maximum limit under the policy, unless the policy is written to complement underlying hospital and medical insurance in which case the deductible may be increased by the amount of the benefits provided by the underlying insurance, for each covered person for at least:

a. Daily hospital room and board expenses for not less than fifty dollars ($50) daily (or in lieu thereof the average daily cost of the semi-private room rate in the area where the insured resides) for a period of not less than thirty-one (31) days during continuous hospital confinement;

b. Miscellaneous hospital services for an aggregate maximum of not less than four thousand five hundred dollars ($4,500) or fifteen (15) times the daily room and board rate if specified in dollar amounts;

c. Surgical services to a maximum of not less than six hundred dollars ($600) for the most expensive surgical procedure when two or more medically necessary surgical procedures are performed during the course of a single operation. Amounts paid for the second and each additional surgical procedure during a single operation shall be reasonably related to the maximum amount stated in this subdivision for the first surgical procedure.

d. Anesthesia services for a maximum of not less than fifteen (15%) percent of the covered surgical fees or, alternatively, if the surgical schedule is based on relative values, not less than the amount provided therein for anesthesia services at the same unit value as used for the surgical schedule;

e. In-hospital medical services, consisting of physicians' services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than eighty percent (80%) of the reasonable charges, or five dollars ($5) per call, one (1) call per day, for at least twenty-one (21) calls during one period confinement.

f. Out-of-hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, and diagnostic X-ray, laboratory services, radiation therapy and hemodialysis order by a physician; and

g. Prosthetic appliances, meaning artificial limbs or other prosthetic appliances (except replacements thereof) and rental of durable medical equipment required for therapeutic use.

5.6. "Disability income protection coverage" is a policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination thereof that:

a. Provides that periodic payments which are payable at ages after sixty-two (62) and reduced solely on the basis of age are at least fifty percent (50%) of amounts payable immediately prior to age sixty-two (62).

b. Contains an elimination period no greater than:

1. Ninety (90) days in the case of coverage providing a benefit of one (1) year or less;

2. One hundred eighty (180) days in the case of coverage providing a benefit of more than one year but not greater than two (2) years; or

3. Three hundred sixty-five (365) days in all other cases during the continuance of disability resulting from sickness or injury.

c. Has a maximum period of time for which it is payable during disability of at least six (6) months except in the case of a policy covering disability arising out of pregnancy, childbirth or miscarriage in which case the period for the disability may be one (1) month. No reduction in benefits may be put into effect because of an increase in Social Security or similar benefits during a benefit period.

d. This subsection does not apply to those disability income protection policies providing business buy-out coverage.

5.7. "Accident-only coverage" is a policy of accident insurance which provides coverage, singly or in combination, for death, dismemberment, disability or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under such a policy shall be at least one thousand dollars ($1,000), and a single dismemberment amount shall be at least five hundred dollars ($500).

5.8. "Specified disease coverage" pays benefits for the diagnosis and treatment of a specifically named disease or diseases. Any such policy shall meet the following rules and one of the following sets of minimum standards for benefits. Such insurance covering cancer, whether cancer only or in conjunction with other conditions(s) or disease(s), shall meet the standards of subdivisions c, d and e of this subsection. Insurance covering specified disease(s) other than cancer shall meet the standards of subdivisions b or e of this subsection.

a. General Rules. -- Except for cancer coverage provided on an expense-incurred basis, either as cancer-only coverage or in combination with one or more other specified diseases, the following provisions shall apply to specified disease coverages in addition to all other requirements imposed by this rule. In cases of conflict between the following and other provisions, the following provisions shall govern:

1. Policies covering a single specified disease or combination of specified diseases may not be sold or offered for sale other than as specified disease coverage under this section.

2. Any policy issued pursuant to this section which conditions payment upon pathological diagnosis of a covered disease shall also provide that if a pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted in lieu thereof.

3. Notwithstanding any other provision of this rule, specified disease policies shall provide benefits to any covered person not only for the specified disease(s) but also for any other conditions(s) or disease(s) directly caused or aggravated by the specified diseases(s) or the treatment of the specified disease(s).

4. Policies containing specified disease coverage shall be at least guaranteed renewable.

5. No policy issued pursuant to this section may contain a waiting or probationary period greater than thirty (30) days.

6. Any application for specified disease coverage shall contain a statement above the signature of the applicant that no person to be covered for specified disease is also covered by any Title XIX program such as Medicaid. The statement may be combined with any other statement for which the insurer may require the applicant's signature.

7. Payments may be conditioned upon a covered person receiving medically necessary care, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment.

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8. Except for the uniform provision regarding other insurance with this insurer, benefits for specified disease coverage shall be paid regardless of other coverage available through other individual health insurance.

9. After the effective date of the coverage (or applicable waiting period, if any), benefits shall begin with the first day of care or confinement if the care or confinement is for a covered disease even though the diagnosis is made at some later date. The retroactive application of the coverage may not be less than ninety (90) days prior to the diagnosis.

b. The following minimum benefits standards apply to noncancer coverages:

1. Coverage for each person insured under the policy for a specifically named disease (or diseases) with a deductible amount not in excess of two hundred fifty dollars ($250) and an overall aggregate benefit limit of not less than five thousand dollars ($5,000), and a benefit period of not less than two (2) years for at least the following incurred expenses:

A. Hospital room and board and any other hospital-furnished medical services or supplies;

B. Treatment by a legally qualified physician or surgeon;

C. Private duty services of a registered nurse (R.N.);

D. X-ray, radium and other therapy procedures used in diagnosis and treatment;

E. Professional ambulance for local service to or from a local hospital;

F. Blood transfusions, including expenses incurred for blood donors;

G. Drugs and medicines prescribed by a physician;

H. Rental of a mechanical ventilator or similar mechanical apparatus;

I. Braces, crutches and wheelchairs as are considered necessary by the attending physician for the treatment of the disease;

J. Emergency transportation if, in the opinion of the attending physician, it is necessary to transport the insured to another locality for treatment of the disease; and

K. Any other expenses necessarily incurred in the treatment of the disease.

2. Coverage for each person insured under the policy for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than twenty-five thousand dollars ($25,000) payable at the rate of not less than fifty dollars ($50) a day while confined in a hospital and a benefit period of not less than five hundred (500) days.

c. A policy which provides coverage for each person insured under the policy for cancer-only coverage or in combination with one or more other specified diseases on an expense-incurred basis for services, supplies, care and treatment of cancer, in amounts not in excess of the usual and customary charges, with a deductible amount not in excess of two hundred fifty dollars ($250), and an overall aggregate benefit limit of not less than ten thousand dollars ($10,000) and a benefit period of not less than three (3) years for at least the following:

1. Treatment by, or under the direction of, a legally qualified physician or surgeon;

2. X-ray, radium, chemotherapy and other therapy procedures used in diagnosis and treatment;

3. Hospital room and board and any other hospital-furnished medical services or supplies;

4. Blood transfusions, and the administration thereof, including expenses incurred for blood donors;

5. Drugs and medicines prescribed by a physician;

6. Professional ambulance for local service to or from a local hospital;

7. Private duty services of a registered nurse (R.N.) provided in a hospital;

8. Any other expenses necessarily incurred in the treatment of the disease: Provided, That paragraphs 1, 2, 4, 5 and 7 of this subdivision plus at least the following shall also

be included, but may be subject to copayment by the covered person not to exceed twenty percent (20%) of covered charges when rendered on an out-patient basis;

9. Braces, crutches and wheelchairs as are considered necessary by the attending physician for the treatment of the disease;

10. Emergency transportation if, in the opinion of the attending physician, it is necessary to transport the insured to another locality for treatment of the disease; and

11. Home health care that is necessary care and treatment provided at the covered person's residence by a home health care agency or by others under arrangements made with a home health care agency. The program of care and treatment shall be ordered in writing by the covered person's attending physician, who shall approve the program prior to its start and renew the order for such care and treatment at least every sixty (60) days. The physician shall certify that hospital confinement would be otherwise required. Home health care coverages shall include:

A. Services provided by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.);

B. Home health aide services to the extent that such services would be covered if provided to the insured on an in-patient basis;

C. Health services provided by physical, occupational, respiratory, or speech and hearing therapists; and

D. Medical supplies, drugs and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent such charges or costs would be covered under the policy if provided to the insured on an in-patient basis.

12. Physical, respiratory, speech, hearing and occupational therapy;

13. Special equipment including hospital beds, toilettes, pulleys, wheelchairs, aspirators, chux, oxygen, surgical dressings, rubber shields, colostomy and ileostomy appliances;

14. Prosthetic devices including wigs and artificial breasts; and

15. Nursing home care for noncustodial services.

d. The following minimum benefits standards apply to cancer coverages written on a per diem indemnity basis. Such coverages shall offer covered persons:

1. A fixed-sum payment of at least one hundred dollars ($100) for each day of hospital confinement for at least three hundred sixty-five (365) days.

2. A fixed-sum payment equal to one-half of the hospital inpatient benefit for each day of hospital or nonhospital outpatient surgery, chemotherapy and radiation therapy, for at least three hundred sixty-five (365) days of treatment.

3. Benefits tied to confinement in a skilled nursing home or to receipt of home health care are optional. If a policy offers these benefits, they shall equal the following:

A. A fixed-sum payment equal to one-fourth of the hospital inpatient benefit for each day of skilled nursing home confinement for at least one hundred (100) days.

B. A fixed-sum payment equal to one-fourth of the hospital inpatient benefit for each day of home health care for at least one hundred (100) days.

C. Benefit payments shall begin with the first day of care or confinement after the effective date of coverage if such care or confinement is for a covered disease, even though the diagnosis of a covered disease is made at some later date (but not retroactive more than thirty (30) days from the date of diagnosis) if the initial care or confinement was for diagnosis or treatment of the covered disease.

D. Notwithstanding any other provision of this rule, any restriction or limitation applied to the benefits in subparagraphs A and B of this paragraph, whether by definition or otherwise, shall be no more restrictive than those under Medicare.

e. The following minimum benefits standards apply to lump-sum indemnity coverage of any specified disease(s):

1. The coverage shall pay indemnity benefits on behalf of covered persons for a specifically named disease or diseases. The benefits are payable as a fixed, one-time payment made within thirty (30) days of submission to the insurer of proof of diagnosis of the specified disease(s). Dollar benefits shall be offered for sale only in even increments of one thousand dollars ($1,000).

2. Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, the same dollar amounts shall be payable regardless of the particular subtype of the disease with one exception. In the case of clearly identifiable subtypes with significantly lower treatments costs, lesser amounts may be payable so long as the policy clearly differentiates that subtype and its benefits.

5.9. "Specified accident coverage" is an accident insurance policy which provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment combined, with a benefit amount not less than one thousand dollars ($1,000) for accidental death, one thousand dollars ($1,000) for double dismemberment, and five hundred dollars ($500) for single dismemberment.

5.10. "Limited benefits insurance coverage" is any policy, other than a policy covering only a specified disease or diseases, which provides benefits that are less than the minimum standards for benefits required under subsections 5.2, 5.3, 5.4, 5.5, 5.7, 5.8 and 5.9 of this rule. A policy covering a single specified disease or combination of diseases shall meet the requirements of subsection 5.8 of this rule and shall not be offered for sale as a limited benefits policy.

§114-12-6. Required Disclosure Provisions

6.1. Each policy or certificate subject to this rule shall include a renewal, continuation or nonrenewal provision. The language or specifications of the provision shall be consistent with the type of policy or certificate to be issued. The provision shall be appropriately captioned, shall appear on the first page of the policy or certificate, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy or certificate is issued and for which it may be renewed.

6.2. Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or certificateholder, or exercises a specifically reserved right under the policy, all riders or endorsements added to a policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder or certificateholder, as appropriate. After date of policy issue, any rider or endorsement which increases benefits or coverage with concomitant increase in premium during the policy term shall be agreed to in writing signed by the policyholder or certificateholder, as appropriate, except if the increased coverage or benefits are required by law.

6.3. 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.

6.4. A policy which 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 such terms within both the policy and its accompanying outline of coverage.

6.5. Any provisions limiting or excluding coverage of preexisting conditions shall appear in a separate paragraph on the first page of the policy, which shall be labeled "Preexisting Condition Limitations," and shall be included in the outline of coverage.

a. An insurer offering accident and sickness insurance coverage, other than excepted benefits, in the individual market may not, with respect to an eligible individual desiring to enroll in accident and sickness insurance coverage, impose any preexisting condition exclusion with respect to such coverage.

6.6. All accident-only policies shall contain as an overlay on the first page of the policy, in contrasting color, a prominent statement as follows: "This is an accident-only policy, and it does not pay benefits for loss from sickness."

6.7. Any accident-only policy providing benefits which vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under

which benefits are payable which are less than the maximum amount payable under the policy.

6.8. All policies, except single-premium nonrenewable policies, shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder has the right to return the policy within ten (10) days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.

6.9. If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy as originally issued, that fact shall be prominently set forth in the outline of coverage.

6.10. If a policy contains a conversion privilege, it shall comply, in substance, with the following: The caption of the provision shall be "Conversion Privilege," or words of similar import. The provision shall indicate the persons eligible for conversion; the circumstances applicable to the conversion privilege, including any limitations on the conversion; and the person by whom the conversion privilege may be exercised. The provision shall specify the benefits to be provided on conversion, or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

6.11. Outlines of coverage delivered in connection with policies defined in this rule as hospital confinement indemnity (Subsection 5.4), specified disease (Subsection 5.8.), specified accident (Subsection 5.9) or limited benefits health insurance coverages (Subsection 5.10) to persons eligible for Medicare shall contain, in addition to the requirements of subsections 6.17 and 6.21 of this rule, the following language which shall be printed on or attached to the first page of the outline of coverage: "This policy is not a Medicare Supplement policy. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurer."

6.12. All specified disease policies shall contain on the first page of the policy or attached thereto, in either contrasting color or in boldface type at least equal to the size of type used for policy captions, a prominent statement as follows: "Caution: This is a limited benefits policy. Read it carefully with the Outline of Coverage."

6.13. Outline of coverage requirements generally as required in this section are as follows:

a. No policy or certificate subject to this rule may be delivered or issued for delivery in this State unless an appropriate outline of coverage, as prescribed in subsections 6.14 through 6.22 of this rule, is completed as to the policy and:

1. In the case of a direct response insurance product is delivered with the policy; or

2. In all other cases is delivered to the applicant at the time application is made and acknowledgment of receipt or certification of delivery of the outline of coverage is provided to the insurer.

b. If an outline of coverage was delivered at the time of application and the policy is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy shall accompany the policy when it is delivered and contain the following statement in no less than twelve (12) point type, immediately above the insurer's name: "Notice: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application, and the policy originally applied for has not been issued."

c. The appropriate outline of coverage for policies providing hospital coverage which only meets the standards of subsection 5.2 of this rule shall be that outline contained in subsection 6.14 of this rule. The appropriate outline of coverage for policies providing coverage which meets the standards of both subsections 5.2 and 5.3 of this rule shall be the outline contained in subsection 6.16 of this rule. The appropriate outline of coverage for policies providing coverage which meets the standards of both subsections 5.2 and 5.5 or subsections 5.3 and 5.5 or subsections 5.2, 5.3 and 5.5 of this rule shall be the outline contained in subsection 6.18 of this rule.

d. Appropriate changes in terminology shall be made in the outline of coverage in the case of subscriber contracts of hospital, medical, dental or health service corporations. In any other case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy, an alternate outline of coverage shall be submitted to the Commissioner for prior approval. Should the Commissioner consider it appropriate to approve policies or contracts containing less than the prescribed minimum standards for benefits as provided in this rule, the outline of coverage issued in connection with any such policy or contract shall be approved prior to use and shall prominently state that the coverages therein described do not meet the minimum standards for benefits established for that category of coverage.

6.14. Basic Hospital Expense Coverage (Outline of Coverage). -- An outline of coverage, in the form prescribed in appendix A, shall be issued in connection with policies meeting the standards of subsection 5.2 of this rule. The items included in the outline of coverage shall appear in the sequence prescribed.

6.15. Basic Medical-Surgical Expense Coverage (Outline of Coverage). -- An outline of coverage, in the form prescribed in appendix B, shall be issued in connection with policies meeting the standards of subsection 5.3 of this rule. The items included in the outline of coverage shall appear in the sequence prescribed.

6.16. Basic Hospital and Medical-Surgical Expense Coverage (Outline of Coverage). -- An outline of coverage, in the form prescribed in appendix C, shall be issued in connection with policies meeting the standards of subsections 5.2 and 5.3 of this rule. The items included in the outline of coverage shall appear in the sequence prescribed.

6.17. Hospital Confinement Indemnity Coverage (Outline of Coverage). -- An outline of coverage, in the form prescribed in appendix D, shall be issued in connection with policies meeting the standards of subsection 5.4 of this rule. The items included in the outline of coverage shall appear in the sequence prescribed.

6.18. Major Medical Expense Coverage (Outline of Coverage). -- An outline of coverage, in the form prescribed in appendix E, shall be issued in connection with policies meeting the standards of subsection 5.5 of this rule. The items included in the outline of coverage shall appear in the sequence prescribed.

6.19. Disability Income Protection Coverage (Outline of Coverage). -- An outline of coverage, in the form prescribed in appendix F, shall be issued in connection with policies meeting the standards of subsection 5.6 of this rule. The items included in the outline of coverage shall appear in the sequence prescribed.

6.20. Accident-Only Coverage (Outline of Coverage). -- An outline of coverage, in the form prescribed in appendix G, shall be issued in connection with policies meeting the standards of subsection 5.7 of this rule. The items included in the outline of coverage shall appear in the sequence prescribed.

6.21. Specified Disease or Specified Accident Coverage (Outline of Coverage). -- An outline of coverage, in the form prescribed in appendix H, shall be issued in connection with policies meeting the standards of subsections 5.8 or 5.9 of this rule. The coverage shall be identified by the appropriate bracketed title. The items included in the outline of coverage shall appear in the sequence prescribed.

6.22. Limited Benefits Health Coverage (Outline of Coverage). -- An outline of coverage, in the form prescribed in appendix I, shall be issued in connection with policies which do not meet the minimum standards of subsections 5.2, 5.3, 5.4, 5.5, 5.6, 5.7, 5.8 and 5.9 of this rule. The items included in the outline of coverage shall appear in the sequence prescribed.

§114-12-7. Requirements for Replacement

7.1. Application forms shall include a question designed to elicit information as to whether the policy to be issued is intended to replace any other accident and sickness insurance presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

7.2. Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice prescribed in appendix J of this rule. One (1) copy of the notice shall be retained by the insurer. A direct response insurer shall deliver to the applicant, upon issuance of the policy, the notice prescribed in appendix K of this rule. In no event, however, will a notice be required in the solicitation of accident-only and single-premium nonrenewable policies.

§114-12-8. Severability

If any provision of this legislative rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of the provision to other persons or circumstances shall not be affected.

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Bill-Ins, I

H. B. 2487

(By Delegates Hunt, Linch, Compton, Faircloth, Jenkins and Riggs)

[Introduced February 1, 1999; referred to the Committee on Banking and Insurance then the Judiciary.]

A BILL to amend and reenact section three, article seven, chapter sixty-four of the code of West Virginia, one thousand nine hundred thirty-one, as amended, relating to authorizing the insurance commissioner to promulgate a legislative rule relating to individual accident and sickness insurance minimum standards.

Be it enacted by the Legislature of West Virginia:

That section three, article seven, chapter sixty-four of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be amended and reenacted, to read as follows:

ARTICLE 7. AUTHORIZATION FOR DEPARTMENT OF TAX AND REVENUE TO PROMULGATE LEGISLATIVE RULES.

§64-7-3. Insurance commissioner.

1 (a) The legislative rule filed in the state register
2 on the second day of July, one thousand nine hundred
3 ninety-six, authorized under the authority of section ten,
4 article two, chapter thirty-three of this code, modified by
5 the insurance commissioner to meet the objections of the
6 legislative rule-making review committee and refiled in the
7 state register on the twentieth day of February, one
8 thousand nine hundred ninety-seven, relating to the
9 insurance commissioner (medicare supplement insurance, 114
10 CSR 24), is authorized.
11 (b) The legislative rule filed in the state register
12 on the twentieth day of August, one thousand nine hundred
13 ninety-six, authorized under the authority of section
14 fifteen, article four, chapter thirty-three of this code,
15 modified by the insurance commissioner to meet the
16 objections of the legislative rule-making review committee
17 and refiled in the state register on the thirtieth day of
18 January, one thousand nine hundred ninety-seven, relating
19 to the insurance commissioner (life and health reinsurance
20 agreements, 114 CSR 48), is authorized.
21 (c) The legislative rule filed in the state register
22 on the twenty-ninth day of August, one thousand nine
23 hundred ninety-six, authorized under the authority of

section twenty, article fifteen, chapter thirty-three of this code, modified by the insurance commissioner to meet the objections of the legislative rule-making review committee and refiled in the state register on the thirty-first day of January, one thousand nine hundred ninety-seven, relating to the insurance commissioner (individual medical savings accounts, 114 CSR 47), is disapproved and is not authorized for promulgation.

(d) The legislative rule filed in the state register on the twentieth day of August, one thousand nine hundred ninety-six, authorized under the authority of section ten, article two, chapter thirty-three of this code, modified by the insurance commissioner to meet the objections of the legislative rule-making review committee and refiled in the state register on the eighteenth day of February, one thousand nine hundred ninety-seven, relating to the insurance commissioner (valuation of life insurance policies, 114 CSR 49), is authorized, with the following amendment:

"On page one, section 1.4 of the rule, by following the words 'effective date' inserting the following:

'The portions of the rule amended as a result of modifications offered by the Insurance Commissioner and

1 filed with the Secretary of State on August 20, 1996, shall
2 not become effective until January 1, 1998.'"
3 (e) The legislative rule filed in the state register
4 on the twenty-ninth day of August, one thousand nine
5 hundred ninety-six, authorized under the authority of
6 section one, article fifteen-c, chapter thirty-three of
7 this code, modified by the insurance commissioner to meet
8 the objections of the legislative rule-making review
9 committee and refiled in the state register on the
10 twentieth day of February, one thousand nine hundred
11 ninety-seven, relating to the insurance commissioner
12 (diabetes, 114 CSR 52), is authorized.
13 (f) The legislative rule filed in the state register
14 on the twenty-ninth day of August, one thousand nine
15 hundred ninety-six, authorized under the authority of
16 section twenty-three, article four-c, chapter sixteen of
17 this code, modified by the insurance commissioner to meet
18 the objections of the legislative rule-making review
19 committee and refiled in the state register on the
20 eighteenth day of February, one thousand nine hundred
21 ninety-seven, relating to the insurance commissioner
22 (emergency medical services, 114 CSR 50), is authorized.
23 (g) The legislative rule filed in the state register

on the twenty-ninth day of August, one thousand nine hundred ninety-six, authorized under the authority of section ten, article two, chapter thirty-three of this code, modified by the insurance commissioner to meet the objections of the legislative rule-making review committee and refiled in the state register on the eighteenth day of February, one thousand nine hundred ninety-seven, relating to the insurance commissioner (utilization management, 114 CSR 51), is authorized.

(h) The legislative rule filed in the state register on the twenty-ninth day of August, one thousand nine hundred ninety-six, authorized under the authority of section ten, article two, chapter thirty-three of this code, modified by the insurance commissioner to meet the objections of the legislative rule-making review committee and refiled in the state register on the eighteenth day of February, one thousand nine hundred ninety-seven, relating to the insurance commissioner (replacement of life insurance, 114 CSR 8), is authorized.

(i) The legislative rule filed in the state register on the thirtieth day of July, one thousand nine hundred ninety-eight, authorized under the authority of section ten, article two, chapter thirty-three, of this code,

1 relating to the insurance commissioner (individual accident
2 and sickness insurance minimum standards, 114 CSR 12), is
3 authorized.
4
5 NOTE: The purpose of this bill is to authorize the
6 Insurance Commissioner to promulgate a legislative rule
7 relating to Individual Accident and Sickness Insurance
8 Minimum Standards.
9
10 Strike-throughs indicate language that would be
11 stricken from the present law, and underscoring indicates
12 new language that would be added.