

WEST VIRGINIA

SECRETARY OF STATE

KEN HECHLER

ADMINISTRATIVE LAW DIVISION

FILED

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OFFICE OF WEST VIRGINIA SECRETARY OF STATE

NOTICE OF AGENCY APPROVAL OF A PROPOSED RULE AND FILING WITH THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

AGENCY: Insurance Commissioner TITLE NUMBER: 114

CITE AUTHORITY WV Code §§ 33-2-10, 33-28-4, 33-28-5 and 33-28-6

AMENDMENT TO AN EXISTING RULE: YES NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED:

TITLE OF RULE BEING AMENDED:

IF NO, SERIES NUMBER OF NEW RULE BEING PROPOSED: Series 12

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

THE ABOVE PROPOSED LEGISLATIVE RULE HAVING GONE TO A PUBLIC HEARING OR A PUBLIC COMMENT PERIOD IS HEREBY APPROVED BY THE PROMULGATING AGENCY FOR FILING WITH THE SECRETARY OF STATE AND THE LEGISLATIVE RULE MAKING REVIEW COMMITTEE FOR THEIR REVIEW.

Hanley C. Clark

Hanley C. Clark Insurance Commissioner

17.50



STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner

Legal Division

GASTON CAPERTON
Governor

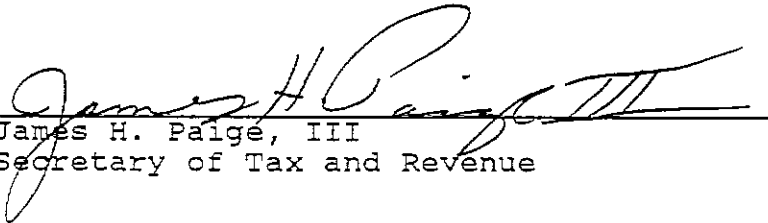
HANLEY C. CLARK
Insurance Commissioner

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.

Signed this 9th day of July, 1993.


James H. Paige, III
Secretary of Tax and Revenue

APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Individual Accident and Sickness Insurance
Minimum Standards (Title 114, Series 12)

Type of Rule: X Legislative Interpretive Procedural

Agency Insurance Commissioner

Address 2019 Washington Street, East
P. O. Box 50540
Charleston, WV 25305-0540

1. Effect of Proposed Rule

	ANNUAL FISCAL YEAR				
	INCREASE	DECREASE	CURRENT	REPEAL	HEREAFTER
<u>ESTIMATED TOTAL COST</u>	\$ NONE	\$ NONE	\$ NONE	\$ NONE	\$ NONE
PERSONAL SERVICES					
CURRENT EXPENSE					
REPAIRS & ALTERNATIONS					
EQUIPMENT					
OTHER					

2. Explanation of above estimates:

The proposed rule will have no cost impact on state, local or federal government.

3. Objectives of these rules:

The objectives of this rule are to establish minimum policy standards for group accident and sickness insurance that are consistent with modern-day terminology and the health insurance industry's current custom and practice. The rule repeals and replaces the Insurance Commissioner's existing 18-year-old rule on this subject.

Rule Title: Individual Accident and Sickness Insurance
Minimum Standards (Title 114, Series 12)

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

The rule will have no economic impact on state government.

B. Economic Impact on Political Subdivisions; Specific Industries; Specific groups of Citizens.

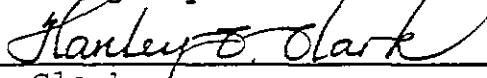
The rule will have no economic impact on political subdivision or specific groups of citizens. It may increase administrative costs for sellers of individual health insurance policies, who may have to reprint policy forms to comply with the new rule.

C. Economic Impact on Citizens/Public at Large.

Depending upon coverages currently being sold by health care insuring entities subject to the rule, the public at large may receive greater benefits in return for the dollars they spend on health insurance and health care plans.

Date: July 9, 1993

Signature of Agency Head or Authorized Representative



Hanley C. Clark
Insurance Commissioner

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INDIVIDUAL ACCIDENT AND SICKNESS
INSURANCE MINIMUM STANDARDS

OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

Title 114, Series 12

BRIEF SUMMARY OF RULE AND
DETAILED STATEMENT OF CIRCUMSTANCES
REQUIRING PROPOSED LEGISLATIVE RULE

During its 1993 Regular Session, the West Virginia Legislature enacted West Virginia Code § 33-16-3(f) to mandate that the Insurance Commissioner promulgate a legislative rule establishing minimum policy coverage standards for group accident and sickness insurance. While researching and drafting that rule, the Commissioner's staff determined that the long-standing legislative rule entitled "Individual Accident and Sickness Insurance Minimum Standards" (Series 12, effective April 1, 1975) needed to be updated using modern terminology and requiring policy provisions that comport with current health insurance industry custom and practice. Therefore, the Insurance Commissioner has approved this rule to repeal and replace the existing legislative rule setting minimum standards for individual health insurance.

This proposed rule repeals and replaces the Insurance Commissioner's existing rule, which took effect in 1975, on minimum standards for individual accident and sickness insurance. The rule updates terminology and policy provisions in the existing rule, to make them consistent with modern-day definitions and current custom and practice in the health insurance industry. The rule defines terms, prohibits certain specified policy provisions, establishes minimum standards for benefits, sets forth required disclosure provisions, and prescribes requirements for replacement of policies. It applies to individual accident and sickness insurance policies, as well as to individual subscriber contracts of hospital, medical, dental and health service corporations.

114CSR12

TITLE 114
LEGISLATIVE RULE
INSURANCE COMMISSIONER

SERIES 12
INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS

Section

- 114-12-1. General
- 114-12-2. Definitions
- 114-12-3. Policy Definitions
- 114-12-4. Prohibited Policy Provisions
- 114-12-5. Minimum Standards for Benefits
- 114-12-6. Required Disclosure Provisions
- 114-12-7. Requirements for Replacement
- 114-12-8. Severability

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114CSR12

TITLE 114
LEGISLATIVE RULE
INSURANCE COMMISSIONER

OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

SERIES 12
INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS

§ 114-12-1. General

1.1. Purpose. -- 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 and subscriber contracts of hospital, medical, dental and health service corporations; 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.

1.2. Scope and Applicability. -- This rule applies to all individual accident and sickness insurance policies and all subscriber contracts of hospital, medical, dental and health service corporations, delivered or issued for delivery in this State on and after the effective date hereof, except that it does not apply to:

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

1.2.b. Accident and sickness insurance contracts covering members of fraternal benefit societies organized pursuant to West Virginia Code Chapter 33, Article 23;

1.2.c. Credit accident and sickness insurance subject to WV 114CSR6 "Regulation of Credit Life Insurance and Credit Accident and Sickness Insurance";

1.2.d. Medicare supplement insurance policies subject to WV 114CSR24 "Permanent Regulations on Medicare Supplement Insurance";

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1.2.e. Individual minimum benefits accident and sickness insurance policies subject to WV 114CSR33 "Individual and Employer Group Minimum Benefits Accident and Sickness Insurance Policies";

1.2.f. Long-term care insurance policies subject to WV 114CSR32 "Long-Term Care Insurance";

1.2.g. Coverage under the West Virginia Public Employees Insurance Act (West Virginia Code Chapter 5, Article 16);

1.2.h. Coverage under Medicare or Medicaid; and

1.2.i. 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 adopted.

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

1.4. Filing Date. --

1.5. Effective Date. --

1.6. Repeal of Former Rule. -- This legislative rule repeals and replaces WV 114CSR12 "Individual Accident and Sickness Insurance Minimum Standards" filed December 13, 1974 and effective April 1, 1975.

§ 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. "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.

2.5. "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; or a hospital, medical, dental or health service corporation organized pursuant to West Virginia Code Chapter 33, Article 24.

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

2.7. "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 or 1833 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.) or an issued policy under a demonstration project authorized pursuant to amendments to the federal Social Security Act, 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.

2.8. "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.

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

§ 114-12-3. Policy Definitions

3.1. Except as provided hereafter, no policy or certificate subject to this rule may be advertised, solicited, delivered or issued for delivery in this State unless such 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.

3.2.a. The definition may not be more restrictive than the following: "Injury or injuries, for which benefits are

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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.

3.2.b. Such 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.

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

3.3.a.A. Be operated pursuant to law;

3.3.a.B. Be approved for payment of Medicare benefits or be qualified to receive such approval if so requested;

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

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

3.3.a.E. Maintain a daily medical record of each patient.

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

3.3.b.A. Any home, facility or part thereof used primarily for rest;

3.3.b.B. A home or facility for the aged or for the care of drug addicts or alcoholics; or

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

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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.

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

3.4.a.A. Be an institution operated pursuant to law;

3.4.a.B. 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

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

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

3.4.b.A. 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 such 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.

3.4.b.B. Convalescent homes, convalescent, rest or nursing facilities; or

3.4.b.C. Facilities for the aged, drug addicts or alcoholics and those primarily affording custodial, educational or rehabilitary 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

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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 such terms requires the insurer to recognize the services of any individual who qualifies under such 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 such 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 such 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

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(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 other 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.

3.14.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:

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

3.14.a.B. Engage in any training or rehabilitation program.

3.14.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.

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 such a dividend policy or rider. No such 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 policy issue.

4.5. A disability income policy may contain a "return of premium" or "cash value benefit" so long as: (1) such 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 (2) the insurer demonstrates that the reserve basis for such 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. 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 deemed 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 the following subsections. 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 shall preclude 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.

5.1.a. 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.

5.1.b. 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 above, 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.

5.1.c. 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 said definition.

5.1.d. 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.

5.1.e. 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.

5.1.f. 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.

5.1.g. 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.

5.1.h. 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: (1) incapable of

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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 (2) 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 such 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.

5.1.i. 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.

5.1.j. 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 such disability.

5.1.k. 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.

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

5.1.m. 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. -- "Basic Hospital Expense Coverage" is a policy of accident and sickness insurance

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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:

5.2.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;

5.2.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

5.2.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.

5.2.d. Benefits provided under subdivisions 5.2.a and 5.2.b above may be provided subject to a combined deductible amount not in excess of one hundred dollars (\$100).

5.3. Basic Medical-Surgical Expense Coverage. -- "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:

5.3.a. Surgical services:

5.3.a.A. 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

5.3.a.B. Not less than eighty percent (80%) of the reasonable charges.

5.3.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:

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

5.3.b.B. Fifteen percent (15%) of the surgical service benefit.

5.3.b.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. -- "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. -- "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 such deductible may be increased by the amount of the benefits provided by such underlying insurance, for each covered person for at least:

5.5.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;

5.5.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;

5.5.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 above-stated maximum amount for the first such surgical procedure.

5.5.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;

5.5.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) such calls during one period confinement.

5.5.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

5.5.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.

5.6.a. "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:

5.6.a.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).

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5.6.a.B. Contains an elimination period no greater than:

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

5.6.a.B.(b). 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

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

5.6.a.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 such 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.

5.6.b. Subsection 5.6 does not apply to those disability income protection policies providing business buy-out coverage.

5.7. Accident-Only Coverage. -- "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 and Specified Accident Coverage.

5.8.a. "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 subparagraphs 5.8.a.C, 5.8.a.D and 5.8.a.E. Insurance covering specified disease(s) other than cancer shall meet the standards of subparagraphs 5.8.a.B or 5.8.a.E.

5.8.a.A. General Rules. -- Except for cancer coverage provided on an expense-incurred basis, either as cancer-

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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 ones shall govern:

5.8.a.A.(a). 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.

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

5.8.a.A.(c). 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).

5.8.a.A.(d). Policies containing specified disease coverage shall be at least guaranteed renewable.

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

5.8.a.A.(f). 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. Such statement may be combined with any other statement for which the insurer may require the applicant's signature.

5.8.a.A.(g). 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.

5.8.a.A.(h). 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.

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5.8.a.A.(i). 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 such care or confinement is for a covered disease even though the diagnosis is made at some later date. The retroactive application of such coverage may not be less than ninety (90) days prior to such diagnosis.

5.8.a.B. The following minimum benefits standards apply to noncancer coverages:

5.9.a.B.(a). 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:

5.8.a.B.(a)(A). Hospital room and board and any other hospital-furnished medical services or supplies;

5.8.a.B.(a)(B). Treatment by a legally qualified physician or surgeon;

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

5.8.a.B.(a)(D). X-ray, radium and other therapy procedures used in diagnosis and treatment;

5.8.a.B.(a)(E). Professional ambulance for local service to or from a local hospital;

5.8.a.B.(a)(F). Blood transfusions, including expenses incurred for blood donors;

5.8.a.B.(a)(G). Drugs and medicines prescribed by a physician;

5.8.a.B.(a)(H). Rental of a mechanical ventilator or similar mechanical apparatus;

5.8.a.B.(a)(I). Braces, crutches and wheelchairs as are deemed necessary by the attending physician for the treatment of the disease;

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5.8.a.B.(a)(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

5.8.a.B.(a)(K). Any other expenses necessarily incurred in the treatment of the disease.

5.8.a.B.(b). 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.

5.8.a.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:

5.8.a.C.(a). Treatment by, or under the direction of, a legally qualified physician or surgeon;

5.8.a.C.(b). X-ray, radium, chemotherapy and other therapy procedures used in diagnosis and treatment;

5.8.a.C.(c). Hospital room and board and any other hospital-furnished medical services or supplies;

5.8.a.C.(d). Blood transfusions, and the administration thereof, including expenses incurred for blood donors;

5.8.a.C.(e). Drugs and medicines prescribed by a physician;

5.8.a.C.(f). Professional ambulance for local service to or from a local hospital;

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

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5.8.a.C.(h). Any other expenses necessarily incurred in the treatment of the disease: **Provided**, That subdivisions 5.8.a.C.(a), 5.8.a.C.(b), 5.8.a.C.(d), 5.8.a.C.(e) and 5.8.a.C.(g) 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;

5.8.a.C.(i). Braces, crutches and wheelchairs as are deemed necessary by the attending physician for the treatment of the disease;

5.8.a.C.(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

5.8.a.C.(k). 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.

5.8.a.C.(k)(A). A "home health care agency" is (1) an agency approved under Title XVIII of the Social Security Act (42 U.S.C. § 1395 et seq.) (Medicare), or (2) an agency certified to provide home health care in this State.

5.8.a.C.(k)(B). Home health care coverages shall include:

5.8.a.C.(k)(B)1. Services provided by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.);

5.8.a.C.(k)(B)2. Home health aide services to the extent that such services would be covered if provided to the insured on an in-patient basis;

5.8.a.C.(k)(B)3. Health services provided by physical, occupational, respiratory, or speech and hearing therapists; and

5.8.a.C.(k)(A)4. Medical supplies, drugs and medicines prescribed by a physician and

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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.

5.8.a.C.(l). Physical, respiratory, speech, hearing and occupational therapy;

5.8.a.C.(m). Special equipment including hospital beds, toilettes, pulleys, wheelchairs, aspirators, chux, oxygen, surgical dressings, rubber shields, colostomy and ileostomy appliances;

5.8.a.C.(n). Prosthetic devices including wigs and artificial breasts; and

5.8.a.C.(o). Nursing home care for noncustodial services.

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

5.8.a.D.(a). 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.

5.8.a.D.(b). 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.

5.8.a.D.(c). 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:

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

5.8.a.D.(c)(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.

5.8.a.D.(c)(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 such covered disease.

5.8.a.D.(c)(D). Notwithstanding any other provision of this rule, any restriction or limitation applied to the benefits in 5.8.a.D.(c)(A) and 5.8.a.D.(c)(B), whether by definition or otherwise, shall be no more restrictive than those under Medicare.

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

5.8.a.E.(a). Such coverage shall pay indemnity benefits on behalf of covered persons for a specifically named disease or diseases. Such 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).

5.8.a.E.(b). 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.

5.8.b. Specified Accident Coverage. -- "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.

5.9. Limited Benefits Insurance Coverage. -- "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 and 5.8. A policy covering a single specified disease or combination of diseases shall meet the requirements of subsection 5.8 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 such provision shall be consistent with the type of policy or certificate to be issued. Such 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, such 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 paragraph shall be labeled "Preexisting Condition Limitations," and shall be included in the outline of 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 shall have 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, such 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 (Section 5.4), specified disease (Section 5.8.), or limited benefits health insurance coverages (Section 5.9) to persons eligible for Medicare shall contain, in addition to the requirements of subsections 6.17 and 6.21, 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. --

6.13.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 subsection 6.14 through 6.22 of this subsection, is completed as to such policy and:

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

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

6.13.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."

6.13.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 these rules. The appropriate outline of coverage for policies providing coverage which meets the standards of both subsections 5.2 and 5.3 of these rules shall be the outline contained in subsection 6.16 of these rules. 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 these rules shall be the outline contained in subsection 6.18 of these rules.

6.13.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 deem it appropriate to approve policies or contracts containing less than the prescribed minimum standards for benefits as provided in these rules, 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.

6.13.e. In the outline of coverage forms that follow, only the material appearing in brackets is to be composed by the insurer in language appropriate for the coverage provided. All other material shall appear in exactly the form set forth in this rule.

6.14. Basic Hospital Expense Coverage (Outline of Coverage). -- An outline of coverage, in the form prescribed below, 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.

[COMPANY NAME]
BASIC HOSPITAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

(1) Read Your Policy Carefully. -- This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance policy, and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurer. It is, therefore, important that you **Read Your Policy Carefully!**

(2) Basic Hospital Expense Coverage: -- Policies of this category are designed to provide, to persons insured, coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services and hospital outpatient services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided

for physicians' or surgeons' fees or unlimited hospital expenses. [Note: Final sentence may be appropriately modified, if necessary, to reflect coverage provided].

(3) [A brief specific description of the benefits contained in this policy, in the following order:

- (a) Daily hospital room and board;
- (b) Miscellaneous hospital services;
- (c) Hospital outpatient services; and
- (d) Other benefits, if any.]

(4) [A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Subdivision (3) above.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

6.15. Basic Medical-Surgical Expense Coverage (Outline of Coverage). -- An outline of coverage, in the form prescribed below, 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.

[COMPANY NAME]
BASIC MEDICAL-SURGICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

(1) **Read Your Policy Carefully.** -- This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance policy, and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurer. It is, therefore, important that you **Read Your Policy Carefully!**

(2) **Basic Medical-Surgical Expense Coverage.** -- Policies of this category are designed to provide, to persons insured, coverage for medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical

services, anesthesia services and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for hospital expenses or unlimited medical-surgical expenses. [Note: Final sentence may be appropriately modified, if necessary, to reflect coverage provided.]

(3) [A brief specific description of the benefits, including dollar amounts and number of days' duration where applicable, contained in this policy, in the following order:

- (a) Surgical services;
- (b) Anesthesia services;
- (c) In-hospital medical services; and
- (d) Other benefits, if any.]

(4) [A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Subdivision (3) above.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

6.16. Basic Hospital and Medical-Surgical Expense Coverage (Outline of Coverage). -- An outline of coverage, in the form prescribed below, 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.

[COMPANY NAME]
BASIC HOSPITAL AND MEDICAL-SURGICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

(1) Read Your Policy Carefully. -- This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance policy, and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurer. It is, therefore, important that you **Read Your Policy Carefully!**

(2) Basic Hospital and Medical-Surgical Expense Coverage. -- Policies of this category are designed to provide, to persons insured, coverage for hospital and medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital outpatient services, surgical services, anesthesia services and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for unlimited hospital or medical-surgical expenses. [Note: Final sentence may be appropriately modified, if necessary, to reflect coverage provided.]

(3) [A brief specific description of the benefits, including dollar amounts and number of days' duration where applicable, contained in this policy, in the following order:

- (a) Daily hospital room and board;
- (b) Miscellaneous hospital services;
- (c) Hospital outpatient services;
- (d) Surgical services;
- (e) Anesthesia services;
- (f) In-hospital medical services; and
- (g) Other benefits, if any.]

(4) [A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Subdivision (3) above.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

6.17. Hospital Confinement Indemnity Coverage (Outline of Coverage). -- An outline of coverage, in the form prescribed below, 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.

[COMPANY NAME]
HOSPITAL CONFINEMENT INDEMNITY COVERAGE

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(1) **Read Your Policy Carefully.** -- This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance policy, and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurer. It is, therefore, important that you **Read Your Policy Carefully!**

(2) **Major Medical Expense Coverage.** -- Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, out-of-hospital care and prosthetic appliances, subject to any limitations, deductibles or copayment requirements set forth in the policy. Basic hospital or basic medical insurance coverage is not provided. [Note: Final sentence may be appropriately modified, if necessary, to reflect coverage provided.]

(3) [A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:

- (a) Daily hospital room and board;
- (b) Miscellaneous hospital services;
- (c) Surgical services;
- (d) Anesthesia services;
- (e) In-hospital medical services;
- (f) Out-of-hospital care;
- (g) Prosthetic appliances;
- (h) Maximum dollar amount for covered charges; and
- (i) Other benefits, if any.]

(4) [A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Subdivision (3) above.]

OUTLINE OF COVERAGE

(1) Read Your Policy Carefully. -- This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance policy, and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurer. It is, therefore, important that you **Read Your Policy Carefully!**

(2) Hospital Confinement Indemnity Coverage. -- Policies of this category are designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations, deductibles and copayment requirements set forth in the policy. Such policies do not provide any benefits other than the fixed daily indemnity for hospital confinement. [Note: Final sentence may be appropriately modified to reflect additional benefits provided, if any.]

(3) [A brief specific description of the benefits contained in this policy, in the following order:

- (a) Daily benefit payable during hospital confinement; and
- (b) Duration of benefit described in Subdivision (a) above.

(4) [A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefit described in Subdivision (3) above.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

(6) [Any benefits provided in addition to the daily hospital confinement indemnity benefit.]

6.18. Major Medical Expense Coverage (Outline of Coverage). -- An outline of coverage, in the form prescribed below, 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.

[COMPANY NAME]
MAJOR MEDICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

(5) [A description of any policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

6.19. Disability Income Protection Coverage (Outline of Coverage). -- An outline of coverage, in the form prescribed below, 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.

[COMPANY NAME]
DISABILITY INCOME PROTECTION COVERAGE
OUTLINE OF COVERAGE

(1) Read Your Policy Carefully. -- This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance policy, and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurer. It is, therefore, important that you **Read Your Policy Carefully!**

(2) Disability Income Protection Coverage. -- Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations, deductibles or copayment requirements set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical or major-medical expenses. [Note: Final sentence may be appropriately modified, if necessary, to reflect coverage provided.]

(3) [A brief specific description of the benefits contained in this policy.]

(4) [A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Subdivision (3) above.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

6.20. Accident-Only Coverage (Outline of Coverage). -- An outline of coverage, in the form prescribed below, 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.

[COMPANY NAME]
ACCIDENT-ONLY COVERAGE
OUTLINE OF COVERAGE

(1) Read Your Policy Carefully. -- This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance policy, and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurer. It is, therefore, important that you **Read Your Policy Carefully!**

(2) Accident-Only Coverage. -- Policies of this category are designed to provide, to persons insured, coverage for certain losses resulting from a covered accident only, subject to any limitations, deductibles or copayment requirements set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical or major-medical expenses. [Note: Final sentence may be appropriately modified, if necessary, to reflect coverage provided.]

(3) [A brief specific description of the benefits contained in this policy.]

(4) [A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Subdivision (3) above.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

6.21. Specified Disease or Specified Accident Coverage (Outline of Coverage). -- An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of subsection 5.8 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.

[COMPANY NAME]
[SPECIFIED DISEASE] [SPECIFIED ACCIDENT] COVERAGE
OUTLINE OF COVERAGE

(1) Read Your Policy Carefully. -- This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance policy, and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurer. It is, therefore, important that you **Read Your Policy Carefully!**

(2) [Specified Disease] [Specified Accident] Coverage. -- Policies of this category are designed to provide, to persons insured, restricted coverage paying benefits **only** when certain losses occur as a result of [specified diseases] [specified accidents], subject to any limitations, deductibles or copayment requirements set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical or major medical expenses. [Note: Final sentence may be appropriately modified, if necessary, to reflect coverage provided.]

(3) [A brief specific description of the benefits, including dollar amounts, contained in this policy.]

(4) [A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Subdivision (3) above.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

6.22. Limited Benefits Health Coverage (Outline of Coverage). -- An outline of coverage, in the form prescribed below, 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, and 5.8 of this rule. The items included in the outline of coverage shall appear in the sequence prescribed.

[COMPANY NAME]
LIMITED BENEFITS HEALTH COVERAGE
OUTLINE OF COVERAGE

(1) Read Your Policy Carefully -- This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance policy, and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your

insurer. It is, therefore, important that you **Read Your Policy Carefully!**

(2) Limited Benefits Health Coverage -- Policies of this category are designed to provide, to persons insured, limited or supplemental insurance coverage, subject to any limitations, deductibles or copayment requirements set forth in the policy.

(3) [A brief specific description of the benefits, including dollar amounts, contained in this policy.]

(4) [A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in (3) above.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

§ 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 described in subsection 7.3 below. One (1) copy of such notice shall be retained by the insurer. A direct response insurer shall deliver to the applicant, upon issuance of the policy, the notice described in subsection 7.4 below. In no event, however, will such a notice be required in the solicitation of the following types of policies: accident-only and single-premium nonrenewable policies.

7.3. The notice required by subsection 7.2 above for an insurer, other than a direct response insurer, shall be as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by [insert company name] Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the insurer to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)

7.4. The notice required by subsection 7.2 above for a direct response insurer shall be as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS INSURANCE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing

Insurance Commission
Legislative Rule
Title 114, Series 12

accident and sickness insurance and replace it with the policy delivered herewith issued by [insert company name] Insurance Company. Your new policy provides ten days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) [To be included only if the application is attached to the policy]. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [insert company name and address] within ten days if any information is not correct and complete, or if any past medical history has been left out of the application.

[COMPANY NAME]

§ 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 such provision to other persons or circumstances shall not be affected thereby.

DATE: AUGUST 17, 1993

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: OFFICE OF THE INSURANCE COMMISSIONER

Individual Accident and Sickness Insurance

LEGISLATIVE RULE TITLE: Minimum Standards (Title 114, Series 12)

1. Authorizing statute(s) citation West Virginia Code
§§ 33-2-10, 33-28-4, 33-28-5 and 33-28-6
2. a. Date filed in State Register with Notice of Hearing
July 16, 1993
b. What other notice, including advertising, did you give of the hearing?
None

c. Date of Hearing(s) The public comment period, held in lieu of a hearing, ended on August 16, 1993 at 8:00 a.m. EDT.
d. Attach list of persons who appeared at hearing, comments received, amendments, reasons for amendments.
Attached No comments received
e. Date you filed in State Register the agency approved proposed Legislative Rule following public hearing: (be exact)
August 17, 1993
f. Name and phone number(s) of agency person(s) to contact for additional information:
Linda Gay, Associate Counsel
Office of the Insurance Commissioner
(304) 558-0401

3. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:

a. Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.

Not applicable

b. Date of hearing: Not applicable

c. On what date did you file in the State Register the findings and determinations required together with the reasons therefor?

Not applicable

d. Attach findings and determinations and reasons:

Attached Not applicable

ATTACHMENT TO QUESTION 2(d):

Richard W. Adkins, Associate Corporate Counsel for Mountain State Blue Cross & Blue Shield, Inc., ("MSBCBS") of Parkersburg, West Virginia, submitted comments to the Insurance Commissioner ("Commissioner") regarding this proposed Series 12 rule on minimum standards for individual accident and sickness insurance. A copy of Mr. Adkins' comments, contained in an August 13, 1993 letter to Associate Counsel Linda Gay of the Commissioner's office, is attached hereto and incorporated herein by reference.

Prior to setting forth his responses to the section-by-section comments of MSBCBS regarding this proposed rule, the Commissioner wishes to note at the outset that many of the rule provisions criticized by MSBCBS are contained in his existing Series 12 rule on individual health insurance which has been law in West Virginia since April 1, 1975 ("the existing Series 12 rule"), and/or in the July 1989 "Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act" adopted by the National Association of Insurance Commissioners (NAIC) ("the Model Regulation.") Therefore, many of the rule provisions commented upon by MSBCBS are not new requirements placed by the Commissioner on insurers subject to this agency-approved rule who market individual health insurance policies.

The Commissioner's response to the comments filed on behalf of MSBCBS are set forth below, in the same section order in which the comments appear in Mr. Adkins' aforementioned August 13, 1993 letter.

Section 1.2.g excepts the West Virginia Public Employees Insurance Agency (PEIA) from the provisions of this rule. This section merely recognizes that, as a matter of law, the Commissioner has no jurisdiction or authority whatsoever over the PEIA, which is governed by the provisions of West Virginia Code Chapter 5, Article 16 and not by the state's insurance statutes contained in West Virginia Code Chapter 33. Therefore, the Commissioner declines to delete Section 1.2.g from this agency-approved rule.

Sections 3.2 and 3.2.a define "accident," "accidental injury," "accidental means" and "injury or injuries, for which benefits are provided." These definitions are based on Section 5D of the Model Regulation, and similar definitions are contained in Section 2.5 of the existing Series 12 rule. These definitions have been modified somewhat in accordance with updated language used in parallel definitions in the July 1991 model regulation of the NAIC relating to "Medigap" insurance upon which the Commissioner's "Permanent Regulations on Medicare Supplement Insurance" (114CSR24) are based. Therefore, the Commissioner declines to change these definitions in this agency-approved rule.

Section 3.4.d.A mentioned in Mr. Adkins' comments does not exist in this agency-approved rule. The Commissioner believes that this is intended as a reference to Section 3.4.b.A of the proposed rule, because it is similar to a comment filed by MSBCBS on a parallel provision in the Commissioner's proposed new Series 39 legislative rule establishing minimum standards for group

health insurance. The language in **Section 3.4.b.A** of the instant proposed replacement for the existing Series 12 rule is based upon Section 5A(2)(d) of the Model Regulation, except for the proviso which reiterates the prohibition contained in West Virginia Code § 33-15-11. That statute states that an individual health insurance policy providing hospital indemnity coverage may not exclude coverage because of confinement in a state or federal government hospital. The Commissioner is relying upon the expertise of the NAIC in using this model provision in his agency-approved rule. He notes that MSBCBS has failed to cite with specificity the federal law that it believes might be violated by **Section 3.4.b.A** of this agency-approved rule, which the Commissioner declines to modify or delete.

Section 4.8 is virtually identical to Section 3(g) of the existing Series 12 rule, which took effect in West Virginia more than eighteen years ago. Moreover, much of the language in this section of the agency-approved replacement for the Series 12 rule is taken verbatim from Section 6H of the Model Regulation. The Commissioner concedes that **Section 4.8** of this agency-approved rule gives him broad discretionary powers to disapprove policy provisions which, in his opinion, are unjust, unfair or unfairly discriminatory. The Commissioner disagrees with the MSBCBS comment that the language in this section is "overbroad and . . . an improper delegation of legislative authority." Therefore, he declines to revise or delete **Section 4.8** from this agency-approved rule.

Section 5.1.f relates to extension of pregnancy benefits, under policies providing such coverage, as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force, in the event that the insurer cancels or refuses to renew the policy. Section 4.2(f) of the existing Series 12 rule contains similar language. Furthermore, a provision the same as Section 5.1.f of the instant agency-approved rule is contained verbatim in Section 7A(6) of the Model Regulation. The Commissioner does not intend to modify or delete this consumer protection provision, which the insurance industry in West Virginia had managed to accommodate since 1975, in his proposed Series 12 replacement rule. Therefore, he declines to revise or delete this section from the agency-approved rule.

Section 5.1.h contains provisions on continuation of health insurance coverage under specified conditions for a child of an insured after he or she attains any limiting age set forth in the policy. MSBCBS contends that this section should reference Internal Revenue Code dependency requirements in subdivision two. The Commissioner disagrees that federal income tax law need be used to define dependency of an insured's adult child for health insurance purposes. The language of Section 5.1.h of this agency-approved rule is based upon similar wording in Section 4.2(h) of the existing Series 12 rule and Section 7A(8) of the Model Regulation. The Commissioner prefers to use those two rules as the basis for dependency language in this agency-approved rule, rather than adopting Internal Revenue Code

dependency requirements.

Sections 5.2.b, 5.3.a.B, 5.3.b.A, 5.3.b.C and 5.5 of this proposed replacement rule all elicited the same comment from MSBCBS, i.e., that these provisions relating to basic hospital expense coverage, surgical services, anesthesia services, and major medical expense coverage should not be subject to eighty (80%) percent payment by an insurer as provided in this proposed replacement rule. The Commissioner notes that this requirement exists in the existing Series 12 rule, as well as in the Model Regulation, and he declines to change it in this agency-approved rule.

Section 5.2.b relates to miscellaneous expenses for in-patient hospital services and supplies covered by basic hospital expense coverage in an individual accident and sickness insurance policy. The Commissioner obtained the language of Section 5.2.b of the proposed rule from Section 7B(2) of the Model Regulation. In addition, the existing Series 12 rule contains an identical provision in Section 4.3(b). Therefore, the Commissioner declines to revise or delete Section 5.2.b of this agency-approved rule.

Section 5.2.d and 5.5.b are included in both the existing Series 12 rule (as Sections 4.3(c) and 4.6(b), respectively) and in the Model Regulation. The Commissioner declines to modify or delete these long-standing regulations in this agency-approved replacement rule.

Sections 5.5.c employs "reasonably related" language regarding expenses for each medically necessary surgical

procedure after the first that is performed during the course of a single operation. MSBCBS maintains that such language is unclear and vague. The Commissioner paraphrased this wording from the PEIA's current explanation of surgical benefits for its members. The reasonableness standard employed in this language is a commonly used objective legal test. The Commissioner does not believe this "reasonably related" language to be unclear or vague in the context in which it appears in **Section 5.5.c**. He therefore declines to modify this language.

Sections 5.5.f. and 5.5.g are criticized in the MSBCBS comments because they make no reference to services that can be excluded from an individual accident and sickness insurance policy for out-of-hospital care and prosthetic appliances, respectively. The Commissioner notes that these two sections, which are contained in Section 4.6(f) and (g) of the existing Series 12 rule, adequately describe what items must be included as minimum benefits provided under such a policy. He believes that these sections do not need to list specific items which can be excluded from these two categories of major medical expense coverage. Therefore, he declines to change these sections of this agency-approved rule based on the comments by MSBCBS.

Section 6.2 is a consumer protection provision which requires disclosure to and acceptance by the insured of certain riders and endorsements added to an existing individual health insurance policy. This section of the proposed rule is nearly identical to Section 8A(2) of the Model Regulation. Furthermore, with an individual health insurance policy, there is no "entire

risk pool," as cited in the MSBCBS comments regarding this section, that is of concern to the insurer. Therefore, the Commissioner declines to revise or delete **Section 6.2** from this agency-approved rule.

Section 6.13 is based upon provisions in Section 8B of the Model Regulation, which require an insurer to provide an outline of proposed insurance coverage when a person applies for an individual accident and sickness insurance policy. MSBCBS has criticized these provisions as being confusing to the consumer, due to the fact that outlines of coverage issued at the time of application for insurance "do not exactly mirror the coverage contained in their policy or certificate." The Commissioner has taken this fact into account by including in this proposed rule **Section 6.13.b**, which requires that a notice printed in bold-face type be included in any outline of coverage delivered when a policy is issued that differs from the outline of coverage delivered at the time of application. Section 5.2(b) of the existing Series 12 rule contains the same notice requirement as **Section 6.13.b** of this proposed replacement rule. The Commissioner believes that the alternative suggested by MSBCBS, delivery of a sample policy instead of a tentative outline of coverage at the time of application for insurance, would be even more confusing to the consumer due to the many terms of art and technical provisions contained in most insurance policies. Therefore, he declines to modify **Section 6.13** of this agency-approved rule.

Section 7.1 of this replacement rule relates to questions on

an individual health insurance policy application that are designed to elicit information on whether the policy applied for is intended to replace existing accident and sickness insurance. MSBCBS has commented that this section is unclear as to whether or not an insurer can refuse to accept an insured who carries another policy. This section is essentially the same as Section 6.1(a) of the existing Series 12 rule and Section 9A of the Model Regulation. It relates to replacement of existing policies and not duplication of policies. Therefore, the Commissioner declines to add language to this section relating to whether or not an insurer can refuse to accept an insured who carries another policy.



**Mountain State
Blue Cross Blue Shield**

700 Market Square
P.O. Box 1844
Parkersburg, West Virginia 26102

Local 304 / 404-7700
Toll Free 800 / 544-3514

Writer's Direct Dial Number

August 13, 1993

Linda Gay, Esquire
Associate Counsel
Offices of the Insurance Commissioner
2019 Washington Street, East
Charleston, West Virginia 25305-0540

RE: INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS

Dear Ms. Gay:

Please accept the following comments of Mountain State Blue Cross & Blue Shield, Inc., concerning the above entitled regulation:

- Section 1.2.g. As a matter of policy, governments should not impose requirements on private entities which it will not enforce against itself, particularly when the government is in direct competition with those private entities.
- Section 3.2. and
Section 3.2.a. The definition is unclear inasmuch as it uses the defined term in the definition itself.
- Section 3.4.d.A. It is unclear whether this section complies with the federal law allowing private insurers to exempt coverage for veterans for service related accidents, injuries or illnesses.
- Section 4.8. This section is overbroad and is an improper delegation of legislative authority.
- Section 5.1.f. The insurer should be able to cancel for non-payment of premium without having to continue to pay benefits beyond the period for which premiums have been paid. Furthermore, MSBCBS insures against the cost of health care not against the disease, injury, illness or condition itself. In addition, if the subscriber has moved out of area, payment of benefits may result in transacting the business of insurance in a state for which the insurer has no license.

- [Section 5.1.h Subdivision two should reference Internal Revenue Code dependency requirements.]
 Section 5.4.h. Subdivision two should reference Internal Revenue Code
- Section 5.2.b. The 80% requirement does not recognize the payment differentials normally associated with preferred provider organization (PPO) contracts. In addition, it reduces the insured's options to obtain lower premiums in return for higher co-payments. The provision would price some products out of the market. It would eliminate all of our managed care and PPO products. We limit a members out-of-pocket exposure by including stop-loss provisions.
- Section 5.2.d. This section does not take into consideration additional deductibles for failure to pre-certify admissions. Larger deductibles are also a means of reducing premiums. Individuals should be allowed to choose larger deductibles if they wish. Limiting the deductible options could result in members dropping coverage in lieu of paying higher premiums.
- Section 5.3.a.B. See our comments to Section 5.2.b.
- Section 5.3.b.A. See our comments to Section 5.2.b.
- Section 5.3.b.C. See our comments to Section 5.2.b.
- Section 5.5. See our comments to Section 5.2.b.
- Section 5.5.b. It is unclear what time period the \$4,500.00 maximum relates to: benefit period, hospital admission or calendar year.
- Section 5.5.c. The "reasonably related" language is unclear and vague.
- Section 5.5.f. There is no reference to what services can be excluded.
- Section 5.5.g. See our comments to Section 5.5.f.
- Section 6.2. Allowing subscribers to individually accept or deny benefits allows adverse selection. Insurers need to add or delete benefits to the entire risk pool as a whole in order to adequately distribute the risk. Apparently, however, if the insurer reserves the right to amend the policy at any time, this procedure need not be followed.
- Section 6.13. Statutory and regulatory requirement to provide an outline of coverage to subscribers prior to issue is confusing to subscribers inasmuch as the outlines do not exactly mirror the coverage contained in their policy or certificate. A better requirement would be to provide the subscriber with

a sample policy prior to issue.

Section 7.1

It is unclear whether or not an insurer can refuse to accept an insured who carries another policy.

I hope these comments will be helpful. Should you need to contact us concerning these comments, please do not hesitate to do so.

Sincerely,



Richard W. Adkins
Associate Corporate Counsel

RWA/kij

**TITLE 114
LEGISLATIVE RULES
INSURANCE COMMISSIONER**

**SERIES 12
INDIVIDUAL ACCIDENT AND SICKNESS
INSURANCE MINIMUM STANDARDS**

§114-12-1. General.

1.1. Scope. -- The purpose of this regulation is to implement the provisions of section one, article twenty-eight, chapter thirty-three, et seq. of the West Virginia Code (1931, as amended) to provide for reasonable standardization and simplification of terms and coverages of individual accident and sickness insurance policies and individual subscriber contracts of hospital, medical and dental service corporations in order to facilitate public understanding and comparison and to eliminate provisions contained in such policies and subscriber contracts which may be misleading or confusing in connection either with the purchase of such coverages or with the settlement of claims and to provide for full disclosure in the sale of such coverages. This regulation shall apply to all individual accident and sickness insurance policies and subscriber contracts of hospital, medical and dental service corporations delivered or issued for delivery in this State on and after the effective date hereof, except that it shall not apply to individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group insurance. The requirements contained in this regulation shall be in addition to any other applicable regulations previously adopted.

1.2. Authority. -- W. Va. Code §33-28-4, §33-28-5, §33-28-6 and §33-2-10

1.3. Filing Date. -- December 13, 1974

1.4. Effective Date. -- April 1, 1975

§114-12-2. Policy definitions.

2.1. General. -- Except as provided hereafter, no individual accident and sickness insurance policy or hospital, medical and dental service corporation subscriber contract delivered or issued for delivery in this State shall contain definitions respecting the matters set forth below unless such definitions comply with the requirements of this section.

2.2. One (1) period of confinement. -- Shall mean one or more separate, combined or successive periods of confinement in a hospital, due to the same or related causes, separated by an interval of not more than ninety (90) consecutive days between the end of one (1) such period and the beginning of the succeeding period.

2.3. 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 the term "Hospital" shall 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 (except an accredited institution for the treatment of chronic diseases) 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 (24) hour nursing service by or under the supervision of registered graduate professional nurses (R.N.'s).

(b) The definition of the term "Hospital" may state that such term shall not be inclusive of:

(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;

(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 rehabilitary care.

2.4. Convalescent nursing home, extended care facility or skilled nursing facility. -- May be defined in relation to its status, facilities and available services

(a) A definition of such home or facility shall 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 such approval, if so 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 (24) hours a day nursing service 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 such term shall not be inclusive of:

(1) Any home, facility or part thereof 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 aged or for the care and treatment of mental diseases or disorders or custodial or educational care.

2.5. Accident, accidental injury, accidental means. - The definition shall 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.

The definition shall not be more restrictive than

the following: Injury or injuries, for which benefits are provided, means accidental bodily injuries sustained by the insured person which are the direct cause, independently of disease, bodily infirmity or any other cause, of the loss and occur while the insurance is in force.

Such definition may provide that injuries shall not include injuries for which benefits are provided under any workers' compensation, employer's liability or similar law, motor vehicle no-fault plan, unless prohibited by law or injuries occurring while the insured person is engaged in any activity pertaining to any trade, business, employment or occupation for wage or profit.

2.6. Sickness. -- The definition of sickness shall not be more restrictive than the following: Sickness means sickness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness which anticipates the exclusion of coverage of preexisting conditions may not use the phrase "The Cause of Which Originates" or any similar phrase. Such definition may provide for a probationary period which will not exceed thirty (30) days from the effective date of the policy or the effective date of coverage. The definition may be further modified to exclude sickness or disease for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

2.7. Preexisting condition. -- Shall 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 five (5) 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 five (5) year period preceding the effective date of the policy.

2.8. Physician. -- May be defined by including words such as "Duly Qualified Physician" or "Duly Licensed Physician." The use of such terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when such services are within the scope of the providers licensed authority and are provided pursuant to applicable laws.

2.9. Nurse. -- The definition or description of

"Nurse" may be 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," or "Registered Nurse" are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualifies under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

2.10. Total disability. -- A general definition of total disability cannot be more restrictive than one requiring the insured to be totally disabled from engaging in any employment or occupation for which he is or becomes qualified by reason of education, training or experience and not in fact engaged in any employment or occupation for wage or profit.

(a) Total disability may be defined in relation to the inability of the insured to perform duties but shall not be based solely upon an insured's inability to:

(1) Perform "Any Occupation whatsoever," "Any Occupational Duty," or "Any and Every Duty of His Occupation"; or

(2) Engage in any training or rehabilitation program.

(b) An insurer may require that the insured be unable to perform substantially all of the material duties of his regular occupation or words of similar import and is not in fact so engaged. An insurer may require care by a physician (other than the insured or a member of the insured's immediate family).

2.11. Partial disability. -- May be defined in relation to the insured's inability to perform some part or 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.

2.12. Medicare. -- A definition of "Medicare" shall be included in any hospital, surgical or medical expense policy which relates its coverage to eligibility for Medicare or Medicare benefits. Medicare may be substantially 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 Laws 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.

2.13. Mental or nervous disorder. -- Shall be defined as neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

§114-12-3. Prohibited policy provisions.

(a) No policy shall utilize an initial premium which is less than a pro rata portion of the applicable annual premium.

(b) Except as provided in Subsection 2.6 of these rules, no policy shall contain a provision establishing a probationary or waiting period during which no coverage is provided under the policy except that a policy may contain a probationary or waiting period not to exceed ninety (90) days for coverage of specific illnesses or diseases. Accident policies shall not contain probationary or waiting periods.

(c) No policies or riders for additional coverage may be issued in lieu of a dividend unless an equivalent cash payment is offered to the policyholder as an alternative to such a dividend policy or rider.

(d) Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder 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. After date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured.

(e) A disability policy may contain a "Return Of Premium" or "Cash Value Benefit" so long as:

(1) Such 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

(2) The insurer demonstrates that the reserve basis for such policies is adequate. No other policy shall provide a return of premium or cash value benefit, except return of unearned premium upon ter-

mination or suspension of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies or experience rating refunds.

(f) Policies providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.

(g) The above enumeration of specifically prohibited policy provisions 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 regulation, which policy provisions are deemed by the Commissioner to be unjust, unreasonable or unfairly discriminatory either to the policyholder, subscriber, beneficiary or to any person insured under the policy

§114-12-4. Minimum standards for benefits.

4.1. General. -- The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. No individual policy of accident and sickness insurance or hospital, medical or dental service corporation subscriber contract shall 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 contracts 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 section nine, article six, chapter thirty-three of the West Virginia Code (1931, as amended). Nothing in this section shall preclude the issuance of any policy or contract combining two (2) or more categories or coverage set forth in West Virginia Code subdivisions (1) through (6), section five-a, article twenty-eight, chapter thirty-three.

4.2. General rules.

(a) The terms "Noncancelable," "Guaranteed Renewable," or "Noncancelable and Guaranteed Renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of Subdivisions (a) and (b) of Subsection 5.1 of this regulation.

(b) A "Guaranteed Renewable" or "Noncancelable 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) In a family policy covering both husband and wife, the age of the younger spouse must be used as the basis for meeting the age and durational requirements of the definitions of "Noncancelable" and "Guaranteed Renewable." However, this requirement shall 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 said definition.

(d) When accidental death and dismemberment coverage is part of the insurance coverage offered under the contract, such coverage shall provide an option to include all insureds under the contract and not just the principal insured.

(e) 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 such person on a pro rata basis.

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

(g) Policies providing convalescent or extended care benefits following hospitalization shall 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.

(h) Any policy which provides coverage of a dependent child shall not terminate coverage for such dependent child if upon attainment of any limiting age set forth in the policy such child is and continues to be both (1) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (2) chiefly dependent on the policyholder for support and maintenance. The policy may require that within thirty-one (31) days of the child's attainment of

the limiting age the insurer receive due proof of such incapacity in order for the insured to elect to continue the policy in force with respect to such child. As an alternative to this requirement, a separate converted policy may be issued to the child at the option of the insured.

(i) 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.

(j) 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, shall not require the loss to commence less than thirty (30) days after the date of accident, nor shall 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.

(k) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit exceeds the other benefits.

(l) Any accident only policy providing benefits which vary according to the type of accidental cause shall prominently set forth in the disclosure statement the circumstances under which benefits are payable which are less than the maximum amount payable under the policy.

(m) A policy designed solely to supplement Medicare Part A, shall include as a benefit the initial Part A Medicare deductible as established from time to time by the Social Security Administration.

(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.

4.3. Basic hospital expense coverage. — "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 one period of 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 (\$30.00) 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 (\$50.00) for hospital services rendered to an insured as an outpatient for any one accident or sickness.

Benefits provided under Subdivisions (a) and (b) above may be provided subject to a combined deductible amount not in excess of one hundred dollars (\$100).

4.4. Basic medical-surgical expense coverage. — "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 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 service rendered by a physician other than the physician (or his 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 serv-

ice benefit.

(c) In-hospital medical services, consisting of physician 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 (\$5.00) per call, one (1) call per day, for at least twenty-one (21) such calls during one period of confinement.

4.5. Hospital confinement indemnity coverage. -- "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 (\$30.00) per day and not less than thirty-one (31) days during any one (1) period of confinement for each person insured under the policy.

4.6. Major medical expense coverage. -- "Major Medical Expense Coverage" is an accident and sickness insurance 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; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of such basis not to exceed five percent (5%) of the aggregate maximum limit under the policy, unless the policy is written to complement underlying hospital and medical insurance in which case such deductible may be increased by the amount of the benefits provided by such underlying insurance, for each covered person for at least:

(a) Daily hospital room and board, as defined in Subdivision (a) of Subsection 4.3 of these rules;

(b) Miscellaneous hospital services, as defined in Subdivision (b) of Subsection 4.3 of these rules;

(c) Surgical services, as defined in Subdivision (a) of Subsection 4.4 of these rules;

(d) Anesthesia services, as defined in Subdivision (b) of Subsection 4.4 of these rules;

(e) In-hospital medical services, as defined in Subdivision (c) of Subsection 4.4 of these rules.

(f) Out of hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diag-

nosis 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.

4.7. Disability income protection coverage. -- "Disability Income Protection Coverage" is either an accident or sickness insurance policy or a combination thereof which:

(a) Provides for periodic payments in an amount of at least one hundred dollars (\$100) per month payable at issue ages up to sixty-two (62) and fifty dollars (\$50.00) per month payable at ages after sixty-two (62).

(b) Contains an elimination period no greater than:

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

(2) Three hundred sixty-five (365) days if the benefit is payable for not less than two (2) years and is payable in an amount of at least two hundred dollars (\$200) per month; or

(3) One hundred eighty (180) 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 disability period may be one (1) month. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period. This provision does not apply to those policies providing business buy out coverage.

4.8. Accident only coverage. -- "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).

4.9. Specified disease and specified accident coverage.

(a) "Specified Disease Coverage" is a policy which provides 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 no 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:

(1) Hospital room and board and any other hospital furnished medical services or supplies;

(2) Treatment by a legally qualified physician or surgeon;

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

(4) X ray, radium and other therapy procedures used in diagnosis and treatment;

(5) Professional ambulance for local service to or from a local hospital;

(6) Blood transfusions, including expense incurred for blood donors;

(7) Drugs and medicines prescribed by a physician;

(8) The rental of an iron lung or similar mechanical apparatus;

(9) Braces, crutches and wheel chairs as are deemed 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) May include coverage of any other expenses necessarily incurred in the treatment of the disease.

(b) "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 of no less than one thou-

sand dollars (\$1,000) for accidental death; one thousand dollars (\$1,000) for double dismemberment and five hundred dollars (\$500) for single dismemberment.

§114-12-5. Required disclosure provisions.

5.1. General rules.

(a) Each individual policy of accident and sickness insurance or hospital, medical or dental service corporation subscriber contract shall include a renewal, continuation or nonrenewal provision. The language or specifications of such provision must be consistent with the type of contract to be issued. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

(b) The terms "Noncancelable" or "Guaranteed Renewable" shall not be used without further explanatory language. The term "Noncancelable" shall not be used unless the insured has the right to continue the policy in force by the timely payment of premiums until age sixty-five (65) or to eligibility for Medicare, during which period the insurer may not unilaterally make any change in the policy provisions while the policy is in force. The insurer shall not reserve the right to change rates in connection with the term "Guaranteed Renewable" except on a class basis unless this limitation is clearly set forth on the first page of the policy and identified as a limitation of the term "Guaranteed Renewable." The insurer may include a policy provision for termination or nonrenewal of disability income policies prior to age sixty-five (65), subject to approval by the Commissioner, where

(1) The insured is receiving retirement income; and

(2) The insured is no longer subject to the risk of loss of income as a result of accident or sickness.

(c) Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

(d) 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 an explanation of such

terms within both the policy and its accompanying disclosure statement.

(e) Any provisions limiting or excluding coverage of preexisting conditions shall be labeled as such, shall appear in a separate paragraph on the first page of the policy, and shall be included in the disclosure statement.

(f) 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."

(g) All policies shall have a notice prominently displayed on the first page of the policy stating in substance that the policyholder shall have 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.

(h) If age is to be used as a factor in reducing the maximum aggregate benefits made available in the policy as originally issued, such fact must be prominently set forth in the disclosure statement.

(i) If a policy contains a conversion privilege, it shall comply, in substance, with the following: The caption of the provisions 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.

5.2. Disclosure requirements for individual coverages. -- No individual accident and sickness insurance policy or hospital, medical or dental service corporation subscriber contract shall be delivered or issued for delivery in this State unless an appropriate disclosure statement, as prescribed in Subdivisions (c) through (j) of this Subsection, is completed as to such policy or contract, and:

(a) In the case of a direct response insurance product is delivered with the policy; or

(b) In all other cases is delivered to the appli-

cant at the time application is made and acknowledgment of receipt or certification of delivery of such disclosure statement is provided to the insurer.

In the event that a policy or contract is issued on a basis other than that applied for, a disclosure statement properly describing the policy or contract must accompany the policy or contract when it is delivered and contain the following statement, in no less than twelve (12) point type, immediately above the company name: "NOTICE: Read this disclosure statement carefully. It is not identical to the disclosure statement provided upon application and the coverage originally applied for has not been issued."

The appropriate disclosure statement for policies or contracts providing hospital coverage which only meets the standards of Subsection 4.9 of these rules, shall be that statement contained in Subdivision (j) of these rules. The appropriate disclosure statement for policies providing coverage which meets the standards of both Subsections 4.3 and 4.4 of these rules shall be the statement contained in Subdivision (e) of these rules. The appropriate disclosure statement for policies providing coverage which meets the standards of both Subsections 4.3 and 4.6 or Subsections 4.4 and 4.6 or Subsections 4.3, 4.4 and 4.6 of these rules shall be the statement contained in Subdivision (g) of these rules.

Appropriate changes in terminology shall be made in disclosure statements in the case of contracts of hospital, medical or dental service corporations. In any other case where the prescribed disclosure statement is inappropriate for the coverage provided by the policy or contract, an alternate disclosure statement shall be submitted to the Commissioner for prior approval. Should the Commissioner deem it appropriate to approve policies or contracts containing less than the prescribed minimum standards for benefits as provided in Subsection 4.1 of these rules, the disclosure statement 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.

The disclosure statements required by this subsection shall be plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten (10) point with a lower-case unspaced alphabet length not less than one hundred twenty (120) point.

In the disclosure statement forms that follow, only

the material appearing in brackets is to be composed by the insurer in language appropriate for the coverage provided. All other material shall appear in exactly the form set forth in this regulation.

(c) Basic hospital expense coverage (disclosure statement). -- A disclosure statement, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection 4.3 of this regulation. The items included in the disclosure statement must appear in the sequence prescribed:

(Company Name) Basic Hospital Expense Coverage - Required Disclosure Statement

(1) Read your policy carefully. -- This disclosure statement provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you Read Your Policy Carefully!

(2) Basic hospital expense coverage. -- Policies of this category are designed to provide, to persons insured, coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services and hospital outpatient services, subject to any limitations set forth in the policy. Coverage is not provided for physicians or surgeons fees or unlimited hospital expenses. (Note: Final sentence may be appropriately modified, if necessary, to reflect coverage provided).

(3) (A brief specific description of the benefits contained in this policy, in the following order:

- (a) Daily hospital room and board;
- (b) Miscellaneous hospital services;
- (c) Hospital outpatient services; and
- (d) Other benefits, if any.

Note: The above description of benefits shall be stated clearly and concisely and shall include a description of any deductible or copayment provision applicable to the benefits described.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify pay-

ment of the benefits described in Subdivision (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(d) Basic medical-surgical expense coverage (disclosure statement). -- A disclosure statement, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection 4.4 of this regulation. The items included in the disclosure statement must appear in the sequence prescribed:

(Company Name) Basic Medical-Surgical Expense Coverage Required Disclosure Statement

(1) Read your policy carefully. -- This disclosure statement provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you Read Your Policy Carefully!

(2) Basic medical-surgical expense coverage. -- Policies of this category are designed to provide, to persons insured, coverage for medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services and in-hospital medical services, subject to any limitations set forth in the policy. Coverage is not provided for hospital expenses or unlimited medical-surgical expenses. (Note: Final sentence may be appropriately modified, if necessary, to reflect coverage provided.)

(3) (A brief specific description of the benefits contained in this policy, in the following order:

- (a) Surgical services;
- (b) Anesthesia services;
- (c) In-hospital medical services; and
- (d) Other benefits, if any.

Note: The above description of benefits shall be stated clearly and concisely and shall include a description of any deductible or copayment provision applicable to the benefits described.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Subdivision (3) above.)

(5) (A description of policy provisions respecting renewability or continuation coverage, including age restrictions or any reservation of right to change premiums.)

(e) Basic hospital and medical-surgical expense coverage (disclosure statement). -- A disclosure statement, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsections 4.3 and 4.4 of this regulation. The items included in the disclosure statement must appear in the sequence prescribed.

(Company Name)

Basic Hospital And Medical-Surgical
Expense Coverage Required Disclosure
Statement

(1) Read your policy carefully. -- This disclosure statement provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you Read Your Policy Carefully!

(2) Basic hospital and medical-surgical expense coverage. -- Policies of this category are designed to provide, to persons insured, coverage for hospital and medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital outpatient services, surgical services, anesthesia services and in-hospital medical services, subject to any limitations set forth in the policy. Coverage is not provided for unlimited hospital or medical-surgical expenses. (Note: Final sentence may be appropriately modified, if necessary, to reflect coverage provided.)

(3) (A brief specific description of the benefits contained in this policy, in the following order:

- (a) Daily hospital room and board;
- (b) Miscellaneous hospital services;
- (c) Hospital outpatient services;

(d) Surgical services;

(e) Anesthesia services;

(f) In-hospital medical services; and

(g) Other benefits, if any.

Note: The above description of benefits shall be stated clearly and concisely and shall include a description of any deductible or copayment provision applicable to the benefits described.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Subdivision (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums)

(f) Hospital confinement indemnity coverage (disclosure statement). -- A disclosure statement, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection 4.5 of this regulation. The items included in the disclosure statement must appear in the sequence prescribed:

(Company Name)

Hospital Confinement Indemnity
Coverage Required Disclosure
Statement

(1) Read your policy carefully. -- This disclosure statement provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you Read Your Policy Carefully!

(2) Hospital confinement indemnity coverage. -- Policies of this category are designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Such policies do not provide any benefits other than the fixed daily indemnity for hospital confinement. (Note: Final sentence may be appropriately modified, if necessary, to reflect coverage provided.)

(3) (A brief specific description of the benefits contained in this policy, in the following order:

(a) Daily benefit payable during hospital confinement; and

(b) Duration of benefit described in Subdivision (a) above.

Note: The above description of benefits shall be stated clearly and concisely and shall include a description of any deductible or copayment provision applicable to the benefits described.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Subdivision (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(g) Major medical expense coverage (disclosure statement). -- A disclosure statement, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection 4.6 of this regulation. The items included in the disclosure statement must appear in the sequence prescribed:

(Company Name)
Major Medical Expense Coverage
Required Disclosure Statement

(1) Read your policy carefully. -- This disclosure statement provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you read your policy carefully!

(2) Major medical expense coverage. -- Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, out of hospital care and prosthetic appliances, subject to any deductibles, copayment provisions or other limitations which may be set forth in

the policy. Basic hospital or basic medical insurance coverage is not provided. (Note: Final sentence may be appropriately modified, if necessary, to reflect coverage provided.)

3) (A brief specific description of the benefits contained in this policy, in the following order:

(a) Daily hospital room and board;

(b) Miscellaneous hospital services;

(c) Surgical services;

(d) Anesthesia services;

(e) In-hospital medical services;

(f) Out of hospital care;

(g) Prosthetic appliances; and

(h) Other benefits, if any.

Note: The above description of benefits shall be stated clearly and concisely and shall include a description of any deductible or copayment provision applicable to the benefits described.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Subdivision (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(h) Disability income protection coverage (disclosure statement). -- A disclosure statement, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection 4.7 of this regulation. The items included in the disclosure statement must appear in the sequence prescribed:

(Company Name)
Disability Income Protection Coverage
Required Disclosure Statement

(1) Read your policy carefully. -- This disclosure statement provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provi-

sions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you Read Your Policy Carefully!

(2) Disability income protection coverage. -- Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic medical-surgical or major-medical expenses. (Note: Final sentence may be appropriately modified, if necessary, to reflect coverage provided.)

(3) (A brief specific description of the benefits contained in this policy:

Note: The above description of benefits shall be stated clearly and concisely and shall include a description of any deductible or copayment provision applicable to the benefits described.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Subdivision (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(i) Accident only coverage (disclosure statement). -- A disclosure statement, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection 4.8 of this regulation. The items included in the disclosure statement must appear in the sequence prescribed:

(Company Name)
 Accident Only Coverage
 Required Disclosure Statement

(1) Read your policy carefully. -- This disclosure statement provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you Read Your Policy Carefully!

(2) Accident only coverage. -- Policies of this

category are designed to provide, to persons insured, coverage for certain losses resulting from a covered accident only, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical or major-medical expenses. (Note: Final sentence may be appropriately modified, if necessary, to reflect coverage provided.)

(3) (A brief specific description of the benefits contained in this policy:

Note: The above description of benefits shall be stated clearly and concisely and shall include a description of any deductible or copayment provision applicable to the benefits described.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Subdivision (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(j) Specified disease or specified accident coverage (disclosure statement). -- A disclosure statement, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection 4.9 of this regulation. The coverage shall be identified by the appropriate bracketed title. The items included in the disclosure statement must appear in the sequence prescribed:

(Company Name)
 (Specified Disease) (Specified Accident)
 Coverage Required Disclosure
 Statement

(1) Read your policy carefully. -- This disclosure statement provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you Read Your Policy Carefully!

(2) (Specified disease) (specified accident) coverage. -- Policies of this category are designed to provide, to persons insured, coverage paying benefits only when certain losses occur as a result of (specified diseases) or (specified accidents). Coverage is not provided for basic hospital, basic medical-surgical or

major medical expenses. (Note: Final sentence may be appropriately modified, if necessary, to reflect coverage provided.)

(3) (A brief specific description of the benefits contained in this policy:

Note: The description of benefits shall be stated clearly and concisely and shall include a description of any deductible or copayment provisions applicable to the benefits described.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Subdivision (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

§114-12-6. Requirements for replacement.

6.1. Requirements for replacement.

(a) Application forms shall include a question designed to elicit information as to whether the insurance 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.

(b) Upon determining that a sale will involve replacement, the agent or insurer shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in Subdivision (c) below. One (1) copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer.

(c) The notice required by Subdivision (b) above shall be as follows:

**Notice To Applicant Regarding Replacement
Of Accident And Sickness Insurance**

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by _____ (Company Name)

_____ Insurance Company. For your own information and protection, you should be aware of and seriously consider certain fac-

tors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is to your advantage to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded. (Note: Final sentence may, for direct response insurers, be changed to read as follows: "Carefully reread your application, as attached to the policy issued, to be certain that all information has been properly recorded.")

The above "Notice to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)

§114-12-7. Recurrent conditions.

7.1. Recurrent conditions. -- A policy may contain a provision relating to recurrent disabilities: Provided, however, That no such provision shall specify that a recurrent disability be separated by a period greater than six (6) months.

§114-12-8. Separability.

8.1. Partial invalidity. -- If any provision of this regulation or the application thereof to any person or

circumstance is for any reason held to be invalid, the remainder of the regulation and the application of

such provision to other persons or circumstances shall not be affected thereby.

Insurance Commissioner
Legislative Rule
Title 114, Series 12

**INDIVIDUAL ACCIDENT AND SICKNESS
INSURANCE MINIMUM STANDARDS**

Title 114, Series 12

**BRIEF SUMMARY OF RULE TO BE REPEALED
AND REPLACED BY THIS AGENCY-APPROVED RULE**

The Insurance Commissioner's existing legislative rule entitled "Individual Accident and Sickness Insurance Minimum Standards" (Title 114, Series 12) took effect April 1, 1975. That rule provides for standardization and simplification of terms and coverages in individual accident and sickness insurance policies, and individual subscriber contracts of hospital, medical and dental service corporations. The rule sets forth definitions allowed in such individual health insurance policies and subscriber contracts, prohibits the use of certain policy and contract provisions, establishes minimum insurance benefits, requires inclusion of specified disclosure provisions, establishes requirements for the replacement of such individual policies and contracts, and permits the use therein of recurrent conditions provisions that do not specify a separation of recurrent disabilities by a period greater than six months.

MODEL REGULATION TO IMPLEMENT THE INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS ACT

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Section 1. Purpose

The purpose of this regulation is to implement [cite section of law which sets forth the NAIC Individual Accident and Sickness Insurance Minimum Standards Act] so as to provide reasonable standardization and simplification of terms and coverages of individual accident and sickness insurance policies and individual subscriber contracts of hospital, medical and dental service corporations in order to facilitate public understanding and comparison and to eliminate provisions contained in individual accident and sickness insurance policies and individual subscriber contracts of hospital, medical and dental service corporations which may be misleading or confusing in connection either with the purchase of such coverages or with the settlement of claims, and to provide for full disclosure in the sale of such coverages.

Section 2. Authority

This regulation is issued pursuant to the authority vested in the commissioner under [cite appropriate section of law enacting NAIC Individual Accident and Sickness Insurance Minimum Standards Act and any other appropriate section of law regarding authority of commissioner to issue or promulgate rules and regulations].

Section 3. Applicability and Scope

This regulation shall apply to all individual accident and sickness insurance policies and subscriber contracts of hospital, medical and dental service corporations delivered or issued for delivery in this state on and after the effective date hereof, except it shall 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 such group or individual policy or contract includes provisions which are inconsistent with the requirements of this regulation;
- B. Policies being issued to employees or members as additions to franchise plans in existence on the effective date of this regulation;
- C. Medicare supplement policies subject to [cite rule implementing the Medicare Supplement Insurance Minimum Standards Regulation];
- D. Long-term care insurance policies subject to [cite rule implementing the Long-Term Care Insurance Act].

The requirements contained in this regulation shall be in addition to any other applicable regulations previously adopted.

Section 4. Effective Date

This regulation shall be effective on [insert a date not less than 120 days after the date of adoption or promulgation of the regulation] and shall be applicable to all individual accident and sickness insurance policies and nonprofit hospital, medical and dental service contracts delivered or issued for delivery in this state on and after such date which are not specifically exempt from this regulation.

Section 5. Policy Definitions

Except as provided hereafter, no individual accident or sickness insurance policy or hospital, medical or dental service corporation subscriber contract delivered or issued for delivery to any person in this state and to which this regulation applies shall contain definitions respecting the matters set forth below unless such definitions comply with the requirements of this section.

- A. "One 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 occurs 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 180 days.
- B. "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.
 - (1) The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:
 - (a) Be an institution operated pursuant to law; and
 - (b) 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
 - (c) Provide twenty-four-hour nursing service by or under the supervision of registered graduate professional nurses (R.N.s).
 - (2) The definition of the term "hospital" may state that such term shall not be inclusive of:
 - (a) Convalescent homes, convalescent, rest, or nursing facilities; or
 - (b) Facilities primarily affording custodial, educational or rehabilitory care; or
 - (c) Facilities for the aged, drug addicts or alcoholics; or
 - (d) 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 such services.

Drafting Note: The laws of the several states relating to the type of hospital facilities recognized in health insurance policies are not uniform. References to individual state law may be required in structuring this definition of this regulation.

C. "Convalescent Nursing Home," "Extended Care Facility," or "Skilled Nursing Facility" shall be defined in relation to its status, facilities, and available services.

- (1) A definition of such home or facility shall not be more restrictive than one requiring that it:
 - (a) Be operated pursuant to law;
 - (b) Be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;
 - (c) Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;
 - (d) Provide continuous twenty-four-hour-a-day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and
 - (e) Maintains a daily medical record of each patient.
- (2) The definition of such home or facility may provide that such term shall not be inclusive of:
 - (a) Any home, facility or part thereof used primarily for rest;
 - (b) A home or facility for the aged or for the care of drug addicts or alcoholics; or
 - (c) A home or facility primarily used for the care and treatment of mental diseases, or disorders, or custodial or educational care.

Drafting Note: The laws of the several states relating to nursing and extended care facilities recognized in health insurance policies are not uniform. Reference to the individual state law may be required in structuring this definition of this regulation.

D. "Accident," "Accidental Injury," "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.

The definition shall 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 are the direct cause, independent of disease or bodily infirmity or any other cause and occur while the insurance is in force.

Such definition may provide that injuries shall not include injuries for which benefits are provided under workmen's compensation, employer's liability or similar law, motor vehicle no-fault plan, unless prohibited by law, or injuries occurring while the insured person is engaged in any activity pertaining to any trade, business, employment, or occupation for wage or profit.

E. "Sickness" shall not be defined to be more restrictive than the following: Sickness means sickness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period which will not exceed thirty (30) days from the effective date of the coverage of the insured person. The definition may be further modified to exclude sickness or disease for which benefits are provided under any workman's compensation, occupational disease, employer's liability or similar law.

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- F. "Preexisting condition" shall 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 five (5) year period preceding the effective date of the coverage of the insured person or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a five (5) year period preceding the effective date of the coverage of the insured person.

Drafting Note: This definition does not prohibit an insurer, using an application form designed to elicit the complete health history of a prospective insured and on the basis of the answers on that application, from underwriting in accordance with that insurer's established standards. It is assumed that an insurer that elicits a complete health history of a prospective insured will act on the information and if the review of the health history results in a decision to exclude a condition, the policy will be endorsed or amended by including the specific exclusion. This same requirement of notice to the prospective insured of the specific exclusion will also apply to insurers which elect to use simplified application forms containing questions relating to the prospective insured's health.

This definition does, however, prohibit an insurer that elects to use a simplified application, with or without a question as to the applicant's health at the time of application, from reducing or denying a claim on the basis of the existence of a preexisting condition that is defined more restrictively than above.

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

Note: The laws of the several states relating to the type of practitioners services recognized in health insurance policies are not uniform. References to the individual state law may be required in structuring this definition of this regulation.

- H. "Nurses" 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" or "registered nurse" are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualifies under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

I. "Total Disability"

- (1) A general definition of total disability cannot be more restrictive than one requiring that the individual who is totally disabled not be engaged in any employment or occupation for which he is or becomes qualified by reason of education, training or experience; and not in fact engaged in any employment or occupation for wage or profit.
- (2) 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:
 - (a) Perform "any occupation whatsoever," "any occupational duty," or "any and every duty of his occupation," or
 - (b) Engage in any training or rehabilitation program.
- (3) An insurer may specify the requirement of the complete inability of the person to perform all of the substantial and material duties of his 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).

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- J. "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 elimination period may be required.
- K. "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 must 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 other term of similar import which in the opinion of the commissioner adequately and fairly describes the benefit.
- L. "Medicare" shall be substantially 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 Laws 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.
- M. "Mental or Nervous Disorder" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychosis, or mental or emotional disease or disorder of any kind.

Section 6. Prohibited Policy Provisions

- A. Except as provided in Section 5E, no policy shall contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy, subject to the further exception that a policy may specify a probationary or waiting period not to exceed six (6) months for specified diseases or conditions and losses resulting therefrom for hernia, disorder of reproduction organs, varicose veins, adenoids, appendix and tonsils. However, the permissible six (6) months exception shall not be applicable where such specified diseases or conditions are treated on an emergency basis. Accident policies shall not contain probationary or waiting periods.

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

The initial renewal subsequent to the issuance of any policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that such renewal is optional with the policyholder.

- C. No policy shall exclude coverage for a loss due to a preexisting condition for a period greater than twelve (12) months following policy issue where the application for such insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and such preexisting condition is not specifically excluded by the terms of the policy.

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Drafting Note: Where the jurisdiction has enacted the 1973 NAIC Individual Accident and Sickness Insurance Minimum Standard Act this provision is unnecessary.

- D. A disability income policy may contain a "return of premium" or "cash value benefit" so long as: (1) such 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 (2) the insurer demonstrates that the reserve basis for such policies is adequate. No other policy shall provide a return of premium or cash value benefit, except return of unearned premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds.

Drafting Note: This provision is optional and the desirability of its use should be reviewed by the individual states.

- E. Policies providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.

- F. No policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:

- (1) Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;
- (2) Mental or emotional disorders, alcoholism and drug addiction;
- (3) Pregnancy, except for complications of pregnancy, other than for policies defined in Section 7F of this regulation;
- (4) Illness, treatment or medical condition arising out of:
 - (i) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary thereto,
 - (ii) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury,
 - (iii) Aviation,
 - (iv) With respect to short-term nonrenewable policies, interscholastic sports;
- (5) Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect;
- (6) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;
- (7) Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;

Editor's Note: When adopting this model, states should examine any existing "freedom of choice" statutes which require reimbursement of treatment provided by chiropractors, and make adjustments if needed.

- (8) Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any state or federal workmen's com-

pensation, employers liability or occupational disease law, or any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family; and services for which no charge is normally made in the absence of insurance.

- (9) Dental care or treatment;
- (10) Eye glasses, hearing aids and examination for the prescription or fitting thereof;
- (11) Rest cures, custodial care, transportation and routine physical examinations;
- (12) Territorial limitations.

Drafting Note: Some of the exclusions set forth in this provision may be unnecessary or in conflict with existing state legislation and, thus, should be deleted.

- G. This regulation shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical condition or extra hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required unless on initial issuance the full text of the waiver is contained either on the first page or specification page.
- H. Policy provisions precluded in this section shall not be construed as a limitation on the authority of the commissioner to disapprove other policy provisions in accordance with [cite Section 3B of the Individual Accident and Sickness Insurance Minimum Standards Act] which in the opinion of the commissioner are unjust, unfair, or unfairly discriminatory to the policyholders, beneficiary or any person insured under the policy.

Section 7. Accident and Sickness Minimum Standards for Benefits

The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. No individual policy of accident and sickness insurance or nonprofit hospital, medical or dental service corporation contract shall 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 such policies or contracts are approvable as limited benefit health insurance and the outline of coverage complies with the appropriate outline in Section 8L of this regulation.

Nothing in this section shall preclude the issuance of any policy or contract combining two or more categories set forth in [cite Section 4A and B of the Model Act].

A. General Rules

- (1) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" policy shall 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.
- (2) The terms "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of Section 8A(1). The terms "noncancellable" or "noncancellable and guaranteed renewable" may be used only in a policy which the insured

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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: Provided however, any accident and health or accident-only policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age sixty (60) if, at age sixty (60), the insured has the right to continue the policy in force at least to age sixty-five (65) while actively or regularly employed. Except as provided above, 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: Provided however, any accident and health or accident-only policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age sixty (60) if, at age sixty (60), the insured has the right to continue the policy in force at least to age sixty-five (65) while actively and regularly employed.

- (3) In a family policy covering both husband and wife the age of the younger spouse must be used as the basis for meeting the age and durational requirements of the definitions of "noncancellable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age limit (e.g., age 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 said definition.
- (4) When accidental death and dismemberment coverage is part of the insurance coverage offered under the contract, the insured shall have the option to include all insureds under such coverage and not just the principal insured.
- (5) If a policy contains a status-type military service exclusion or a provision which suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to such person on a pro rata basis.
- (6) 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.
- (7) Policies providing convalescent or extended care benefits following hospitalization shall 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.
- (8) Family coverage shall continue for any dependent child who is incapable of self-sustaining employment due to mental retardation or physical handicap on the date that such child's coverage would otherwise terminate under the policy due to the attainment of a specified age limit for children and is chiefly dependent on the insured for support and maintenance. The policy may require that within thirty-one (31) days of such date the company receive due proof of such incapacity in order for the insured to elect to continue the policy in force with respect to such child, or that a separate converted policy be issued at the option of the insured or policyholder.

- (9) Any policy providing coverage for the recipient in a transplant operation shall also provide 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.
- (10) A policy may contain a provision relating to recurrent disabilities; provided however, that no such provision shall specify that a recurrent disability be separated by a period greater than six (6) months.
- (11) 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, shall not require the loss to commence less than thirty (30) days after the date of accident, nor shall 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.
- (12) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.
- (13) 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 lesser than the maximum amount payable under the policy.
- (14) Termination of the policy shall be without prejudice ~~of~~ 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 total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

B. Basic Hospital Expense Coverage

"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 expense incurred for necessary treatment and services rendered as a result of accident or sickness for at least the following:

- (1) Daily hospital room and board in an amount not less than the lesser of (a) [80%] of the charges for semiprivate room accommodations or (b) [\$30] per day;

Drafting Note: The material in brackets is variable so that a commissioner may determine the level of daily room and board benefits which he considers appropriate as a minimum for a basic hospital contract in his state. It should be an underlying principle for the establishment of any such benefits that the amounts are to be minimums, not maximums. In order to accommodate those states which have a substantial differential in hospital room and board costs between urban and rural areas within a state, the following language may be used in addition to the language in B(1) above: "except that \$[insert amount] may be reduced to \$[insert amount] outside the area." Other dollar amounts and percentage applicable to the various minimum benefits which follow are also bracketed to permit a commissioner to set the level of minimum benefits for his particular state.

- (2) Miscellaneous hospital services 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 any one period of confinement in an amount not less than either [80%] of the charges incurred up to at least [\$1,000] or [ten times] the daily hospital room and board benefits; and

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- (3) Hospital outpatient services consisting of (a) hospital services on the day surgery is performed, (b) hospital services rendered within seventy-two (72) hours after accidental injury, in an amount not less than [\$50], and (c) X-ray and laboratory tests to the extent that benefits for such services would have been provided to an extent of less than [\$100] if rendered to an in-patient of the hospital.
- (4) Benefits provided under (1) and (2) of (B) above, may be provided subject to a combined deductible amount not in excess of [\$100].

C. Basic Medical-Surgical Expense Coverage

"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:

- (1) Surgical services:
 - (a) In amounts not less than those provided on a fee schedule based on the relative values contained in the State of New York Certified Surgical Fee Schedule, or the 1964 California Relative Value Schedule or other acceptable relative value scale of surgical procedures, up to a maximum of at least [\$500] for any one procedure; or
 - (b) Not less than [80%] of the reasonable charges.
- (2) Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician (or his assistant) performing the surgical services:
 - (a) In an amount not less than [80%] of the reasonable charges; or
 - (b) [15%] of the surgical service benefit.
- (3) In-hospital medical services, consisting of physician 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 [80%] of the reasonable charges; or [\$5] per day for not less than twenty-one (21) days during one period of confinement.

D. Hospital Confinement Indemnity Coverage

"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 [\$20] per day and not less than thirty-one (31) days during any one period of confinement for each person insured under the policy.

E. Major Medical Expense Coverage

"Major medical expense coverage" is an accident and sickness insurance policy which provide hospital, medical and surgical expense coverage, to an aggregate maximum of not less than [\$10,000]; copayment by the covered person not to exceed twenty-five percent (25%) of covered charges; 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 percent (5%) of the aggregate maximum limit under the policy, unless the policy is written to

complement underlying hospital and medical insurance in which case such deductible may be increased by the amount of the benefits provided by such underlying insurance, for each covered person for at least:

- (1) Daily hospital room and board expenses, prior to application of the copayment percentage, for not less than [\$50] daily (or in lieu thereof the average daily cost of the semiprivate room rate in the area where the insured resides) for a period of not less than thirty-one (31) days during continuous hospital confinement;
- (2) Miscellaneous hospital services, prior to application of the copayment percentage, for an aggregate maximum of not less than [\$4,500] or [15] times the daily room and board rate if specified in dollar amounts;
- (3) Surgical services, prior to application of the copayment percentage to a maximum of not less than [\$600] for the most severe operation with the amounts provided for other operations reasonably related to such maximum amount;
- (4) Anesthesia services prior to application of the copayment percentage, for a maximum of not less than [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;
- (5) In-hospital medical services, prior to application of the co-payment percentage, as defined in Section 7C(3);
- (6) Out-of-hospital care prior to application of the copayment percentage, 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 ordered by a physician; and
- (7) Not fewer than three of the following additional benefits, prior to application of the copayment percentage, for an aggregate maximum of such covered charges of not less than [\$1,000]:
 - (a) In-hospital private duty graduate registered nurse services;
 - (b) Convalescent nursing home care;
 - (c) Diagnosis and treatment by a radiologist or physiotherapist;
 - (d) Rental of special medical equipment, as defined by the insurer in the policy;
 - (e) Artificial limbs or eyes, casts, splints, trusses or braces;
 - (f) Treatment for functional nervous disorders, and mental and emotional disorders;
or
 - (g) Out-of-hospital prescription drugs and medications.

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F. Disability Income Protection Coverage

"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 which:

- (1) 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 sixty-two.
- (2) Contains an elimination period no greater than:
 - (a) Ninety (90) days in the case of a coverage providing a benefit of one (1) year or less;
 - (b) One hundred and eighty (180) days in the case of coverage providing a benefit of more than one year but not greater than two (2) years, or
 - (c) Three hundred sixty five (365) days in all other cases during the continuance of disability resulting from sickness or injury.
- (3) 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 such disability may be one (1) month. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period. Section 7F does not apply to those policies providing business buy-out coverage.

G. Accident Only Coverage

"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 [\$1,000] and a single dismemberment amount shall be at least [\$500].

H. Specified Disease and Specified Accident Coverage

- (1) "Specified disease coverage" pays benefits for the diagnosis and treatment of a specifically named disease or diseases. Any such policy must 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)—must meet the standards of Subparagraph (c), (d), or (e); insurance covering specified disease(s) other than cancer must meet the standards of Subparagraph (b) or (e).

(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 rules shall apply to specified disease coverages in addition to all other rules imposed by this regulation; in cases of conflict between the following and other rules, the following ones shall govern:

- (i) 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.
- (ii) Any policy issued pursuant to this section which conditions payment upon pathological diagnosis of a covered disease, shall also provide that if such a pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted in lieu thereof.
- (iii) Notwithstanding any other provision of this regulation, specified disease policies shall provide benefits to any covered person not only for the specified disease(s) but also for any other condition(s) or disease(s), directly caused or aggravated by the specified disease(s) or the treatment of the specified disease(s).
- (iv) Policies containing specified disease coverage shall be at least Guaranteed Renewable.
- (v) No policy issued pursuant to this section shall contain a waiting or probationary period greater than thirty (30) days.
- (vi) 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 (Medicaid, MediCal or any similar name). Such statement may be combined with any other statement for which the insurer may require the applicant's signature.
- (vii) Payments may be conditioned upon a covered person's receiving medically necessary care, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment.
- (viii) 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 individual health insurance.

Drafting Note: Specified disease coverage is recognized as supplemental coverage. Any specified disease coverage, therefore, must be payable in addition to and regardless of other individual coverage. The same general rule should apply so that group insurance cannot reduce its benefits because of the existence of an individual specified disease policy. Section 3F of the Group Coordination of Benefits Model Regulation states that the definition of a "plan" (for the purpose of COB) "shall not include individual or family insurance contracts..." It is recommended that states use this language to prevent benefit reductions that could otherwise occur because of the existence of an individual specified disease policy purchased by the insured.

- (ix) 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 such care or confinement is for a covered disease even though the diagnosis is made at some later date. The retroactive application of such coverage may not be less than ninety (90) days prior to such diagnosis.
- (b) The following minimum benefits standards apply to noncancer coverages:
- (i) Coverage for each person insured under the policy for a specifically named disease (or diseases) with a deductible amount not in excess of [\$250] and an overall aggregate benefit limit of no less than [\$5,000] and a benefit period of not less than [two (2) years] for at least the following incurred expenses.

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- (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 expense incurred for blood donors;
 - (G) Drugs and medicines prescribed by a physician;
 - (H) The rental of an iron lung or similar mechanical apparatus;
 - (I) Brace, crutches and wheel chairs as are deemed 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) May include coverage of any other expenses necessarily incurred in the treatment of the disease.
- (ii) 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 [\$25,000] payable at the rate of not less than [\$50] a day while confined in a hospital and a benefit period of not less than 300 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 [\$250], and an overall aggregate benefit limit of not less than [\$10,000] and a benefit period of not less than three (3) years for at least the following:
- (i) Treatment by, or under the direction of, a legally qualified physician or surgeon;
 - (ii) X-ray, radium chemotherapy and other therapy procedures used in diagnosis and treatment;
 - (iii) Hospital room and board and any other hospital furnished medical services or supplies;
 - (iv) Blood transfusions, and the administration thereof, including expense incurred for blood donors;

- (v) Drugs and medicines prescribed by a physician;
- (vi) Professional ambulance for local service to or from a local hospital;
- (vii) Private duty services of a registered nurse (R.N.) provided in a hospital;
- (viii) May include coverage of any other expenses necessarily incurred in the treatment of the disease; provided however, that Items (i), (ii), (iv), (v) and (vii) 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;
- (ix) Braces, crutches and wheelchairs as are deemed necessary by the attending physician for the treatment of the disease;
- (x) Emergency transportation if in the opinion of the attending physician in its necessary to transport the insured to another locality for treatment of the disease; and
- (xi) 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 treatment must be prescribed in writing by the covered person's attending physician, who must approve the program prior to its start. The physician must certify that hospital confinement would be otherwise required. A "home health care agency" is (1) an agency approved under Title XVIII of the Social Security Act (Medicare), or (2) is licensed to provide home health care under applicable state law, or (3) meets all of the following requirements:
 - (A) It is primarily engaged in providing home health care services;
 - (B) Its policies are established by a group of professional personnel (including at least one physician and one registered nurse (R.N.));
 - (C) Supervision of home health care services is provided by a physician or a registered nurse (R.N.);
 - (D) It maintains clinical records on all patients; and
 - (E) It has a full time administrator.

Drafting Note: State licensing laws vary concerning the scope of "home health care" or "home health agency services" and should be consulted. In addition, a few states have mandated benefits for home health care including the definition of required services.

Home health includes, but is not limited to:

- (A) Part-time or intermittent skilled nursing services provided by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.);
- (B) Part-time or intermittent home health aide services which provide supportive services in the home under the supervision of a registered nurse or a physical, speech or hearing occupational therapists;
- (C) Physical, occupational or speech and hearing therapy; and

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- (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 have been covered under the policy if the insured person had remained in the hospital.
 - (xii) Physical, speech, hearing and occupational therapy;
 - (xiii) Special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, chux, oxygen, surgical dressings, rubber shields, colostomy and ileostomy appliances;
 - (xiv) Prosthetic devices including wigs and artificial breasts;
 - (xv) 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 must offer covered persons:
- (i) A fixed-sum payment of at least [\$100] for each day of hospital confinement for at least [365] days.
 - (ii) A fixed-sum payment equal to one half the hospital inpatient benefit for each day of hospital or nonhospital outpatient surgery, chemo- and radiation therapy, for at least 365 days of treatment.

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 must equal the following:

- (iii) A fixed-sum payment equal to one-fourth the hospital in-patient benefit for each day of skilled nursing home confinement for at least 100 days.
 - (iv) A fixed-sum payment equal to one-fourth the hospital inpatient benefit for each day of home health care for at least 100 days.
 - (v) 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 such covered disease.
 - (vi) Notwithstanding any other provision of this regulation, any restriction or limitation applied to the benefits in (d) (iii) and (d) (iv), 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):
- (i) Such coverages must pay indemnity benefits on behalf of covered persons of a specifically named disease or diseases. Such 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 \$1,000.

Drafting Note: Policies that offer extremely high dollar benefits may induce fraud and concealment on the part of applicants for coverage. Commissioners should be sensitive to this possibility in approving policies.

- (ii) Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, the same dollar amounts must 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.

Drafting Note: The purpose of requiring equal coverage for all subtypes of a specified disease is to ensure that specified disease policies actually provide what people reasonable expect them to. In approving skin cancer or other exceptions, commissioners should consider whether a specified disease policy might mislead if it treats a subtype of a disease differently from the rest of the specified disease.

- (2) "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 [\$1,000] for accidental death, [\$1,000] for double dismemberment [\$500] for single dismemberment.

I. Limited Benefit Insurance Coverage

"Limited Benefit Health Insurance Coverage" is any policy or contract, other than a policy or contract covering only a specified disease or diseases, which provides benefits that are less than the minimum standards for benefits required under Section 7B, C, D, E, G, and H. A policy covering a single specified disease or combination of diseases shall meet the requirements of Section 7H and shall not be offered for sale as a "Limited Coverage." Such policies or contracts may be delivered or issued for delivery in this state only if the outline of coverage required by Section 8H of this regulation is completed and delivered as required by Section 8B of this regulation. This subsection does not apply to policies designed to provide coverage for long-term care or Medicare supplements, as defined in [cite provisions of Long-Term Care Act and Medicare Supplement Insurance Minimum Standards Act].

Section 8. Required Disclosure Provisions

A. General Rules

- (1) Each individual policy of accident and sickness insurance or hospital, medical or dental service corporation subscriber contract shall include a renewal, continuation or nonrenewal provision. The language or specification of such provision must be consistent with the type of contract to be issued. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.
- (2) Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder 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. After date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage is required by law.

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- (3) Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.
- (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 and an explanation of such terms in its accompanying outline of coverage.
- (5) If a policy contains any limitations with respect to preexisting conditions, such limitations must appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."
- (6) All accident-only policies shall contain a prominent statement 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:

"This is an accident-only policy and it does not pay benefits for loss from sickness."
- (7) All policies, except single-premium nonrenewable policies and as otherwise provided in this paragraph, shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have 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.

Drafting Note: This section should be included only if state has proper legislation.

- (8) If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy as originally issued, such fact must be prominently set forth in the outline of coverage.
- (9) 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.
- (10) Outlines of coverage delivered in connection with policies defined in this regulation as hospital confinement indemnity (Section 7D), Specified Disease (Section 7H), or Limited Benefit Health Insurance Coverages (Section 7I) to persons eligible for Medicare by reason of age shall contain, in addition to the requirements of subsections 8F and 8J, 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 company.
- (11) Insurers, except direct response insurers, shall give any person applying for specified disease insurance a Buyer's Guide approved by the commissioner at the time of application and shall obtain all recipients' written acknowledgement of the guide's delivery. Direct response insurers shall provide the Buyer's Guide upon request but not later than the time the policy is delivered.

- (12) All specified disease policies shall contain a prominent statement on the first page of the policy or attached thereto in either contrasting color or in boldface type at least equal to the size type used for policy captions, a prominent statement as follows: CAUTION: This is a limited policy. Read it carefully with the outline of coverage and the Buyer's Guide.

Drafting Note: The second sentence of this caption should only be required in those states where the commissioner exercises his discretionary authority and requires such guide.

B. Outline of Coverage Requirements for Individual Coverages

No individual accident and sickness insurance policy or nonprofit hospital, medical or dental service corporation subscriber contract subject to this regulation shall be delivered or issued for delivery in this state unless an appropriate outline of coverage, as prescribed in Section 8C through K is completed as to such policy or contract and the outline is either:

- (1) Delivered with the policy; or
- (2) Delivered to the applicant at the time application is made and acknowledgement of receipt or certification of delivery of such outline of coverage is provided to the insurer.

If an outline of coverage was delivered at the time of application and the policy or contract is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or contract must accompany the policy or contract when it is delivered and contain the following statement in no less than twelve (12) point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application, and the coverage originally applied for has not been issued."

The appropriate outline of coverage for policies or contracts providing hospital coverage which only meets the standards of Section 7B shall be that statement contained in Section 8C. The appropriate outline of coverage for policies providing coverage which meets the standards of both Sections 7B and C shall be the statement contained in Section 8E. The appropriate outline of coverage for policies providing coverage which meets the standards of both Sections 7B and E or Section 7C and E or Section 7B, C, and E shall be the statement contained in Section 8G.

Appropriate changes in terminology may be made in the outline of coverage in the case of contracts of hospital, medical or dental service corporations. In any other case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or contract, an alternate outline of coverage shall be submitted to the commissioner for prior approval.

C. Basic Hospital Expense Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7B of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

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[COMPANY NAME]

BASIC HOSPITAL EXPENSE COVERAGE

OUTLINE OF COVERAGE

- (1) **Read Your Policy Carefully** — This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**
- (2) **Basic Hospital Coverage** — Policies of this category are designed to provide, to persons insured, coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services and hospital outpatient services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for physicians or surgeons fees or unlimited hospital expenses.
- (3) [A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:
 - (a) Daily hospital room and board;
 - (b) Miscellaneous hospital services;
 - (c) Hospital out-patient services; and
 - (d) Other benefits, if any.]

Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.

- (4) [A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in (3) above.]
- (5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

D. **Basic Medical-Surgical Expense Coverage (Outline of Coverage)**

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7C of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

BASIC MEDICAL-SURGICAL EXPENSE COVERAGE

OUTLINE OF COVERAGE

- (1) **Read Your Policy Carefully** — This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control your policy. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

- (2) Basic Medical-Surgical Expense Coverage — Policies of this category are designed to provide, to persons insured, coverage for medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for hospital expenses fees or unlimited medical-surgical expenses.
- (3) [A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:
 - (a) surgical services:
 - (b) anesthesia services:
 - (c) in-hospital medical services; and
 - (d) other benefits, if any]

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Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.

- (4) [A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in (3) above.]
- (5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

E. Basic Hospital and Medical-Surgical Expense Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7B and C of this regulation. The items included in the outline of coverage must appear in the sequence prescribed.

[COMPANY NAME]

BASIC HOSPITAL AND MEDICAL-SURGICAL EXPENSE COVERAGE

OUTLINE OF COVERAGE

- (1) Read Your Policy Carefully — This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore important that you **READ YOUR POLICY CAREFULLY!**
- (2) Basic Hospital and Medical-Surgical Expense Coverage — Policies of this category are designed to provide, to persons insured, coverage for hospital and medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital out-patient services, surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for unlimited hospital or medical surgical expenses.
- (3) [A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

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- (a) Daily hospital room and board;
- (b) Miscellaneous hospital services;
- (c) Hospital out-patient services;
- (d) Surgical services;
- (e) Anesthesia services;
- (f) In-hospital medical services; and
- (g) Other benefits, if any.]

Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.

- (4) [A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in (3) above.]
- (5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

F. Hospital Confinement Indemnity Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7D of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

HOSPITAL CONFINEMENT INDEMNITY COVERAGE

OUTLINE OF COVERAGE

- (1) Read Your Policy Carefully — This outline of coverage provides a very brief description of the important feature of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!
- (2) Hospital Confinement Indemnity Coverage — Policies of this category are designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Such policies do not provide any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.
- (3) [A brief specific description of the benefits contained in this policy, in the following order:
 - (a) Daily benefit payable during hospital confinement; and
 - (b) Duration of benefit described in (a).]

Note: The above description of benefits shall be stated clearly and concisely.

- (4) [A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefit, described in (3) above.]
- (5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]
- (6) [Any benefits provided in addition to the daily hospital benefit.]

G. Major Medical Expense Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7E of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

MAJOR MEDICAL EXPENSE COVERAGE

OUTLINE OF COVERAGE

- (1) **Read Your Policy Carefully** — This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**
- (2) **Major Medical Expense Coverage** — Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations which may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.
- (3) [A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:
 - (a) Daily hospital room and board;
 - (b) Miscellaneous hospital services,
 - (c) Surgical services;
 - (d) Anesthesia services;
 - (e) In-hospital medical services,
 - (f) Out-of-hospital care;
 - (g) Maximum dollar amount for covered charges; and
 - (h) Other benefits, if any]

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Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.

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- (4) [A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in (3) above.]
- (5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

H. Disability Income Protection Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7F of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

DISABILITY INCOME PROTECTION COVERAGE

OUTLINE OF COVERAGE

- (1) Read Your Policy Carefully — This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!
- (2) Disability Income protection Coverage — Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.
- (3) [A brief specific description of the benefits contained in this policy:]

Note: The above description of benefits shall be stated clearly and concisely.

- (4) [A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in (3) above.]
- (5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

I. Accident-Only Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7G of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

ACCIDENT-ONLY COVERAGE

OUTLINE OF COVERAGE

- (1) Read Your Policy Carefully — This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you

and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

- (2) Accident-Only coverage—Policies of this category are designed to provide, to persons insured, coverage for certain losses resulting from a covered accident **ONLY**, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.
- (3) [A brief specific description of the benefits contained in this policy.]

Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with Section 7A(13) of this regulation.

- (4) [A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in (3) above.]
- (5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

J. Specified Disease or Specified Accident Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7H of this regulation. The coverage shall be identified by the appropriate bracketed title. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

[SPECIFIED DISEASE] [SPECIFIED ACCIDENT] COVERAGE

OUTLINE OF COVERAGE

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- (1) This policy is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. It should not be purchased by persons covered under Medicaid. Read the Buyer's Guide's discussion of the possible limits on benefits in this type of policy.
- (2) Read Your Policy Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**
- (3) [Specified Disease] [Specified Accident] Coverage—Policies of this category are designed to provide, to persons insured, restricted coverage paying benefits **ONLY** when certain losses occur as a result of [specified diseases] or [specified accidents]. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.
- (4) [A brief specific description of the benefits, including dollar amounts, contained in this policy.]

Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with Section 7A(13) of this regulation.

K. Limited Benefit Health Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies which do not meet the minimum standards of Section 7B, C, D, E, F, G and H of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

LIMITED BENEFIT HEALTH COVERAGE

OUTLINE OF COVERAGE

- (1) Read Your Policy Carefully — The outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore important that you READ YOUR POLICY CAREFULLY!
- (2) Limited Benefit Health Coverage — Policies of this category are designed to provide, to persons insured, limited or supplemental coverage.
- (3) [A brief specific description of the benefits, including dollar amounts, contained in this policy.]

Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with Section 7A(13) of this regulation.

- (4) [A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in (3) above.]
- (5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

Section 9. Requirements for Replacement

- A. Application forms shall include a question designed to elicit information as to whether the insurance 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 questions may be used.
- B. 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 described in C below. One (1) copy of such notice shall be retained by the insurer. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in D below. In no event, however, will such a notice be required in the solicitation of the following types of policies; accident-only and single-premium nonrenewable policies.
- C. The notice required by B above for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS INSURANCE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by [insert company name] Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

- (1) Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy.

Drafting Note: This subsection may be modified if preexisting conditions are covered under the new policy.

- (2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
- (3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concern your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

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(Date)

(Applicant's Signature)

D. The notice required by B above for a direct response insurer shall be as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS INSURANCE

According to [your application] [information you have furnished] you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with the policy delivered herewith issued by [insert company name] Insurance Company. Your new policy provides ten days within which you may decide without cost whether you desire to keep the policy. For your own information and protection you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

- (1) Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
- (2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

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- (3) [To be included only if the application is attached to the policy]. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [insert company name and address] within ten days if any information is not correct and complete, or if any past medical history has been left out of the application.

[COMPANY NAME]

Section 10. Separability

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

Legislative History (all references are to the Proceedings of the NAIC).

1975 Proc. I 2, 6, 573, 575, 590-605 (adopted).

1977 Proc. I 26, 28, 54-77, 317, 325 (amended).

1979 Proc. II 31, 34, 327, 333, 339-344 (amended regarding Medicare supplement insurance).

1980 Proc. II 22, 26, 588, 591, 594, 622, 634-636 (amended).

1989 Proc. II 13, 23-24, 467-468, 518-519, 548-570 (amended to remove reference to Medicare supplement insurance).



STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner

Legal Division

GASTON CAPERTON
Governor

HANLEY C. CLARK
Insurance Commissioner

August 17, 1993

HAND-DELIVERED

Ms. Judy Cooper, Director
Administrative Law Division
Office of the Secretary of State
State Capitol
Charleston, West Virginia 25305

Dear Ms. Cooper:

Enclosed please find copies of the following documents for filing:

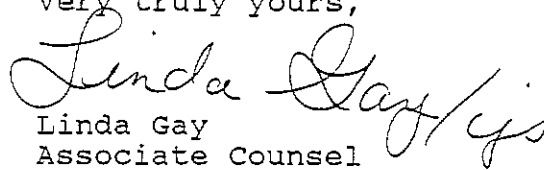
- (1) The agency-approved rule entitled "Individual Accident and Sickness Insurance Minimum Standards" (Title 114, Series 12);
- (2) The fiscal note for this proposed rule;
- (3) The Notice of Agency Approval of a Proposed Rule and Filing with the Legislative Rule-Making Review Committee;
- (4) A brief summary of the rule, combined with a detailed statement of the circumstances which require the proposed legislative rule;
- (5) The consent for the proposed rule, signed by Tax and Revenue Secretary James H. Paige, III;
- (6) The completed Legislative Rule-Making Review Committee Questionnaire regarding this rule, with attached copies of all written comments received during the public comment period on the proposed rule;
- (7) The existing Title 114, Series 12 rule entitled "Individual Accident and Sickness Insurance Minimum Standards" (effective April 1, 1975), which this agency-approved rule will repeal and replace;
- (8) A brief summary of the content of the existing rule referenced in (7) above, which this proposed rule will repeal and replace; and

Ms. Judy Cooper
Page Two
August 17, 1993

- (9) The National Association of Insurance Commissioners' (NAIC) model regulation adopted in July 1989 and entitled "Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act," upon which this agency-approved rule is based.

Please contact me if further information is required.

Very truly yours,


Linda Gay
Associate Counsel

LG/sar
Enclosures