



STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner

Legal Division

GASTON CAPERTON
Governor

HANLEY C. CLARK
Insurance Commissioner

July 27, 1995

HAND DELIVERED

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

Re: Technical Changes - 114CSR39

Dear Ms. Cooper:

Enclosed for filing for technical purposes, please find one (1) copy of 114CSR39, "Group Accident and Sickness Insurance Minimum Policy Coverage Standards." The numbering under section 1 of the rule is incorrect and should be changed as follows:

- 1) On page 1, subsection 1.2, Scope and Applicability, should be renumbered as 1.1.
- 2) On page 2, subsection 1.3, Authority, should be renumbered as 1.2.
- 3) On page 2, subsection 1.4, Filing Date, should be renumbered as 1.3.
- 4) On page 2, subsection 1.5, Effective Date, should be renumbered as 1.4.
- 5) On page 1, subsection 1.1, Purposes, should be renumbered as 1.5 and moved to follow section 1.4.

A computer disk with underlining and strike-through corrections is also enclosed for your convenience. Please contact me if any further information is required.

Very truly yours,

Donna S. Quesenberry
Associate Counsel

DSQ/sar
Enclosures

OFFICE OF WEST VIRGINIA
SECRETARY OF STATE
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114CSR39

TITLE 114
LEGISLATIVE RULE
INSURANCE COMMISSIONER

SERIES 39
GROUP ACCIDENT AND SICKNESS INSURANCE
MINIMUM POLICY COVERAGE STANDARDS

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114CSR39

TITLE 114
LEGISLATIVE RULE
INSURANCE COMMISSIONER

OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

SERIES 39
GROUP ACCIDENT AND SICKNESS INSURANCE
MINIMUM POLICY COVERAGE STANDARDS

§ 114-39-1. General

~~1.1. Purpose. -- The purpose of this legislative rule is to provide reasonable standardization of coverage and simplification of terms and benefits of group accident and sickness insurance policies, subscriber contracts of hospital, medical, dental and health service corporations and health care corporations, and enrollee agreements and contracts of health maintenance organizations; to facilitate public understanding and comparison of such policies, contracts and agreements; to eliminate provisions contained in such policies, contracts and agreements 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, contracts and agreements.~~

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

1.21.a. Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group insurance;

1.21.b. Accident and sickness insurance contracts covering members of fraternal benefit societies organized pursuant to West Virginia Code §§ 33-23-1 et seq.;

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

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

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

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

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

1.21.h. Coverage under Medicare or Medicaid;

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

1.21.j. Coverage under a managed care program;

1.21.k. Bona Fide Associations;

1.21.l. Basic Hospital and Medical-Surgical Expense Coverage;

1.21.m. Coverage under policies issued to groups of 61 or more under which the coverage is negotiated by the policy holder; and

1.21.n. Individual limited benefits policies subject to the requirements of West Virginia Code §§ 33-16E-1, et seq.

The requirements contained in this rule are in addition to any other applicable rules previously adopted.

1.32. Authority. -- West Virginia Code §§ 33-2-10 and 33-16-3(f).

1.43. Filing Date. -- May 20, 1994.

1.54. Effective Date. -- August 18, 1994.

1.5. Purpose. -- The purpose of this legislative rule is to provide reasonable standardization of coverage and simplification of terms and benefits of group accident and sickness insurance policies, subscriber contracts of hospital, medical, dental and health service corporations and health care corporations, and

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enrollee agreements and contracts of health maintenance organizations; to facilitate public understanding and comparison of such policies, contracts and agreements; to eliminate provisions contained in such policies, contracts and agreements 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, contracts and agreements.

§ 114-39-2. Definitions

As used in this legislative rule:

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

2.2. "Basic Hospital and Medical Surgical Expense Coverage" means policies designed to provide coverage for hospital and medical surgical expenses only 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.

2.3. "Bona Fide Association" means plans with a minimum of one hundred members which shall have been organized in good faith for purposes other than that of obtaining or providing insurance: Provided, however, That the association shall also have been in active existence for at least two years and shall have a constitution and bylaws which provide that: (1) the Association holds annual meetings to further purposes of its members; (2) except in the case of credit unions, the association collects dues or solicits contributions from members; (3) the members have voting privileges and representation on the governing board and committees that exist under the authority of the association.

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

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

2.6. "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

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insurance; a hospital, medical, dental or health service corporation organized pursuant to West Virginia Code §§ 33-24-1 et seq.; a health care corporation organized pursuant to West Virginia Code §§ 33-25-1 et seq.; or a health maintenance organization organized pursuant to West Virginia Code §§ 33-25A-1 et seq.

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

2.8. "Medicare supplement policy" means a policy of accident and sickness insurance, a subscriber contract of a hospital, medical, dental or health service corporation or health care corporation, or an enrollee agreement or contract of a health maintenance organization, 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.

2.9. "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.

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

2.11. 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.

2.12. "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.

2.13. "Limited benefits insurance coverage," for purposes of this rule, 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, 5.5 and 5.6 of this rule.

§ 114-39-3. Policy Definitions

3.1. Except as provided in this rule, no policy subject to this rule may be advertised, solicited, delivered or issued for delivery in this State unless the policy contains definitions or terms which conform to the requirements of this section. Certificates issued under a policy subject to this rule and the terms used therein shall be consistent with this section.

3.2. "Accident", "accidental injury", or "accidental means" shall be defined to employ "result" language and may 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 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. The definition may provide that the term "injuries" excludes injuries for which benefits are provided or available under any motor vehicle no-fault, workers' compensation, employer's liability, occupational disease or similar law, unless prohibited by law.

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

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 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;

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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 the 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.

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 the term excludes:

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

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3.4.b.B. Facilities primarily affording custodial, educational or rehabilitory care;

3.4.b.C. Facilities for the aged, drug addicts or alcoholics; or

3.4.b.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 the services: **Provided**, That no policy providing hospital indemnity coverage may exclude coverage because of confinement in a hospital operated by the federal or state government.

3.5. "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 Law 89-97 as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

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

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

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

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

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

3.11. "Preexisting condition" may not be defined to be more restrictive than the following: "Preexisting condition" means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a two-year (2-year) period preceding the effective date of the coverage of the insured person under 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 coverage of the insured person under 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 the term "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 the policy and while the policy is in force. The definition may be further modified to exclude sickness or disease 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).

§ 114-39-4. Prohibited Policy Provisions

4.1. No policy may exclude coverage for a loss due to a preexisting condition for a period greater than twelve (12) months following policy issue.

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

4.3. 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.

4.4. 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 determined by the Commissioner to be unjust, unfair, unreasonable or unfairly discriminatory either to the policyholder, subscriber, beneficiary or any person insured under the policy.

§ 114-39-5. Minimum Standards for Benefits

5.1. General. -- The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subparagraphs. No insurer may deliver or issue for delivery in this state a policy which does not meet the required minimum standards for the specified categories, unless the Commissioner finds that policies 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. The benefits described in a certificate issued under a policy subject to this rule shall be consistent with the benefits contained in the policy and shall be no less than those required under this section.

5.1.a. 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.b. If an insurer terminates coverage under a policy providing pregnancy coverage, such policy 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, provided that this subsection shall not apply when termination of coverage is due to fraud, nonpayment of premium or any breach of the terms of the policy for which termination is authorized under chapter thirty-three of the code.

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

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5.1.d. 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 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 the termination date, the insurer must receive due proof of the incapacity in order for the insured to elect to continue the policy in force with respect to the dependent child. As an alternative to this requirement, a separate converted policy may be issued to the child at the option of the insured or policyholder.

5.1.e. 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 provided such benefits may be limited to those expenses directly relating to the organ donation.

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

5.1.g. 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.h. Specific dismemberment benefits may not be in lieu of other benefits unless the specific benefit exceeds the other benefits.

5.1.i. Termination of coverage under a policy 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: **Provided**, That this

subsection shall not apply when termination of coverage is due to fraud, nonpayment of premium or any breach of the terms of the policy for which termination is authorized under chapter thirty-three of the code.

5.2. Hospital Confinement Indemnity Coverage. -- "Hospital confinement indemnity coverage" is a policy 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.

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

5.3.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;

5.3.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;

5.3.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 such single operation shall be reasonably related to the above-stated maximum amount for the first surgical procedure.

5.3.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 in the surgical schedule for anesthesia services at the same unit value as used for the surgical schedule;

5.3.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 hospital call, one (1) call per day, for at least twenty-one (21) calls during one period of confinement.

5.3.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

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

5.4. Disability Income Protection Coverage.

5.4.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 of sickness or injury that:

5.4.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).

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

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

5.4.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

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

5.4.a.C. Has a maximum period of time for which it is payable during disability of at least six (6) months. No reduction in benefits may be put into effect because of an increase in Social Security or similar benefits during a benefit period.

5.4.b. Subsection 5.4 of this rule does not apply to those disability income protection policies providing business buy-out coverage.

5.5. 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 an accident-only policy shall be at least one thousand dollars (\$1,000), and a single dismemberment amount shall be at least five hundred dollars (\$500).

5.6. Specified Disease and Specified Accident Coverage.

5.6.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 5.6.a.C, 5.6.a.D, and 5.6.a.E in this section. Insurance covering specified disease(s) other than cancer shall meet the standards of subparagraphs 5.6.a.B or 5.6.a.E of this section.

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

5.6.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.

5.6.a.A.(b). Any policy issued pursuant to this section which conditions payment upon pathological diagnosis

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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.

5.6.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).

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

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

5.6.a.A.(f). 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.

5.6.a.A.(g). 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.

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

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

5.6.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

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of not less than two (2) years for at least the following incurred expenses:

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

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

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

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

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

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

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

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

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

5.6.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

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

5.6.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.

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5.6.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:

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

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

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

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

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

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

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

5.6.a.C.(h). Any other expenses necessarily incurred in the treatment of the disease: **Provided**, That parts 5.6.a.C.(a), 5.6.a.C.(b), 5.6.a.C.(d), 5.6.a.C.(e), and 5.6.a.C.(g) of this rule, 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:

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

5.6.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;

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5.6.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.

5.6.a.C.(k)(A). Home health care coverages shall include:

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

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

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

5.6.a.C.(k)(A)4. Medical supplies, drugs and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent the charges or costs would be covered under the policy if provided to the insured on an in-patient basis.

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

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

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

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

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

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5.6.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.

5.6.a.D.(b). A fixed-sum payment equal to one half of the hospital in-patient benefit for each day of hospital or non-hospital out-patient surgery, chemotherapy and radiation therapy, for at least three hundred sixty-five (365) days of treatment.

5.6.a.E. The following minimum benefits standards apply to cancer coverages written on a per diem indemnity basis. 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:

5.6.a.E.(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;

5.6.a.E.(b). A fixed-sum payment equal to one-fourth of the hospital in-patient benefit for each day of home health care for at least one hundred (100) days;

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

5.6.a.E.(d). Notwithstanding any other provision of this rule, any restriction or limitation applied to the benefits in 5.6.a.D.(c)(A) and 5.6.a.D.(c)(B) of this rule, whether by definition or otherwise, shall be no more restrictive than those under Medicare.

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

5.6.a.F.(a). The coverages shall pay indemnity benefits on behalf of covered persons for a specifically named disease or diseases. The benefits are payable as a fixed, one-time payment made within thirty (30) days of submission to the insurer of proof of diagnosis of the specified

disease(s). Dollar benefits shall be offered for sale only in even increments of one thousand dollars (\$1,000); and

5.6.a.F.(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 treatment costs, lesser amounts may be payable so long as the policy clearly differentiates that subtype and its benefits.

5.7. Specified disease coverage. -- A policy covering a single specified disease or combination of diseases shall meet the requirements of subsection 5.6 of this rule and shall not be offered for sale as a limited benefits policy.

§ 114-39-6. Required Disclosure Provisions

6.1. Each policy 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 to be issued. The provision shall be appropriately captioned, 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.

6.2. Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or certificate holder, 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 require signed acceptance by the policyholder or certificate holder, as appropriate. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the policyholder or certificate holder, as appropriate, except if the increased coverage or benefits are required by law.

6.3. Where a separate additional premium is paid for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

6.4. A policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include a definition of those terms within the policy.

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6.5. Any provisions limiting or excluding coverage of preexisting conditions shall appear in a separate paragraph of the policy and shall be labeled as "Preexisting Condition Limitations".

6.6. All accident-only 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: **"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 the circumstances under which benefits are payable which are less than the maximum amount payable under the policy.

6.8. 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."**

6.9. All policies shall have a notice prominently printed on the first page of the policy or attached thereto, stating in substance that the group 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 group policyholder is not satisfied for any reason. The notice shall also state that in the event the policy holder exercises this right, the insurer shall not be obligated to pay any benefits under the policy for claims submitted to the insurer during such ten (10) day period.

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

6.11. 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

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provided on a policy form then being used by the insurer for that purpose.

§ 114-39-7. Severability

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