Table of Contents

18.01.30 - INDIVIDUAL ACCIDENT AND SICKNESS DISABILITY INSURANCE MINIMUM STANDARDS ACT

000. LEGAL AUTHORITY. 2
001. TITLE AND SCOPE. 2
002. -- 003. (RESERVED). 2
004. POLICY DEFINITIONS. 2
005. -- 010. (RESERVED). 5
011. PROHIBITED POLICY PROVISIONS. 5
012. DISABILITY MINIMUM STANDARDS FOR BENEFITS. 7
013. GENERAL RULES. 7
014. BASIC HOSPITAL EXPENSE COVERAGE. 8
015. BASIC MEDICAL-SURGICAL EXPENSE COVERAGE. 9
016. HOSPITAL CONFINEMENT INDEMNITY COVERAGE. 9
017. MAJOR MEDICAL EXPENSE COVERAGE. 10
018. DISABILITY INCOME PROTECTION COVERAGE. 11
019. ACCIDENT ONLY COVERAGE. 11
020. SPECIFIED DISEASE AND SPECIFIED ACCIDENT COVERAGE. 11
.....11
021. LIMITED BENEFIT HEALTH INSURANCE COVERAGE. 12
022. REQUIRED DISCLOSURE PROVISIONS. 12
023. OUTLINE OF COVERAGE REQUIREMENTS FOR INDIVIDUAL COVERAGES. 13
024. BASIC HOSPITAL EXPENSE COVERAGE. 14
025. BASIC MEDICAL-SURGICAL EXPENSE COVERAGE. 15
026. BASIC HOSPITAL AND MEDICAL-SURGICAL EXPENSE COVERAGE. 15
027. HOSPITAL CONFINEMENT INDEMNITY COVERAGE. 16
028. MAJOR MEDICAL EXPENSE COVERAGE. 17
029. DISABILITY INCOME PROTECTION COVERAGE. 18
030. ACCIDENT ONLY COVERAGE. 19
031. SPECIFIED DISEASE OR SPECIFIED ACCIDENT COVERAGE. 19
032. LIMITED BENEFIT HEALTH COVERAGE. 20
033. REQUIREMENTS FOR REPLACEMENT. 20
034. SEVERABILITY. 22
035. -- 999. (RESERVED). 22

18.01.30 - INDIVIDUAL ACCIDENT AND SICKNESS DISABILITY INSURANCE MINIMUM STANDARDS ACT

000. LEGAL AUTHORITY.
This rule chapter is issued pursuant to the authority vested in the director under Chapter 42, Title 41, Idaho Code, and Chapter 52, Title 67, Idaho Code. (7-1-93)

001. TITLE AND SCOPE.
The purpose of this rule chapter is to implement Chapter 42, Title 41, Idaho Code, so as to provide reasonable standardization and simplification of terms and coverages of individual disability insurance policies, franchise disability policies, and nongroup subscriber contracts of hospital, medical or dental service corporations delivered or issued for delivery in this state in order to facilitate public understanding and comparison and to eliminate provisions 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 rule chapter shall apply to all individual disability insurance policies, franchise disability insurance policies (See Section 41-2137, Idaho Code), and nongroup subscriber contracts of nonprofit hospital, medical or dental service corporations delivered or issued for delivery in this state on and after the effective date hereof, except it shall not apply to contracts issued pursuant to a conversion privilege under a policy or contract of group insurance when such group policy or contract includes provisions which are inconsistent with the requirements contained in this rule chapter shall be in addition to any other applicable regulations previously adopted. (7-1-93)

002. -- 003. (RESERVED).

004. POLICY DEFINITIONS.
Except as provided hereafter, no individual disability insurance policy, franchise disability insurance policy, nor nongroup subscriber contract of any nonprofit hospital, medical or dental service corporation delivered or issued for delivery to any person in this State shall contain definitions respecting the matters set forth below unless such definitions comply with the requirements of this Section. (7-1-93)

01. One Period of Confinement. "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 (3) times the maximum number of days of in-hospital coverage provided by the policy to a maximum of one hundred and eighty (180) days. (7-1-93)

02. Hospital. "Hospital" may be defined in relation to its status, facilities or available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals. (7-1-93)

a. The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital: (7-1-93)

i. Be an institution operated pursuant to law; and (7-1-93)

ii. 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 (7-1-93)

iii. Provide twenty-four (24) hour nursing service by or under the supervision of registered graduate professional nurses (R.N.'s). (7-1-93)

b. The definition of the term "hospital" may state that such term shall not be inclusive of: (7-1-93)

i. Convalescent homes, convalescent, rest or nursing facilities; or (7-1-93)

ii. Facilities primarily affording custodial or education care; or (7-1-93)

iii. Facilities for the aged, drug addicts or alcoholics; or (7-1-93)

iv. 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, and except that this subsection does not apply to a hospital confinement indemnity policy (7D). (7-1-93)

03. Convalescent Nursing Home. "Convalescent Nursing Home," "Extended Care Facility," or "Skilled Nursing Facility" shall be defined in relation to its status, facilities or available services. (7-1-93)

a. A definition of such home or facility shall not be more restrictive than one requiring that it: (7-1-93)

i. Be operated pursuant to law; (7-1-93)

ii. Be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested; (7-1-93)

iii. Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician; (7-1-93)

iv. Provide continuous twenty-four (24) hour nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and (7-1-93)

v. Maintains a daily medical record of each patient. (7-1-93)

b. The definition of such a home or facility may provide that such term shall not be inclusive of: (7-1-93)

i. Any part of any home or facility used primarily for rest; (7-1-93)

ii. Any part of any home or facility for the aged or for the care of drug addicts or alcoholics; or (7-1-93)

iii. Any part of any home or facility primarily used for the care and treatment of mental diseases, mental disorders or custodial or educational care. (7-1-93)

04. Accident, Accidental Injury, Accidental Means. "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. (7-1-93)

a. The definition shall not be more restrictive than the following: Injury or injuries, for which policy benefits are provided, means accidental bodily injuries sustained by the insured person which are the direct cause of the loss, independent of disease or bodily infirmity or any other cause and occur while the insurance is in force. (7-1-93)

b. Such definition may provide that injuries shall not include injuries for which benefits are provided under any 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. (7-1-93)

05. Sickness. "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 policy or the effective date of coverage of a newly added family member. 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. (7-1-93)

06. Pre-Existing Condition. "Pre-existing condition" shall not be defined to be more restrictive than the following: Pre-existing 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. Pre-existing conditions exclusions shall not apply to newborn children who shall be covered from the moment of birth (see sections 41-2140, and 41-3437, Idaho Code.) (7-1-93)

a. 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. (7-1-93)

b. 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 the application, from reducing or denying a claim on the basis of the existence of a pre-existing condition that is defined more restrictively than above. (7-1-93)

07. Physician. "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. (7-1-93)

08. Nurses. "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. (7-1-93)

09. Total Disability. (7-1-93)

a. A general definition of total disability cannot be more restrictive than one requiring the individual 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 engaged in any employment or occupation for wage or profit. (7-1-93)

b. Total disability may be defined in relation to the inability of the insured to perform duties but may not be based solely upon an individual's inability to: (7-1-93)

i. Perform "any occupation whatsoever", "any occupational duty" or "any and every duty of his occupation;" or (7-1-93)

ii. Engage in any training or rehabilitation program. (7-1-93)

c. An insurer may specify the requirement of the complete inability of the insured 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). (7-1-93)

10. Partial Disability. "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. (7-1-93)

11. Residual Disability. "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 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 director adequately and fairly describes the benefit. (7-1-93)

12. Medicare. "Medicare" shall be defined 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. (7-1-93)

13. Mental or Nervous Disorders. "Mental or Nervous Disorders" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopath, psychosis, or mental or emotional disease or disorder of any kind. (7-1-93)

005. -- 010. (RESERVED).

011. PROHIBITED POLICY PROVISIONS.

01. Waiting Period. Except as provided in Subsection 004.05 of this rule chapter, 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. (7-1-93)

02. Dividend Policy or Rider. No policy or rider for additional coverage may be issued as a dividend unless an equivalent cash payment is offered in writing to the policyholders 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. (7-1-93)

03. Preexisting Condition. No policy shall exclude coverage for a loss due to a pre-existing condition for a period greater than twelve (12) months following policy issue where the application for such insurance does not adequately seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and such pre-existing condition is not specifically excluded by the terms of the policy. (7-1-93)

04. Return of Premium or Cash Value Benefits. A disability income policy or hospital confinement indemnity 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. (7-1-93)

05. Hospital Confinement Indemnity. Policies providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.

(7-1-93)

06. Coverage Exclusions. No policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows: (7-1-93)

a. Pre-existing conditions or diseases, except for congenital anomalies of a covered newborn dependent child; (7-1-93)

b. Mental or emotional disorders, alcoholism and drug addiction; (7-1-93)

c. Pregnancy, except for complications of pregnancy; (7-1-93)

d. Illness, treatment or medical condition arising out of: (7-1-93)

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,: (7-1-93)

ii. Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; (7-1-93)

iii. Aviation; (7-1-93)

iv. With respect to short-term nonrenewable policies, interscholastic sports. (7-1-93)

e. 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 newborn dependent child; (7-1-93)

f. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet; (7-1-93)

g. 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; (7-1-93)

h. Benefits provided under Medicare or other governmental program (except Medicaid), any state or federal workmen's compensation, employer's liability or occupational disease law, services performed by a member of the covered person's immediate family or services for which no charge is normally made in the absence of insurance; (7-1-93)

i. Dental care or treatment; (7-1-93)

j. Eye glasses, hearing aids and examination for the prescription or fitting thereof; (7-1-93)

k. Rest cures, custodial care, transportation and routine physical examinations; (7-1-93)

l. Territorial limitations. (7-1-93)

07. Waivers. Except with respect to Medicare supplement coverages as defined in IDAPA 18.01.54, Rules of the Department of Insurance, other provisions of this rule chapter shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described pre-existing 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 of the policy or unless notice of the waiver appears on the first page or specification page. Waivers to exclude, limit or reduce coverage or benefits for specifically named or described pre-existing diseases or physical conditions shall not be used in Medicare supplement coverages. (7-1-93)

08. Medicare Terms Prohibited. Except as otherwise provided in Subsection 022.01.f., the terms "Medicare supplement," "Medigap," and words of similar import shall not be used unless the policy is issued in compliance with IDAPA 18.01.54. (7-1-93)

09. Additional Disapproval Conditions. Policy provisions precluded in this Section shall not be construed as a limitation on the authority of the director to disapprove other policy provisions in accordance with Section 41-4203(2), Idaho Code, which, in the opinion of the director, are unjust, unfair or unfairly discriminatory to the policyholder, beneficiary or any person insured under the policy. (7-1-93)

10. Medicare Supplement Coverage. A policy issued as a "Medicare Supplement Coverage" pursuant to IDAPA 18.01.54 shall not include, when issued, limitations or exclusions of the type enumerated in Subsections 030.06.d., 030.06.g., 030.06.k., or 030.06.l. above if such limitations or exclusions are more restrictive than those of Medicare for any type of care covered under such policy. (7-1-93)

012. DISABILITY 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 disability insurance, franchise disability insurance, non-group subscriber contract of any non-profit hospital, medical or dental service corporation nor any non-group subscriber contract of any health maintenance organization shall be delivered or issued for delivery in this state which does not meet the required minimum standards for the specified categories unless the director finds that such policies or contracts are approvable as Limited Benefit Health Insurance and the Outline of Coverage complies with the appropriate outline in Subsection 022.01.a. of this rule chapter. Nothing in this Section shall preclude the issuance of any policy or contract combining two or more categories of coverage set forth in Section 41-4204(1) and (2), Idaho Code. (7-1-93)

013. GENERAL RULES.

01. Termination of Coverage of Spouse Limitations. A "non-cancellable," "guaranteed renewable," or "non-cancellable 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. (7-1-93)

02. Terminology Requirements and Limitations. The terms "non-cancellable," "guaranteed renewable," or "non-cancellable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of Subsection 022.01.a. The terms "non-cancellable" or "non-cancellable 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: 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. (7-1-93)

03. Age and Durational Requirements. 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 "non-cancellable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age (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. (7-1-93)

04. Accidental Death and Dismemberment Coverage. 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 enshrouds under such coverage and not just the principal insured. (7-1-93)

05. Military Service. 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. (7-1-93)

06. Pregnancy Benefits. In the event the insurer cancels or refuses to renew for reasons other than nonpayment of premiums, 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. (7-1-93)

07. Convalescent or Extended Care Benefits. 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. (7-1-93)

08. Coverage of Dependents. 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. The insurer may require at reasonable intervals during the two (2) years following the child's attainment of the limiting age subsequent proof of the child's disability and dependency. After the two (2) year period, such subsequent proof may not be required more than once each year. (7-1-93)

09. Recurrent Disabilities. 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. (7-1-93)

10. Accidental Death and Dismemberment. 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. (7-1-93)

11. Specific Dismemberment Benefits. Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits. (7-1-93)

12. Accident Only Policy. 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. (7-1-93)

13. Medicare Supplement In-Hospital Benefits. All Medicare supplement policies providing in-hospital benefits shall include in their provided benefits the initial Part A Medicare deductible as established from time to time by the Social Security Administration. Premiums may be reduced or raised to correspond with changes in the covered deductible. (7-1-93)

14. Continuous Loss. Termination of the policy by the insurer other than for nonpayment of premium 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 total disability of the insured, limited to the duration of the benefit period, if any, or payment of the maximum benefits. (7-1-93)

014. BASIC HOSPITAL EXPENSE COVERAGE.

"Basic Hospital Expense Coverage" is a policy of disability 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 expense incurred for necessary treatment and services rendered as a result of accident or sickness for at least the

following: (7-1-93)

01. Daily Hospital Room and Board. Daily hospital room and board in an amount not less than the lesser of: (7-1-93)

a. Eighty percent (80%) of the charges for semi-private room accommodations; or (7-1-93)

b. Thirty dollars ($30) per day. (7-1-93)

02. Miscellaneous Hospital Services. 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: (7-1-93)

a. Eighty percent (80%) of the charges incurred up to at least one thousand dollars ($1,000); or (7-1-93)

b. Ten (10) times the daily hospital room and board benefits. (7-1-93)

03. Hospital Outpatient Services. Hospital outpatient services consisting of: (7-1-93)

a. Hospital services on the day surgery is performed; and (7-1-93)

b. Hospital services rendered within seventy-two (72) hours after accidental injury, in an amount not less than the lesser of fifty dollars ($50) or eighty percent (80%) of the charges incurred. (7-1-93)

04. Deductible Limitations. Benefits provided under Subsections 014.01 and 014.02, may be provided subject to a combined deductible amount not in excess of one hundred dollars ($100). (7-1-93)

015. BASIC MEDICAL-SURGICAL EXPENSE COVERAGE.
"Basic Medical-Surgical Expense Coverage" is a policy of disability 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: (7-1-93)

01. Surgical Services. (7-1-93)

a. In amounts not less than those provided on a fee schedule based on the relative values contained in the most recent State of New York certified surgical fee schedule, or the most recent California Relative Value Schedule or other relative value scale of surgical procedures, which has been accounted by the director, up to a maximum of at least five hundred dollars ($500) for any one procedure; or (7-1-93)

b. Not less than eighty percent (80%) of the reasonable charges. (7-1-93)

02. Anesthesia Services. 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: (7-1-93)

a. In an amount not less than eighty percent (80%) of the reasonable charges; or (7-1-93)

b. Fifteen percent (15%) of the surgical service benefit. (7-1-93)

03. In-Hospital Medical Services. 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) per day for not less than twenty-one (21) days during one period of confinement. (7-1-93)

016. HOSPITAL CONFINEMENT INDEMNITY COVERAGE.
"Hospital Confinement Indemnity Coverage" is a policy of disability insurance which provides daily benefits for

hospital confinement on an indemnity basis in an amount not less than thirty dollars ($30) per day and not less than thirty-one (31) days during any one period of confinement for each person insured under the policy. (7-1-93)

017. MAJOR MEDICAL EXPENSE COVERAGE.

Major Medical Expense Coverage" is a disability insurance policy which provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than ten thousand dollars ($10,000); co-payment 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 compliment 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: (7-1-93)

01. Daily Hospital Room and Board Expense. Daily hospital room and board expense, prior to application of the co-payment percentage, for not less than fifty dollars ($50) daily (or in lieu thereof the average daily cost of 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. (7-1-93)

02. Miscellaneous Hospital Services. Miscellaneous hospital services, prior to application of the co-payment percentage, for an aggregate maximum of not less than one thousand five hundred dollars ($1,500) or fifteen (15) times the daily room and board rate if specified in dollar amounts. (7-1-93)

03. Surgical Services. Surgical services, prior to application of co-payment percentage to a maximum of not less than six hundred dollars ($600) for the most severe operation with the amounts provided for other operations reasonably related to such maximum amount. (7-1-93)

04. Anesthesia Services. Anesthesia services, prior to application of the co-payment percentage, for a maximum of not less than fifteen percent (15%) 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. (7-1-93)

05. In-Hospital Medical Services. In-hospital medical services, prior to application of the co-payment percentage, as defined in IDAPA 18.01.54. (7-1-93)

06. Out of Hospital Care. Out of hospital care prior to application of the co-payment 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. (7-1-93)

07. Additional Benefits. Not fewer than three of the following additional benefits, prior to application of the co-payment percentage, for an aggregate maximum of such covered charges of not less than one thousand dollars ($1,000): (7-1-93)

a. In-hospital private duty graduate registered nurse services. (7-1-93)

b. Convalescent nursing home care. (7-1-93)

c. Diagnosis and treatment by a radiologist or physiotherapist. (7-1-93)

d. Rental of special medical equipment, as defined by the insurer in the policy. (7-1-93)

e. Artificial limbs or eyes, casts, splints, trusses or braces. (7-1-93)

f. Treatment for functional nervous disorders, and mental and emotional disorders. (7-1-93)

g. Out-of-hospital prescription drugs and medications. (7-1-93)

018. DISABILITY INCOME PROTECTION COVERAGE.
"Disability Income Protection Coverage" is a policy which provides for periodic payments for a specified period during the continuance of disability resulting from either sickness or injury or a combination thereof which: (7-1-93)

01. Periodic Payments. 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 (62). (7-1-93)

02. Elimination Period. Contains an elimination period no greater than: (7-1-93)

a. Ninety (90) days in the case of a coverage providing a benefit of one (1) year or less; (7-1-93)

b. One hundred and eighty (180) days in the case of coverage providing a benefit of more than one (1) year but not greater than two (2) years, or (7-1-93)

c. Three hundred sixty-five (365) days in all other cases during the continuance of disability resulting from sickness or injury. (7-1-93)

03. Payable Time Period During Disability. 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 of similar benefits during a benefit period. IDAPA 18.01.54 does not apply to those policies providing business buyout coverage. (7-1-93)

019. 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). (7-1-93)

020. SPECIFIED DISEASE AND SPECIFIED ACCIDENT COVERAGE.

01. Specified Disease Coverage. "Specified Disease Coverage" is a policy which meets one (1) of the following definitions: (7-1-93)

a. 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: (7-1-93)

i. Hospital room and board and any other hospital furnished medical services or supplies; (7-1-93)

ii. Treatment by a legally qualified physician or surgeon; (7-1-93)

iii. Private duty services of a registered nurse (R.N.); (7-1-93)

iv. X-ray, radium and other therapy procedures used in diagnosis and treatment; (7-1-93)

v. Professional ambulance for local service to or from a local hospital; (7-1-93)

vi. Blood transfusions, including expense incurred for blood donors; (7-1-93)

vii. Drugs and medicines prescribed by a physician; (7-1-93)

viii. The rental of an iron lung or similar mechanical apparatus; (7-1-93)

ix. Braces, crutches and wheelchairs as are deemed necessary by the attending physician for the

treatment of the disease; (7-1-93)

x. Emergency transportation if in the opinion of the attending physicians it is necessary to transport the insured to another locality for treatment of the disease; and (7-1-93)

xi. May include coverage of any other expenses necessarily incurred in the treatment of the disease. (7-1-93)

b. A policy which provides 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. (7-1-93)

02. 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. (7-1-93)

021. LIMITED BENEFIT HEALTH INSURANCE COVERAGE.
"Limited Benefit Health Insurance Coverage" is any policy or contract which provides benefits that are less than the minimum standards for benefits required under IDAPA 18.01.54. Such policies or contracts may be delivered or issued for delivery in this state only if the outline of coverage required by Section 022.01.a. of this chapter is completed and delivered as required by Subsection 022.02 of this chapter. (7-1-93)

022. REQUIRED DISCLOSURE PROVISIONS.

01. General Rules. (7-1-93)

a. Each individual disability insurance policy, franchise disability insurance policy, or non-group subscriber contract of any non-profit hospital, medical or dental service corporation delivered or issued for delivery to any person in this State 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 provisions 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. (7-1-93)

b. 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 by the insured, except if the increased benefits or coverage is required by law. (7-1-93)

c. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be adequately disclosed to the insured. (7-1-93)

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 a definition of such terms and an explanation of such terms in its accompanying outline of coverage. (7-1-93)

e. If a policy contains any limitations with respect to pre-existing conditions such limitations must appear as a separate paragraph of the policy and be labeled as "Pre-existing Condition Limitations." (7-1-93)

f. 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 does not pay benefits for loss from

sickness." (7-1-93)

g. All policies, except single premium nonrenewable policies and as otherwise provided in this paragraph, shall have a notice prominently printed on the face page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy to the home or branch office of the insurer, or to the agent through whom it was purchased, 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. With respect to policies issued pursuant to a direct response solicitation to persons eligible for Medicare by reason of age, the policy shall have a notice prominently printed on the face 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. (7-1-93)

h. 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. (7-1-93)

i. 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. (7-1-93)

j. Insurers issuing policies which provide hospital or medical expense coverage on an expense incurred or indemnity basis other than incidentally, to a person(s) eligible for Medicare by reason of age, shall provide to the policyholder, a Medicare supplement buyer's guide in a form prescribed by the Director. Delivery of the buyer's guide shall be made whether or not the policy qualified as a "Medicare Supplement Coverage" in accordance with Rule IDAPA 18.01.54. Except in the case of direct response insurers, delivery of the buyer's guide shall be made at the time of application, and acknowledgement of receipt of certification of delivery of the buyer's guide shall be provided to the insurer. Direct response insurers shall deliver the buyer's guide upon request but not later than at the time the policy is delivered. (7-1-93)

k. Outlines of coverage delivered in connection with policies defined in Sections 016, 020, or 021 to persons eligible for Medicare by reason of age shall contain, in addition to the requirements of Sections 027, 031 and 18.01.54, 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 is available from the company. (7-1-93)

023. OUTLINE OF COVERAGE REQUIREMENTS FOR INDIVIDUAL COVERAGES.
No individual disability insurance policy, franchise disability insurance policy, or nongroup subscriber contract of any nonprofit hospital, medical or dental services corporation subject to this rule chapter shall be delivered or issued for delivery to any person in this State unless an appropriate outline of coverage, as prescribed in Sections 024 through 032 is completed as to such policy or contract and: (7-1-93)

01. Outline of Coverage Requirement for Medicare Supplement Coverage. For policies offered for sale as Medicare Supplement Coverage the outline is delivered to the applicant at the time application is made and, except for the direct response policy, acknowledgement of receipt or certification of delivery of such outline of coverage is provided to the insurer. (7-1-93)

02. Outline for Coverage Requirements for Other Policies. For all other policies, the outline is either: (7-1-93)

a. Delivered with the policy; or (7-1-93)

b. 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. (7-1-93)

03. Other. (7-1-93)

a. 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." (7-1-93)

b. The appropriate outline of coverage for policies or contracts providing hospital coverage which only meets the standards of Section 014 shall be that statement contained in Section 024. The appropriate outline of coverage for policies providing coverage which meets the standards of both Sections 014 and 015.shall be the statement contained in Section 026. The appropriate outline of coverage for policies providing coverage which meets the standards of both Sections 014 and 017 or Section 015 and 017 or Section 014, 015, and 017 shall be the statement contained in section 028. (7-1-93)

c. 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 director for prior approval. (7-1-93)

024. 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 014 of this rule chapter. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)
BASIC HOSPITAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

(7-1-93)

01. Read Your Policy Carefully. This outline of coverage provides a very brief description of the important features of (your policy) (the policy you have applied for). 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! (7-1-93)

02. 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 co-payment requirements set forth in the policy. Coverage is not provided for physicians' or surgeons' fees or unlimited hospital expenses. (7-1-93)

03. Brief Specific Description of Benefits. 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: (7-1-93)

a. Daily hospital room and board; (7-1-93)

b. Miscellaneous hospital services; (7-1-93)

c. Hospital outpatient services; and (7-1-93)

d. Other benefits, if any. (7-1-93)

04. Stated Clearly and Concisely. The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described. (7-1-93)

05. Description of Exclusions, Restrictions. 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 Subsection 024.03 above. (7-1-93)

06. Description of Renewability, Continuation. A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums. (7-1-93)

025. 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 015 of this rule chapter. The items included in the outline of coverage must appear in the sequence prescribed: (7-1-93)

(COMPANY NAME)
BASIC MEDICAL-SURGICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

01. Read Your Policy Carefully. This outline of coverage provides a very brief description of the important features of (your policy) (the policy you have applied for). 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!. (7-1-93)

02. Basic Medical-Surgical Expense Coverage. Policies of this category are designed to provide to persons insured coverage for medical-surgical expense 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 co-payment requirements set forth in the policy. Coverage is not provided for hospital expenses or unlimited medical-surgical expenses. (7-1-93)

03. Brief Description of the Benefits. 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: (7-1-93)

a. Surgical services; (7-1-93)

b. Anesthesia services; (7-1-93)

c. In-hospital medical services; and (7-1-93)

d. Other benefits, if any. (7-1-93)

04. Stated Clearly and Concisely. The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described. (7-1-93)

05. Description of Exclusions, Restrictions. 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 Subsection 025.03 above. (7-1-93)

06. Description of Renewability, Continuation. A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums. (7-1-93)

026. 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 Sections 014 and 015 of this chapter. The items included in the outline of coverage must appear in the sequence prescribed: (7-1-93)

(COMPANY NAME)

BASIC HOSPITAL AND MEDICAL-SURGICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

01. 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! (7-1-93)

02. Basic Hospital and Medical-Surgical Expense Coverage. Policies of this category are designed to provide, to persons insured, coverage for hospital and medical-surgical expense 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 co-payment requirements set forth in the policy. Coverage is not provided for unlimited hospital or medical-surgical expenses. (7-1-93)

03. Brief Specific Description of the Benefits. 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: (7-1-93)

a. Daily hospital room and board; (7-1-93)

b. Miscellaneous hospital services; (7-1-93)

c. Hospital outpatient services; (7-1-93)

d. Surgical services; (7-1-93)

e. Anesthesia services; (7-1-93)

f. In-hospital medical services; and (7-1-93)

g. Other benefits, if any.) (7-1-93)

04. Stated Clearly and Concisely. The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described. (7-1-93)

05. Description of Exclusions, Restrictions. 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 Subsection 026.03 above. (7-1-93)

06. Description of Renewability, Continuation. A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums. (7-1-93)

027. 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 016 of the chapter. The items included in the outline of coverage must appear in the sequence prescribed: (7-1-93)

(COMPANY NAME)
HOSPITAL CONFINEMENT INDEMNITY COVERAGE
OUTLINE OF COVERAGE

01. 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! (7-1-93)

02. 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. (7-1-93)

03. Brief Specific Description of the Benefits. A brief specific description of the benefits contained in this policy, in the following order: (7-1-93)

a. Daily benefit payable during hospital confinement; and (7-1-93)

b. Duration of benefit described in Subsection 027.03.a. (7-1-93)

04. Stated Clearly and Concisely. The above description of benefits shall be stated clearly and concisely. (7-1-93)

05. Description of Exclusions, Restrictions. 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 Subsection 027.03 above. (7-1-93)

06. Description of Renewability, Continuation. A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums. (7-1-93)

07. Additional Benefits. (Any benefits provided in addition to the daily hospital benefit.) (7-1-93)

028. 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 017 of this chapter. The items included in the outline of coverage must appear in the sequence prescribed: (7-1-93)

(COMPANY NAME)
MAJOR MEDICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

01. 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 details the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY! (7-1-93)

02. 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 initial prosthetic appliances, subject to any deductibles, co-payment provisions, or other limitations which may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided. (7-1-93)

03. Brief Specific Description of the Benefits. A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order: (7-1-93)

a. Daily hospital room and board; (7-1-93)

b. Miscellaneous hospital services; (7-1-93)

c. Surgical services; (7-1-93)

d. Anesthesia services; (7-1-93)

e. In-hospital medical services; (7-1-93)

f. Out of hospital care; (7-1-93)

g. Initial prosthetic appliances; (7-1-93)

h. Maximum dollar amount for covered charges; and (7-1-93)

i. Other benefits, if any.) (7-1-93)

04. Stated Clearly and Concisely. The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described. (7-1-93)

05. Description of Exclusions, Restrictions. 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 Subsection 028.03 above. (7-1-93)

06. Description of Renewability, Continuation. A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation or right to change premiums. (7-1-93)

029. 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 018 of this chapter. The items included in the outline of coverage must appear in the sequence prescribed: (7-1-93)

(COMPANY NAME)
DISABILITY INCOME PROTECTION COVERAGE
OUTLINE OF COVERAGE

01. 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! (7-1-93)

02. 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. (7-1-93)

03. Brief Specific Description of the Benefits. (A brief specific description of the benefits contained in this policy.) (7-1-93)

04. Clearly and Concisely. The above description of benefits shall be stated clearly and concisely. (7-1-93)

05. Description of Exclusions, Restrictions. 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 Subsection 029.03 above. (7-1-93)

06. Description of Renewability, Continuation. A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums. (7-1-93)

030. 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 019 of this chapter. The items included in the outline of coverage must appear in the sequence prescribed: (7-1-93)

(COMPANY NAME)
ACCIDENT ONLY COVERAGE
OUTLINE OF COVERAGE

01. 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! (7-1-93)

02. 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. (7-1-93)

03. Brief Specific Description of the Benefits. A brief specific description of the benefits contained in this policy. (7-1-93)

04. Stated Clearly and Concisely. The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with Subsection 013.13 of this chapter. (7-1-93)

05. Description of Exclusions, Restrictions. 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 Subsection 030.03 above. (7-1-93)

06. Description of Renewability, Continuation. A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums. (7-1-93)

031. 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 020 of this rule chapter. The coverage shall be identified by the appropriate bracketed title. The items included in the outline of coverage must appear in the sequence prescribed: (7-1-93)

(COMPANY NAME)
(SPECIFIED DISEASE) (SPECIFIED ACCIDENT) COVERAGE
OUTLINE OF COVERAGE

01. 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! (7-1-93)

02. (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. (7-1-93)

03. Brief Specific Description of the Benefits. (A brief specific description of the benefits, including dollar amounts, contained in this policy.) (7-1-93)

04. Stated Clearly and Concisely. The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with Subsection 013.13 of this chapter. (7-1-93)

05. Description of Exclusions, Restrictions. 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 Subsection 031.03 above. (7-1-93)

06. Description of Renewability, Continuation. A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums. (7-1-93)

032. 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 Sections 014, 015, 016, 017, 018, 019, and 020 of this chapter. The items included in the outline of coverage must appear in the sequence prescribed: (7-1-93)

(COMPANY NAME)
LIMITED BENEFIT HEALTH COVERAGE
OUTLINE OF COVERAGE

01. 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! (7-1-93)

02. Limited Benefit Health Coverage. Policies of this category are designed to provide to persons insured, limited or supplemental coverage. (7-1-93)

03. Brief Specific Description of the Benefits. (A brief specific description of the benefits, including dollar amounts, contained in this policy.) (7-1-93)

04. Stated Clearly and Concisely. The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with Subsection 013.13 of this chapter. (7-1-93)

05. Description of Exclusions, Restrictions. 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 Subsection 032.03 above. (7-1-93)

06. Description of Renewability, Continuation. A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums. (7-1-93)

033. REQUIREMENTS FOR REPLACEMENT.

01. Application Form. 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. (7-1-93)

02. Notice Required. 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 033.03 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. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in Subsection 033.04 below. (7-1-93)

03. Notice Requirements for Other Than a Direct Response Insurer. The notice required by Subsection 033.02 above for an insurer, other than a direct response insurer, shall provide, in 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 (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." (7-1-93)

a. Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy; or the new policy may also provide for a waiting period for certain specified conditions. 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. (7-1-93)

b. 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. (7-1-93)

c. 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. The above "Notice to Applicant" was delivered to me on (DATE), (APPLICANT'S SIGNATURE). (7-1-93)

04. Notice Requirements for Direct Response Insurer. The notice required by Subsection 033.02 above for a direct response insurer shall be as follows: (7-1-93)

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 (Company Name) Insurance Company. Your new policy provides ten (10) 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." (7-1-93)

a. Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy; or the new policy may also provide for a waiting period for certain specified conditions. 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. (7-1-93)

b. 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. (7-1-93)

c. (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 (Company Name and Address) within ten (10) past medical history has been left out of the application. (7-1-93)

05. Notice Exceptions. A notice to applicant regarding replacement will not be required in the solicitation of accident only policies, single premium nonrenewable policies, or of medicare supplement policies being issued in the same company, if any of these policies are issued as a conversion policy or to replace a policy

which would otherwise terminate at the insured's age sixty-five (65). (7-1-93)

034. SEVERABILITY.
If any provision of this rule chapter 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. (7-1-93)

035. -- 999. (RESERVED).