South Carolina Department of Insurance Accident and Health Filing Checklist

South Carolina Department of Insurance
1201 Main Street, Suite 1000
Columbia, South Carolina 29201
803-737-6230—Phone
803-737-6233—Fax
http://doi.sc.gov

This checklist is intended to be used as a tool by the insurer to properly prepare and submit filings with the South Carolina Department of Insurance. Please use the ***South Carolina Life, Accident, and HealthType of Insurance Matrix*** along with this checklist, which is located at http://doi.sc.gov/company/ratesrulesandforms.

Please know that improper and/or incomplete filings will result in an automatic disapproval. Filings submitted that are not in compliance with all of the requirements will also result in an automatic disapproval.

Please contact the Rates, Rules and Forms Filings Office directly at 803-737-6230 if you have questions regarding accident and health filings. Please do not contact an employee referenced in the attached bulletin(s) as they may no longer be with the Department or their position within the Department may have changed.

Line Code	DOI Series	Line of Business Description	Type of Filing	How Filing Handled
55	100/200	Accident and Health - Group	Form	Exempt
55	100/300	Accident and Health - Individual	Form	Exempt

Group Accident and Health — Exempt Filings
Use all of the 100 and 200 DOI Series Numbers.

Individual Accident and Health — Exempt Filings
Use all of the 100 and 300 DOI Series Numbers.

100 DOI SERIES NUMBERS - POLICIES AND POSITIONS
This section applies to all policies.

100. Does the insurer have annuity and life authority? Yes ☐ No ☐ N/A ☐
Section 38-1-20 (6) and 38-1-20 (27)

Note:
a) If the filing includes supplemental life insurance, endowment or annuity benefits, the company must also have authority for "life" insurance.
b) HMOs must be licensed as an HMO in accordance with Chapter 33 of Title 38.
c) Accident and health insurance is defined in Section 38-1-20(1) as insurance of human beings against death or personal injury by accident, and every insurance of human beings against sickness, ailment, and any type of physical disability resulting from accident or disease, and prepaid dental service, not including coverage required by the Workers' Compensation Law of this State.

101. Does the filing comply with Bulletin 2003-13? Yes ☐ No ☐ N/A ☐

Compliance with General Provisions of Article I of Chapter 71 of Title 38

102. Whole Contract, Including Application, Must Appear in Policy; Oral Applications Yes ☐ No ☐ N/A ☐
Section 38-71-30

Note:
The application must comply with the following:
a) Application form(s) must also comply with our Readability Regulation 69-5.1. Hence, the agreement area of the application must be printed in ten point type, one point leaded, as required by Section D(1)(b) and we must have a certificate with respect to that form as required by Section D(4).
b) It is the Department's position that a Company may not limit the authority of its agent in acquiring information since that is fundamental to the taking of an application of life or accident and health insurance.
c) This Department takes exception to statements in the agreement area of an application which undertake to make a contract effective during the "good health," "continued good health," or "continued insurability" of the proposed insured unless they are modified to state "as stated in the application."
d) This Department takes exception to wording which indicates that the statements of the applicant are other than representations. Hence, the word "certify" is not allowed.
e) Any reference to "loss of coverage" should be expanded by adding "subject to the Time Limit on Certain Defenses." If you do not wish to add these words, the reference to "loss of coverage" should be deleted.
f) According to Section 38-71-265, in enrolling a person, no health insurer or HMO may take into account Medicaid eligibility or enrollment.
g) Applications must accompany each filing. If the company desires to use a previously approved application and/or endorsement, it should be submitted with the policy form advising the date of approval in the cover letter.

103. Diabetes Mellitus Coverage in Health Insurance Policies; Diabetes Education Yes ☐ No ☐ N/A ☐
Section 38-71-46

104. Alteration of Application Yes ☐ No ☐ N/A ☐
Section 38-71-50

105. Certain Policies May Conform to Laws of Other States Section 38-71-70	Yes ☐	No ☐	N/A ☐
106. Notice of Failure of Employer to Remit Deducted Premium Required Before Forfeiture Section 38-71-110	Yes ☐	No ☐	N/A ☐
107. Mastectomies; Hospitalization Requirements; Early Release Provisions Section 38-71-125	Yes ☐	No ☐	N/A ☐
108. Breast Reconstruction and Prosthetic Devices; Coverage Following Mastectomy Surgery Section 38-71-130	Yes ☐	No ☐	N/A ☐
109. Mothers & Newborns Hospital Stay Section 38-71-135 Note: A common error is to leave out the language not including the day of delivery and/or not including the day of surgery.	Yes ☐	No ☐	N/A ☐
110. Coverage of Newborn Children Section 38-71-140(A)	Yes ☐	No ☐	N/A ☐
111. Coverage for Children Placed for Adoption Section 38-71-143(A)	Yes ☐	No ☐	N/A ☐
114. Required Coverage for Mammograms, Pap Smears, and Prostrate Cancer Examinations; Limitations Section 38-71-145	Yes ☐	No ☐	N/A ☐
115. Required Provision in Policies as to Examination and Surrender of Policy for Return of Premium Section 38-71-150	Yes ☐	No ☐	N/A ☐
116. Conversion Privileges for Former Spouses Section 38-71-170 Note: a) Spouse does not have to be insured for 3 months prior to being eligible for conversion. b) Conversion is mandatory even if the individual is over-insured.	Yes ☐	No ☐	N/A ☐
117. Subrogation Section 38-71-190	Yes ☐	No ☐	N/A ☐
118. Discrimination Forbidden; Benefits for Services of Podiatrist, Oral Surgeon, or Optometrist Section 38-71-200	Yes ☐	No ☐	N/A ☐

119. Chiropractic Services Section 38-71-210	Yes ☐	No ☐	N/A ☐
120. Dermatology Referrals Section 38-71-215	Yes ☐	No ☐	N/A ☐
121. Coverage Required for Cleft Lip and Palate; Certain Policies Exempt Section 38-71-240(A)	Yes ☐	No ☐	N/A ☐
122. Application of Co-payment & Deductible Section 38-71-241	Yes ☐	No ☐	N/A ☐
123. Insurance Coverage for Certain Drugs Not to be Excluded from Policy Definitions Section 38-71-275	Yes ☐	No ☐	N/A ☐
124. Intoxicants and Narcotics Section 38-71-370(9) Note: This provision is not required; however, if it is included, it must be stated in the words shown above. We are of the opinion that the words drunk and intoxicated are synonymous and that either word may be used. However, the use of the words controlled substance is not acceptable.	Yes ☐	No ☐	N/A ☐
125. Thirty-one days written notice of rate increase Section 38-71-620	Yes ☐	No ☐	N/A ☐

200 DOI SERIES NUMBERS— Group Accident and Health

Compliance with General Provisions of Subarticle 1 of Article 5 of Chapter 71 of Title 38

200. Definitions Section 38-71-710	Yes ☐	No ☐	N/A ☐
201. Approval of Forms Required; Refusal or Withdrawal of Approval; Optional Life Insurance Riders Section 38-71-720	Yes ☐	No ☐	N/A ☐
202. What Constitutes a Group Section 38-71-730 (1)	Yes ☐	No ☐	N/A ☐
203. Plan Must Preclude Individual Selection Section 38-71-730 (2)	Yes ☐	No ☐	N/A ☐
204. Evidence of Insurability Section 38-71-730 (3)	Yes ☐	No ☐	N/A ☐
205. Limitations on Pre-existing Condition Exclusions Section 38-71-730 (4)	Yes ☐	No ☐	N/A ☐

206. Payment of Premium Section 38-71-730 (5)	Yes ☐ No ☐ N/A ☐
207. Medicare Supplement Section 38-71-730 (6)	Yes ☐ No ☐ N/A ☐
208. Required Provisions Section 38-71-735	Yes ☐ No ☐ N/A ☐
209. Grace Period Section 38-71-735(a)	Yes ☐ No ☐ N/A ☐
210. Incontestability Section 38-71-735(b)	Yes ☐ No ☐ N/A ☐
211. Entire Contract Section 38-71-735(c)	Yes ☐ No ☐ N/A ☐
212. Evidence of Insurability Section 38-71-735(d)	Yes ☐ No ☐ N/A ☐
213. Misstatement of Age Section 38-71-735(e)	Yes ☐ No ☐ N/A ☐
214. Issuance of Certificate Section 38-71-735(f)	Yes ☐ No ☐ N/A ☐
215. Written Notice of Claim Section 38-71-735(g)	Yes ☐ No ☐ N/A ☐
216. Proof of Loss Section 38-71-735(h)	Yes ☐ No ☐ N/A ☐
217. Proof of Loss - Disability Section 38-71-735(i)	Yes ☐ No ☐ N/A ☐
218. Time Payment of Claims Section 38-71-735(j)	Yes ☐ No ☐ N/A ☐
219. Payment of Claims Section 38-71-735(k)	Yes ☐ No ☐ N/A ☐
220. Physical Exam & Autopsy Section 38-71-735(l)	Yes ☐ No ☐ N/A ☐
221. Legal Action Section 38-71-735(m)	Yes ☐ No ☐ N/A ☐

222. Certificate of Insurance for Debtor Section 38-71-735(n)	Yes ☐	No ☐	N/A ☐
223. Requirement of Coverage for Psychiatric Conditions in Group Health Policies; "Psychiatric Conditions" Defined Section 38-71-737	Yes ☐	No ☐	N/A ☐
224. Restrictions on Mass Marketed Insurance Section 38-71-740	Yes ☐	No ☐	N/A ☐
225. Requirements of Group Policies Extended to Group Policies Issued Outside State to Residents; Prior Approval Needed for Mass-Marketed Policies and Certificates Section 38-71-750	Yes ☐	No ☐	N/A ☐

Note:
a) Bulletin 1-89 requires group accident & health insurance policies, other than mass marketed policies and certificates, issued outside of this State which cover residents of this State to be filed with the South Carolina Department of Insurance on an informational basis.
b) All such filings must be accompanied by a certification executed by an officer of the insurer that the policy forms comply fully with Article 5 of Chapter 71 of Title 38. The certification should also state that the insurer will comply with the requirements of this State relating to advertising and to claims settlement practices with respect to the insurance. For paper filings, a postage paid return envelope must be enclosed with the filing. (If this certificate is submitted, do not submit the certificate required in Section IV 10. of Bulletin 2003-13.)

226. Standards for Group Accident and Health Insurance Coverage, Discontinuance, and Replacement Section 38-71-760	Yes ☐	No ☐	N/A ☐
227. Mandatory State Continuation Section 38-71-770	Yes ☐	No ☐	N/A ☐
228. Required Provision for Continuation for Handicapped and Dependent Children Section 38-71-780	Yes ☐	No ☐	N/A ☐
229. Payment of Benefits Section 38-71-790	Yes ☐	No ☐	N/A ☐
230. Hospital & Medical Expenses Section 38-71-800	Yes ☐	No ☐	N/A ☐
231. Readjustment of Rates or Refunds or Dividends Section 38-71-810	Yes ☐	No ☐	N/A ☐

Compliance with Requirements for Issuers and Group Health Insurance Coverage Under the Health Insurance Portability and Accountability Act of 1996
Subarticle 1 of Article 5 of Chapter 71 of Title 38
Note: Refer to Bulletin 97-1 for filing requirements for HIPAA policy provisions.

232. Definitions (A) Section 38-71-840 Note: Definitions (14), (22), and (28) must be included in the policy.	Yes ☐	No ☐	N/A ☐
233. Limitations on Preexisting Condition Exclusions Section 38-71-850 Note: South Carolina is unique in the exclusion of a pre-existing condition. Use language set forth in Section 38-71-750(A)(2)	Yes ☐	No ☐	N/A ☐
234. Creditable Coverage Section 38-71-850 (B)	Yes ☐	No ☐	N/A ☐
235. Additional Limitations on Preexisting Condition Exclusions Section 38-71-850(C)	Yes ☐	No ☐	N/A ☐
236. Certifications of Creditable Coverage Section 38-71-850(D)	Yes ☐	No ☐	N/A ☐
237. Special Enrollment Periods Section 38-71-850(E)	Yes ☐	No ☐	N/A ☐
238. Affiliation Periods for HMOs Section 38-71-850 (F)	Yes ☐	No ☐	N/A ☐
239. Additional Requirements for Certifications of Creditable Coverage Section 38-71-850(G)	Yes ☐	No ☐	N/A ☐
240. Non-discrimination Provisions Section 38-71-860	Yes ☐	No ☐	N/A ☐
241. Guaranteed Renewability Provisions Section 38-71-870	Yes ☐	No ☐	N/A ☐
242. Mental Health Parity Provisions Section 38-71-880	Yes ☐	No ☐	N/A ☐

Small Group Rating Requirements - Subarticle 3 of Article 5 of Chapter 71 of Title 38	
243. Definitions Section 38-71-920	Yes ☐ No ☐ N/A ☐
244. Applicability of Rating Provisions Section 38-71-930	Yes ☐ No ☐ N/A ☐
245. Requirements for Premium Rates Section 38-71-940	Yes ☐ No ☐ N/A ☐
246. Disclosure Requirements Section 38-71-960	Yes ☐ No ☐ N/A ☐
Small Employer Health Insurance Availability Act - Article 13 of Chapter 71 of Title 38	
247. Definitions Section 38-71-1330	Yes ☐ No ☐ N/A ☐
248. Application of Article Section 38-71-1340	Yes ☐ No ☐ N/A ☐
249. Guaranteed Issue of All Plans Section 38-71-1360	Yes ☐ No ☐ N/A ☐
250. Applicability of Certain Code Sections Section 38-71-1370	Yes ☐ No ☐ N/A ☐
Access to Emergency Medical Care - Article 15 of Chapter 71 of Title 38	
251. Definitions Section 38-71-1520	Yes ☐ No ☐ N/A ☐
252. Role of Managed Care Organization; Payments to Providers Section 38-71-1530	Yes ☐ No ☐ N/A ☐
Health Carrier External Review Act - Article 15 of Chapter 71 of Title 38	
253. Definitions Section 38-71-1920	Yes ☐ No ☐ N/A ☐
254. Application of Article Section 38-71-1930	Yes ☐ No ☐ N/A ☐
255. Notice of Right to Request a Review; Notice of Adverse Determination Section 38-71-1940	Yes ☐ No ☐ N/A ☐

256. Request for External Review Section 38-71-1950	Yes ☐ No ☐ N/A ☐
257. Exhaustion of Internal Appeal Process Section 38-71-1960	Yes ☐ No ☐ N/A ☐
258. Request for External Review Section 38-71-1970	Yes ☐ No ☐ N/A ☐
259. Request for Expedited External Review Section 38-71-1980	Yes ☐ No ☐ N/A ☐
260. External Review Decisions Final; Exceptions Section 38-71-1990	Yes ☐ No ☐ N/A ☐
261. External Review; Written Records; Reports Section 38-71-2030	Yes ☐ No ☐ N/A ☐
262. Health Carrier to Pay for External Review Section 38-71-2040	Yes ☐ No ☐ N/A ☐
263. Health Carrier to Inform Covered Person of Rights Section 38-71-2050	Yes ☐ No ☐ N/A ☐
264. Coordination of Benefits Regulation Regulation 69-43	Yes ☐ No ☐ N/A ☐
265. Medicare Supplement Insurance Regulation 69-46	Yes ☐ No ☐ N/A ☐
266. Long Term Care Insurance Act Chapter 72 of Title 38	Yes ☐ No ☐ N/A ☐
267. Long Term Care Insurance Regulation Regulation 69-44	Yes ☐ No ☐ N/A ☐
300 DOI SERIES NUMBERS—Individual Accident and Health	
Subarticle 1 of Article 3 of Chapter 71 of Title 38 - Policy Forms and Rates	
300. Filing of forms and rates; approval or disapproval; withdrawal of approval; exceptions; loss ratio guarantee Section 38-71-310	Yes ☐ No ☐ N/A ☐
301. Requirements for approval of new individual major medical expense coverage policies Section 38-71-325	Yes ☐ No ☐ N/A ☐

302. Form of policies Section 38-71-330	Yes ☐	No ☐	N/A ☐
303. Accident and/or health insurance cancellation provision prohibited; optionally renewable policies prohibited; notice of nonrenewal	Yes ☐	No ☐	N/A ☐
304. Entire Contract; Changes Section 38-71-340(1)	Yes ☐	No ☐	N/A ☐
305. Time Limit on Certain Defenses Section 38-71-340(2)	Yes ☐	No ☐	N/A ☐
306. Grace Period Section 38-71-340(3)	Yes ☐	No ☐	N/A ☐
307. Reinstatement Section 38-71-340(4)	Yes ☐	No ☐	N/A ☐
308. Notice of Claim Section 38-71-340(5)	Yes ☐	No ☐	N/A ☐
309. Claim Forms Section 38-71-340(6)	Yes ☐	No ☐	N/A ☐
310. Proofs of Loss Section 38-71-340(7)	Yes ☐	No ☐	N/A ☐
311. Time of Payment of Claims Section 38-71-340(8)	Yes ☐	No ☐	N/A ☐
312. Payment of Claims Section 38-71-340(9)	Yes ☐	No ☐	N/A ☐
313. Physical Examinations and Autopsy Section 38-70-340(10)	Yes ☐	No ☐	N/A ☐
314. Legal Actions Section 38-71-340(11)	Yes ☐	No ☐	N/A ☐
315. Change of Beneficiary Section 38-71-340(12)	Yes ☐	No ☐	N/A ☐
316. Conformity with State Statutes Section 38-71-340(13)	Yes ☐	No ☐	N/A ☐
317. Required provision for continuation of coverage for handicapped and dependent children of policyholder Section 38-71-350	Yes ☐	No ☐	N/A ☐

318. Continuation of coverage for non-handicapped dependent children Section 38-71-360	Yes ☐	No ☐	N/A ☐
319. Change of Occupation Section 38-71-370(1)	Yes ☐	No ☐	N/A ☐
320. Misstatement of Age Section 38-71-370(2)	Yes ☐	No ☐	N/A ☐
321. Other Insurance In This Insurer Section 38-71-370(3)	Yes ☐	No ☐	N/A ☐
322. Insurance With Other Insurers Section 38-71-370(4)	Yes ☐	No ☐	N/A ☐
323. Insurance With Other Insurers Section 38-71-370(5)	Yes ☐	No ☐	N/A ☐
324. Relation of Earnings to Insurance Section 38-71-370(6)	Yes ☐	No ☐	N/A ☐
325. Unpaid Premium Section 38-71-370(7)	Yes ☐	No ☐	N/A ☐
326. Illegal Occupation Section 38-71-370(8)	Yes ☐	No ☐	N/A ☐
327. Intoxicants and Narcotics Section 38-71-370(9) Note: We are of the opinion that the words drunk and intoxicated are synonymous and that either word may be used. However, the use of the words controlled substance is not acceptable.	Yes ☐	No ☐	N/A ☐
328. Placement of required and optional provisions in policy Section 38-71-420	Yes ☐	No ☐	N/A ☐
329. Additional provisions may not make policy less favorable Section 38-71-430	Yes ☐	No ☐	N/A ☐
330. HMOs and health benefits plans offering medical eye care or vision care benefits; prohibited actions Section 38-71-440	Yes ☐	No ☐	N/A ☐
Subarticle 3 of Article 3 of Chapter 71 of Title 38 - Standardization and Simplification of Terms and Coverages			
331. Outline of coverage required Section 38-71-550	Yes ☐	No ☐	N/A ☐
332. Effect of use of simplified application form Section 38-71-560	Yes ☐	No ☐	N/A ☐

Subarticle 5 of Article 3 of Chapter 71 of Title 38 - General Provisions			
333. Notice of premiums due required Section 38-71-610	Yes ☐	No ☐	N/A ☐
334. Advance notice required for increase in premium Section 38-71-620	Yes ☐	No ☐	N/A ☐
335. Acceptance of premium for period beyond expiration date of policy Section 38-71-630	Yes ☐	No ☐	N/A ☐
336. Person with insurable interest may take out policy on insured Section 38-71-640	Yes ☐	No ☐	N/A ☐
337. Right to transfer to policy of equal or lesser benefits with same insurer Section 38-71-650	Yes ☐	No ☐	N/A ☐
Subarticle 7 of Article 3 of Chapter 71 of Title 38 - Requirements for Issuers and Individual Health Insurance Coverage Under the Health Insurance Portability and Accountability Act of 1996			
338. Definitions Section 38-71-670	Yes ☐	No ☐	N/A ☐
339. Renewal or continuance of coverage at option of insurer; conditions for nonrenewal or discontinuance; modification of coverage Section 38-71-675	Yes ☐	No ☐	N/A ☐
340. Application of § 38-71-850(D) Section 38-71-680	Yes ☐	No ☐	N/A ☐
Article 9 of Chapter 71 of Title 38 - Blanket Accident and Health Insurance			
341. "Blanket accident and health insurance" defined Section 38-71-1010	Yes ☐	No ☐	N/A ☐
342. Requirements as to policies Section 38-71-1020	Yes ☐	No ☐	N/A ☐
343. Individual applications and certificates not required Section 38-71-1030	Yes ☐	No ☐	N/A ☐
344. Payment of benefits Section 38-71-1040	Yes ☐	No ☐	N/A ☐
345. Legal liability of policyholders not affected Section 38-71-1050	Yes ☐	No ☐	N/A ☐
Article 11 of Chapter 71 of Title 38 - Franchise Accident and Health Insurance			
346. "Franchise accident and health insurance" defined Section 38-71-1110	Yes ☐	No ☐	N/A ☐

Article 15 of Chapter 71 of Title 38 - Access to Emergency Medical Care	
347. Definitions Section 38-71-1520	Yes ☐ No ☐ N/A ☐
348. Role of Managed Care Organization; Payments to Providers Section 38-71-1530	Yes ☐ No ☐ N/A ☐
Article 19 of Chapter 71 of Title 38 - Health Carrier External Review Act	
349. Definitions Section 38-71-1920	Yes ☐ No ☐ N/A ☐
350. Application of Article Section 38-71-1930	Yes ☐ No ☐ N/A ☐
351. Notice of Right to Request a Review; Notice of Adverse Determination Section 38-71-1940	Yes ☐ No ☐ N/A ☐
352. Request for External Review Section 38-71-1950	Yes ☐ No ☐ N/A ☐
353. Exhaustion of Internal Appeal Process Section 38-71-1960	Yes ☐ No ☐ N/A ☐
354. Request for External Review Section 38-71-1970	Yes ☐ No ☐ N/A ☐
355. Request for Expedited External Review Section 38-71-1980	Yes ☐ No ☐ N/A ☐
356. External Review Decisions Final; Exceptions Section 38-71-1990	Yes ☐ No ☐ N/A ☐
357. External Review; Written Records; Reports Section 38-71-2030	Yes ☐ No ☐ N/A ☐
358. Health Carrier to Pay for External Review Section 38-71-2040	Yes ☐ No ☐ N/A ☐
359. Health Carrier to Inform Covered Person of Rights Section 38-71-2050	Yes ☐ No ☐ N/A ☐
360. Medicare Supplement Insurance Regulation 69-46	Yes ☐ No ☐ N/A ☐
361. Long Term Care Insurance Act Chapter 72 of Title 38	Yes ☐ No ☐ N/A ☐
362. Long Term Care Insurance Regulation Regulation 69-44	Yes ☐ No ☐ N/A ☐
363. Does the policy comply with Regulation 69-34: Individual A&H Insurance Minimum Standards?	Yes ☐ No ☐ N/A ☐

South Carolina

Code of Laws, Regulations and Bulletins References

This section of the Code of Laws applies to all policies.

SECTION 38-1-20. Definitions.

In this title unless the context otherwise requires: …
(1) "Accident and health insurance" means insurance of human beings against death or personal injury by accident, and every insurance of human beings against sickness, ailment, and any type of physical disability resulting from accident or disease, and prepaid dental service, but not including coverages required by the Workers' Compensation Law of this State.

(6) "Annuity" means every contract or agreement to make periodic payments, whether in fixed or variable dollar amounts, or both, at specified intervals….

(27) "Life Insurance" means a contract of insurance upon the lives of human beings. The following contracts are deemed to be contracts of life insurance within the meaning of this definition:
(a) a contract providing acceleration of life benefits, beginning on the contract's original effective date, in advance of the time they otherwise would be payable for long term care as defined in Section 38-72-40;
(b) a contract providing acceleration of life benefits, beginning on the contract's original effective date, in advance of the time they otherwise would be payable for a life threatening illness or a terminal illness as specified in the contract.

SECTION 38-33-10. Short title.

This chapter may be cited as the Health Maintenance Organization Act of 1987.

SECTION 38-33-20. Definitions.

As used in this chapter:
(1) "Basic health care services" means emergency care, inpatient hospital and physician care, and outpatient medical services. It does not include dental services, mental health services, or services for alcohol or drug abuse, although a health maintenance organization at its option may elect to provide these services in its coverage.
(2) "Director" means the person who is appointed by the Governor upon the advice and consent of the Senate and who is responsible for the operation and management of the Department of Insurance, including all of its divisions. The director may appoint or designate the person or persons who shall serve at the pleasure of the director to carry out the objectives or duties of the department as provided by law. Furthermore, the director may bestow upon his designee or deputy director any duty or function required of him by law in managing or supervising the insurance department.
(3) "Copayment" or "deductible" means the amount specified in the evidence of coverage that the enrollee shall pay directly to the provider for covered health care services, which may be stated in either specific dollar amounts or as a percentage of the negotiated rate or lesser charge of the provider. For good cause shown, the Director of the South Carolina Department of Insurance may, in his discretion, approve forms with provisions which vary from the provisions required in this subsection if he finds the provisions are more favorable to the enrollee.
(4) "Employing entity" means a person employing one or more providers and agreeing to perform or provide a duty or function of the provider pursuant to this chapter, where the provider is prevented by contract with the employing entity or the employing entity's governing documents from performing such statutory duty or function individually. With respect to a statutory duty or function for which the employing entity acts for providers, an employing entity shall possess all corresponding rights and duties of its providers and shall be allowed to collectively satisfy such duty or function under this chapter as to all its providers (for example, by furnishing one hold harmless agreement and one participation agreement to a health maintenance organization on behalf of all the employing entity's providers).

SECTION 38-33-20 continued

(5) "Enrollee" means an individual who is enrolled in a health maintenance organization.

(6) "Evidence of coverage" means a certificate, an agreement, or a contract issued to an enrollee setting out the coverage to which he is entitled.

(7) "Health care services" means services included in furnishing an individual medical or dental care or hospitalization or incident to the furnishing of care or hospitalization, and other services to prevent, alleviate, cure, or heal human illness, injury, or physical disability.

(8) "Health maintenance organization" means a person who undertakes to provide or arrange for basic health care services to enrollees for a fixed prepaid premium.

(9) "Person" means a natural or an artificial person including, but not limited to, individuals, partnerships, associations, trusts, or corporations.

(10) "Provider" means a physician, dentist, hospital, or other person properly licensed, where required, to furnish health care services.

(11) "Designee or Deputy Director" means the person or person appointed by director, serving at his will and pleasure as his designee, to supervise and carry out the functions and duties of the department as provided by law. Any duty or function of the director to manage and supervise the insurance department may be conferred by the director's authority upon his designee or deputy director.

SECTION 38-33-30. Necessity of certificate of authority; foreign corporation.

(A) No person may establish or operate a health maintenance organization in this State without first obtaining a certificate of authority from the director or his designee. A foreign corporation, upon compliance with the provisions of this chapter, may be issued a certificate of authority upon further conditions that:

1. the applicant is registered as a foreign corporation to do business in this State;
2. the applicant is subject to regulation of its financial condition by authorities in its state of domicile, including regular financial examination not less frequently than once every three years; and
3. the applicant complies with such conditions as the director or his designee may prescribe with respect to the maintenance of books, records, accounts, and facilities in this State.

(B) Each application for a certificate of authority must be verified by an officer or authorized representative of the applicant, must be filed in a form prescribed by the director or his designee, and must set forth the following:

1. a copy of the organizational documents of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments;
2. a copy of the bylaws and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;
3. a list of the names, addresses, and official positions of the persons who are to be responsible for the management and conduct of the affairs of the applicant, including, but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal offices in the case of a corporation, and the partners or members in the case of a partnership or association;
4. a copy of any contract made or to be made between any providers or persons listed in item (3) and the applicant;
5. a copy of the form of evidence of coverage to be issued to the enrollees;
6. a copy of the form or group contract, if any, which is to be issued to employers, unions, trustees, or other organizations;
7. financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent certified financial statements satisfies this requirement unless the director or his designee directs that additional or more recent financial information is required for the proper administration of this chapter;

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8. a description of the proposed method of marketing, a financial plan which includes a projection of operating results anticipated until the organization has had net income for at least one year, and a statement as to the sources of working capital as well as any other sources of funding;
9. a power of attorney duly executed by the applicant appointing the director and his authorized deputies or designees, as the lawful attorney of the applicant in this State upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this State may be served;
10. a statement reasonably describing the geographic area to be served;
11. a description of the complaint procedures to be utilized as required under Section 38-33-110;
12. adescription of the procedures and programs to be implemented to meet the quality of health care requirements in Section 38-33-40;
13. a description of the mechanism by which enrollees have an opportunity to participate in matters of policy and operation under Section 38-33-60(2);
14. aany other information as the director or his designee may require to make the determination required in Section 38-33-40.

(C)(1) An applicant or a health maintenance organization holding a certificate of authority granted hereunder shall, unless otherwise provided for in this chapter, file a notice describing any material modification of the operation set out in the information required by subsection (B). The notice must be filed with the director or his designee prior to the modification. If the director or his designee does not disapprove within thirty days of filing, the modification is considered approved.

(2) The department may promulgate regulations exempting from the filing requirements of item (1) those items he considers unnecessary.

(D) An applicant or a health maintenance organization holding a certificate of authority shall file all contracts of reinsurance or a summary of the plan of self insurance. Any agreement between the organization and an insurer is subject to the laws of this State regarding reinsurance. All reinsurance agreements or summaries of plans of self insurance and any modifications thereto must be filed and approved. Reinsurance agreements shall remain in full force and effect for at least thirty days following written notice by registered mail of cancellation by either party to the director or his designee.

SECTION 38-33-40. Issuance of certificate of authority; criteria and considerations; arrangements for participation of providers in each geographic area served.

(A) The director or his designee shall issue a certificate of authority to a person filing an application pursuant to Section 38-33-30 if, upon payment of the application fee prescribed in Section 38-33-220, the director or his designee is satisfied that:

(1) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy, and possess good reputations.

(2) The health maintenance organization's proposed plan of operation has arrangements for an on going quality assurance program.

(3) The health maintenance organization effectively provides or arranges for the provision of basic health care services for a fixed prepaid premium, except to the extent of reasonable requirements for deductibles or co payments.

(4) The health maintenance organization is financially responsible, is able to meet its obligations to enrollees and prospective enrollees, and otherwise meets the requirements of this chapter. In making this determination, considerations by the director or his designee may include, but are not limited to:

(a) the financial soundness of the arrangements for health care services and the schedule of charges used in connection with them;

(b) the adequacy of working capital;

(c) an agreement with an insurer, a government, or other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage if the health maintenance organization is discontinued;

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(d) an agreement with providers for the provision of health care services;
(e) a deposit of cash or securities submitted in accordance with Section 38-33-130.
(5) The enrollees are afforded an opportunity to participate in matters of policy and operation pursuant to Section 38-33-60.
(6) Nothing in the proposed method of operation, pursuant to Section 38-33-30 or by independent investigation, is contrary to the public interest.
(B) No health maintenance organization may be licensed unless it has employed or contracted with or made arrangements satisfactory to the director or his designee with both physicians and hospitals to participate as providers in each geographic area to be served, as identified by the health maintenance organization under Section 38-33-30.

SECTION 38-33-50. Powers of health maintenance organization; notice prior to exercise of powers.

(A) The powers of a health maintenance organization include, but are not limited to, the following:
(1) the purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and such property as may reasonably be required for its principal office or for such purposes as may be necessary in the transaction of the business of the organization;
(2) the making of loans to a medical group under contract with it in furtherance of its program or the making of loans to a corporation under its control for the purpose of acquiring or constructing medical facilities and hospitals or in furtherance of a program providing health care services to enrollees;
(3) the furnishing of health care services through providers which are under contract with or employed by the health maintenance organization;
(4) the contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment, and administration;
(5) the contracting with an insurance company licensed in this State for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization;
(6) the offering of other health care services, in addition to basic health care services;
(7) providing services included in federal health care programs such as "Medicare", "Medicaid", "Champus", and veterans administration and other health programs funded in whole or in part by federal funds, in accordance with the laws governing these programs.
(8) the offering of an out of network coverage under a point of service option; the Director of the Department of Insurance shall, by regulations and/or policy bulletin, implement the provisions of this item.
(B)(1) A health maintenance organization shall file notice, with adequate supporting information, with the director or his designee prior to the exercise of any power granted in subsection (A)(1), (2), (4), or (7). The director or his designee may disapprove such exercise of power if in his opinion it would adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the director or his designee does not disapprove within thirty days of the filing, it is considered approved.
(2) The department may promulgate regulations exempting from the filing requirement of item (1) those activities having a de minimis effect.
(C) Any contract issued by a Health Maintenance Organization in this State on or after January 1, 1988, may include provision for subrogation by the Health Maintenance Organization to the enrollee's right of recovery against a liable third party for not more than the amount of insurance benefits that the Health Maintenance Organization has paid previously in relation to the enrollee's injury by the liable third party. If the director or his designee, upon being petitioned by the enrollee, determines that the exercise of subrogation by a Health Maintenance Organization is inequitable and commits an injustice to the enrollee, subrogation is not allowed. Attorney's fees and costs must be paid by the Health Maintenance Organization from the amounts recovered. This determination by the director or his designee may be appealed to the Administrative Law Judge Division as provided by law in accordance with Section 38-3-210.

SECTION 38-33-60. Members of governing body; advisory panels, etc.

(A) The governing body of any health maintenance organization may include providers, or other individuals, or both.
(B) The governing body shall establish a mechanism to afford the enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other mechanisms.

SECTION 38-33-70. Fiduciary relationship in handling of funds.

Any director, officer, employee, or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of an organization is responsible for the funds in a fiduciary relationship to the organization.

SECTION 38-33-80. Enrollee entitled to evidence of coverage; contents of evidence of coverage; discontinuance or replacement of coverage; charges for services.

(A)(1) Every enrollee is entitled to an evidence of coverage issued by the health maintenance organization. If any of the enrollee's benefits are provided through an insurance policy, the insurer shall issue a separate evidence of coverage for those benefits provided. However, for a point of service option offered jointly by a health maintenance organization and an insurer, only one evidence of coverage is required, as long as the benefits provided by each party are clearly identified therein.
(2) Evidence of coverage, or an amendment to it, may not be issued or delivered to a person in this State until a copy of the form of the evidence of coverage, or amendment to it, has been filed with and approved by the director or his designee pursuant to Section 38-71-310(A) or 38-71-720(A).
(3) No evidence of coverage may contain provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, which encourage misrepresentation, or which are untrue, misleading, or deceptive as defined in Section 38-33-140; and
(4) An evidence of coverage must contain a clear and concise statement, if a contract, a summary, or a certificate, of:
(a) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;
(b) any limitations on the services, kind of services, benefits, or kind of benefits, to be provided, including any deductible or co payment feature;
(c) where and in what manner information is available as to how services may be obtained;
(d) the total amount of payment for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts;
(e) clear and understandable description of the health maintenance organization's method for resolving enrollee complaints; and
(f) the contract period during which the enrollee is entitled to health care services and benefits, the applicable charges for coverage during that contract period, and the time and manner in which charges and benefits under the contract or certificate can be changed. Any subsequent change may be evidenced in a separate document issued to the enrollee.
(5) The director or his designee may require additional provisions in the evidence of coverage as may be necessary to the fair, just, and equitable treatment of enrollees. The additional provisions may include, but are not limited to, any of the provisions required of health insurance policies in Chapter 71 of Title 38 and regulations promulgated thereunder, if in the opinion of the director or his designee, the provisions are appropriate for the coverages provided under the health maintenance organization's evidence of coverage.
(6) The provisions of Section 38-71-760 governing discontinuance and replacement of coverage are applicable to group health maintenance organization contracts, except to the extent that the director or his designee determines the provisions to be inappropriate to the coverage provided.
(7) A health maintenance organization that issues a health maintenance organization contract which requires the enrollee to pay a specified percentage of the cost of covered health care services shall

SECTION 38-33-80. Continued

calculate those copayments and deductibles on the negotiated rate or lesser charge of the provider. Nothing in this section precludes a health maintenance organization from issuing a contract which contains fixed dollar copayments and deductibles.

(B) No schedule of charges applicable to individual health maintenance organization contracts may be used until a copy of the schedule has been filed with and approved by the director or his designee. The director or his designee may disapprove this schedule of charges if it is determined that the benefits provided in the contracts are unreasonable in relation to the charges.

(C) The director or his designee shall approve within thirty days any form if the requirements of subsection (A) are met. The director or his designee, in his discretion, may extend for up to an additional sixty days the period within which he shall approve or disapprove the form. The director or his designee shall approve, within a reasonable period, any schedule of charges if the requirements of subsection (B) are met. It is unlawful to issue a form or to use a schedule of charges until approved. If the director or his designee disapproves the filing, he shall notify the filer. The notice must contain the reasons for disapproval, and the filer, upon request in writing, is entitled to a public hearing on it. If action is not taken to approve or disapprove any form within thirty days of the filing of the form, if the period is not extended, or at the expiration of the extended period, if any, the filing is deemed approved. If action is not taken to approve or disapprove any schedule of charges within ninety days of the filing of the charges, the filing is deemed approved. An organization may not use a form or schedule of charges deemed approved pursuant to the default provision of this section until the organization has filed with the director or his designee a written notice of its intent to use the form or schedule of charges. The notice must be filed in the office of the director at least ten days before the organization uses the form or schedule of charges.

(D) At any time the director or his designee, after a public hearing of which at least thirty days' notice has been given, may withdraw approval of a schedule of charges previously approved under subsection (B) or an evidence of coverage approved under subsection (A) if he determined that the schedule of charges or evidence of coverage no longer meets the standards for approval specified in this section.

SECTION 38-33-90. Statements and reports.

(A) Every health maintenance organization annually shall file with the department by March first, in the form and detail the director or his designee prescribes, a statement showing the business standing and financial condition of the health maintenance organization on December thirty first of the preceding year, except that upon timely written request by the president or chief executive officer setting forth reasons why the statement cannot be filed within the time provided, the director or his designee may grant in writing an extension of filing time for not more than thirty days. This statement must conform substantially to the statement form adopted by the National Association of Insurance Commissioners. Unless the director or his designee provides otherwise, the annual statement is to be prepared in accordance with the annual statement instructions and the Accounting Practices and Procedures Manual adopted by the National Association of Insurance Commissioners.

(B) The director or his designee may require every health maintenance organization to file quarterly reports and additional information considered necessary to enable the director or his designee to carry out his duties under this chapter. The reports and information must be furnished in the time and manner prescribed by the director or his designee.

(C) Every health maintenance organization which is authorized to write business in this State shall file annually with the National Association of Insurance Commissioners by March first a copy of its annual statement convention blank along with any additional filings prescribed by the director or his designee for the preceding year. The information filed with the National Association of Insurance Commissioners must be in the same format and scope as that required by the director or his designee and must include the signed jurat page and the actuarial certification. Any amendments and addenda to the annual statement filing subsequently filed with the director or his designee also must be filed with the National Association of Insurance Commissioners. Foreign health maintenance organizations domiciled in a state which has a law substantially similar to this subsection are considered in compliance with this section.

SECTION 38-33-90. Continued

(D) In the absence of actual malice, members of the National Association of Insurance Commissioners, their authorized committees, subcommittees, and task forces, their delegates, National Association of Insurance Commissioners' employees, and all others charged with the responsibility of collecting, reviewing, analyzing, and disseminating the information developed from the filing of the annual statement convention blanks are acting as agents of the director or his designee under the authority of this section and are not subject to civil liability for libel, slander, or any other cause of action by virtue of their collection, review, and analysis or dissemination of the data and information collected from the filings required by this section.

SECTION 38-33-100. Financial requirements before issuance of certificate of authority to health maintenance organization.

(A) No health maintenance organization may be issued a certificate of authority unless it is possessed of net worth of at least one million two hundred thousand dollars, six hundred thousand dollars of which must be capital if it is a stock health maintenance organization. After the issuance, the health maintenance organization shall maintain a net worth of not less than seven hundred fifty thousand dollars, six hundred thousand dollars of which must be capital if it is a stock health maintenance organization. Net worth means total assets less total liabilities. Instruments acceptable to the director or his designee may be utilized in determining net worth. If the director or his designee determines that the number of enrollees in the health maintenance organization is excessive or may become excessive in relation to the organization's net worth, the director or his designee may require that future enrollment be limited until it is no longer necessary.

(B) If the surplus of a stock health maintenance organization is less than twenty five percent of the surplus initially required, as set forth in subsection (A), the health maintenance organization is considered delinquent, and the director or his designee may begin delinquency proceedings as provided by Chapter 27.

(C) If the capital of a stock health maintenance organization is impaired, the health maintenance organization is delinquent, and the director or his designee shall begin delinquency proceedings.

(D) If the surplus of a licensed mutual health maintenance organization is less than the sum of the capital and minimum surplus required to be maintained by a stock health maintenance organization licensed to write the same kind or kinds of business, the mutual health maintenance organization is considered delinquent, and the director or his designee may begin delinquency proceedings as provided by Chapter 27.

(E) If the surplus of a licensed mutual health maintenance organization is less than the minimum capital required to be possessed by a stock health maintenance organization licensed to write the same kind or kinds of business, the mutual health maintenance organization is delinquent, and the director or his designee shall begin delinquency proceedings.

SECTION 38-33-110. Complaint procedures; reports; malpractice claims; applicability of Freedom of Information Act.

(A)(1) Every health maintenance organization shall establish and maintain a complaint system which is approved by the director or his designee to provide reasonable procedures for the resolution of written complaints initiated by enrollees.

(2) Each health maintenance organization, with the annual report required in Section 38-33-90, shall submit to the department an annual report in a form the director prescribes which must include:

(a) a summary of written complaints handled through the health maintenance organization's approved complaint system. The summary must include the total number of complaints organized by the nature of the complaint and the average time taken to resolve the complaint;

(b) the number, amount, and disposition of malpractice claims made by enrollees of the health maintenance organization that it settled during the year.

(B) The director or his designee at any time may examine the complaint system. Information concerning complaints and malpractice claims filed pursuant to this section must be held in confidence and are not subject to disclosure under the Freedom of Information Act.

SECTION 38-33-120. Investment of funds.

With the exception of investments made in accordance with Section 38-33-50 (A)(1) and (2) and (B), the funds of a health maintenance organization must be invested only in securities or other investments permitted by the laws of this State for the investment of assets which qualify to cover policyholder obligations of life insurance companies or such other securities or investments as the director or his designee may permit.

SECTION 38-33-130. Security deposit; individual stop loss coverage; provisions for unpaid claim liability; individual conversion policy.

(A) Each health maintenance organization shall deposit and maintain with the department cash or securities which qualify as legal investments under the laws of this State for public sinking funds in the amount of three hundred thousand dollars. The director or his designee may require a health maintenance organization to make deposits in excess of the amount specified in this section if in his opinion the additional deposits are necessary for the protection of enrollees and the public. All income from deposits must belong to the depositing organization and must be paid to it as it becomes available. A health maintenance organization that has made a security deposit may withdraw that deposit or part of it after making a substitute deposit of cash, securities, or a combination of these of equal amount and value. Securities must be approved by the director or his designee before being substituted. The return of cash or securities deposited with the department by a health maintenance organization pursuant to this section is governed by Section 38-9-150.
(B) Each health maintenance organization shall require every provider who participates in the health maintenance organization and furnishes health care services to the health maintenance organization's enrollees to execute an agreement not to bill the enrollees or otherwise hold the enrollees financially responsible for services rendered. Provided, an employing entity may execute one agreement on behalf of the employing entity and all of its providers. An employing entity may also execute one participation agreement and one of other similar required forms on behalf of the employing entity and all of its providers. The provider's agreement must be given on forms prescribed or approved by the director or his designee, shall extend to all services furnished to the enrollee during the time he was enrolled in the health maintenance organization, and shall apply even where the provider or employing entity had not been paid by the health maintenance organization.
(C) Each health maintenance organization shall procure and maintain a policy of individual excess stop loss coverage provided by an insurance company licensed by the state. The policy must also include provisions to cover all incurred, unpaid claim liability in the event of the health maintenance organization's termination due to insolvency or otherwise. In addition, the director or his designee may require that the policy provide that the insurer will issue an individual conversion policy to any enrollee upon termination of the health maintenance organization or the enrollee's ineligibility for further coverage in the health maintenance organization. Any such conversion policy must meet at least the minimum requirements of Section 38-71-770.

SECTION 38-33-140. Advertisements; application of provisions relating to trade practices; use of term "insurer" or "health maintenance organization".

(A) No health maintenance organization, or representative thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purposes of this chapter:
(1) A statement or item of information is considered to be untrue if it does not conform to fact in any respect which is significant to a reasonable person enrolled in, or considering enrollment with, a health maintenance organization.
(2) A statement or item of information is considered to be misleading, whether or not it may be literally untrue, if, in the total context in which the statement is made or the item of information is communicated, the statement or item of information may be reasonably understood by a reasonable person, not

SECTION 38-33-140. Continued

possessing special knowledge regarding health care coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation, or disadvantage of possible significance to an enrollee of, or person considering enrollment in a health maintenance organization if the benefit or advantage or absence of limitation, exclusion, or disadvantage does not in fact exist.

(3) An evidence of coverage is considered to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as language, causes a reasonable person, not possessing special knowledge regarding health maintenance organizations and evidences of coverage therefore, to expect benefits, services, charges, or other advantages which the evidence of coverage does not provide or which the health maintenance organization issuing the evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage.

(B) Chapter 57 of Title 38 is construed to apply to health maintenance organizations and evidences of coverage except to the extent that the director or his designee determines that the nature of health maintenance organizations and evidences of coverage render such sections clearly inappropriate.

(C) A health maintenance organization may not cancel or refuse to renew an enrollee, except for reasons stated in the organization's regulations applicable to all enrollees, or for the failure to pay the charge for such coverage, or for such other reasons as may be promulgated by the department.

(D) No health maintenance organization may refer to itself as an insurer or use a name deceptively similar to the name or description of any insurance or surety corporation doing business in the state.

(E) Any person not in possession of a valid certificate of authority issued pursuant to this chapter may not use the phrase "health maintenance organization" or "HMO" in the course of operation.

SECTION 38-33-150. Agent for organization; exemption from licensing requirements.

(A) An agent means a person who is appointed or employed by a health maintenance organization and who engages in solicitation of membership in the organization. This definition does not include a person enrolling members on behalf of an employer, union, or other organization to whom a master subscriber contract has been issued.

(B) The department may by regulation exempt certain classes of persons from the requirement of obtaining a license:

(1) if the functions they perform do not require special competence, trustworthiness, or the regulatory surveillance made possible by licensing; or

(2) if other existing safeguards make regulation unnecessary.

SECTION 38-33-160. Operation of health maintenance organization by insurance company; contracts for cost of care.

(A) An insurance company licensed in this State may through a subsidiary or affiliate organize and operate a health maintenance organization under the provisions of this chapter. Any two or more such insurance companies or subsidiaries or affiliates thereof may jointly organize and operate a health maintenance organization.

(B) An insurer may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations. Among other things, under such contracts, the insurer may make benefit payments to health maintenance organizations for health care services rendered by providers.

SECTION 38-33-170. Examination of affairs of organization; quality of health care services; books and records; expense of examination; reports.

(A) The director or his designee may make an examination of the affairs of a health maintenance organization and providers with whom the organization has contracts, agreements, or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this State but not less frequently than once every three years. The director or his designee may accept the report of an examination made by the state where the health maintenance organization is domiciled.
(B) The director or his designee may make an examination concerning the quality of health care service of a health maintenance organization and providers with whom the organization has contracts, agreements, or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this State but not less frequently than once every three years.
(C) Every health maintenance organization and provider shall submit its relevant books and records for the examinations and facilitate them. For the purpose of examinations, the director or his designee and the department may administer oaths to and examine the officers and agents of the health maintenance organization and the principals of the providers concerning their business.
(D) The expenses of examinations under this section are assessed against the organization being examined and remitted to the director or his designee for whom the examination is being conducted.

SECTION 38-33-180. Suspension or revocation of certificate of authority.

(A) The director or his designee may suspend or revoke a certificate of authority issued to a health maintenance organization if he finds that one or more of the following conditions exist:
(1) The health maintenance organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in other information submitted under
Section 38-33-30, unless amendments to the submissions have been filed with and approved by the director or his designee.
(2) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of Section 38-33-80.
(3) The health maintenance organization does not provide or arrange for basic health care services.
(4) The health maintenance organization does not meet the requirements of Section 38-33-40 or is unable to fulfill its obligations to furnish health care services.
(5) The health maintenance organization is financially unsound or reasonably may be expected to be unable to meet its obligations to enrollees or prospective enrollees.
(6) The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under Section 38-33-60.
(7) The health maintenance organization has failed to implement the complaint system required by Section 38-33-110 in a reasonable manner to resolve valid complaints.
(8) The health maintenance organization, or a person on its behalf, advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner.
(9) The continued operation of the health maintenance organization is hazardous to its enrollees.
(10) The health maintenance organization otherwise has failed to comply with this chapter or regulations promulgated under it by the department.
(B) A certificate of authority is suspended or revoked only after compliance with the requirements of Section 38-33-210.
(C) When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization, during the suspension, may not enroll additional enrollees except newborn children or other newly acquired dependents of existing enrollees and may not engage in advertising or solicitation.
(D) When the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and may conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization.

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It may not engage in further advertising or solicitation. The director or his designee, by written order, may permit further operation of the organization he finds to be in the best interest of enrollees, to the end that enrollees are afforded the greatest practical opportunity to obtain continuing health care coverage.

SECTION 38-33-190. Rehabilitation, liquidation, or conservation of a health maintenance organization; priorities.

Any rehabilitation, liquidation, or conservation of a health maintenance organization is considered to be the rehabilitation, liquidation, or conservation of an insurance company and must be conducted under the supervision of the director or his designee pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies. The director or his designee may apply for an order directing him to rehabilitate, liquidate, or conserve a health maintenance organization upon any one or more grounds set out in Sections 38-27-310 and 38-27-370, or when in his opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this State. Enrollees shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

SECTION 38-33-200. Implementation of regulations.

The department may, after notice and hearing, promulgate regulations to carry out the provisions of this chapter.

SECTION 38-33-210. Notification of grounds for denial, suspension or revocation of certificate of authority; hearings; judicial review.

(A) When the director or his designee has cause to believe that grounds for the denial of an application for a certificate of authority exist, or that grounds for the suspension or revocation of a certificate of authority exist, he shall notify the health maintenance organization in writing specifically stating the grounds for denial, suspension, or revocation and fixing a time of at least thirty days thereafter for a hearing on the matter. However, if the ground for suspension or revocation relates solely to financial condition, the director or his designee may immediately and without hearing suspend the certificate of authority of the health maintenance organization.

(B) The provisions of Article 3, Chapter 23, Title 1, apply to administrative proceedings under this section. Whenever the director or his designee issues an order of suspension without an administrative hearing before the director or his designee based upon a health maintenance organization's financial condition, as authorized under subsection (A), the health maintenance organization has a right to judicial review before the Administrative Law Judge Division in accordance with law.

SECTION 38-33-220. Fees.

(A) Every health maintenance organization subject to this chapter shall pay to the department the following fees:

(1) for filing an application for a certificate of authority, two thousand dollars;

(2) for filing an amendment to the organization documents that requires approval, one hundred dollars;

(3) for filing each annual report, one thousand dollars;

(4) for transferring a certificate of authority from one entity to another which qualifies for such a certificate of authority, two thousand dollars.

(B) Fees charged under this section must be deposited in the general fund of the state. Fees required in this section must be fully earned when paid and are not refundable, proratable, nor transferable.

SECTION 38-33-230. Levy of administrative penalty in lieu of revocation or suspension of certificate of authority; monetary penalty; notice and hearings; injunctions.

(A) The director or his designee may, in lieu of revocation or suspension of a certificate of authority under Section 38-33-180, levy an administrative penalty of not more than fifteen thousand dollars for each violation or ground as prescribed therein. A series of acts by an organization which merely implement a basic violation and are not separate and distinct violations of an independent nature are considered to be part of the basic violation and only one penalty may be imposed. A monetary penalty may be imposed under this paragraph only after notice and an opportunity to be heard have been afforded in accordance with Section 38-33-210.
(B) Whenever the director or his designee has reason to believe that any person has transacted the business of, or is about to transact the business of, a health maintenance organization without a certificate of authority, he may cause a complaint to be filed in the court of common pleas of Richland County to enjoin and restrain the unauthorized transaction of business. The court has power to make and enter an order or judgment awarding such preliminary or final injunctive relief as may be necessary and proper. In addition, the court may impose a civil penalty of not more than ten thousand dollars upon such person for each unauthorized act of business so transacted.

SECTION 38-33-240. Application of provisions of insurance law or law relating to solicitation or advertising by health professionals; practice of medicine, dentistry or other healing profession.

(A) Except as otherwise specifically provided, the provisions of the insurance law do not apply to any health maintenance organization granted a certificate of authority under this chapter.
(B) Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, are not construed to violate any provision of law relating to solicitation or advertising by health professionals.
(C) No health maintenance organization authorized under this chapter is considered to be practicing medicine, dentistry, or other healing professions.

SECTION 38-33-250. Records of organization as public documents; trade secrets, etc.

All applications and filings required under Section 38-33-30 and any annual and quarterly financial reports required under Section 38-33-90 must be treated as public documents. Nothing herein may be construed to require disclosure of trade secrets, privileged or confidential commercial information, or replies to a specific request for information made by the director or his designee.

SECTION 38-33-260. Confidentiality of health records.

Any data or information pertaining to the diagnosis, treatment, or health of any enrollee or applicant obtained from such person or from any provider by any health maintenance organization is confidential and may not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this chapter, or upon the express consent of the enrollee or applicant, or pursuant to statute or court order for the production of evidence or the discovery thereof, or in the event of claim or litigation between such person and the health maintenance organization wherein the data or information is pertinent. A health maintenance organization is entitled to claim any statutory privileges against such disclosure which the provider who furnished the information to the health maintenance organization is entitled to claim.

SECTION 38-33-270. Contractual powers of Department to assist in investigative duties; assessments for consulting expenses.

(A) The director or his designee, in carrying out the obligations under Sections 38-33-40, 38-33-170(B), and 38-33-180(A), may contract with qualified persons to make recommendations concerning the determinations required to be made by him. The recommendations may be accepted in full or in part by the director or his designee.
(B) The director or his designee may assess the health maintenance organization directly for consulting expenses incurred pursuant to subsection (A) and require the organization to remit payment directly to the consultant. These expenses must be reasonable. The director or his designee is not required to but may consider the results of a quality assurance examination made at an appropriate time by a person with whom the health maintenance organization has a contract to provide health care services or by a person who has a legitimate interest in the quality of care provided by the organization.

SECTION 38-33-280. Acquisition or exchange of securities of a health maintenance organization; merger or consolidation of HMO.

(A) No person may make a tender for or a request or invitation for tenders of, or enter into an agreement to exchange securities for or acquire in the open market or otherwise, any voting security of a health maintenance organization or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the health maintenance organization, and no person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a health maintenance organization, unless, at the time any offer, request, or invitation is made or any agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the person has filed with the department and has sent to the health maintenance organization, information required by Section 38 21 70 and the offer, request, invitation, agreement, or acquisition has been approved by the director or his designee. Approval by the director or his designee is governed by Section 38-21-90.
(B) The provisions of Section 38-21-250 shall apply to health maintenance organizations.

SECTION 38-33-290. Participation by physician, podiatrist, optometrist, or oral surgeon as provided in HMO.

No health maintenance organization may prohibit any licensed physician, podiatrist, optometrist, or oral surgeon from participating as a provider in the organization on the basis of his profession. Nothing in this section may be construed to interfere in any way with the medical decision of the primary health care provider to use or not use any health professional on a case by case basis.

SECTION 38-33-300. Liability for participation in quality of care or utilization review.

There may be no monetary liability on the part of, and no cause of action may arise against, any person who participates in quality of care or utilization reviews by a peer review committee established in accordance with regulations of the department under Section 38-33-40(A)(2) for any act performed during such reviews, provided such person acts in good faith and without malice, has made a reasonable effort to obtain the facts of the matter, and reasonably believes that the action taken is warranted by the facts.

SECTION 38-33-310. HMO may contract with out of state provider.

Nothing in this chapter may be construed to prevent a health maintenance organization from contracting with an out of state provider.

SECTION 38-33-325. Obstetrician gynecologist services; referrals; authorization for services; member notification of plan provisions.

(A) A health benefit plan shall allow a female enrollee thirteen years of age or older a minimum of two visits annually pursuant to the health benefit plan, without prior referral, to the health care services of an obstetrician gynecologist in the health benefit plan.
(B) For any continuing treatment resulting from obstetrical or gynecological, or both, complications diagnosed during the two visits for a calendar year, authorization must be made for medical necessity directly by the health maintenance organization. Written communication should be sent by the obstetrician gynecologist to the patient's primary care physician regarding the condition being treated within a reasonable time after each visit.
(C) A health benefit plan must notify its members of the provisions of this subsection (A). The information must be provided in the Summary Plan Description materials and enrollment materials.
(D) For purposes of this section:
(1) "Health benefit plan" means a health maintenance organization, a preferred provider plan, an exclusive provider plan, or other managed care arrangement plan;
(2) "Health care services" means the full scope of medically necessary services provided by the participating obstetrician gynecologist in the care of or related to the female reproductive system and breasts.

SECTION 38-71-30. Whole contract, including application, must appear in policy; oral applications.
Every insurer doing accident or health insurance business in the State shall deliver with each policy of insurance issued by it a copy of the application made by the insured so that the whole contract appears in the application and policy of insurance. If the insurer violates this requirement, no defense is allowed to the policy on account of anything contained in or omitted from the application. If the insurance policy is issued upon an oral application, no defense is allowed to the policy on account of anything contained in or omitted from the oral application.

SECTION 38-71-46. Diabetes Mellitus coverage in health insurance policies; diabetes education.

(A) On or after January 1, 2000, every health maintenance organization, individual and group health insurance policy, or contract issued or renewed in this State must provide coverage for the equipment, supplies, Food and Drug Administration approved medication indicated for the treatment of diabetes, and outpatient self management training and education for the treatment of people with diabetes mellitus, if medically necessary, and prescribed by a health care professional who is legally authorized to prescribe such items and who demonstrates adherence to minimum standards of care for diabetes mellitus as adopted and published by the Diabetes Initiative of South Carolina. This subsection does not prohibit a health maintenance organization or an individual or a group health insurance policy from providing coverage for medication according to formulary or using network providers. Coverage must not be denied unless the health care professional demonstrates a persistent pattern of failure to adhere to the minimal standards of care and unless the health maintenance organization or insurer has first provided written notice to the health care professional that coverage will be denied if the health care professional fails to adhere to the minimal standards of care.
(B) Services and payment for diabetes education programs shall conform to regulations of the Health Care Financing Administration, US Department of Health and Human Services, pursuant to Section 4105 of the Balanced Budget Act of 1997. Diabetes outpatient self management training and education shall be provided by a registered or licensed health care professional with certification in diabetes by the National Certification Board of Diabetes Educators, or other accredited program approved by the Diabetes Initiative of South Carolina, or by the Diabetes Control Program of the SC Department of Health and Environmental Control in order to meet the needs of rural communities wherein certified health care professionals providing this service are not available.
(C) Nothing contained in this section may be construed to affect in any way the ability of a managed care plan to credential or re credential a provider.
(D) For purposes of this section: "Health insurance policy" means a health benefit plan, contract, or evidence of coverage providing health insurance coverage as defined in Section 38-71-670(6) and Section 38-71-840(14).

SECTION 38-71-50. Alteration of application.

No alteration of any written application for insurance by erasure, insertion, or otherwise may be made by any person other than the applicant without his written consent, and the making of any such alteration without the consent of the applicant is a misdemeanor. However, insertions may be made by the insurer, for administrative purposes only, in a manner that clearly indicates that the insertions are not to be ascribed to the applicant.

SECTION 38-71-70. Certain policies may conform to laws of other states.

Any foreign insurer authorized to do business in this State may, with the approval of the director or his designee, insert in any policy covered by this chapter so issued or delivered any provision required by the laws of any state or country in which the insurer is licensed, if the provision is not substantially in conflict with any law of this State. A domestic insurer may insert in any policy covered by this chapter issued for delivery in another state or foreign country and governed by the laws thereof any provision required by the laws of the other state or country applicable to the policy.

SECTION 38-71-110. Notice of failure of employer to remit deducted premium required before forfeiture.

No insurer doing business in this State and issuing health or accident insurance policies, other than contracts of group insurance of disability, accidental death, or disability and accidental death benefits in connection with policies of life insurance, the premium for which is to be collected in weekly, monthly, or other periodic installments by authority of a payroll deduction order executed by the insured and delivered to the insurer or the insured's employer authorizing the deduction of premium installments from the insured's salary or wages, may, during the period for which the policy is issued and while the insured remains employed by the authorized employer, declare forfeited or lapsed the policy until and unless a written or printed notice of the failure of the employer to remit the premium or installment thereof, stating the amount or portion thereof due on the policy and to whom it must be paid, has been duly addressed and mailed to the person who is insured under the policy at least fifteen days before the policy is terminated or lapsed.

SECTION 38-71-125. Mastectomies; hospitalization requirements; early release provisions.

All individual and group health insurance policies and health maintenance organizations providing coverage for the hospitalization for mastectomies must provide benefits for hospitalization for at least forty eight hours following a mastectomy. Nothing in this section shall be construed to prohibit an attending physician from releasing the patient prior to the expiration of the time provided herein. In the case of an early release, coverage shall include at least one home care visit if ordered by the attending physician.

SECTION 38-71-130. Breast reconstruction and prosthetic devices; coverage following mastectomy surgery.

All individual and group health insurance policies and health maintenance organizations providing coverage for mastectomy surgery must provide coverage for prosthetic devices and reconstruction of the breast on which surgery for breast cancer has been performed and surgery and reconstruction of the non diseased breast, if determined medically necessary by the patient's attending physician with the approval of the insurer or HMO. The provisions of this section shall not require supplemental health insurance policies to provide coverage for reconstruction of the non diseased breast.

SECTION 38-71-135. Minimum postpartum hospitalization and attendant services for mothers and newborns.

All individual and group health insurance and health maintenance organization policies providing coverage for the hospitalization and attendant professional services of a mother and her newborn child or children must provide for the mother and her newborn child or children to remain in the hospital for at least forty eight hours after a vaginal delivery, not including the day of delivery, and at least ninety six hours following a Cesarean Section, not including the day of surgery. Nothing in this section shall be construed to prohibit the attending physician, in consultation with the mother, from requesting additional time for hospitalization or from releasing the mother or her newborn child or children prior to the expiration of time provided herein.

SECTION 38-71-140. Coverage of newborn children.

(A) All individual and group health insurance policies providing coverage on an expense incurred basis and individual and group service or indemnity type contracts issued by a nonprofit corporation which provide coverage for a family member of the insured or subscriber, as to the family member's coverage, also must provide that the health insurance benefits applicable for children are payable with respect to a newly born child of the insured or subscriber from the moment of birth.
(B) The coverage for a newly born child consists of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.
(C) If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within thirty one days after the date of birth in order to have the coverage continue beyond the thirty one day period.
(D)(1) The provisions of this section apply to a child with respect to whom a decree of adoption by the insured or subscriber has been entered within thirty one days after the date of his birth and to a child with respect to whom:
(a) Adoption proceedings have been instituted by the insured or subscriber within thirty one days after the date of his birth and the insured or subscriber has temporary custody pursuant to Section 20-7-1738;
(b) The adoption proceedings have been completed and a decree of adoption entered within one year from the institution of proceedings, unless extended by order of the court by reason of the special needs of the child pursuant to Section 20-7 -1760.
(2) Coverage must be provided as long as the insured or subscriber has custody of the child pursuant to decree of the court and the required premiums or fees are furnished to the insurer or nonprofit service or indemnity corporation.

SECTION 38-71-143. Health plans must provide same coverage for children placed for adoption.

(A) If an individual or group health plan provides coverage for dependent children of participants or beneficiaries, the plan shall provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply to the natural, dependent children of the participants and beneficiaries, irrespective of whether the adoption has become final.
(B) A group health plan may not restrict coverage under the plan of a dependent child adopted by a participant or beneficiary or placed with a participant or beneficiary for adoption solely on the basis of a preexisting condition of the child at the time that the child would otherwise become eligible for coverage under the plan, if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for coverage under the plan.
(C) For the purposes of this section:
(1) "child" means, in connection with an adoption or placement for adoption of the child, an individual who has not attained age eighteen as of the date of the adoption or placement for adoption;
(2) "placement for adoption" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates upon the termination of the legal obligations.

SECTION 38-71-145. Required coverage for mammograms, pap smears, and prostate cancer examinations; limitations.

(A) All individual and group health insurance and health maintenance organization policies in this State shall include coverage in the policy for:
(1) mammograms;
(2) annual pap smears;
(3) prostate cancer examinations, screenings, and laboratory work for diagnostic purposes in accordance with the most recent published guidelines of the American Cancer Society.
(B) The coverage required to be offered under subsection (A) may not contain any exclusions, reductions, or other limitations as to coverages, deductibles, or coinsurance provisions which apply to that coverage unless these provisions apply generally to other similar benefits provided and paid for under the health insurance policy.
(C) Nothing in this section prohibits a health insurance policy from providing benefits greater than those required to be offered by subsections (A) and (B) or more favorable to the enrollee than those required to be offered by subsections (A) and (B).
(D) This section applies to individual and group health insurance policies issued by a fraternal benefit society, an insurer, a health maintenance organization, or any similar entity, except as exempted by ERISA.
(E) For purposes of this section:
(1) "Mammogram" means a radiological examination of the breast for purposes of detecting breast cancer when performed as a result of a physician referral or by a health testing service which utilizes radiological equipment approved by the Department of Health and Environmental Control, which examination may be made with the following minimum frequency:
(a) once as a base line mammogram for a female who is at least thirty five years of age but less than forty years of age;
(b) once every two years for a female who is at least forty years of age but less than fifty years of age;
(c) once a year for a female who is at least fifty years of age; or
(d) in accordance with the most recent published guidelines of the American Cancer Society.
(2) "Pap smear" means an examination of the tissues of the cervix of the uterus for the purpose of detecting cancer when performed upon the recommendation of a medical doctor, which examination may be made once a year or more often if recommended by a medical doctor.
(3) "Health insurance policy" means a health benefit plan, contract, or evidence of coverage providing health insurance coverage as defined in Section 38-71-670(6) and Section 38-71-840(14).

SECTION 38-71-150. Required provision in policies as to examination and surrender of policy for return of premium.

Every individual or family accident and health or hospitalization policy, certificate, contract, or plan, except trip or travel ticket policies, issued for delivery in this State shall have printed thereon or attached thereto a notice to the insured that ten days are allowed, from the date of the receipt of the policy to examine its provisions and that the insured may for any reason surrender the policy to the insurer. In addition, if the policy was solicited by a direct response insurer, rather than through a licensed insurance agent, the policy, certificate, contract, or plan shall have printed thereon or attached thereto a notice to the insured that thirty days are allowed from the date of the receipt of the policy to examine its provisions and that the insured may for any reason surrender the policy to the insurer. Any premium advanced by the insured, upon appropriate surrender as provided herein, must be immediately returned in full by the insurer to the insured.

SECTION 38-71-170. Required provision in policies for conversion privileges for former spouses.

No policy or certificate of accident, health, or accident and health insurance issued or delivered in this State which in addition to covering the insured also provides coverage to the spouse of the insured may contain a provision for termination of coverage for a spouse covered under the policy solely as a result of a break in the marital relationship except by reason of an entry of a valid decree of divorce between the parties.

Every policy which contains a provision for termination of coverage of the spouse upon divorce shall contain a provision to the effect that upon the entry of a valid decree of divorce between the insured parties the divorced spouse is entitled to have issued to him or her, without evidence of insurability, upon application made to the insurer within sixty days following the entry of the decree, and upon payment of the appropriate premium, an individual policy of accident and health insurance. The policy shall provide the coverage then being issued by the insurer which is most nearly similar to, but not greater than, the terminated coverages. Any probationary or waiting periods set forth in the policy are considered as being met to the extent coverage was in force under the prior policy.

SECTION 38-71-190. Subrogation of insurer to insured's rights against third party.

Any policy or contract of accident and health insurance issued in this State may include provision for subrogation by the insurer to the insured's right of recovery against a liable third party for not more than the amount of insurance benefits that the insurer has paid previously in relation to the insured's injury by the liable third party. If the director or his designee, upon being petitioned by the insured, determines that the exercise of subrogation by an insurer is inequitable and commits an injustice to the insured, subrogation is not allowed. Attorneys' fees and costs must be paid by the insurer from the amounts recovered. This determination by the director or his designee may be appealed to the Administrative Law Judge Division as provided by law in accordance with Section 38-3-210.

SECTION 38-71-200. Discrimination forbidden; benefits for services of podiatrist, oral surgeon, or optometrist.

Discrimination between individuals of the same class in the amount of premiums or rates charged for a policy of insurance covered by this chapter, in the benefits payable on the policy, in terms or conditions of the policy, or in another manner is prohibited except as provided in Sections 38-57-140 and 38-71-1110. If a policy of insurance governed by this chapter provides for payment or reimbursement for a service which is within the scope of practice of a licensed podiatrist, licensed oral surgeon, licensed optometrist, or licensed doctoral psychologist, the insured or other person entitled to benefits under the policy is entitled to payment or reimbursement in accordance with the usual and customary fee for the services whether the services are performed by a licensed physician or a licensed podiatrist, a licensed oral surgeon, a licensed optometrist, or a licensed doctoral psychologist, notwithstanding a provision in the policy, and the policyholder, insured, or beneficiary may choose the provider of the services.

SECTION 38-71-210. Health insurance policies to include chiropractic services.

If an insurer offers a policy containing a provision for medical expense benefits that does not provide payment for chiropractic services, it shall offer as a part thereof an optional rider or endorsement, if specifically requested by the insured or subscriber under an individual policy or a certificate holder or subscriber under a master policy, which defines such benefits as including payment to a chiropractor for procedures specified in the policy which are within the scope of the practice of chiropractic. Any additional cost to the insured or certificate holder must be reasonably related to benefits provided.

SECTION 38-71-215. Dermatology referrals.

(A) If a primary care physician makes a referral to a dermatologist, the enrollee in a managed care plan may see the in network dermatologist to whom the enrollee is referred, without further referral, for a minimum of six months or four visits, whichever first occurs, for diagnosis, medical treatment, or surgical procedures for the referral problem or related complications.
(B) Written communication from the dermatologist should be sent to the primary care physician after each visit.
(C) An enrollee with a documented past history of malignant melanoma may be referred by his or her primary care physician to an in network dermatologist for an annual evaluation and, as necessary, biopsy or surgery, or both.
(D) All services provided pursuant to this section are subject to contractual provisions regarding medical necessity and benefit coverage.
(E) Nothing in this section may be construed to extend benefits to an enrollee past the contract period.

SECTION 38-71-240 (A). Coverage required for cleft lip and palate; certain policies exempt.

(A) As used in this section:
(1) "Cleft lip and palate" means a congenital cleft in the lip or palate, or both.
(2) "Medically necessary care and treatment" shall include, but not be limited to:
(a) oral and facial surgery, surgical management, and follow up care made necessary because of a cleft lip and palate;
(b) prosthetic treatment such as obdurators, speech appliances, and feeding appliances;
(c) medically necessary orthodontic treatment and management;
(d) medically necessary prosthodontic treatment and management;
(e) otolaryngology treatment and management;
(f) audiological assessment, treatment, and management performed by or under the supervision of a licensed doctor of medicine, including surgically implanted amplification devices; and
(g) medically necessary physical therapy assessment and treatment.

SECTION 38-71-241. Percentage copayment and deductible must be applied to negotiated rate or lesser charge of that provider.

An insurer that negotiates rates with providers for covered health care services under an individual or group accident and health insurance policy must provide that percentage copayments and deductibles paid by the insured are applied to the negotiated rates or lesser charge of that provider. Nothing in this section precludes an insurer from issuing a policy which contains fixed dollar copayments and deductibles.

SECTION 38-71-265. Health insurer not to consider State medical assistance; subrogation of state to right to insurance payment for health care.

(A) In enrolling a person or in making any payments for benefits to a person or on behalf of a person, no health insurer, including a group health plan as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974 or health maintenance organization as defined in Section 38-33-20, may take into account that the person is eligible for or is provided medical assistance under a State Plan for Medical Assistance pursuant to Title XIX of the Social Security Act.
(B) In a case where a health insurer, including a group health plan as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974 or health maintenance organization as defined in Section 38 33 20, has a legal liability to make payments for medical assistance to or on behalf of a person, to the extent that payment has been made under a State Plan for Medical Assistance pursuant to Title XIX of the Social Security Act for health care items or services furnished to the person, the State is considered to have acquired the rights of the person to the payment for the health care items or services.

SECTION 38-71-275. Insurance coverage for certain drugs not to be excluded from policy definitions.

(A) No insurance policy which provides coverage for drugs shall exclude coverage of any such drug used for the treatment of cancer on the grounds that the drug has not been approved by the Federal Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed; provided, that such drug is recognized for treatment of that specific type of cancer in one of the standard reference compendia or in the medical literature.
(B) This section shall not be construed to:
(1) alter existing law with regard to provisions limiting the coverage of drugs that have not been approved by the Federal Food and Drug Administration;
(2) require coverage for any drug when the Federal Food and Drug Administration has determined its use to be contraindicated;
(3) require coverage for experimental drugs not otherwise approved for any indication by the Federal Food and Drug Administration;
(4) create, impair, alter, limit, modify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition.
(C) For purposes of this section:
(1) "Insurance policy" means an individual, group, or blanket policy written by a medical expense indemnity corporation, a hospital service corporation, a health care service plan contract, or a private insurance plan issued, amended, delivered, or renewed in this State or which provides insurance for residents of this State.
(2) "Standard reference compendia" means:
(a) the United States Pharmacopoeia Drug Information;
(b) the American Medical Association Drug Evaluations; or
(c) the American Hospital Formulary Service Drug Information.
(3) "Medical literature" means two articles from major peer reviewed professional medical journals that have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed unless one article from major peer reviewed professional medical journals has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed.

Section 38-71-370 (9). Optional provisions

(9) A provision as follows:
INTOXICANTS AND NARCOTICS:
The company is not liable for any loss resulting from the insured being drunk or under the influence of any narcotic unless taken on the advice of a physician.

SECTION 38-71-620. Advance notice required for increase in premium.

If an accident and health insurance policy contains provisions which reserve the right to the insurer to increase the premium, the policy shall also provide that at least thirty one days' prior written notice of a rate increase must be given to the insured before the rate increase becomes effective.

This section of the Code of Laws applies to group policies.

SECTION 38-71-710. Definitions.

(1) "Employees" as used in this article includes, for the purposes of insurance hereunder, as employees of a single employer, the officers, managers, and employees of the employer and of subsidiary or affiliated corporations of a corporate employer and the individual proprietors, partners, and employees of individuals and firms the business of which is controlled by the insured employer through stock ownership, contract, or otherwise. The policy or contract may provide that the term "employees" includes retired employees.
(2) "Employer" as used in this article may include any municipal corporation or the proper officers, as such, of any unincorporated municipality or any department of the municipal corporation or unincorporated municipality determined by conditions pertaining to the employment.
(3) A "group accident insurance policy" is a policy or contract of insurance against death or injury resulting from accident or from accidental means which covers more than one person, except blanket accident policies, family accident policies, and accident and health policies.
(4) A "group accident and health policy" is a policy or contract which combines the coverage of group accident insurance and of group health insurance.
(5) A "group health insurance policy" is a policy or contract which insures against disablement, disease, or sickness of the insured, excluding disablement which results from accident or from accidental means, which covers more than one person, except blanket health policies, family health policies, franchise health policies, and accident and health policies.

SECTION 38-71-720. Approval of forms required; refusal or withdrawal of approval; optional life insurance riders.

(A) A policy or contract of group accident, group health, or group accident and health insurance may not be issued or delivered in this State, nor may any application, endorsement, or rider which becomes a part of the policy be used, until a copy of the form has been filed with and approved by the director or his designee except as exempted by the director or his designee as permitted by Section 38-61-20. The director or his designee may disapprove the form if the form:
(1) does not meet the requirements of law;
(2) contains provisions which are unfair, deceptive, ambiguous, misleading, or unfairly discriminatory; or
(3) is solicited by means of advertising, communication, or dissemination of information which is deceptive or misleading.
If action is not taken to approve or disapprove a policy, contract, certificate, application, endorsement, or rider after the document has been filed for thirty days, it is deemed to be approved. The director or his designee, in his discretion, may extend for up to an additional sixty days the time period for approval or disapproval of the form. An organization may not use a form deemed approved pursuant to the default provision of this section until the organization has filed with the director or his designee a written notice of its intent to use the form. The notice must be filed in the office of the director at least ten days before the organization uses the form. The director or his designee, as soon as is practicable, shall notify in writing the insurer which has filed the form of his approval or disapproval. If the form is disapproved, the notice must contain the reasons for disapproval and the insurer is entitled to a public hearing on that decision. At any time after having given written approval, the director or his designee, after a public hearing of which at least thirty days' written notice has been given, may withdraw approval if he finds that the form:
(1) does not meet the requirements of law;
(2) contains provisions which are unfair, deceptive, ambiguous, misleading, or unfairly discriminatory; or
(3) is solicited by means of advertising, communication, or dissemination of information which is deceptive or misleading.
The withdrawal of approval must be effected by written notice to the insurer and the insurer is entitled to a public hearing on that decision. Any action or decision of the director or his designee to withdraw

SECTION 38-71-720. Continued

approval may be appealed to the Administrative Law Judge Division in accordance with Section 38-3-210.

(B) Nothing in this chapter precludes the issuance of a policy or contract of group accident, group health, or group accident and health insurance that includes an optional life insurance rider. However, the optional life insurance rider must be filed with and approved by the director or his designee pursuant to Section 38-61-20 and comply with all applicable sections of Chapter 65 and, in addition, in the case of a life insurance rider with accelerated long term care benefits, Chapter 72 of this title.

SECTION 38-71-730. Requirements for group accident, group health, and group accident and health policies.

No policy of group health, group accident, or group accident and health insurance may be delivered or issued for delivery in this State unless it conforms to the following description:

(1) Except as provided in this item, the policy is issued to a trust or to insure two or more persons who are associated in a common group for purposes other than the obtaining of insurance.

(a) Group policies of credit accident and health insurance may be issued to persons other than those in a common group. (b) A common group of small employers may be formed solely for the purpose of obtaining insurance. Such a group must comply with the following provisions:

(i) It contains at least one thousand eligible employees.

(ii) It establishes requirements for membership. However, the common group cannot exclude any small employer, which otherwise meets the requirements for membership, on the basis of claim experience or any health status related factors, as defined in Section 38-71-840, in relation to the employee or a dependent of the employee.

(iii) It holds an open enrollment period at least once a year during which new members can join the common group.

(iv) It allows eligible employees and their dependents, upon initial enrollment and during subsequent open enrollment periods, to choose among health insurance plans offered through the group. Persons covered by a health insurance plan offered through the group which requires an enrollment period in excess of one year are eligible to choose among available plans upon the completion of the enrollment period.

(v) It offers coverage under all plans offered through the group to all eligible employees of member small employers and their dependents. Coverage may not be offered only to certain employees of member small employers and their dependents except as provided in Section 38-71-1370(B) of this chapter.

(vi) It does not assume any risk or form self insurance plans among its members unless it complies with the provisions of Chapter 41 of this title.

(vii) It has the option of using any type of rating arrangement with the health insurance plans and, at its discretion, premiums may be paid to the health insurance plans by the common group, by member small employers, or by eligible employees and their dependents.

(A) Health insurance plans offered through the common group which rate each member small employer separately are subject to the laws governing small employer health insurance; and

(B) Health insurance plans offered through the common group which rate the entire group as a whole must charge each insured person based on a community rate within the common group, adjusted for case characteristics as permitted by Section 38-71-940 and plan selection, and are subject to the laws governing group accident and health insurance.

(viii) It may not act as an agent or engage in any activities for which an insurance agent's license is required.

(ix) Before offering any health insurance plans through the common group, and annually thereafter, it registers with the department and demonstrates continued compliance with the subitems b)(i) through (viii).

(2) The benefits provided by the policy are based on some plan or plans precluding individual selection, except that insurance supplemental to the basic coverage may be available to persons insured under the policy.

SECTION 38-71-730. Continued

(3) For all groups, no evidence of individual insurability may be required at the time the person first becomes eligible for insurance or within thirty one days thereafter. Nothing in this section precludes the obtaining of medical information with respect to the members of the group for use in determining the insurability of the group, but the information may not be used to exclude an individual from coverage. In addition, group health insurance coverage, as defined in Section 38-71-840 must adhere to the requirements of Section 38-71-860 prohibiting discrimination against individual participants and beneficiaries based on health status related factors.

(4) Except for group health insurance coverage as defined in Section 38-71-840, the policies may contain a provision limiting coverage for preexisting conditions. The preexisting conditions must be covered no later than twelve months without medical care, treatment, or supplies ending after the effective date of the coverage or twelve months after the effective date of the coverage, whichever occurs first. Policies of disability income insurance may exclude coverage for disabilities beginning during the first twelve months after the effective date of coverage which result from a preexisting condition. Preexisting conditions are defined as those conditions for which medical advice or treatment was received or recommended no more than twelve months before the effective date of a person's coverage. However, whenever a covered person moves from one insured group to another, the insurer of the group to which the covered person moves shall give credit for the satisfaction of the preexisting condition period or portion thereof already served under the prior plan if the coverage is selected when the person first becomes eligible and the coverage is continuous to a date not more than thirty days prior to the effective date of the new coverage. Service under a probationary waiting period required by the employer is not considered to interrupt continuous service. The requirements with respect to limitations on preexisting condition exclusions for group health insurance coverage are described in Section 38-71-850.

(5) Except as provided in item (1)(b)(vii) of this section, the premium for the policy must be paid by the policyholder from the policyholder's funds or from funds contributed by the insured persons, or from both.

(6) A group policy or subscriber contract of accident and health insurance 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 must equal, and may exceed, the minimum standards for Medicare supplement policies as contained in regulations promulgated by the department.

SECTION 38-71-735. Required provisions.

No policy of group accident, group health, or group accident and health insurance may be delivered in this State unless it contains in substance the following provisions, or provisions which in the opinion of the director or his designee are more favorable to the persons insured, or at least as favorable to the persons insured, and more favorable to the policyholder. However, (1) items (f) and (k) do not apply to policies issued to a creditor; (2) the standard provisions required for individual policies do not apply to group policies; and (3) if any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the director or his designee, shall omit from the policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in a manner as to make the provision contained in the policy consistent with the coverage provided by the policy:

(a) A provision that the policyholder is entitled to a grace period of thirty one days for the payment of any premium due except the first, during which grace period the policy continues in force, unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder is liable to the insurer for the payment of a pro ratio premium for the time the policy was in force during the grace period.

(b) A provision that the validity of the policy may not be contested after it has been in force for two years from its date of issue and that no statement, except fraudulent misstatements, made by any person covered under the policy relating to insurability may be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force prior to the contest

SECTION 38-71-735. Continued

for a period of two years during the person's lifetime nor unless it is contained in a written instrument signed by the person making the statement. The provision does not preclude the assertion at any time of defenses based upon the person's ineligibility for coverage under the policy or upon other provisions in the policy.

(c) A provision that a copy of the application, if any, of the policyholder must be attached to the policy when issued, that all statements made by the policyholder or by the persons insured are considered representations and not warranties, and that no statement made by any person insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the person or, in the event of the death or incapacity of the insured person, to the individual's beneficiary or personal representative.

(d) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the individual's coverage.

(e) If the premiums or benefits vary by age, there must be a provision specifying an equitable adjustment of premiums or of benefits, or both, to be made in the event the age of a covered person has been misstated. The provision must contain a clear statement of the method of adjustment to be used.

(f) A provision that the insurer will issue to the policyholder for delivery to each person insured a certificate setting forth a statement as to the insurance protection to which that person is entitled, to whom the insurance benefits are payable, and a statement as to any family member's or dependent's coverage.

(g) A provision that written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy. Failure to give notice within the time does not invalidate nor reduce any claim if it can be shown not to have been reasonably possible to give the notice and that notice was given as soon as was reasonably possible.

(h) A provision that the insurer will furnish to the person making claim, or to the policyholder for delivery to such person, such forms as are usually furnished by it for filing proof of loss. If the forms are not furnished before the expiration of fifteen days after the insurer received notice of any claim under the policy, the person making the claim is considered to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

(i) A provision that in the case of claim for loss of time for disability, written proof of the loss must be furnished to the insurer within ninety days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of the disability must be furnished to the insurer at intervals the insurer may reasonably require, and that in the case of claim for any other loss, written proof of the loss must be furnished to the insurer within ninety days after the date of the loss. Failure to furnish proof within the time does not invalidate nor reduce any claim if it was not reasonably possible to furnish the proof within that time so long as the proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

(j) A provision that all benefits payable under the policy other than benefits for loss of time will be paid not more than sixty days after receipt of proof of the loss. Subject to proof of loss, all accrued benefits payable under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of liability will be paid as soon as possible after receipt of the proof.

(k) A provision that benefits for loss of life of the person insured are payable to the beneficiary designated by the person insured. If the policy contains conditions pertaining to family status the beneficiary may be the family member specified by the policy terms. In either case, payment of these benefits is subject to the provisions of law of this State if no such designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy are payable to the person insured. The policy also may provide that if any benefit is payable to the estate of a person or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay the benefit, up to an amount not exceeding five thousand dollars, to any relative by blood or connection by marriage of the person who is considered by the insurer to be equitably entitled to the benefit.

SECTION 38-71-735. Continued

(l) A provision that the insurer at its own expense may examine the person of the individual for whom claim is made as often as reasonably necessary while a claim is pending and in cases of death of the insured the insurer at its own expense also may have an autopsy performed during the period of contestability unless prohibited by law. The autopsy must be performed in this State.

(m) A provision that no action at law or in equity may be brought to recover on the policy before the expiration of sixty days after written proof of loss has been filed in accordance with the requirements of the policy and that no such action may be brought at all unless brought within six years after the time written proof of loss is required to be furnished.

(n) In the case of a policy issued to a creditor, a provision that the insurer will furnish the policyholder for delivery to each debtor insured under the policy a certificate of insurance describing the coverage and specifying that the benefits payable first must be applied to reduce or extinguish the indebtedness.

SECTION 38-71-737. Requirement of coverage for psychiatric conditions in group health insurance policies; "psychiatric conditions" defined.

(A) An offer to sell a group health insurance policy must include an offer of an optional rider or endorsement to provide benefits for psychiatric conditions as defined in this section. The offer of coverage may contain provisions prescribing different benefits for psychiatric conditions and physical conditions with respect to any deductible amount, coinsurance provision, or contract term affecting benefit determinations based upon use or nonuse of preferred providers.

(B) The offer of an optional rider or endorsement for a group health insurance policy must provide minimum benefits for psychiatric conditions not less than two thousand dollars for each member for each benefit year with a lifetime maximum benefit of ten thousand dollars. In the case of group health insurance coverage, as defined in Section 38-71-840, the requirements of Section 38-71-880 regarding parity in the application of certain limits to mental health benefits shall apply to those benefits defined as mental health benefits in Section 38-71-880(E). However, if group health insurance coverage is exempted from the requirements of Section 38-71-880, then the requirements of this provision shall apply. In addition, for group health insurance coverage, the requirements of this provision shall apply to benefits for psychiatric conditions which are not considered mental health benefits.

(C) This section does not prohibit an insurer from issuing or continuing to issue a health insurance policy which provides benefits greater than the minimum benefits required by this section or benefits generally more favorable to the insured than those required by this section.

(D) As used in this section, "psychiatric conditions" means those mental and nervous conditions, drug and substance addiction or abuse, alcoholism, or other conditions that are defined, described, or classified as psychiatric disorders or conditions in the most current publication of the American Psychiatric Association entitled "The Diagnostic and Statistical Manual of Mental Disorders".

SECTION 38-71-740. Restrictions on mass marketed insurance.

No mass marketed accident, health, or accident and health insurance may be effected on a person in this State if the charges to the individual insureds are unreasonable in relation to the benefits provided. "Mass marketed accident, health, or accident and health insurance" for purposes of this chapter means coverage under any group or blanket policy which is offered by means of direct response solicitation whether through a sponsoring organization or the mails or other media, except that it does not include coverage offered to an employee or union member through his employer or union, to a member of a professional association, to a member of a national association of retired or aged persons through the association, or to a member of a national association of war veterans either chartered by Congress or composed of veterans of a particular ethnic, racial, or religious background through the association. This coverage offered through a trust formed by one or more employers, labor unions, or both, or by a professional association or association of retired or aged persons or war veterans to provide insurance coverage for employees, union members, and their dependents, or for association members and their dependents, is considered to be offered through the employer, union, or association respectively. "Direct response solicitation" means any offer by an insurer to persons in this State to effect such insurance coverage which enables the individual to apply or enroll for the insurance on the basis of that offer.

SECTION 38-71-750. Requirements of group policies extended to group policies issued outside State to residents; approval required for mass marketed policies and certificates.

(1) No group accident, group health, or group accident and health insurance coverage may be extended to residents of this State under a policy issued outside this State which does not provide in substance the provisions of this article unless the director or his designee determines that certain provisions are not appropriate for the coverage provided.
(2) Any insurer extending blanket or group accident, health, or accident and health insurance under a policy issued outside this State to residents of this State shall comply with the requirements of this State relating to advertising and to claims settlement practices with respect to the insurance.
(3) Upon request of the director or his designee, copies of policies and certificates under a policy of group accident, group health, or group accident and health insurance issued outside this State and covering residents of this State must be made available on an informational basis only. However, mass marketed accident, health, or accident and health insurance policies and certificates must receive approval of the director or his designee pursuant to Section 38-71-720 before they can be offered for sale to residents of this State.

SECTION 38-71-760. Standards for group accident and health insurance coverage, discontinuance, and replacement.

(a) This section applies to a group accident, group health, or group accident and health insurance or health maintenance organization policy or certificate that is delivered, issued for delivery, or renewed in this State which provides hospital, surgical, or major medical expense insurance, or any combination of these coverages, on an expense incurred basis. It specifically includes a certificate issued under a policy that was issued to a trust located out of the State but which includes participating units located in the State. Renewal of these policies or certificates is presumed to occur on the anniversary date of the date that coverage was first effective unless another renewal date is specifically stated in the certificate.
(b) If a policy or contract subject to this article provides for automatic discontinuance of the policy or contract after a premium or subscription charge has remained unpaid through the grace period allowed for the payment, the carrier is liable for valid claims for covered losses incurred prior to the end of the grace period.
(c) If the actions of the carrier after the end of the grace period indicate that it considers the policy or contract as continuing in force beyond the end of the grace period such as by continuing to recognize claims subsequently incurred, the carrier is liable for valid claims for losses beginning on or before the effective date of the written notice of discontinuance to the policyholder or other entity responsible for making payments or submitting subscription charges to the carrier. The effective date of discontinuance may not be prior to midnight at the end of the third scheduled work day after the date upon which the notice is delivered.
(d) In addition to the notice required under Section 38-71-870 or Section 38-71-675, any notice of discontinuance by the carrier shall include a request to the group policyholder or other entity involved to notify certificate holders covered under the policy or subscriber contract of the date when the group policy or contract will discontinue and advise that, unless otherwise provided in the policy or contract, the carrier is not liable for claims for losses incurred after such date. The notice also shall advise, when the plan involves certificate holder contributions, that, if the policyholder or other entity continues to collect contributions for the coverage beyond the date of discontinuance, the policyholder or other entity may be held solely liable for the benefits for which the contributions are collected.
(e) The carrier shall prepare and furnish to the policyholder or other entity at the same time an appropriate sample notice form to be distributed to the certificate holders concerned indicating the effective date of the discontinuance and urge the certificate holders to refer to their certificates or contracts in order to determine what rights are available to them as a result of the discontinuance.
(f) Every group policy, contract, or certificate issued subject to this article or under which the level of benefits is modified or amended shall provide a reasonable provision for extension of benefits in the event of total disability at the date of discontinuance of the group policy, contract, or certificate as required by the following subsections.

SECTION 38-71-760. Continued

(g) In the case of a group life plan which contains a disability benefit extension of any type such as premium waiver extension, extended death benefit in the event of total disability, or payment of income for a specified period during total disability, the discontinuance of the group policy, contract or certificate does not operate to terminate the extension.

(h) In the case of a group plan providing benefits for loss of time from work or specific indemnity during hospital confinement, discontinuance of the group policy, contract or certificate during a disability has no effect on benefits payable for that disability or confinement.

(i) In the case of hospital or medical expense coverages other than dental expense, a reasonable extension of benefits or accrued liability provision is required. The provision is considered reasonable if it provides an extension of at least twelve months under major medical and comprehensive medical type coverages and under other types of hospital or medical expense coverages provides either an extension of at least ninety days or an accrued liability for expenses incurred during a period of disability or during a period of at least ninety days starting with a specific event which occurred while coverage was in force such as an accident.

(j) Any applicable extension of benefits or accrued liability must be described in any policy, contract, or certificate involved. The benefits payable during any period of extension or accrued liability are subject to the policy's, contract's, or certificate's regular benefit limits such as benefits ceasing at exhaustion of a benefit period or of maximum benefits. For hospital or medical expense coverages, the benefit payments are limited to payments applicable to the disabling condition only. However, the carrier may not charge any premium during any period of extension.

(k) A replacement carrier is considered to be a succeeding carrier within the meaning of this section if the effective date of the coverage provided by it is sixty two days or less after the date of termination of coverage of the prior carrier.

(l) This subsection applies to the prior carrier.

(1) The prior carrier remains liable only to the extent of its accrued liabilities and extensions of benefits. The position of the prior carrier is the same whether the group policyholder or other entity secures replacement coverage from a new carrier, self insures, or foregoes the provision of coverage.

(2) For health insurance coverage as defined in Section 38-71-840, in all situations except the prior carrier's withdrawal from the large group market, the small group market or both markets in this State, the liability of the prior carrier for extension of benefits terminates at the earliest of the following:

(A) The date the individual has full coverage for the disabling condition under a group health plan with similar benefits and that plan makes reasonable provision for continuity of care for the disabling condition.

(B) The date the individual is no longer totally disabled.

(C) The date the extension period required in subparagraph (i) expires.

(D) The date of exhaustion of a benefit period of the payment of maximum benefits as provided for in subparagraph (j).

(m) This subsection applies to all groups.

(1) Each person who is eligible for coverage in accordance with the succeeding carrier's plan of benefits with respect to classes eligible and actively at work and non-confinement rules must be covered by the succeeding carrier's plan of benefits. For health insurance coverage as defined in Section 38-71-840, non-confinement rules are not permitted and absence from work due to any health status related factor must be treated as being actively at work.

(2) Each person not covered under the succeeding carrier's plan of benefits in accordance with item (1) of this subsection (m) nevertheless must be covered by the succeeding carrier in accordance with the following rules if the individual was validly covered, including benefit extension, under the prior plan on the date of discontinuance and if the individual is a member of the class of individuals eligible for coverage under the succeeding carrier's plan. Any reference in the following rules to an individual who was or was not totally disabled is a reference to the individual's status immediately prior to the date the succeeding carrier's coverage becomes effective.

(A) The minimum level of benefits to be provided by the succeeding carrier must be the applicable level of benefits of the succeeding carrier's plan reduced by any benefits payable by the prior plan.

SECTION 38-71-760. Continued

(B) Coverage must be provided by the succeeding carrier until at least the earliest of the following dates:

(i) The date the individual becomes eligible under the succeeding carrier's plan as described in item (1) of this subsection (m).

(ii) For each type of coverage, the date the individual's coverage would terminate in accordance with the succeeding carrier's plan provisions applicable to individual termination of coverage, such as at termination of employment or ceasing to be an eligible dependent, as the case may be.

(iii) In the case of an individual who was totally disabled, and in the case of a type of coverage for which subsections (f) through (j) of this section require an extension of benefits or accrued liability, the end of any period of extension or accrued liability which is required of the prior carrier by those subsections or, if the prior carrier's policy or contract is not subject to those subsections, would have been required of that carrier had its policy or contract been subject to those subsections at the time the prior plan was discontinued and replaced by the succeeding carrier's plan.

(3) For health insurance coverage as defined in Section 38-71-840, in the case of an individual who was totally disabled at the time the prior plan was discontinued and replaced by a group health plan with similar benefits, and in the case in which subsection (1) of this section requires an extension of benefits or accrued liability, the minimum level of benefits to be provided by the succeeding carrier must be the applicable level of benefits of the succeeding carrier's plan. This benefit may be reduced by any benefits paid by the prior plan.

(4) In the case of a preexisting conditions limitation included in the succeeding carrier's plan, the level of benefits applicable to preexisting conditions of persons becoming covered by the succeeding carrier's plan in accordance with this subsection (m) during the period of time this limitation applies under the new plan must be the lesser of:

(A) the benefits of the new plan determined without application of the preexisting conditions limitation; and

(B) the benefits of the prior plan.

(5) The succeeding carrier, in applying any deductibles, coinsurance amounts applicable to the out of pocket maximums or waiting periods in its plan, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. In the case of deductible provisions or coinsurance amounts applicable to the out of pocket maximums, the credit must apply for the same or overlapping benefit periods and must be given for expenses actually incurred and applied against the deductible provisions or to the out of pocket maximums of the prior carrier's plan during the ninety days preceding the effective date of the succeeding carrier's plan but only to the extent these expenses are recognized under the terms of the succeeding carrier's plan and are subject to similar deductible or coinsurance provisions.

(6) In any situation where a determination of the prior carrier's benefit is required by the succeeding carrier, at the succeeding carrier's request the prior carrier shall furnish a statement of the benefits available or pertinent information sufficient to permit verification of the benefit determination or the determination itself by the succeeding carrier. For the purposes of this section, benefits of the prior plan are determined in accordance with all of the definitions, conditions, and covered expense provisions of the prior plan rather than those of the succeeding plan. The benefit determination must be made as if coverage had not been replaced by the succeeding carrier.

SECTION 38-71-770. Mandatory continuation and conversion privileges.

A group policy issued for delivery or renewed in this State which provides hospital, surgical, or major medical expense insurance, or any combination of these coverages, on an expense incurred basis must provide that an employee or member who has been insured continuously under the group policy for at least six months whose insurance under the group policy has been terminated for any reason other than nonpayment of the required contribution is entitled to continue coverage under the group policy for the fractional policy month remaining at termination plus six additional policy months. A group policy is considered to be a successor policy within the meaning of this section if the effective date of the coverage provided by it is sixty two days or less after the date of termination of coverage of the prior carrier. The employee or member is not entitled to have his coverage continued if the employee or member was entitled under federal law to continuation of his coverage for a period of greater duration than provided by this section. Continuation of coverage is subject to the group policy or a successor policy remaining in force and the employee paying the entire group premium, including any portion usually paid by the former employer, before the date each month that the group policy month begins. Policies which provide benefits for other than hospital, surgical, major medical, or which provide benefits for specific diseases or accidental injuries only are not affected by this section.

A notification of the privilege to continue coverage after termination must be included in each certificate of coverage. In addition, the employer shall clearly and meaningfully advise an employee upon termination of the right to continue insurance and shall advise the employee of the amount of premium required and of the employee's responsibility to pay the premium each month before the date that the policy month begins. An employee is not entitled to continue coverage under the group if eligible for other group coverage which provides similar benefits nor if the person is eligible for Medicare benefits provided by Title XVIII of the United States Social Security Act or of any successor acts. Any benefits, except extended benefits payable by the policy during the period of continuation, are considered secondary to benefits under any other group health policy that is in force on a person insured through this continuation privilege.

SECTION 38-71-780. Required provision for continuation of coverage for handicapped and dependent children.

A group hospital or medical expense insurance policy, hospital service plan contract, or medical service plan contract delivered or issued for delivery in this State which provides that coverage of a dependent child of an employee or other member of the coverage group terminates upon attainment of the limiting age for dependent children specified in the policy or contract shall also provide in substance that attainment of the limiting age does not operate to terminate the coverage of the child while the child is and continues to be both (a) incapable of self sustaining employment by reason of mental retardation or physical handicap, and (b) chiefly dependent upon the employee or member for support and maintenance, as long as proof of the incapacity and dependency is furnished to the insurer by the employee or member within thirty one days of the child's attainment of the limiting age and subsequently as may be required by the insurer, but not more frequently than annually after the two year period following the child's attainment of the limiting age.

SECTION 38-71-790. Payment of benefits.

The benefits payable under any policy or contract of group accident, group health, and group accident and health insurance are payable to the employee or to some beneficiary or beneficiaries designated by him, other than the employer. However, if there is no designated beneficiary as to all or any part of the insurance at the death of the employee or member, then the amount of insurance payable for which there is no designated beneficiary is payable to the estate of the employee or member, except that:

(1) The insurer may in such case, at its option, pay the insurance to any one or more of the following surviving relatives of the employee or member: wife, husband, mother, father, child or children, or brothers or sisters; and

(2) Payment of benefits for expenses incurred on account of hospitalization or medical or surgical aid, as provided in Section 38-71-800, may be made by the insurer to the hospital or other person furnishing the aid. Payment so made discharges the insurer's obligation with respect to the amount of insurance so paid.

SECTION 38-71-800. Hospital and medical expenses.

Any policy or contract of group accident, group health, or group accident and health insurance may include provisions for the payment by the insurer of benefits to the employee or other member of the insured group on account of hospitalization or medical or surgical aid for himself, his spouse, his child or children, or other individuals chiefly dependent upon him for support and maintenance.

SECTION 38-71-810. Readjustment of rates or refunds or dividends.

Any policy or contract of group accident, group health, or group accident and health insurance may provide for readjustment of the rate of premium based on experience thereunder at the end of the first year or of any subsequent year of insurance thereunder. The readjustment may be retroactive only for that policy year. Any refund under any plan for readjustment of the rate of premium based on the experience under group policies and any dividend paid under these policies may be used to reduce the policyholder's contribution to group insurance for the insureds of the policyholder and the excess over the contribution by the employer must be applied by the policyholder for the sole benefit of the insureds.

SECTION 38-71-840. Definitions.

(A) As used in this subarticle:
(1) "Affiliation period" means a period which, under the terms of the health insurance coverage offered by a health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during the period, and no premium may be charged to the participant or beneficiary for any coverage during the period. The period begins on the enrollment date and runs concurrently with any waiting period under the plan.
(2) "Beneficiary" has the meaning given the term under Section 3(8) of the Employee Retirement Income Security Act of 1974.
(3) "Bona fide association" means, with respect to health insurance coverage offered in the State, an association which:
(a) has been actively in existence for at least five years;
(b) has been formed and maintained in good faith for purposes other than obtaining insurance;
(c) does not condition membership in the association on any health status related factor relating to an individual, including an employee of an employer or a dependent of an employee;
(d) makes health insurance coverage offered through the association available to all members regardless of any health status related factor relating to the members or individuals eligible for coverage through a member;
(e) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and
(f) meets additional requirements as may be imposed under state law.
(4) "COBRA continuation provision" means any of the following:
(a) Part 6, Subtitle B, Title I of the Employee Retirement Income Security Act of 1974 other than Section 609 of the act;
(b) Section 4908B of the Internal Revenue Code of 1986, other than subsection (f)(1) of the section insofar as it relates to pediatric vaccines; or
(c) Title XXII of the Public Health Service Act.
(5) "Church plan" has the meaning given the term under Section 3(33) of the Employee Retirement Income Security Act of 1974.
(6) "Director of Insurance" or "director" means the person who is appointed by the Governor upon the advice and consent of the Senate and who is responsible for the operation and management of the Department of Insurance, including all of its divisions. The director may appoint or designate the person or persons who shall serve at the pleasure of the director to carry out the objectives or duties of the department as provided by law. "Director" also includes a designee or deputy director upon whom the director has bestowed any duty or function required of the director by law in managing or supervising the Department of Insurance.

SECTION 38-71-840. Continued

(7) "Employee" has the meaning given the term under Section 3(6) of the Employee Retirement Income Security Act of 1974.

(8) "Employer" has the meaning given the term under Section 3(5) of the Employee Retirement Income Security Act of 1974, except that the term includes only employers of two or more employees.

(9) "Employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries.

(10) "Enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for the enrollment.

(11) "Governmental plan" has the meaning given the term under Section 3(32) of the Employee Retirement Income Security Act of 1974 and any governmental plan established or maintained for its employees by the government of the United States or by any agency or instrumentality of the government.

(12) "Group health insurance coverage" means, in connection with a group health plan, health insurance coverage offered by a health insurance issuer in connection with the plan.

(13) "Group health plan" means an employee welfare benefit plan, as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, to the extent that the plan provides medical care, including items and services paid for as medical care, to employees or their dependents, as defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise.

(14) "Health insurance coverage" means benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer, except:

(a) coverage only for accident, or disability income insurance, or any combination of accident and disability income insurance;

(b) coverage issued as a supplement to liability insurance;

(c) liability insurance, including general liability insurance and automobile liability insurance;

(d) workers' compensation or similar insurance;

(e) automobile medical payment insurance;

(f) credit only insurance;

(g) coverage for on site medical clinics;

(h) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(i) if offered separately:

(i) limited scope dental or vision benefits;

(ii) benefits for long term care, nursing home care, home health care, community based care, or any combination of these;

(iii) other similar, limited benefits as are specified in regulations;

(j) if offered as independent, noncoordinated benefits:

(i) coverage only for a specified disease or illness;

(ii) hospital indemnity or other fixed indemnity insurance;

(k) if offered as a separate insurance policy:

(i) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

(ii) coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code; and

(iii) similar supplemental coverage under a group health plan.

(15) "Group participation rule" means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage of number of eligible individuals or employees of an employer.

(16) "Health insurance issuer" or "issuer" means any entity that provides health insurance coverage in this State. For purposes of this section, "issuer" includes an insurance company, a health maintenance organization, and any other entity providing health insurance coverage which is licensed to engage in the business of insurance in this State and which is subject to state insurance regulation.

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(17) "Health maintenance organization" means an organization as defined in Section 38-33-20(7).

(18) "Health status related factor" means any of the following factors in relation to the individual or a dependent of the individual: health status; medical condition, including both physical and mental illnesses; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; or disability.

(19) "Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market but does not include short term limited duration insurance.

(20) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan. The term includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year unless the State elects to regulate coverage as coverage issued to small employers as defined in Section 38-71-1330.

(21) "Large group market" means the health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health plan maintained by an employer that is not a small employer, as defined in Section 38-71-1330.

(22) "Late enrollee" means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during:

(a) the first period in which the individual is eligible to enroll under the plan if the initial enrollment period is a period of at least thirty days; or

(b) a special enrollment period under Section 38-71-850(E).

(23) "Medical care" means amounts paid for:

(a) the diagnosis, cure, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;

(b) amounts paid for transportation primarily for and essential to medical care referred to in subitem (a); and

(c) amounts paid for insurance covering medical care referred to in subitems (a) and (b).

(24) "Network plan" means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(25) "Participant" has the meaning given the term under Section 3(7) of the Employee Retirement Income Security Act of 1974.

(26) "Placement" or being "placed" for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by the person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child's placement with the person terminates upon the termination of such legal obligation.

(27) "Plan sponsor" has the meaning given the term under Section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

(28) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the date. Genetic information may not be treated as a preexisting condition in the absence of a diagnosis of the condition related to the information.

(29) "Small group market" means the health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health plan maintained by a small employer, as defined in Section 38-71-1330.

(30) "Waiting period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

SECTION 38-71-850. Preexisting condition exclusion; limitations; creditable coverage; certification; enrollment for coverage.

(A) Subject to subsection (C), a health insurance issuer offering group health insurance coverage, may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if the:
(1) exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six month period ending on the enrollment date;
(2) exclusion extends for not more than twelve months without medical care, treatment, or supplies ending after the effective date of coverage or twelve months after the enrollment date, whichever occurs first, or eighteen months after the enrollment date in the case of a late enrollee; and
(3) period of any preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage if any, as defined in item (B)(1), applicable to the participant or beneficiary as of the enrollment date.
(B)(1) For purposes of this subarticle, "creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:
(a) a group health plan;
(b) health insurance coverage;
(c) Part A or Part B, Title XVIII of the Social Security Act;
(d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928;
(e) Chapter 55, Title 10 of the United States Code;
(f) a medical care program of the Indian Health Service or of a tribal organization;
(g) a state health benefits risk pool, including the South Carolina Health Insurance Pool;
(h) a health plan offered under Chapter 89 of Title 5, United States Code;
(i) a public health plan as defined in regulations;
(j) a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).
The term does not include coverage consisting solely of those benefits excepted from the definition of health insurance coverage.
(2)(a) A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a sixty three day period during all of which the individual was not covered under any creditable coverage.
(b) For purposes of item (2)(a) and item (C)(4), any period that an individual is in a waiting period for any coverage under a group health plan or for group health insurance coverage or is in an affiliation period, as defined in Section 38 71 840, shall not be taken into account in determining the continuous period under subitem (a).
(3)(a) Except as otherwise provided under subitem (b), for purposes of applying subitem (A)(3), a health insurance issuer offering group health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.
(b) A health insurance issuer offering group health insurance, may elect to apply item (A)(3) based on coverage of benefits within each of several classes or categories of benefits specified in regulations rather than as provided under subitem (a). The election must be made on a uniform basis for all participants and beneficiaries. Under the election an issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.
(c) In the case of an election under subitem (b) with respect to health insurance coverage offered by an issuer in the small or large group market, the issuer:
(i) shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the issuer has made such election; and
(ii) shall include in the statements a description of the effect of the election.
(4) Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (D) or in such other manner as may be specified in regulations.
(C)(1) Subject to item (4), a health insurance issuer offering group health insurance coverage, may not

SECTION 38-71-850. Continued

impose any preexisting condition exclusion in the case of an individual who, as of the last day of the thirty one day period beginning with the date of birth, is covered under creditable coverage.

(2) Subject to item (4), a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty one day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This item does not apply to coverage before the date of such adoption or placement for adoption.

(3) A health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(4) Items (1) and (2) no longer apply to an individual after the end of the first sixty three day period during all of which the individual was not covered under any creditable coverage.

(D)(1)(a) A health insurance issuer offering group health insurance coverage, shall provide the certification described in subitem (b):

(i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision;

(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision; and

(iii) on the request on behalf of an individual made not later than twenty four months after the date of cessation of the coverage described in subitem (a)(i) or (ii), whichever is later.

The certification under sub subitem (i) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

(b) The certification described in this subitem is a written certification of:

(i) the period of creditable coverage of the individual under the plan and the coverage, if any, under the COBRA continuation provision; and

(ii) the waiting period, if any, and affiliation period, if applicable, imposed with respect to the individual for any coverage under the plan.

(2) In the case of an election described in subitem (B)(3)(b) by a group health plan or health insurance issuer, if the plan or issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under item (1):

(a) upon request of the plan or issuer, the issuer which issued the certification provided by the individual shall promptly disclose to the requesting plan or issuer information on coverage of classes and categories of health benefits available under the entity's plan or coverage; and

(b) the issuer may charge the requesting plan or issuer for the reasonable cost of disclosing the information.

(3) The Director of Insurance shall establish rules to prevent an issuer's failure to provide information under item (1) or (2) with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

(E)(1) A health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan, or a dependent of the employee if the dependent is eligible, but not enrolled, for coverage under such terms, to enroll for coverage under the terms of the plan if each of the following conditions is met:

(a) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

(b) The employee stated in writing at the time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer, if applicable, required such a statement at the time and provided the employee with notice of the requirement and the consequences of the requirement at the time.

(c) The employee's or dependent's coverage described in subitem (a):

(i) was under a COBRA continuation provision and the coverage under the provision was exhausted; or

(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage, including as a result of legal separation, divorce, death, termination of employment,

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or reduction in the number of hours of employment, or employer contributions toward the coverage were terminated;

(iii) was one of multiple health insurance plans offered by an employer and the employee elects a different plan during an open enrollment period.

(d) Under the terms of the plan, the employee requests the enrollment not later than thirty days after the date of exhaustion of coverage described in subitem (c)(i) or termination of coverage or employer contribution described in subitem (c)(ii).

(2)(a) If:

(i) a group health plan makes coverage available with respect to a dependent of an individual;

(ii) the individual is a participant under the plan, or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period; and

(iii) a person becomes a dependent of the individual through marriage, birth, or adoption or placement for adoption, the health insurance issuer offering health insurance coverage in connection with the group health plan shall provide for a dependent special enrollment period described in subitem (b) during which the person or, if not otherwise enrolled, the individual may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

(b) A dependent special enrollment period under this subitem must be not less than thirty one days and begins on the later of:

(i) the date dependent coverage is made available; or

(ii) the date of the marriage, birth, or adoption or placement for adoption as the case may be described in subitem (a)(iii).

(c) If an individual seeks to enroll a dependent during the first thirty one days of a dependent special enrollment period, the coverage of the dependent shall become effective:

(i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(ii) in the case of a dependent's birth or a dependent's adoption or placement for adoption within thirty one days of birth, as of the date of the birth; or

(iii) in the case of a dependent's adoption or placement for adoption beyond thirty one days from the date of birth, the date of the adoption or placement for adoption.

(3) A health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit a dependent, spouse, or minor or dependent child, of an employee, if the dependent is eligible, but not enrolled for coverage, to enroll for coverage under the terms of the plan if a court has ordered that coverage be provided for the dependent under a covered employee's health insurance plan and a request for enrollment is made within thirty days after the issuance of the court order.

(F)(1) A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not impose any preexisting condition exclusion allowed under subsection (A) with respect to any particular coverage option may impose an affiliation period for such coverage option, but only if:

(a) the period is applied uniformly without regard to any health status related factors; and

(b) the period does not exceed two months, or three months in the case of a late enrollee.

(2) A health maintenance organization described in subitem (1) may use alternative methods from those described in item (1) to address adverse selection as approved by the Director of Insurance or his designee.

(G)(1)(a)(i) Subject to subitem (a)(ii), no period before July 1, 1996, shall be taken into account in determining creditable coverage.

(ii) The Director of Insurance shall provide for a process either by bulletin or by order whereby individuals who need to establish creditable coverage for periods before July 1, 1996, and who would have the coverage credited but for subitem (a)(i) may be given credit for creditable coverage for the periods through the presentation of documents or other means.

(b)(i) Subject to subitems (b)(ii) and (iii), subsection (D) applies to events occurring after June 30, 1996.

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(ii) In no case is a certification required to be provided under subsection (D) before June 1, 1997.
(iii) In the case of an event occurring after June 30, 1996, and before October 1, 1996, a certification is not required to be provided under subsection (D) unless an individual, with respect to whom the certification is otherwise required to be made, requests the certification in writing.
(c) In the case of an individual who seeks to establish creditable coverage for any period for which certification is not required because it relates to an event occurring before June 30, 1996:
(i) the individual may present other credible evidence of the coverage in order to establish the period of creditable coverage; and
(ii) a health insurance issuer shall not be subject to any penalty or enforcement action with respect to the issuer's crediting or not crediting the coverage if the issuer has sought to comply in good faith with the applicable requirements under this section.

SECTION 38-71-860. Health status related factors in relation to individual enrollees and their dependents; restrictions on eligibility rules and premium charges.

(A)(1) Subject to item (2), a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the plan based on any of the following health status related factors in relation to the individual or a dependent of the individual:
(a) health status;
(b) medical condition, including both physical and mental illnesses;
(c) claims experience;
(d) receipt of health care;
(e) medical history;
(f) genetic information;
(g) evidence of insurability, including conditions arising out of acts of domestic violence;
(h) disability.
(2) To the extent consistent with Sections 38-71-850 and 38-71-1360 and any other applicable state law, item (1) shall not be construed:
(a) to require group health insurance coverage to provide particular benefits other than those provided under the terms of such coverage; or
(b) to prevent such a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.
(3) For purposes of item (1), rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for the enrollment.
(B)(1) A health insurance issuer offering health insurance coverage in connection with a group health plan, may not require any individual, as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution which is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.
(2) To the extent consistent with Sections 38-71-940, 38-71-200, and 38-55-50 and any other applicable state law, nothing in item (1) shall be construed to:
(a) restrict the amount that an employer may be charged for coverage under a group health plan under applicable state law; or
(b) prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention, in accordance with applicable state law.

SECTION 38-71-870. Coverage in small or large group market in connection with group health plan; nonrenewal or discontinuance; restrictions; modification of coverage; plan sponsor.

(A) Except as provided in this section, if a health insurance issuer offers health insurance coverage in the small or large group market in connection with a group health plan, the issuer must renew or continue in force such coverage for all eligible employees and dependents at the option of the plan sponsor of the plan.
(B) A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a group health plan in the small or large group market based only on one or more of the following:
(1) The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments.
(2) The plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage or, with respect to coverage of an insured individual, fraud, or intentional misrepresentation by the insured individual or the individual's representative. If the fraud or intentional misrepresentation is made by a person with respect to any person's prior health condition, the insurer has the right also to deny coverage to that person or to impose as a condition of continued coverage the exclusion of the condition misrepresented.
(3) The plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules as permitted under Section 38-71-1360(A)(4) in the case of the small group market or pursuant to applicable state law in the large group market.
(4) The issuer is ceasing to offer coverage in such market in accordance with subsection (C) and applicable state law.
(5) In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, there is no longer any enrollee in connection with such plan who lives, resides, or works in the service area of the issuer or in the area for which the issuer is authorized to do business and, in the case of the small group market, the issuer would deny enrollment with respect to such plan under Section 38-71-1360(C)(1).
(6) In the case of health insurance coverage that is made available in the small or large group market only through one or more bona fide associations, the membership of an employer in the association, on the basis of which the coverage is provided, ceases but only if such coverage is terminated under this item uniformly without regard to any health status related factor relating to any covered individual.
(C)(1) In any case in which an issuer decides to discontinue offering a particular type of group health insurance coverage offered in the small or large group market, coverage of such type may be discontinued by the issuer in accordance with applicable state law in such market only if the issuer:
(a) provides notice to each plan sponsor provided coverage of this type in such market, and participants and beneficiaries covered under the coverage, of the discontinuation at least ninety days before to the date of the discontinuation of the coverage;
(b) offers to each plan sponsor provided coverage of this type in the market, the option to purchase all or, in the case of the large group market, any other health insurance coverage currently being offered by the issuer to a group health plan in such market; and
(c) in exercising the option to discontinue coverage of this type and in offering the option of coverage under subitem (b), the issuer acts uniformly without regard to the claims experience of those sponsors or any health status related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for the coverage.
(2)(a) In any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the small group market or the large group market, or both markets, in this State, health insurance coverage may be discontinued by the issuer only in accordance with applicable state law and if:
(i) the issuer provides notice to the Director of Insurance and to each plan sponsor, and participants and beneficiaries covered under the coverage, of the discontinuation at least one hundred eighty days before the date of the discontinuation of the coverage; and
(ii) all health insurance coverage issued or delivered for issuance in the State in such market is discontinued and coverage under the health insurance coverage in the market is not renewed.

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(b) In the case of a discontinuation under subitem (a) in a market, the issuer may not provide for the issuance of any health insurance coverage in the market in this State during the five year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(D) At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a product offered to a group health plan in the:

(1) large group market; or

(2) small group market if, for coverage that is available in the market other than only through one or more bona fide associations, the modification is consistent with state law and effective on a uniform basis among group health plans with that product.

(E) In applying this section in the case of health insurance coverage that is made available by a health insurance issuer in the small or large group market to employers only through one or more associations, a reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

SECTION 38-71-880. Medical and surgical benefits and mental health benefits coverage; aggregate lifetime limits; application to small employers; applicability of section.

(A)(1) In the case of health insurance coverage offered in connection with a group health plan that provides both medical and surgical benefits and mental health benefits:

(a) if the coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the coverage may not impose any aggregate lifetime limit on mental health benefits;

(b) if the coverage includes an aggregate lifetime limit, also referred to in this item as the "applicable lifetime limit", on substantially all medical and surgical benefits, the coverage shall either:

(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of the limit between the medical and surgical benefits and mental health benefits; or

(ii) not include any aggregate lifetime limit on mental health benefits that is less than the applicable lifetime limit.

(c) In the case of coverage that is not described in subitem (a) or (b) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the Director of Insurance shall promulgate regulations under which subitem (b) is applied to the coverage with respect to mental health benefits by substituting for the applicable lifetime limit an average aggregate limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to the categories.

(2) In the case of health insurance coverage offered in connection with a group health plan that provides both medical and surgical benefits and mental health benefits:

(a) if the coverage does not include an annual limit on substantially all medical and surgical benefits, the coverage may not impose any annual limit on mental health benefits;

(b) if the coverage includes an annual limit on substantially all medical and surgical benefits, referred to as the "applicable annual limit", the coverage shall either:

(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

(ii) not include any annual limit on mental health benefits that is less than the applicable annual limit.

(c) In the case of coverage that is not described in subitem (a) or (b) and that includes no or different annual limits on different categories of medical and surgical benefits, the Director of Insurance shall promulgate regulations under which subitem (b) is applied to the coverage with respect to mental health benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to the categories.

(B) To the extent consistent with Section 38-71-737 and any other applicable state law, nothing in this section shall be construed:

(1) as requiring health insurance coverage offered in connection with a group health plan to provide any mental health benefits; or

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(2) in the case of such coverage that provides such mental health benefits, as affecting the terms and conditions, including cost sharing, limits on number of visits or days of coverage, and requirements relating to medical necessity, relating to the amount, duration, or scope of mental health benefits under the coverage, except as specifically provided in subsection (A) in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits.

(C)(1)(a) This section shall not apply to any group health insurance coverage offered in connection with a group health plan for any plan year of a small employer.

(b) For purposes of subitem (a), "small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two but not more than fifty employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

(c) For purposes of this item:

(i) All persons treated as a single employer under subsection (b), (c), (m), or (o) of Section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

(ii) In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(iii) Any reference in this item to an employer shall include a reference to any predecessor of the employer.

(2) This section shall not apply with respect to health insurance coverage offered in connection with a group health plan if the application of this section to such coverage results in an increase in the cost for such coverage of at least one percent.

(D) In the case of health insurance coverage offered in connection with a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, subsections (A) and (C)(2), shall be applied separately with respect to each such option.

(E) For purposes of this section:

(1) "Aggregate lifetime limit" means, with respect to benefits under health insurance coverage, a dollar limitation on the total amount that may be paid with respect to the benefits under the health insurance coverage with respect to an individual or other coverage unit.

(2) "Annual limit" means, with respect to benefits under health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to the benefits in a twelve month period under the health insurance coverage with respect to an individual or other coverage unit.

(3) "Medical or surgical benefits" means benefits with respect to medical or surgical services, as defined under the terms of the plan, but does not include mental health benefits.

(4) "Mental health benefits" means benefits with respect to mental health services, as defined under the terms of the plan, but does not include benefits with respect to treatment of substance abuse or chemical dependency.

(F) This section does not apply to benefits for services furnished on or after December 31, 2006.

SECTION 38-71-920. Definitions.

As used in this subarticle:
(1) "Small employer" means, in connection with a health insurance plan with respect to a calendar year and a plan year, any person, firm, corporation, partnership, association, or employer, as defined in Section 3(5) of the Employee Retirement Income Security Act of 1974 that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar year, employed no more than fifty eligible employees or employed an average of not more than fifty employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.
(a) In determining the number of eligible employees, companies which are affiliated companies, or which are eligible to file a combined tax return for purposes of state taxation, or that are treated as a single employer under subsections (b), (c), (m), or (o) of Section 414 of the Internal Revenue Code of 1986 must be considered one employer; and
(b) In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected to employ on business days in the current calendar year; and
(c) Any reference in the subarticle to an employer includes a reference to any predecessor of the employer.
(2) "Insurer" means any person who provides health insurance in this State. For the purposes of this subarticle, insurer includes a licensed insurance company, a health maintenance organization, a multiple employer welfare arrangement, or any other person providing a plan of health insurance subject to state insurance regulation.
(3) "Health insurance plan" or "plan" means any hospital or medical policy or certificate, major medical expense insurance, hospital or medical service plan contract, or health maintenance organization subscriber contract which provides benefits consisting of medical care, provided directly, through insurance or reimbursement, or otherwise and including items and services paid for medical care. It includes the entire contract between the insurer and the insured, including the policy, riders, endorsements, and the application, if attached. "Health insurance plan" does not include: accident only; blanket accident and sickness; specified disease or hospital indemnity or other fixed indemnity insurance if offered as independent non-coordinated benefits; credit; limited scope dental or vision if offered separately; Medicare supplement if offered as a separate policy; long term care if offered separately; disability income insurance; coverage issued as a supplement to liability or other liability insurance, including general liability insurance and automobile liability insurance; coverage designed solely to provide payments on a per diem, fixed indemnity, or nonexpense incurred basis; coverage for Medicare or Medicaid services pursuant to a contract with state or federal government; workers' compensation or similar insurance; automobile medical payment insurance; coverage for on site medical clinics; or other similar coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.
(4) "Small employer insurer" means an insurer which offers health insurance plans covering the employees of a small employer.
(5) "Case characteristics" means the following characteristics of a small employer, as determined by a small employer insurer, which are considered by the insurer in the determination of premium rates for the small employer: age, gender, geographic area, industry, group size, and family composition. Geographic areas smaller than a county may not be used without prior approval of the director or his designee. Claim experience, health status, and duration of coverage since issue are not case characteristics for the purposes of this subarticle. The adjustment for case characteristics must be objective and meet sound actuarial practices.
(6) "Director" means the person who is appointed by the Governor upon the advice and consent of the Senate and who is responsible for the operation and management of the Department of Insurance, including all of its divisions. The director may appoint or designate the person or persons who shall serve at the pleasure of the director to carry out the objectives or duties of the department as provided by law.

SECTION 38-71-920. Continued

"Director" also includes a designee or deputy director upon whom the director has bestowed any duty or function required of the director by law in managing or supervising the Department of Insurance.

(7) "Department" means the Department of Insurance.

(8) "New business premium rate" means, for each class of business as to a rating period, the lowest premium charged or offered, or which could have been charged or offered, by the small employer insurer to small employers with similar case characteristics for newly issued health insurance plans with the same or similar coverage.

(9) "Class of business" means all or a distinct grouping of small employers as shown on the records of the small employer insurer.

(a) A distinct grouping may be established only by the small employer insurer on the basis that the applicable health insurance plans:

(i) are marketed and sold through individuals and organizations which are not participating in the marketing or sale of other distinct groupings of small employers for such small employer;

(ii) have been acquired from another small employer insurer as a distinct grouping of plans;

(iii) are provided through an association with membership of not less than fifty small employers which have been formed for purposes other than obtaining insurance; or

(iv) are provided through a common group formed solely for the purpose of obtaining insurance as permitted by Section 38-71-730(1)(b).

(b) A small employer insurer may establish no more than two additional groupings on the basis of criteria, except group size, which are expected to produce substantial variation in administrative and marketing costs.

(c) The director or his designee may approve the establishment of additional distinct groupings upon application to the director or his designee and a finding by the director or his designee that action would enhance the efficiency and fairness of the small employer insurance marketplace.

(10) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the director or his designee that a small employer insurer is in compliance with the provisions of Section 38-71-940 and that the rating methods used in establishing premium rates for applicable health insurance plans are objective and based on sound actuarial practices. This statement must be based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the insurer in establishing premium rates for applicable health insurance plans.

(11) "Rating period" means the calendar period for which premium rates established by a small employer insurer are assumed to be in effect as determined by the small employer insurer.

(12) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or which could have been charged under a rating system for that class of business, by the small employer insurer to small employers with similar case characteristics for health insurance plans with the same or similar coverage.

(13) "Index rate" means, for each class of business for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(14) "Restricted network provision" means any provision of a health insurance plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the insurer pursuant to the laws and regulations of the State to provide health care services to covered individuals.

SECTION 38-71-930. Application of this subarticle.

(A) Except as provided in subsection (B), the provisions of this subarticle apply to any health insurance plan which provides coverage to one or more employees of a small employer.
(B) The provisions of this subarticle do not apply to individual health insurance policies which are subject to policy form and premium rate approval as may be provided in Title 38.

SECTION 38-71-940. Premium rates for health insurance plans; rating factors; involuntary business class transfer prohibited.

(A) Premium rates for health insurance plans subject to this subarticle are subject to the following requirements:
(1) The index rate for a rating period for a class of business may not exceed the index rate for any other class of business by more than twenty percent.
(2) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates which could be charged to these employers under the rating system for that class of business, may not vary from the index rate by more than twenty five percent of the index rate.
(3) The percentage increase in the renewal premium rate charged to a small employer for a new rating period may not exceed the sum of:
(a) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer insurer is not issuing new policies, the insurer shall use the percentage change in the base premium rate. However, in the case of health insurance plans issued prior to the effective date of this section, if the change in the new business premium rate used to determine the maximum percentage increase in the premium rate is less than zero percent, then zero percent may be used as the percentage change in the new business premium rate during the first twelve month period from the effective date of this section.
(b) an adjustment, not to exceed fifteen percent annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the insurer's rate manual for the class of business.
(c) any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the insurer's rate manual for the class of business.
(4) A health insurance plan that contains a restricted network provision shall not be considered similar coverage to a health insurance plan that does not contain such a provision, provided that the restriction of benefits to network providers results in substantial differences in claim costs.
(5) If group size is used as a case characteristic by a small employer insurer, the highest rate factor associated with a group size classification may not exceed the lowest rate factor associated with such a classification by more than twenty percent.
(B) Nothing in this section is intended to affect the use by a small employer insurer of legitimate rating factors other than claim experience, health status, or duration of coverage in the determination of premium rates. Small employer insurers shall apply rating factors, including case characteristics, consistently with respect to all small employers within a class of business.
(C) Unless the small employer no longer meets the criteria established for its existing class of business:
(1) a small employer insurer may not transfer involuntarily a small employer into or out of a class of business; and
(2) a small employer insurer may not offer to transfer a small employer into or out of a class of business, unless the offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status, or duration since issue.

SECTION 38-71-960. Required disclosure in solicitation and sales materials; proprietary or trade secret information.

In connection with offering any health insurance plans to small employers, each small employer insurer shall make reasonable disclosure in solicitation and sales materials provided to small employers of:
(1) the extent to which premium rates for a specific small employer are established or adjusted due to case characteristics, family composition, class of business, and the claim experience, health status, or duration of coverage of the employees or dependents of the small employer;
(2) the provisions concerning the insurer's right to change premium rates and the factors, including case characteristics, which affect changes in premium rates;
(3) a description of the class of business in which the small employer is or will be included, including the applicable grouping of plans;
(4) the provisions relating to renewability of coverage;
(5) the provisions relating to any preexisting condition exclusion; and
(6) the benefits and premiums available under all health insurance plans for which the employer is qualified.
Information under this section must be provided to small employers in a manner determined to be understandable by the average small employer and must be sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage.
An insurer is not required under this section to disclose any information that is proprietary or trade secret information under applicable law.

SECTION 38-71-1330. Definitions.

As used in this article:
(1) "Basic health insurance plan" means a lower cost health insurance plan developed pursuant to Section 38-71-1420.
(2) "Board" means the board of directors of the program established pursuant to Section 38-71-1410.
(3) "Commissioner" means the Chief Insurance Commissioner of this State.
(4) "Committee" means the advisory committee to the commissioner referred to in Section 38-71-1420.
(5) "Dependent" means a spouse, an unmarried child under the age of nineteen years, an unmarried child who is a full time student between the ages of nineteen and twenty two and who is financially dependent upon the parent, and an unmarried child of any age who is medically certified as disabled and dependent upon the parent.
(6) "Eligible employee" means an employee as defined in Section 38-71-710(1) or Section 38-71-840 who works on a full time basis and has a normal work week of thirty or more hours.
(7) "Employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries.
(8) "Group participation rule" means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.
(9)"Health insurance plan" or "plan" means any hospital or medical policy or certificate, major medical expense insurance, hospital or medical service plan contract, or health maintenance organization subscriber contract which provides benefits consisting of medical care provided directly through insurance or reimbursement, or otherwise and including items and services paid for medical care. It includes the entire contract between the insurer and the insured, including the policy, riders, endorsements, and the application, if attached. "Health insurance plan" does not include: accident only; blanket accident and sickness; specified disease or hospital indemnity or other fixed indemnity insurance if offered as independent non-coordinated benefits; credit; limited scope dental or vision if offered separately; Medicare supplement if offered as a separate policy; long term care if offered separately; disability income insurance; coverage issued as a supplement to liability or other liability insurance, including general liability insurance and automobile liability insurance; coverage designed solely to provide payments on a per diem, fixed indemnity, or no expense incurred basis; coverage for Medicare or Medicaid services

SECTION 38-71-1330. Continued

pursuant to a contract with state or federal government; workers' compensation or similar insurance; automobile medical payment insurance; coverage for on site medical clinics; or other similar coverage specified in regulations under which benefits for medical care are secondary or incidental to other insurance benefits.

(10) "Insurer" means any entity that provides health insurance in this State. For the purposes of this article, insurer includes an insurance company, a health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation, including multiple employer self insured health plans licensed pursuant to Section 38-41-10, et seq.

(11) "Medical care" means amounts paid for:

(a) the diagnosis, cure, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;

(b) amounts paid for transportation primarily for and essential to medical care referred to in subitem (a); and

(c) amounts paid for insurance covering medical care referred to in subitems (a) and (b).

(12) "Network plan" means a health insurance plan issued by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the insurer.

(13) "Plan of operation" means the plan of operation of the program established pursuant to Section 38-71-1410.

(14) "Program" means the South Carolina Small Employer Insurer Reinsurance Program created by Section 38-71-1410.

(15) "Reinsuring insurer" means a small employer insurer participating in the reinsurance program pursuant to Section 38-71-1410.

(16) "Risk assuming insurer" means a small employer insurer whose application is approved by the commissioner pursuant to Section 38-71-1390.

(17) "Small employer" means, in connection with a health insurance plan with respect to a calendar year and a plan year, any person, firm, corporation, partnership, association, or employer, as defined in Section 3(5) of the Employee Retirement Income Security Act of 1974, that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar year, employed no more than fifty eligible employees or employed an average of not more than 50 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.

(1) In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, or that are treated as a single employer under subsections (b), (c), (m), or (o) of Section 414 of the Internal Revenue Code of 1986 shall be considered one employer; and

(2) In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected to employ on business days in the current calendar year; and

(3) Any reference in this article to an employer includes a reference to any predecessor of the employer.

(18) "Small employer insurer" means an insurer that offers health insurance plans covering eligible employees of one or more small employers in this State.

(19) "Standard health insurance plan" means a health insurance plan developed pursuant to Section 38-71-1420.

SECTION 38-71-1340. Application of article.

(A) Except as provided in subsection (B), the provisions of this article apply to any health insurance plan which provides group coverage to groups of two to fifty.
(B) The provisions of this article do not apply to individual health insurance policies which are subject to policy form and premium rate approval as may be provided in Title 38 of the 1976 Code.

SECTION 38-71-1360. Insurers required to offer all plans actively marketed to small employers; availability to all eligible employees; network plans; denial of coverage.

(A)(1) Every small employer insurer shall, as a condition of transacting business in this State with small employers, actively offer to small employers all health insurance plans actively marketed to small employers in this State, including at least two health insurance plans. One health insurance plan offered by each small employer insurer must be a basic health insurance plan and one plan must be a standard health insurance plan.
(2) Coverage under such health insurance plan must be offered to every eligible employee of a small employer and his or her dependents who apply for enrollment during the period in which the employee first becomes eligible to enroll under the terms of the health insurance plan and may not place any restriction which is inconsistent with Section 38-71-860 on an eligible employee being a participant or beneficiary. A small employer insurer may not offer coverage only to certain individuals in a small employer group, or to only part of the group, except as provided in Section 38-71-850 for late enrollees.
(3) Except with respect to applicable preexisting condition limitation periods or late enrollees as provided in Section 38-71-850, a small employer insurer shall not modify a health insurance plan with respect to a small employer or any eligible employee or dependent through rider, endorsement, or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions or services otherwise covered under the plan.
(4)(a) Except as provided in Sections 38-71-1360(C) and (D), a small employer insurer shall issue these health insurance plans to any eligible small employer that applies for any such plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health insurance plan relating to employer contribution rules and group participation rules and not inconsistent with this article.
(b) In the case of a small employer insurer that establishes more than one class of business pursuant to Section 38-71-920, the small employer insurer shall maintain and issue to eligible small employers these health insurance plans in addition to at least one basic health insurance plan and at least one standard health insurance plan in each class of business so established. A small employer insurer may apply reasonable criteria in determining whether to accept a small employer into a class of business, provided that:
(i) the criteria are not intended to discourage or prevent acceptance of small employers applying for a basic or standard health insurance plan;
(ii) the criteria are not related to the health status or claim experience of the small employer;
(iii) the criteria are applied consistently to all small employers applying for coverage in the class of business; and
(iv) the small employer insurer provides for the acceptance of all eligible small employers into one or more classes of business.
The requirement to offer these health insurance plans to small employers shall not apply to a class of business into which the small employer insurer is no longer enrolling new small businesses.
(5) The provisions of this subsection (A) of this section shall be effective one hundred eighty days after the commissioner's approval of the basic health insurance plan and the standard health insurance plan developed pursuant to Section 38-71-1420; provided that if the Small Employer Insurer Reinsurance Program created pursuant to Section 38-71-1410 is not yet operative on that date, the provisions of this paragraph shall be effective on the date that the program begins operation.
(B)(1) After the commissioner's approval of the basic health insurance plan and the standard health insurance plan developed pursuant to Section 38-71-1420, a small employer insurer shall file with the

SECTION 38-71-1360. Continued

commissioner, in the form and manner prescribed by the commissioner, the basic and standard health insurance plans to be used by the insurer. The insurer shall certify to the commissioner that the plans as filed are in substantial compliance with the provisions as approved by the commissioner. Upon the commissioner's receipt of the certification, the insurer may use the certified plans unless their use is disapproved by the commissioner.

(2) The commissioner may, at any time, after providing notice and an opportunity for hearing, disapprove the continued use by a small employer insurer of a basic or standard health insurance plan on the grounds that the plan does not meet the requirements of this article.

(C)(1) In the case of a small employer insurer that offers health insurance coverage through a network plan, the small employer insurer may:

(a) limit the employers that may apply for such coverage to those with eligible employees who live, work, or reside in the service area for such network plan; and

(b) within the service area of any such plan, deny such coverage to such employers if such insurer has demonstrated to the satisfaction of the commissioner that:

(i) it will not have the capacity to deliver services adequately to members of any additional groups because of its obligations to existing group contract holders and enrollees, and

(ii) it is applying this item uniformly to all employers without regard to claims experience of those employers and their employees and their dependents or any health status related factors relating to such employees and dependents.

(2) A small employer insurer that offers health insurance coverage through a network plan that cannot offer coverage pursuant to item (1)(b) may not offer coverage in the applicable area to new cases of employer groups with more than fifty eligible employees or to any small employer groups until the later of one hundred eighty days following each such refusal or the date on which the insurer notifies the commissioner that it has regained capacity to deliver services to small employer groups.

(D)(1) A small employer insurer may deny health insurance coverage to small employers for any period of time for which the commissioner determines that requiring the acceptance of small employers in accordance with the provisions of subsection (A) would place the small employer insurer in a financially impaired condition or if the small employer insurer has demonstrated to the commissioner that it:

(a) does not have the financial reserves necessary to underwrite additional coverage; and

(b) is applying this item uniformly to all small employers in the State without regard to claims experience of those employers and their employees and their dependents or any health status related factor relating to such employees and dependents.

(2) A small employer insurer that denies coverage to a small employer pursuant to item (1) may not offer coverage in the State to new cases of employer groups with more than fifty eligible employees or to any small employer groups until the later of one hundred eighty days following each such refusal or the date on which the small employer insurer demonstrates to the commissioner that it has sufficient financial reserves to underwrite additional coverage. The commissioner may provide for the application of this subsection on a service area specific basis.

SECTION 38-71-1370. Applicability of certain code sections; late enrollees.

(A) Except to the extent inconsistent with specific provisions of this article, all provisions of Article 5, are applicable to any insurance plans required to be offered by small employer insurers.

(B) Late enrollees may be excluded from coverage for the greater of eighteen months or an eighteen month preexisting condition exclusion; however, if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed eighteen months.

This section of the Code of Laws applies to individual policies.

SECTION 38-71-310. Filing of forms and rates; approval or disapproval; withdrawal of approval; exceptions; loss ratio guarantee.

(A) A policy or certificate of accident, health, or accident and health insurance may not be issued or delivered in this State, nor may any application, endorsement, or rider which becomes a part of the policy be used, until a copy of its form has been filed with and approved by the director or his designee, except as exempted by the director or his designee as permitted by Section 38-61-20. The director or his designee may disapprove the form if the form:
(1) does not meet the requirements of law;
(2) contains provisions which are unfair, deceptive, ambiguous, misleading, or unfairly discriminatory; or
(3) is solicited by means of advertising, communication, or dissemination of information which is deceptive or misleading.
The director or his designee shall notify in writing, as soon as is practicable, the insurer that has filed the form of his approval or disapproval. If the form is disapproved, the notice must contain the reasons for disapproval, and the insurer is entitled to a public hearing on that decision. If action is not taken to approve or disapprove a policy or certificate, application, endorsement, or rider after the document has been filed for thirty days, it is deemed to be approved.
The director or his designee, in his discretion, may extend for up to an additional sixty days the period for approval or disapproval of the form. An organization may not use a form deemed approved pursuant to the default provision of this section until the organization has filed with the director or his designee a written notice of its intent to use the form. The notice must be filed in the office of the director at least ten days before the organization uses the form.
(B) No premium rates applicable to accident policies, health policies, or combined accident and health policies or certificates for individual or family protection may be used unless they have been filed with the department and approved by the director or his designee. The director or his designee may disapprove premium rates if he determines that the benefits provided in the policies or certificates are unreasonable in relation to the premiums charged. The director or his designee shall notify in writing the insurer, as soon as is practicable, which has filed the premium rates of his approval or disapproval with the department. In the event of disapproval, the notice must contain the reasons for disapproval, and the insurer is entitled to appeal the decision or determination of disapproval before the Administrative Law Judge Division as provided by law. If no action has been taken to approve or disapprove the premium rates after they have been filed for ninety days, they are deemed to be approved.
(C) At any time the director or his designee, after a public hearing of which at least thirty days' written notice has been given, may withdraw approval of forms or rates previously approved under subsections (A) and (B) if he determines that the forms or rates no longer meet the standards for approval specified in subsections (A) and (B).
(D) The provisions of this section do not apply to policies issued in connection with loans made under the Small Loan Act of 1966.
(E) For major medical expense coverage individual accident and health insurance policies, as defined by regulation of the department, the benefits are deemed reasonable in relation to the premium charged if the insurer has filed a loss ratio guarantee with the department. This guaranteed loss ratio must be equivalent to, or greater than, the most recent loss ratios detailed within the National Association of Insurance Commissioners' "Guidelines for Filing of Rates for Individual Health Insurance Forms." This loss ratio guarantee must be in writing and must contain at least the following:
(1) A recitation of the anticipated (target) loss ratio standards contained in the original actuarial memorandum filed with the policy form when it was originally approved.
(2) A guarantee that the actual South Carolina loss ratios for the calendar year in which the new rates take effect, and for each year thereafter until new rates are filed will meet or exceed the loss ratio standards referred to in item (1) above.

SECTION 38-71-310. Continued

(3) A guarantee that the actual South Carolina loss ratio results for the year at issue will be independently audited at the insurer's expense. This audit must be done in the second quarter of the next year and the audited results must be reported to the department not later than the date for filing the applicable Accident and Health Policy Experience Exhibit.

(4) A guarantee that affected South Carolina policyholders will be issued a proportional refund (based on premium paid) of the amount necessary to bring the actual aggregate loss ratio up to the anticipated loss ratio standards referred to in item (1) above. The refund must be made to all South Carolina policyholders insured under the applicable policy form as of the last day of the year at issue if the refund would equal five dollars or more. The refund must include statutory interest from the end of the year at issue until the date of payment. Payments must be made during the third quarter of the next year.

(5) As used herein, the term "loss ratio" means the ratio of incurred losses to earned premium by number of years of policy duration, for all combined durations.

(6) The reference in item (1) of this subsection to the "anticipated (target) loss ratio standards contained in the original actuarial memorandum filed with the policy form when it was originally approved" may not be considered or construed as evidence of legislative intent that the use of, or adherence to, such "anticipated (target) loss ratio standards" is approved or disapproved in any application for a rate increase for any policy form approved prior to the effective date of these amendments to Section 38-71-310.

(F) Nothing in this chapter precludes the issuance of an individual accident, health, or accident and health insurance policy that includes an optional life insurance rider. However, the optional life insurance rider must be filed with and approved by the director or his designee pursuant to Section 38-61-20 and comply with all applicable sections of Chapter 63 and, in addition, in the case of a life insurance rider with accelerated long term care benefits, Chapter 72 of this title.

SECTION 38-71-325. Requirements for approval of new individual major medical expense coverage policies.

On January 1, 1992, in addition to any other requirements of law, no new individual major medical expense coverage policy, as defined in regulations promulgated by the department, may be approved unless:

(1) Premium rates, after appropriate allowance for the actuarial value of the difference in benefits, for any such policy form first approved for use by the insurer in South Carolina within the two year period immediately prior to the effective date of this section and any such policy form first approved for use after the effective date of this section do not exceed the premium rates for any other such policy form first approved for use during this period by more than thirty percent.

(2)The actuarial value of the difference in benefits set out in such policy forms of the insurer, as specified in an opinion by a qualified actuary or other qualified person acceptable to the director or his designee, is reported not less often than once a year to the director or his designee and used in demonstrating compliance with item (1) above.

(3)The anticipated (target) loss ratio for the combined experience for all the policy forms specified in item (1) must be equivalent to or greater than the most recent loss ratios detailed within the National Association of Insurance Commissioner's 'Guidelines for Filing of Rates for Individual Health Insurance Forms' or successor publications. The anticipated (target) loss ratio for the combined experience is defined as the average anticipated (target) loss ratio for all these policy forms included in the combined experience weighted by premium volume. With respect to the policy form, the insurer shall have the right to file a loss ratio guarantee in accordance with the procedures specified in Section 38 71 310(E) or to request approval of any rate change before the use thereof, but the anticipated loss ratios of each policy form whether or not a loss ratio guarantee has been filed must be combined as provided in the preceding item (3).

The initial policy form proposed to be used by a domestic insurer after its organization under the laws of this State and the initial policy form proposed to be used by a foreign insurer after authorization by the director or his designee to do business in this State may be disapproved by the director or his designee if he determines that the rates proposed to be used with the policy form are set at a level substantially less than rates charged by other insurers in this State offering comparable coverage.

SECTION 38-71-325. Continued

Nothing contained in this section may be construed to prevent the use of age, sex, area, industry, occupational, and avocational factors or to prevent the use of different rates for smokers and nonsmokers or for any other habit or habits of an insured person which have a statistically proven effect on the health of the person and are approved by the director or his designee. Also, nothing contained in this section shall preclude the establishment of a substandard classification based upon the health condition of the insured, but the initial classification may not be changed adversely to the applicant after initial issue.

The director or his designee has the right, upon application by any insurer, to grant relief, for good cause shown, from any requirement of this section.

SECTION 38-71-330. Form of policies.

No policy of accident and health insurance may be delivered or issued for delivery to any person in this State unless:

(1) The entire money and other considerations therefore are expressed therein.

(2) The time at which the insurance takes effect and terminates is expressed therein.

(3) It purports to insure only one individual, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who is considered the policyholder, any two or more eligible members of that family, including husband, wife, dependent children, or any children under a specified age which may not exceed nineteen years, and any other individual dependent upon the policyholder.

(4) The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text and every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light faced type of a style in general use, the size of which must be uniform and not less than ten point with a lower case un-spaced alphabet length not less than one hundred and twenty point (the "text" includes all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions).

(5) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in Sections 38-71-340 and 38-71-370, are printed, at the insurer's option, either included with the benefit provision to which they apply or under an appropriate caption such as "EXCEPTIONS" or "EXCEPTIONS AND REDUCTIONS". However, if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction must be included with the benefit provision to which it applies.

(6) Each form, including riders and endorsements, is identified by a form number in the lower left hand corner of the first page thereof.

(7) It contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless that portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks or short rate table filed with the department.

SECTION 38-71-340. Required provisions.

Except as provided in Section 38-71-410, each accident, health, or accident and health policy delivered or issued for delivery to an individual in this State must contain the provisions specified in this section, in the words in which they appear in this section. The insurer, at its option, may substitute for one or more of these provisions corresponding provisions of different wording approved by the director or his designee which are in each instance not less favorable in any respect to the insured or the beneficiary. These provisions must be preceded individually by the caption appearing in this section or, at the option of the insurer, by appropriate individual or group caption or subcaptions approved by the director or his designee.

(1) A provision as follows:

ENTIRE CONTRACT; CHANGES:

This policy, with the application and attached papers, if any, is the entire contract between the insured and the company.

No change in this policy is effective until approved by a company officer. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions.

(2) A provision as follows:

TIME LIMIT ON CERTAIN DEFENSES:

After two years from the issue date only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred or disability that starts after the two year period.

A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (a) until at least age fifty or (b) in the case of a policy issued after age forty four, for at least five years from its date of issue, may contain in lieu of the foregoing the following provision (from which the clause in parenthesis may be omitted at the insurer's option) "INCONTESTABLE":

(a) Misstatements in the application:

After this policy has been in force for two years during the insured's lifetime (excluding any period during which the insured is disabled), the company cannot contest the statements contained in the application.

(b) Preexisting conditions:

No claim for loss incurred or disability that starts after two years from the issue date will be reduced or denied because a sickness or physical condition not excluded by name or specific description before the date of loss had existed before the effective date of coverage.

(3) A provision as follows:

GRACE PERIOD:

This policy has a ___ day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following ____ days. During the grace period the policy will stay in force. [Note: Insert a number not less than "seven" for weekly premium policies, "ten" for monthly premium policies, and "thirty one" for all other policies.]

(4) A provision as follows:

REINSTATEMENT:

If the renewal premium is not paid before the grace period ends the policy will lapse. Later acceptance of the premium by the company or by an agent authorized to accept payment without requiring an application for reinstatement will reinstate the policy. If the company or its agent requires an application, the insured will be given a conditional receipt for the premium. If the application is approved, the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the forty fifth day after the date of the conditional receipt unless the company has previously written the insured of its disapproval. The reinstated policy will cover only loss that results from an injury sustained after the date of reinstatement or sickness that starts more than ten days after such date.

In all other respects the rights of the insured and the company will remain the same, subject to any provisions noted on or attached to the reinstated policy. Any premiums the company accepts for reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than sixty days before the reinstatement date.

[The last sentence of the above provision may be omitted from any policy which the insured has the

SECTION 38-71-340. Continued

right to continue in force subject to its terms by the timely payment of premiums (a) until at least age fifty or (b) in the case of a policy issued after age forty four, for at least five years from its date of issue.]

(5) A provision as follows:

NOTICE OF CLAIM:

Written notice of claim must be given within twenty days after a covered loss starts or as soon as reasonably possible. The notice may be given to the company at its home office or to the company's agent. Notice should include the name of the insured and the policy number.

Optional paragraph: If the insured has a disability for which benefits may be payable for at least two years, at least once every six months after the insured has given notice of claim, the insured shall give the company notice that the disability has continued. The insured need not do this if legally incapacitated. The first six months after any filing of proof by the insured or any payment or denial of a claim by the company will not be counted in applying this provision.

If the insured delays in giving this notice, the insured's right to any benefits for the six months before the date when the insured gives notice will not be impaired.

(6) A provision as follows:

CLAIM FORMS:

When the company receives notice of claim, it will send the claimant forms for filing proof of loss. If these forms are not given to the claimant within fifteen days the claimant will meet the proof of loss requirements by giving the company a written statement of the nature and extent of the loss within the time limits stated in the Proofs of Loss section.

(7) A provision as follows:

PROOFS OF LOSS:

If the policy provides for periodic payment for a continuing loss, written proof of loss must be given the company within ninety days after the end of each period for which the company is liable. For any other loss, written proof must be given within ninety days after such loss. If it was not reasonably possible to give written proof in the time required, the company may not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. The proof required must be given no later than one year from the time specified unless the claimant was legally incapacitated.

(8) A provision as follows:

TIME OF PAYMENT OF CLAIMS:

After receiving written proof of loss, the Company will pay ___ [insert period for payment which may not be less frequently than monthly] all benefits then due for ___ [insert applicable term for type of benefits].

(9) A provision as follows:

PAYMENT OF CLAIMS:

Benefits will be paid to the insured. Loss of life benefits are payable in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, the benefits will be paid to the insured's estate. Any other benefits unpaid at death may be paid, at the company's option, either to the insured's beneficiary or estate.

Optional paragraph: If benefits are payable to the insured's estate or a beneficiary who cannot execute a valid release, the company can pay benefits up to one thousand dollars to someone related to the insured or beneficiary by blood or marriage whom the company considers to be entitled to the benefits. The company will be discharged to the extent of any such payment made in good faith.

Optional paragraph: The company may pay all or a portion of any indemnities provided for health care services to the provider, unless the insured directs otherwise in writing by the time proofs of loss are filed. The company cannot require that the services be rendered by a particular provider.

(10) A provision as follows:

PHYSICAL EXAMINATIONS AND AUTOPSY:

The company at its own expense may have the insured examined as often as reasonably necessary while a claim is pending and in cases of death of the insured the insurer at its own expense also may have an autopsy performed during the period of contestability unless prohibited by law. The autopsy must be performed in South Carolina.

SECTION 38-71-340. Continued

(11) A provision as follows:

LEGAL ACTIONS:

No legal action may be brought to recover on this policy within sixty days after written proof of loss has been given as required by this policy. No such action may be brought after six years from the time written proof of loss is required to be given.

(12) A provision as follows:

CHANGE OF BENEFICIARY:

The insured can change the beneficiary at any time by giving the company written notice. The beneficiary's consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable.

(13) A provision as follows:

CONFORMITY WITH STATE STATUTES:

Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which the insured resides on that date is amended to conform to the minimum requirements of such laws.

SECTION 38-71-350. Required provision for continuation of coverage for handicapped and dependent children of policyholder.

An individual hospital or medical expense insurance policy, hospital service plan contract, or medical service plan contract delivered or issued for delivery in this State which provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in the policy or contract shall also provide in substance that attainment of the limiting age does not operate to terminate the coverage of the child while the child is and continues to be both (a) incapable of self sustaining employment by reason of mental retardation or physical handicap and (b) chiefly dependent upon the policyholder or subscriber for support and maintenance, so long as proof of the incapacity and dependency is furnished to the insurer by the policyholder or subscriber within thirty one days of the child's attainment of the limiting age and subsequently as may be required by the insurer but not more frequently than annually after the two year period following the child's attainment of the limiting age.

SECTION 38-71-360. Continuation of coverage for non-handicapped dependent children.

An individual hospital, medical, or surgical expense incurred insurance policy, hospital service plan contract, or medical service plan contract, other than a limited classification policy, delivered or issued for delivery in this State which provides that coverage of a non-handicapped dependent child terminates upon attainment of the limiting age for the child as specified in the policy or contract shall also contain a provision to the effect that upon the attainment of the limiting age the child is entitled to have issued to him, without evidence of insurability, upon application made to the insurer within thirty days following the attainment of the age, and upon payment of the appropriate premium, an individual policy of accident and health insurance. The policy shall provide the coverage then being issued by the insurer which is closest to, but not greater than, the terminated coverage. Any probationary or waiting period set forth in the policy must be considered as met to the extent coverage was in force under the prior policy. For purposes of this section, "limited classification policy" means an accident only policy, a limited accident policy, a travel accident policy, or a specified disease policy.

SECTION 38-71-370. Optional provisions.

Except as provided in Section 38-71-410, no individual accident, health, or accident and health policy delivered or issued for delivery to any person in this State may contain provisions respecting the matters set forth below unless the provisions are in the words in which they appear in this section. However, the insurer may, at its option, use in lieu of these provisions a corresponding provision of different wording approved by the director or his designee which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this section, or, at the option of the insurer, by appropriate individual or group captions or subcaptions approved by the director or his designee.

(1) A provision as follows:

CHANGE OF OCCUPATION:

If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent.

In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

(2) A provision as follows:

MISSTATEMENT OF AGE:

If the insured's age has been misstated, the benefits will be those the premium paid would have purchased at the correct age.

(3) A provision as follows:

OTHER INSURANCE IN THIS INSURER:

If the insured has more than one policy _____ [insert designation for limitation such as policy form type form], only one policy chosen by the insured will be effective. The company shall refund all premiums paid for all the other policies.

Optional paragraph: If the insured has more than one policy with this company providing a total indemnity for _____ [insert type of coverage or coverages] of more than _____ [insert maximum limit of indemnity or indemnities] the excess insurance is void. The premiums paid for the excess must be returned to the insured.

Or, in lieu thereof:

Insurance effective at one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his beneficiary, or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

On every application for insurance the insurer shall ask for the amount of insurance which the applicant currently has in force with such insurer. If the insurer fails to ascertain the amount of insurance which an applicant has in force, all policies issued by the insurer to the applicant remain in force and the insurer is liable for all benefits payable thereunder, unless the applicant has misrepresented the amount of existing coverage on the application. In all cases where the applicant indicates that other life, accident, and health insurance is in force with the insurer or the insurer's company, the insurer shall provide the applicant with the total amount of existing coverage with the insurer or insurer's company within sixty days.

SECTION 38-71-370. Continued

(4) A provision as follows:

INSURANCE WITH OTHER INSURERS:

If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

[If the foregoing policy provision is included in a policy which also contains the policy provision set out in item (5) of this section, there shall be added to the caption of the foregoing provision the phrase "EXPENSE INCURRED BENEFITS". The insurer may, at its option, include in this provision a definition of "other valid coverage", approved as to form by the director or his designee, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada and by hospital or medical service organizations and to any other coverage the inclusion of which may be approved by the director or his designee. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations.

For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage".]

(5) A provision as follows:

INSURANCE WITH OTHER INSURERS:

If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss and for the return of such portion of the premium paid as shall exceed the pro ratio portion for the indemnities thus determined.

[If the foregoing policy provision is included in a policy which also contains the policy provision set out in item (4) of this section, there shall be added to the caption of the foregoing provision the phrase "OTHER BENEFITS". The insurer may, at its option, include in this provision a definition of "other valid coverage" approved as to form by the director or his designee, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the director or his designee. In the absence of such definition such term shall not include group insurance or benefits provided by union welfare plans or by employer or employee benefit organizations.

For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage".]

SECTION 38-71-370. Continued

(6) A provision as follows:

RELATION OF EARNINGS TO INSURANCE:

If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall exceed the pro ratio amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of two hundred dollars or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time. [The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of the premiums (a) until at least age fifty or (b) in the case of a policy issued after age forty four, for at least five years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage", approved as to form by the director or his designee, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada or to any other coverage the inclusion of which may be approved by the director or his designee or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, or benefits provided by union welfare plans or by employer or employee benefit organization.]

(7) A provision as follows:

UNPAID PREMIUM:

When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

(8) A provision as follows:

ILLEGAL OCCUPATION:

The company is not liable for any loss which results from the insured committing or attempting to commit a felony or from the insured engaging in an illegal occupation.

(9) A provision as follows:

INTOXICANTS AND NARCOTICS:

The company is not liable for any loss resulting from the insured being drunk or under the influence of any narcotic unless taken on the advice of a physician.

SECTION 38-71-420. Placement of required and optional provisions in policy.

The provisions which are the subject of Sections 38-71-340 and 38-71-370, or any corresponding provisions which are used in lieu thereof in accordance with those sections, must be printed in the consecutive order of the provisions in those sections, or, at the option of the insurer, any such provision may appear as a unit in any part of the policy with other provisions to which it may be logically related, as long as the resulting policy is not in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued.

SECTION 38-71-430. Additional provisions may not make policy less favorable.

A policy provision which is not subject to Sections 38-71-340 and 38-71-370 may not make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions which are subject to either of these sections.

SECTION 38-71-440. HMO's and health benefit plans offering medical eye care or vision care benefits; prohibited actions.

(A) As used in this section:
(1) "Health benefit plan" means any public or private health plan implemented in this State that provides medical eye care or vision care benefits, or both, to covered persons including payments and reimbursements.
(2) "Ophthalmologist" means a physician licensed pursuant to Title 40, Chapter 47 who practices in South Carolina and who specializes in the medical and surgical care of the eye and visual system and routine vision care.
(3) "Optometrist" means a doctor of optometry licensed pursuant to Title 40, Chapter 37 who is engaged in the practice of optometry in South Carolina.
(B) No health maintenance organization or health benefit plan which maintains or contracts with a network of ophthalmologists or optometrists, or both, to provide medical eye care or vision care benefits, or both, shall prohibit a participating optometrist from performing medical services within that optometrist's scope of practice set forth in Title 40, Chapter 37, in accordance with the terms of the health maintenance organization or health benefit plan and in accordance with subsections (C) and (I).
(C) No health maintenance organization or health benefit plan which maintains or contracts with a network of ophthalmologists or optometrists, or both, to provide medical eye care or vision care benefits, or both, excepting all self funded health benefit plans as defined under the Federal Employee Retirement Income Security Act (ERISA) of 1974, shall discriminate against optometry, as a class, or ophthalmology, as a class, with respect to the terms, conditions, privileges, and opportunity of participation or compensation for the same eye care services provided in this section.
(D) No health benefit plan or health maintenance organization shall impose on optometry, as a class, any condition or restriction which is not necessary for the delivery of services or materials, or both, in accordance with and subject to Chapter 37, Title 40.
(E) Any health maintenance organization or health benefit plan may contract for vision care benefits or medical eye care benefits, or both. A health maintenance organization or health benefit plan may contract for surgery only services with ophthalmologists. A health maintenance organization or health benefit plan must be authorized to contract with optometrists and ophthalmologists as either individual panelists or network panelists.
(F) Nothing in this section may be construed to limit, expand, or otherwise affect the scope of practice of optometrists and therapeutically certified optometrists as provided for in Chapter 37, Title 40.
(G) Nothing in this section may be construed to preclude a covered person from receiving emergency medical eye care or to preclude a primary care physician from providing treatment for covered services in accordance with the terms of a health maintenance organization or health benefit plan.
(H) Nothing in this section may be construed to mandate coverage of any service.
(I) Nothing in this plan may be construed to prohibit a health maintenance organization or health benefit plan from professionally credentialing and evaluating all individual optometrists or ophthalmologists within a network or plan in a nondiscriminatory manner. Nothing in this section may be construed to prohibit any health maintenance organization or health benefit plan from limiting the number of optometrists or ophthalmologists in a nondiscriminatory manner or to prohibit a health maintenance organization or health benefit plan from negotiating individually with optometrists or ophthalmologists for individual rates and eye care services in a nondiscriminatory manner.
(J) Any person aggrieved by a violation of this section may file a complaint with the Department of Insurance. After notice to the health maintenance organization or health benefit plan and an opportunity for it to submit a written response to the complaint, the director of the department may make a written determination regarding the complaint. Any party aggrieved by the director's determination is entitled to administrative and judicial review pursuant to Article 3, Chapter 23, Title 1. The director or the administrative law judge, if a hearing before the Administrative Law Judge Division is requested, may impose sanctions that are authorized under current insurance laws if a violation of this section is found to have occurred.

SECTION 38-71-550. Outline of coverage required.

(a) In order to provide for full and fair disclosure in the sale of individual accident and health insurance policies or subscriber contracts of a nonprofit hospital, medical, or dental service association, no such policy or contract may be delivered or issued for delivery in this State unless, in the case of a direct response insurance product, the outline of coverage described in subsection (b) of this section accompanies the policy and, in all other cases, the outline of coverage described in subsection (b) is delivered to the applicant at the time application is made and an acknowledgment of receipt or certificate of delivery of the outline is provided the insured with the application. In the event the policy is issued on a basis other than that applied for, the outline of coverage properly describing the policy or contract shall accompany the policy or contract when it is delivered and clearly state that it is not the policy or contract for which application was made.
(b) The department shall by regulation prescribe the format and content of the outline of coverage required by subsection (a) of this section. For purposes of this subsection (b), 'format' means style, arrangement, and overall appearance, including such items as the size, color, and prominence of type and the arrangement of text and captions. The outline of coverage shall include:
(1) A statement identifying the applicable category or categories of coverage provided by the policy or contract as prescribed in Section 38-71-540.
(2) A description of the principal benefits and coverage provided in the policy or contract.
(3) A statement of the exceptions, reductions, and limitations contained in the policy or contract.
(4) A statement of the renewal provisions, including any reservation by the insurer of a right to change premiums.
(5) A statement that the outline is a summary of the policy or contract issued or applied for and that the policy or contract should be consulted to determine governing contractual provisions.

SECTION 38-71-560. Effect of use of simplified application form.

Notwithstanding the provisions of item (2) of Section 38-71-340 or any other provision of law, if an insurer elects to use a simplified application form, with or without a question as to the applicant's health at the time of application, but without any questions concerning the insured's health history or medical treatment history, the policy shall cover any loss occurring after twelve months from any preexisting condition not specifically excluded from coverage by terms of the policy, and, except as so provided, the policy or contract may not include wording that would permit a defense based upon preexisting conditions.

SECTION 38-71-610. Notice of premiums due required.

(1) All insurers issuing accident or health policies, or combinations thereof, in this State, where the premiums on the policies are collected directly by mail on a quarterly, semiannual, or annual basis, shall give a written notice to the policyholders of any premium due on the policies at least ten days prior to the due date. No premium is considered past due on the policies unless the policyholder has been given this notice and the policy remains in full force and effect until the expiration of the ten day period after notice has been given. In the event the premium is not paid upon first notice at least ten days prior to lapsing of the policy a second notice must be forwarded to the insured. Nothing contained in this section applies to the following kinds of health and accident policies: debit accident insurance, debit health insurance, debit accident and health insurance, group accident and health insurance, franchise accident and health insurance, salaries savings accident and health insurance, credit accident and health insurance, accident and health insurance where premiums are paid by bank draft or preauthorized check service, and blanket insurance.
(2) This section may not be construed to relieve any policyholder from paying any premium or portion thereof, nor may it be construed so as to prevent termination for any other valid reason.

SECTION 38-71-620. Advance notice required for increase in premium.

If an accident and health insurance policy contains provisions which reserve the right to the insurer to increase the premium, the policy shall also provide that at least thirty one days' prior written notice of a rate increase must be given to the insured before the rate increase becomes effective.

SECTION 38-71-630. Acceptance of premium for period beyond expiration date of policy.

If any accident, health, or accident and health policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective and if the date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after the date, the coverage provided by the policy must continue in force until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective or would have ceased prior to the acceptance of the premium or premiums, then the liability of the insurer is limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

SECTION 38-71-640. Person with insurable interest may take out policy on insured.

The term "insured" as used in this article may not be construed as preventing a person other than the insured, with a proper insurable interest, from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits, and rights provided therein.

SECTION 38-71-650. Right to transfer to policy of equal or lesser benefits with same insurer.

Any person purchasing an individual accident, health, or accident and health insurance policy after July 1, 1991, shall have the right to transfer to any individual policy of equal or lesser benefits offered for sale by the insurer at the time the transfer is sought. Any special provision excluding coverage for a specified condition may remain after transfer, and any waiting period or preexisting condition period specified in the policy to which the transfer is made may be required to be served after the transfer.

SECTION 38-71-670. Definitions.

As used in this subarticle:
(1) "Bona fide association" means, with respect to health insurance coverage offered in the State, an association which:
(a) has been actively in existence for at least 5 years;
(b) has been formed and maintained in good faith for purposes other than obtaining insurance;
(c) does not condition membership in the association on any health status related factor relating to an individual, including an employee of an employer or a dependent of an employee;
(d) makes health insurance coverage offered through the association available to all members regardless of any health status related factor relating to the members, or individuals eligible for coverage through a member;
(e) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and
(f) meets such additional requirements as may be imposed under state law.
(2)"Director of Insurance" or "director" means the person who is appointed by the Governor upon the advice and consent of the Senate and who is responsible for the operation and management of the Department of Insurance, including all of its divisions. The director may appoint or designate the person or persons who shall serve at the pleasure of the director to carry out the objectives or duties of the department as provided by law. "Director" also includes a designee or deputy director upon whom the director has bestowed any duty or function required of the director by the director in managing or supervising the Department of Insurance.

SECTION 38-71-670. Continued

(3) "Employee" has the meaning given the term under Section 3(6) of the Employee Retirement Income Security Act of 1974.

(4) "Employer" has the meaning given the term under Section 3(5) of the Employee Retirement Income Security Act of 1974, except that the term shall include only employers of two or more employees.

(5) "Group health plan" means an employee welfare benefit plan, as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, to the extent that the plan provides medical care, including items and services paid for as medical care, to employees or their dependents, as defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise.

(6) "Health insurance coverage" means benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer, except:

(a) coverage only for accident or disability income insurance or any combination of these;

(b) coverage issued as a supplement to liability insurance;

(c) liability insurance, including general liability insurance and automobile liability insurance;

(d) workers' compensation or similar insurance;

(e) automobile medical payment insurance;

(f) credit only insurance;

(g) coverage for on site medical clinics;

(h) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(i) if offered separately:

(i) limited scope dental or vision benefits;

(ii) benefits for long term care, nursing home care, home health care, community based care, or any combination of these;

(iii) other similar, limited benefits as are specified in regulations;

(j) if offered as independent, non-coordinated benefits:

(i) coverage only for a specified disease or illness;

(ii) hospital indemnity or other fixed indemnity insurance;

(k) if offered as a separate insurance policy:

(i) Medicare supplemental health insurance, as defined under Section 1882(g)(1) of the Social Security Act;

(ii) coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code; and

(iii) similar supplemental coverage under a group health plan.

(7) "Health insurance issuer" or "issuer" means any entity that provides health insurance coverage in this State. For purposes of this subarticle, "issuer" includes an insurance company, a health maintenance organization, and any other entity providing health insurance coverage which is licensed to engage in the business of insurance in this State and which is subject to state insurance regulation.

(8) "Health maintenance organization" means an organization as defined in Section 38-33-20(7).

(9) "Health status related factor" means any of the following factors in relation to the individual or a dependent of the individual: health status; medical condition, including both physical and mental illnesses; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; or disability.

(10) "Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short term limited duration insurance.

(11) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan. The term includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year unless the State elects to regulate the coverage as coverage issued to small employers, as defined in Section 38-71-1330.

SECTION 38-71-670. Continued

(12) "Large group market" means the health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health plan maintained by an employer that is not a small employer, as defined in Section 38-71-1330.

(13) "Medical care" means amounts paid for:

(a) the diagnosis, cure, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;

(b) amounts paid for transportation primarily for and essential to medical care referred to in subitem (a); and

(c) amounts paid for insurance covering medical care referred to in subitems (a) and (b).

(14) "Network plan" means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(15) "Participant" has the meaning given the term under Section 3(7) of the Employee Retirement Income Security Act of 1974.

(16) "Small group market" means the health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health plan maintained by a small employer, as defined in Section 38-71-1330.

SECTION 38-71-675. Renewal or continuance of coverage at option of insurer; conditions for nonrenewal or discontinuance; modification of coverage.

(A) Except as provided in this section, a health insurance issuer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual.

(B) A health insurance issuer may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:

(1) the individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments;

(2) the individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(3) the issuer is ceasing to offer coverage in the individual market in accordance with subsection (C) and applicable state law;

(4) with the approval of the director or his designee, in the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area or in an area for which the issuer is authorized to do business but only if the coverage is terminated under this item uniformly without regard to any health status related factor of covered individuals;

(5) with the approval of the director or his designee, in the case of health insurance coverage that is made available in the individual market only through one or more bona fide associations, the membership of the individual in the association, on the basis of which the coverage is provided, ceases but only if the coverage is terminated under this item uniformly without regard to any health status related factor of covered individuals.

(C)(1) In any case in which an issuer decides to discontinue offering a particular type of health insurance coverage offered in the individual market, coverage of such type may be discontinued by the issuer only if the issuer:

(a) provides notice to each covered individual provided coverage of this type in the market of the discontinuation at least ninety days before the date of the discontinuation of the coverage;

(b) offers to each individual in the individual market provided coverage of this type, the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals in such market; and

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(c) in exercising the option to discontinue coverage of this type and in offering the option of coverage under subitem (b), the issuer acts uniformly without regard to any health status related factor of enrolled individuals or individuals who may become eligible for the coverage.

(2)(a) Subject to subitem (c), in any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the individual market in this State, health insurance coverage may be discontinued by the issuer only if:

(i) the issuer provides notice to the director and to each individual of the discontinuation at least one hundred eighty days before the date of the expiration of the coverage; and

(ii) all health insurance issued or delivered for issuance in the State in the market is discontinued and coverage under the health insurance coverage in the market is not renewed.

(b) In the case of a discontinuation under subitem (a) in the individual market, the issuer may not provide for the issuance of any health insurance coverage in the market and this State during the five year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(D) At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a policy form offered to individuals in the individual market so long as the modification is consistent with state law and effective on a uniform basis among all individuals with that policy form.

(E) In applying this section in the case of health insurance coverage that is made available by a health insurance issuer in the individual market to individuals only through one or more associations, a reference to an "individual" is deemed to include a reference to such an association of which the individual is a member.

SECTION 38-71-680. Application of Section 38 71 850(D).

Section 38-71-850(D) applies to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

(D)(1)(a) A health insurance issuer offering group health insurance coverage, shall provide the certification described in subitem (b):

(i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision;

(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision; and

(iii) on the request on behalf of an individual made not later than twenty four months after the date of cessation of the coverage described in subitem (a)(i) or (ii), whichever is later.

The certification under sub subitem (i) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

(b) The certification described in this subitem is a written certification of:

(i) the period of creditable coverage of the individual under the plan and the coverage, if any, under the COBRA continuation provision; and

(ii) the waiting period, if any, and affiliation period, if applicable, imposed with respect to the individual for any coverage under the plan.

(2) In the case of an election described in subitem (B)(3)(b) by a group health plan or health insurance issuer, if the plan or issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under item (1):

(a) upon request of the plan or issuer, the issuer which issued the certification provided by the individual shall promptly disclose to the requesting plan or issuer information on coverage of classes and categories of health benefits available under the entity's plan or coverage; and

(b) the issuer may charge the requesting plan or issuer for the reasonable cost of disclosing the information.

(3) The Director of Insurance shall establish rules to prevent an issuer's failure to provide information under item (1) or (2) with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

SECTION 38-71-1010. "Blanket accident and health insurance" defined.

"Blanket accident and health insurance" is defined to be that form of accident and health insurance covering special groups of individuals as enumerated in one of the following items:
(1) under a policy or contract issued to any common carrier, which must be considered the policyholder, covering a group defined as all individuals who may become passengers on the common carrier;
(2) under a policy or contract issued to an employer, who must be considered the policyholder, covering any group of employees defined by reference to exceptional hazards incident to the employment;
(3) under a policy or contract issued to an employer, who is considered the policyholder, covering employees or independent contractors, or both, under contract to the employer while traveling to and from and while attending meetings at a common location as a group or in groups incident to their employment or contractual arrangement;
(4) under a policy or contract issued to a college, school, or other institution of learning or to the head or principal thereof, which or who must be considered the policyholder, covering students or teachers;
(5) under a policy or contract issued in the name of any volunteer fire department, first aid, or other such volunteer group, which must be considered the policyholder, covering all of the members of the department or group;
(6) under a policy or contract issued to any other similar group which, in the discretion of the director or his designee, may be eligible for issuance of a blanket accident and health policy or contract either under special circumstances, exceptional hazards, or for short periods of duration.

SECTION 38-71-1020. Requirements as to policies.

All blanket accident and health insurance policies are subject to the provisions of Articles 1 and 3 of this chapter. However, no policy is required to contain any of the required policy provisions set forth in Section 38-71-340. However, no policy may contain any provision relative to notice of claim, proofs of loss or time of payment of claims, or the time within which suit may be brought upon the policy which, in the opinion of the director or his designee, is less favorable to the insured than would be permitted by the required policy provisions.

SECTION 38-71-1030. Individual applications and certificates not required.

An individual application is not required from an individual covered under a blanket accident and health policy or contract, nor is it necessary for the insurer to furnish each individual a certificate.

SECTION 38-71-1040. Payment of benefits.

All benefits under any blanket accident and health policy are payable to the individual insured, to his designated beneficiary or beneficiaries, or to his estate, except that if the individual insured is a minor, the benefits may be made payable to his parent, guardian, or other person actually supporting him.

SECTION 38-71-1050. Legal liability of policyholders not affected.

Nothing contained in this article affects the legal liability of policyholders for the death of, or injury to, any member of the group.

SECTION 38-71-1110. "Franchise accident and health insurance" defined.

"Accident and health insurance on a franchise plan" is that form of accident and health insurance issued to (1) three or more employees of any corporation, co-partnership, or individual employer or any governmental corporation, agency, or department or (2)ten or more members of any trade or professional association, labor union, or any other association having had an active existence for at least two years when the association or union has a constitution or bylaws and is formed in good faith for purposes other than that of obtaining insurance, when (a) the insureds, with or without their dependents, are issued the same form of an individual policy varying only as to amounts and kinds of coverage applied for by the insureds and (b) the employer, union, or association has approved and endorsed the policy being sold to its employees or members. Accident and health insurance on a franchise plan may be written under rates less than the usual rates for the insurance, but all premium rates and discounts the insurer proposes to use must be filed with the department and approved by the director or his designee as required by Section 38-71-310.

This section of the Code of Laws applies to both group and individual policies.

SECTION 38-71-1520. Definitions.

As used in this article:
(1) "Emergency medical care" means those health care services provided in a hospital emergency facility to evaluate and treat an emergency medical condition.
(2) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:
(a) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.
(3) "Emergency medical provider" means hospitals licensed by the South Carolina Department of Health and Environmental Control, hospital based services, and physicians licensed by the State Board of Medical Examiners who provide emergency medical care.
(4) "Managed care organization" means a licensed insurance company, a hospital or medical services plan contract, a health maintenance organization, or any other entity which is subject to regulation by the department and which operates a managed care plan.
(5) "Managed care plan" means a plan operated by a managed care organization which provides for the financing and delivery of health care and treatment services to individuals enrolled in the plan through its own employed health care providers or contracting with selected specific providers that conform to explicit selection standards, or both. A managed care plan also customarily has a formal organizational structure for continual quality assurance, a certified utilization review program, dispute resolution, and financial incentives for individual enrollees to use the plan's participating providers and procedures.

SECTION 38-71-1530. Screening; initial intervention; role of managed care organization; payments to providers.

(A) A patient who presents to an emergency department, by the Federal Social Security Act, must be screened to determine whether an emergency medical condition exists. This evaluation may include, but is not limited to, diagnostic testing to assess the extent of the condition, sickness, or injury and radiographic procedures and interpretation.
(B) Appropriate intervention must be initiated by medical personnel to stabilize any emergency medical condition before requesting authorization for the treatment by a managed care organization.
(C) A managed care organization shall inform its insureds, enrollees, patients, and affiliated providers about all policies related to emergency medical care access, coverage, payment, and grievance procedures. It is the ultimate responsibility of the managed care organization to inform any contracted third party administrator, independent contractor, or primary care provider about the emergency medical care provisions contained in this subsection.
(D) A managed care organization which includes emergency medical care services as part of its policy or contract shall provide coverage and shall subsequently pay providers for emergency medical care services provided to an insured, enrollee, or patient who presents an emergency medical condition. This subsection must not be construed to require coverage for illnesses, diseases, equipment, supplies, or procedures or treatments which are not otherwise covered under the terms of the insured's policy or contract.
(E) A managed care organization may not retrospectively deny or reduce payments to providers for emergency medical care of an insured, enrollee, or patient even if it is determined that the emergency medical condition initially presented is later identified through screening not to be an actual emergency, except in these cases:
(1) material misrepresentation, fraud, omission, or clerical error;
(2) a payment reduction due to applicable co payments, co insurance, or deductibles which may be the responsibility of the insured;
(3) cases in which the insured does not meet the emergency medical condition definition, unless the insured has been referred to the emergency department by the insured's primary care physician or other agent acting on behalf of the insurer.

SECTION 38-71-1920. Definitions.

For purposes of this article:
(1) "Adverse determination" means a determination by a health carrier or its designee that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided:
(a) does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness; or (b) is experimental or investigational and involves a condition that is life threatening or seriously disabling, and the requested service or payment for the service is, therefore, denied, reduced, or terminated.
(2) "Authorized representative" means:
(a) a person to whom a covered person has given express written consent to represent the covered person in an external review; (b) a person authorized by law to provide substituted consent for a covered person; or (c) a family member of the covered person or the covered person's treating health care professional when the covered person is unable to provide consent.
(3) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services.
(4) "Covered benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.
(5) "Covered person" means an insured, subscriber, enrollee, or other individual entitled to covered benefits under a health benefit plan.
(6) "Director or his designee" means the Director of the South Carolina Department of Insurance or a person designated by the director.
(7) "Facility" means an institution providing health care services or a health care setting including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings.
(8) "Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health carrier, or its designee, at the completion of the health carrier's internal appeal process.
(9) "Health benefit plan" means a policy, contract, or certificate issued by a health carrier that provides benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise, and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer, except:
(a) coverage only for accident or disability income insurance or any combination of accident and disability income insurance; (b) coverage issued as a supplement to liability insurance; (c) liability insurance, including general liability insurance and automobile liability insurance; (d) workers' compensation or similar insurance; (e) automobile medical payment insurance; (f) credit only insurance; (g) coverage for on site medical clinics; (h) other similar insurance coverage specified in regulations under which benefits for medical care are secondary or incidental to other insurance benefits;
(i) if offered separately:
(i) limited scope dental or vision benefits;
(ii) benefits for long term care, nursing home care, home health care, community based care, or any combination of these;
(iii) other similar, limited benefits, as are specified in regulations;
(j) if offered as independent, non-coordinated benefits:
(i) coverage only for a specified disease or illness;
(ii) hospital indemnity or other fixed indemnity insurance;
(k) if offered as a separate insurance policy:
(i) Medicare supplemental health insurance, as defined under Section 1882(g)(1) of the Social Security Act;

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(ii) coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code; and

(iii) similar supplemental coverage under a group health plan;

(l) any health benefit plan offered or administered by the State Budget and Control Board.

(10) "Health care professional" means a physician, dentist, or other person properly licensed, where required, to furnish health care services.

(11) "Health care provider" or "provider" means a health care professional or a facility.

(12) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(13) "Health carrier" means an entity that provides health insurance coverage in this State and an insurance company, a health maintenance organization, and any other entity providing health insurance coverage which is licensed to engage in the business of insurance in this State and which is subject to state insurance regulation.

(14) "Independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations.

(15) "Life threatening condition or disease" means a condition or disease which, according to the current diagnosis by the covered person's treating physician, has a high probability of causing the covered person's death within three years.

(16) "Medical and scientific evidence" means:

(a) peer reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; (b) peer reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meets the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline and Medlars database Health Services Technology Assessment Research; (c) medical journals recognized by the Secretary of Health and Human Services, under Section 1861 (t)(2) of the federal Social Security Act; (d) these standard reference compendia: the American Hospital Formulary Service Drug Information; the American Medical Association Drug Evaluation; the American Dental Association Accepted Dental Therapeutics; and the United States Pharmacopoeia Drug Information; (e) findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

(17) "Person" means a corporation, partnership, association, voluntary organization, individual, or any other entity, organization, or aggregation of individuals.

(18) "Retrospective review" means a review of medical necessity conducted after services have been provided to a patient; this term does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

(19) "Serious medical condition" means a health condition or illness that requires immediate medical attention, where failure to provide immediate medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

(20)"Seriously disabling" means a health condition or illness that involves a serious impairment to bodily functions or serious dysfunction of a bodily organ or part.

(21)"Utilization review" means a system for reviewing the necessary, appropriate, and efficient allocation of health care resources and services given or proposed to be given to a patient or a group of patients.

SECTION 38-71-1930. Application of this article.

(A) Except as provided in subsection (B), this article applies to all health carriers that provide or perform utilization review, including those plans subject to regulation under Chapter 33. (B) This article does not apply to the administrative services performed on behalf of a self funded plan subject to the Employee Retirement Income Security Act (ERISA) of 1974. (C) For purposes of this article, notice to the subscriber or insured entitled to covered benefits under a health benefit plan shall constitute notice to the covered person. This subsection does not affect the health plan's obligations under a court order requiring a parent to provide health coverage pursuant to Section 20-7-1200, et seq.

SECTION 38-71-1940. Notice of right to request a review; notice of adverse determination.

(A) A health carrier shall notify the covered person in writing of the right to request an external review and include the appropriate statements and information set forth in subsection (B) at the time the health carrier sends written notice of either an adverse determination or a final adverse determination.
(B)(1) The health carrier shall include in the notice required under subsection (A) a clear and concise description of the right of the covered person to request a standard external review pursuant to Section 38 71 1970 or an expedited external review pursuant to Section 38-71-1980 upon receipt of an adverse determination or a final adverse determination and the circumstances under which the covered person is not required to exhaust the health carrier's internal appeal process or is considered to have exhausted the health carrier's internal appeal process pursuant to Section 38-71-1960.
(2) In addition to the information to be provided pursuant to subsection (B)(1), the health carrier shall include a brief description of both the standard and expedited external review procedures.
(3) As part of any forms provided under subsection (B)(2), the health carrier shall include an authorization form, or other document promulgated or approved by the director or his designee, by which the covered person, for purposes of conducting an external review under this article, authorizes the health carrier to disclose protected health information, including medical records, concerning the covered person that are pertinent to the external review.
(C) A notice, statement, or form required by this section must achieve a score of no lower than 70 on the Flesch Reading East Test and must be printed in no smaller than 12 point type. No part of the notice, statement, or form may be printed in all capitals. A notice, statement, or form required by this section must include a statement of the right of the covered person to contact the director or his designee for assistance. The statement must include the telephone number and address of the director or his designee.
(D) A notice, statement, or form required by this section must be approved by the Department of Insurance. The director or his designee shall promulgate standard language, in a specified font size and type for any notice, statement, or form required by this section. Use of the standard language in the specified font size and type promulgated by the department pursuant to this section shall constitute compliance with the notice requirements of this section.

SECTION 38-71-1950. Requests for external review.

(A) All requests for external review must be made in writing to the health carrier.
(B) A covered person or his authorized representative may make a request for an external review of an adverse determination or final adverse determination only when the amount payable for covered benefits is at least five hundred dollars.
(C) A covered person is not entitled to an external review of a retrospective review determination unless the covered person has exhausted the health carrier's internal appeal process and may be held financially responsible for the covered benefits.

SECTION 38-71-1960. Exhaustion of internal appeal process.

(A)(1) Except in cases where the covered person's treating physician has certified in writing that the covered person has a serious medical condition, or where the denial of coverage is based on a determination that the health care service or treatment recommended or requested is experimental or investigational and the covered person's treating physician has provided the certifications required pursuant to Section 38-71-1980, a request for a standard or expedited external review may not be made until the covered person has exhausted the health carrier's internal appeal process.
(2) A covered person is considered to have exhausted the health carrier's internal appeal process for purposes of this section, if the covered person or his authorized representative:
(a) has filed an appeal involving an adverse determination pursuant to the health carrier's internal appeal process; and
(b) the health carrier has not issued a written decision within the time frames set forth in the health carrier's internal appeals process after receipt of all information necessary to complete the appeal and the covered person or his authorized representative has not agreed to a delay.
(B) A request for an external review of an adverse determination may be made before the covered person has exhausted the health carrier's internal appeal process whenever the health carrier agrees to waive the exhaustion requirement.
(C) If the requirement to exhaust the health carrier's internal appeal process is waived under subsection (B), the covered person or his authorized representative may file a request in writing for an external review.

SECTION 38-71-1970. Requests for external review.

(A)(1) Within sixty days after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Section 38-71-1940, a covered person or his authorized representative may file a request for an external review with the health carrier.
(2) If the denial of coverage is based on a determination that the health care service or treatment recommended or requested is experimental or investigational, the request for review must include a certification from the covered person's treating physician who must be a licensed physician qualified to practice in the area of medicine appropriate to treat the covered person's condition that:
(a) the covered person has a life threatening disease or seriously disabling condition; and
(b) at least one of the following situations is applicable:
(i) standard health care services or treatments have not been effective in improving the condition of the covered person;
(ii) standard health care services or treatments are not medically appropriate for the covered person; or
(iii) the recommended or requested service or treatment is more beneficial than the standard health care service or treatment covered by the health carrier; and
(c) medical and scientific evidence using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination or final adverse determination is more beneficial to the covered person than available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of the standard services or treatments.
(B)(1) Within five business days from the date the health carrier receives a request for an external review, the health carrier or its designee shall:
(a) assign an independent review organization from the list of approved independent review organizations compiled and maintained pursuant to Section 38-71-2000 to conduct an external review; and
(b) send the documents and any information considered in making the adverse determination or final adverse determination to the independent review organization; or
(c) inform the covered person or his authorized representative in writing that the request does not meet the criteria for external review pursuant to this article and include a statement explaining the reason for nonacceptance and the right of the covered person to contact the director or his designee for assistance. The statement shall include the telephone number and address of the director or his designee;

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(2) Except as provided in subsection (B)(3), failure by the health carrier or its designee to send the documents and information within the time specified in subsection (B)(1) may not delay the conduct of the external review.

(3)(a) If the health carrier or its designee fails to send the documents and information within the time specified in subsection (B)(1), the independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination .

(b) Immediately upon making the decision under subsection (B)(3)(a), the independent review organization shall notify the covered person or his authorized representative and the health carrier.

(C)(1) Within five business days after receipt of the request for external review from the health carrier, the independent review organization shall determine whether all the information, certifications, and forms required to process an external review, including the release form provided under Section 38-71-1940B(3) have been provided. The independent review organization shall immediately notify the covered person or his authorized representative in writing if additional information is required.

(2) The independent review organization shall include in the notice provided pursuant to subsection (C)(1) a clear statement that the covered person or his authorized representative may submit in writing to the independent review organization within seven business days following the date of receipt of the notice additional information and supporting documentation that the independent review organization shall consider when conducting the external review.

(3) If the request is not:

(a) complete, the independent review organization shall inform the covered person or his authorized representative what information or materials are needed to make the request complete; or

(b) accepted for external review, the independent review organization shall inform the covered person or his authorized representative and the health carrier in writing of the reasons for its nonacceptance.

(D)(1) If a request for external review is accepted for external review, the independent review organization shall notify the health carrier and the covered person or his authorized representative.

(2) In reaching a decision, the independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process, as set forth in Chapter 70, or the health carrier's internal appeal process.

(3) If the denial of coverage is based on a determination that the health care service or treatment recommended or requested is experimental or investigational, at the time a request is accepted for external review pursuant to subsection (C)(3),

(a) the independent review organization shall:

(i) immediately select a clinical peer review panel pursuant to subsection (D)(3)(b) to conduct the external review; and

(ii) based on the opinions of the clinical peer reviewers on the panel, make a decision to uphold or reverse the adverse determination or final adverse determination.

(b)(i) Notwithstanding the provisions of subsection (D)(3)(b)(ii), the panel shall consist of the number of physicians or other health care professionals considered appropriate by the independent review organization who meet the minimum qualifications described in Section 38-71-2010 and, through clinical experience in the past three years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

(ii) The health carrier may require that the panel consist of at least three physicians or other health care professionals who meet the minimum qualifications described in Section 38-71-2010 and, through clinical experience in the past three years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

(iii) Neither the covered person nor his authorized representative, if applicable, nor the health carrier shall choose or control the choice of the physicians or other health care professionals to be selected for the clinical peer review panel.

(c) Each member of the clinical peer review panel shall provide a written opinion to the independent review organization on whether to uphold or reverse the adverse determination or the final adverse determination. Each clinical peer reviewer's opinion shall include a description:

(i) of the covered person's medical condition, which is the subject of the adverse determination or final adverse determination;

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(ii) of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more beneficial to the covered person than standard services or treatments and that the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of the standard services or treatment; and

(iii) analysis of the medical and scientific evidence used in making the determination.

(E)(1) The independent review organization shall review all of the information and documents received from the health carrier and any other information submitted in writing to the independent review organization by the covered person or his authorized representative.

(2) Upon receipt of any information submitted by the covered person or his authorized representative pursuant to subsection (C)(2), the independent review organization immediately shall forward the information to the health carrier.

(F)(1) The health carrier may reconsider its adverse determination or final adverse determination at any time.

(2) Reconsideration by the health carrier may not delay or terminate the external review.

(3) The health carrier may terminate the external review only if the health carrier reverses its adverse determination or final adverse determination.

(4)(a) within five business days of making the decision to reverse its adverse determination or final adverse determination, as provided in subsection (F)(3), the health carrier shall send written notice to the covered person or his authorized representative and the independent review organization.

(b) the independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to subsection (F)(4)(a).

(G) In addition to the documents and information provided or transmitted pursuant to this section, the independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(1) the covered person's relevant medical records;

(2) the treating health care provider's recommendation;

(3) consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, his authorized representative, or the covered person's treating provider;

(4) the most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence based practice guidelines, or any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations;

(5) any applicable clinical review criteria developed and used by the health carrier or its designee; and

(6) If adverse determination or final adverse determination involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, whether:

(a) the recommended or requested health care service or treatment has been approved by the Federal Food and Drug Administration; or

(b) medical and scientific evidence demonstrates that the expected benefits of the recommended or requested health care service or treatment would be greater than the benefits of any available standard service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of standard services or treatments.

(H)(1) Within forty five days after the date of receipt of the request for an external review by the health carrier, the independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to the covered person or his authorized representative and the health carrier.

(2) If adverse determination or final adverse determination involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, the independent review organization shall make a decision to uphold or reverse the health carrier's adverse determination or final adverse determination based upon the recommendation of a majority of the clinical peer review panel, if more than one physician or other health care professional serves on the panel.

SECTION 38-71-1970. Continued

(3) The independent review organization shall include in the notice sent pursuant to subsection (H)(1):
(a) a general description of the reason for the request for external review;
(b) the date the independent review organization received the assignment from the health carrier;
(c) the date the external review was conducted, if appropriate;
(d) the date of its decision;
(e) the principal reason or reasons for its decision;
(f) the rationale for its decision;
(g) references to the evidence or documentation, including the practice guidelines, considered in reaching its decision; and
(h) the written opinions of the clinical peer review panel, if any.
(4) Within five business days of receipt of a notice of a decision pursuant to subsection (H)(1) reversing the adverse determination or final adverse determination, the health carrier shall approve the covered benefit that was the subject of the adverse determination or final adverse determination, subject to applicable contract exclusions, limitations, or other provisions.
(I) The assignment by a health carrier of an approved independent review organization to conduct an external review in accordance with this section must be fair and impartial. The health carrier and the independent review organization shall comply with standards promulgated by the director or his designee by regulation or bulletin to ensure fairness and impartiality in the assignment by health carriers of approved independent review organizations to conduct external reviews, including its term, its termination, and payment arrangement.

SECTION 38-71-1980. Expedited external review.

(A)(1) Within fifteen days after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Section 38-71-1940, a covered person or his authorized representative may file a request for an expedited external review with the health carrier at the time the covered person receives:
(a) an adverse determination if the covered person's treating physician has certified that the covered person has a serious medical condition;
(b) a final adverse determination if:
(i) the covered person's treating physician has certified that the covered person has a serious medical condition; or
(ii) the final adverse determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency medical care, as defined in Section 38-71-1520(2), but has not been discharged from a facility, if the covered person may be held financially responsible for the emergency medical care.
(2) If the denial of coverage is based on a determination that the health care service or treatment recommended or requested is experimental or investigational, the request for review must include a certification from the covered person's treating physician who must be a licensed physician qualified to practice in the area of medicine appropriate to treat the covered person's condition that:
(a) the covered person has a life threatening disease or seriously disabling condition; and
(b) at least one of the following situations is applicable:
(i) standard health care services or treatments have not been effective in improving the condition of the covered person;
(ii) standard health care services or treatments are not medically appropriate for the covered person; or
(iii) the recommended or requested service or treatment is more beneficial than the standard health care service or treatment covered by the health carrier; and
(c) medical and scientific evidence using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination or final adverse determination is more beneficial to the covered person than available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of the standard services or treatments.

SECTION 38-71-1980. Continued

(B)(1) At the time the health carrier receives a request for an expedited external review, the health carrier or its designee as expeditiously as reasonably possible shall:

(a) assign an independent review organization from the list of approved independent review organizations compiled and maintained pursuant to Section 38-71-2000 to conduct the expedited external review; and

(b) send all the documents and any information considered in making the adverse determination or final adverse determination to the independent review organization by overnight delivery service or any other reasonably available expeditious method; or

(c) inform the covered person or his authorized representative that the request does not meet the criteria for external review pursuant to this article and include a statement of the right of the covered person to contact the director or his designee for assistance. The statement shall include the telephone number and address of the director or his designee.

(2) Except as provided in subsection (B)(3), failure by the health carrier or its designee to send the documents and information within the time specified in subsection (B)(1) may not delay the conduct of the external review.

(3)(a) If the health carrier or its designee fails to send the documents and information within the time specified in subsection (B)(1), the independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(b) Immediately upon making the decision under subsection (B)(3)(a), the independent review organization shall notify the covered person or his authorized representative and the health carrier.

(C)(1) In reaching a decision, the independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process, as set forth in Chapter 70, or the health carrier's internal appeal process.

(2) If the denial of coverage is based on a determination that the health care service or treatment recommended or requested is experimental or investigational,

(a) the independent review organization shall:

(i) immediately select a clinical peer review panel pursuant to subsection (C)(2)(b) to conduct the external review; and

(ii) based on the opinions of the clinical peer reviewers on the panel, make a decision to uphold or reverse the adverse determination or final adverse determination.

(b)(i) notwithstanding the provisions of subsection (C)(2)(b)(ii), the panel shall consist of the number of physicians or other health care professionals, considered appropriate by the independent review organization, who meet the minimum qualifications described in Section 38-71-2010 and, through clinical experience in the past three years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

(ii) The health carrier may require that the panel consist of at least three physicians or other health care professionals who meet the minimum qualifications described in Section 38-71-2010 and, through clinical experience in the past three years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

(iii) Neither the covered person nor his authorized representative, if applicable, nor the health carrier shall choose or control the choice of the physicians or other health care professionals to be selected for the clinical peer review panel.

(c) Each member of the clinical peer review panel shall provide an opinion to the independent review organization on whether to uphold or reverse the adverse determination or the final adverse determination. Each clinical peer reviewer's opinion shall include a description:

(i) of the covered person's medical condition, which is the subject of the adverse determination or final adverse determination;

(ii) of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more beneficial to the covered person than standard services or treatments and that the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of the standard services or treatment; and

SECTION 38-71-1980. Continued

(iii) analysis of the medical and scientific evidence used in making the determination.

(D) In addition to the documents and information provided or transmitted pursuant to this section, the independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(1) the covered person's relevant medical records;

(2) the treating health care provider's recommendation;

(3) consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, his authorized representative, or the covered person's treating provider;

(4) the most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence based practice guidelines, or any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations;

(5) any applicable clinical review criteria developed and used by the health carrier or its designee; and

(6) if adverse determination or final adverse determination involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, whether:

(a) the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration; or

(b) medical and scientific evidence demonstrates that the expected benefits of the recommended or requested health care service or treatment would be greater than the benefits of any available standard service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of standard services or treatments.

(E)(1) The health carrier may reconsider its adverse determination or final adverse determination at any time.

(2) Reconsideration by the health carrier may not delay or terminate the external review.

(3) The health carrier may terminate the external review only if the health carrier reverses its adverse determination or final adverse determination.

(4)(a) As expeditiously as reasonably possible upon making the decision to reverse its adverse determination or final adverse determination, as provided in subsection (E)(3), the health carrier shall send notice to the covered person or his authorized representative and the independent review organization.

(b) The independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to subsection (E)(4)(a).

(F)(1) As expeditiously as reasonably possible, but in no event more than three business days after the date of receipt of the request for an expedited external review by the health carrier, the independent review organization shall provide notice of its decision to uphold or reverse the adverse determination or the final adverse determination to the:

(a) covered person or his authorized representative; and

(b) health carrier.

(2) If adverse determination or final adverse determination involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, the independent review organization shall make a decision to uphold or reverse the health carrier's adverse determination or final adverse determination based upon the recommendation of a majority of the clinical peer review panel, if more than one physician or other health care professional serves on the panel.

(3) If the notice provided pursuant to subsection (F)(1) was not in writing, within two days after the date of providing that notice, the independent review organization shall:

(a) provide written confirmation of the decision to the covered person or his authorized representative and the health carrier; and

(b) include the information set forth in Section 38-71-1970(H)(3).

(4)As expeditiously as reasonably possible after receipt of the notice of a decision pursuant to subsection (F)(1) reversing the adverse determination or final adverse determination, the health carrier shall

SECTION 38-71-1980. Continued

approve the covered benefit that was the subject of the adverse determination or final adverse determination, subject to applicable contract exclusions, limitations, or other provisions.

(G) The assignment by a health carrier of an approved independent review organization to conduct an external review in accordance with this section must be fair and impartial. The health carrier and the independent review organization shall comply with standards promulgated by the director or his designee by regulation or bulletin to ensure fairness and impartiality in the assignment by health carriers of approved independent review organizations to conduct external reviews, including its term, its termination, and payment arrangement.

SECTION 38-71-1990. External review decisions final; exceptions.

(A) An external review decision is binding on the health carrier.

(B) An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or state law. If such other remedies are available, the covered person or his authorized representative may not, in these proceedings, utilize, disclose, or introduce in evidence information generated during or findings reached by the independent review organization.

(C) A covered person or his authorized representative may not file a subsequent request for external review involving the same adverse determination or final adverse determination.

SECTION 38-71-2030. External review; written records; reports.

(A)(1) An independent review organization assigned pursuant to Section 38-71-1970 or Section 38-71-1980 to conduct an external review shall maintain written records in the aggregate and by health carrier on all requests for external review for which it conducted an external review during a calendar year and submit a report to the director or his designee, as required under subsection (A)(2).

(2) Each independent review organization required to maintain written records on all requests for external review pursuant to subsection (A)(1) for which it was assigned to conduct an external review shall submit to the director or his designee, no later than March first of each year and upon request by the director or his designee, a report in the format specified by the director or his designee.

(3) The report shall include in the aggregate and for each health carrier:

(a) the total number of requests for external review and the manner in which they were resolved;

(b) the average length of time for resolution;

(c) a summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the director or his designee; and

(d) any other information the director or his designee may request or require.

(4) The independent review organization shall retain the written records required pursuant to this subsection for at least three years.

(B)(1) Each health carrier shall maintain written records in the aggregate and for each general type of health benefit plan offered by the health carrier on all requests for external review that are filed with the health carrier during a calendar year.

(2) Each health carrier required to maintain written records on all requests for external review pursuant to subsection (B)(1) shall submit to the director or his designee, no later than March first of each year and upon request by the director or his designee, a report in the format specified by the director or his designee.

(3) The report shall include in the aggregate and by type of health benefit plan:

(a) the total number of requests for external review and the manner in which they were resolved;

(b) the average length of time for resolution;

(c) a summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the director or his designee; and

(d) any other information the director or his designee may request or require.

(4) The health carrier shall retain the written records required pursuant to this subsection for at least three years.

(C) The director or his designee shall make the reports required in this section available to any person for inspection and copying upon request.

SECTION 38-71-2040. Health carrier to pay for external review.

The health carrier shall pay for the external review.

SECTION 38-71-2050. Health carrier to inform covered persons of rights related to external review.

(A) Each health carrier shall include a description of the external review procedures in either the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to covered persons.
(B) The description required under subsection (A) shall include a statement of the right of the covered person to contact the director or his designee for assistance. The statement shall include the telephone number and address of the director or his designee.
(C) In addition to subsection (B), the statement shall inform the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review.

This section of the Code of Laws applies to both group and individual Long Term Care policies.

SECTION 38-72-10. Purpose

The purpose of this chapter is to promote the public interest, to promote the availability of long term care insurance policies, to protect applicants for long term care insurance as defined from unfair or deceptive sales or enrollment practices, to establish standards for long term care insurance, to facilitate public understanding and comparison of long term care insurance policies, and to facilitate flexibility and innovation in the development of long term care insurance coverage.

SECTION 38-72-20. Chapter not to supersede other insurance laws; exceptions; applications.

This chapter is not intended to supersede the obligations of entities subject to this chapter to comply with the substance of other applicable insurance laws insofar as they do not conflict with this chapter, except that laws and regulations designed and intended to apply to Medicare supplement insurance policies must not be applied to long term care insurance.

SECTION 38-72-30. Short title.

This chapter may be known and cited as the “Long Term Care Insurance Act”.

SECTION 38-72-40. Definitions.

Unless the context requires otherwise, as used in this chapter:
(1) “Long term care insurance” means an insurance policy or a rider advertised, marketed, offered, or designed to provide benefits for not less than twelve consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. The term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long term care insurance. It also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Long term care insurance may be issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations, or a similar organization to the extent they otherwise are authorized to issue life or health insurance. Long term care insurance does not include an insurance policy offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

SECTION 38-72-40. Continued

(2) "Applicant" means:

(a) in the case of an individual long term care insurance policy the person who seeks to contract for benefits; and

(b) in the case of a group long term care insurance policy, the proposed certificate holder.

(3) "Certificate" means any certificate issued under a group long term care insurance policy, which policy has been delivered or issued for delivery in this State.

(4) "Director" means the person who is appointed by the Governor upon the advice and consent of the Senate and who is responsible for the operation and management of the Department of Insurance, including all of its divisions. The director may appoint or designate the person or persons who shall serve at the pleasure of the director to carry out the objectives or duties of the department as provided by law. Furthermore, the director may bestow upon his designee or deputy director any duty or function required of him by law in managing or supervising the insurance department.

(5) "Group long term care insurance" means a long term care insurance policy which is delivered or issued for delivery in this State and issued to:

(a) one or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations or a combination thereof, for employees or former employees or a combination thereof, or for members or former members or a combination thereof of the labor organizations; or

(b) any professional, trade, or occupational association for its members or former or retired members or combination thereof if such association:

(i) is composed of individuals all of whom are or were actively engaged in the same profession, trade, or occupation; and

(ii) has been maintained in good faith for purposes other than obtaining insurance; or

(c) an association or to a trust or to the trustee of a fund established, created, or maintained for the benefit of members of one or more associations. Prior to advertising, marketing, or offering the policy within this State, the association or the insurer of the association shall file evidence with the department that the association has at the outset a minimum of one hundred persons and has been organized and maintained in good faith for purposes other than that of obtaining insurance, has been in active existence for at least one year, and has a constitution and bylaws which provide that the association holds regular meetings not less than annually to further the purposes of its members, except for credit unions, the association collects dues or solicits contributions from members, and the members have voting privileges and representation on the governing board and committees. Ninety days after the filing, the association is considered to have satisfied the organizational requirements unless the director or his designee makes a finding that the association does not satisfy those organizational requirements.

(d) a group other than as described in items (5)(a), (5)(b), and (5)(c), subject to a finding by the director or his designee that the issuance of the group policy is not contrary to the best interest of the public, the issuance of the group policy would result in economies of acquisition or administration, and the benefits are reasonable in relation to the premiums charged.

(6) "Policy" means any policy, contract, subscriber agreement, rider, or endorsement delivered or issued for delivery in this State by an insurer, fraternal benefit society, nonprofit health, hospital, or medical service corporation, prepaid health plan, health maintenance organization, or any similar organization.

SECTION 38-72-50. Group long term care insurance policy must meet requirements of chapter to be offered in state.

No group long term care insurance coverage may be offered to a resident of this State under a group policy issued in another state to a group described in Section 38 72 40(5)(d) unless this State or another state having statutory and regulatory long term care insurance requirements substantially similar to those adopted in this State has made a determination that the requirements have been met.

SECTION 38-72-60. General assembly to approve regulations; terms and conditions applicable to long term care insurance policy and group policy; advertising restrictions.

(A) The director or his designee shall submit to the General Assembly for approval regulations to carry out the purposes of this chapter.
(B) No long term care insurance policy may:
(1) for individual policies, be canceled, nonrenewed, or otherwise terminated except for nonpayment of the premium;
(2) contain a provision establishing a new waiting period if existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder;
(3) contain a provision requiring eligibility for or receipt of benefits under Medicare or Medicaid as a condition for payment of benefits under the policy; or
(4) contain coverage for skilled nursing care only or contain coverage that provides significantly more skilled care in a facility than coverage for lower levels of care in a facility.
(C) The following applies to preexisting conditions:
(1) No long term care insurance policy or certificate, other than a policy or certificate issued to a group as defined in Section 38 72 40(5)(a), may use a definition of "preexisting condition" which is more restrictive than the following: "Preexisting condition" means a condition for which medical advice or treatment was recommended by or received from a provider of health care services within six months preceding the effective date of coverage of an insured person.
(2) No long term care insurance policy or certificate, other than a policy or certificate issued to a group as defined in Section 38 72 40(5)(a), may exclude coverage for a loss or confinement which is the result of a preexisting condition unless loss or confinement begins within six months following the effective date of coverage of an insured person.
(3) The director or his designee may extend the limitation periods set forth in items (1) and (2) of this subsection as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.
(4) The definition of "preexisting condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards.
(D)(1) No long term care insurance policy may be delivered or issued for delivery in this State if the policy conditions eligibility for benefits:
(a) on a prior hospitalization requirement;
(b) provided in an institutional care setting on the receipt of a higher level of institutional care; or
(c) other than waiver of premium, post confinement, post acute care, or recuperative benefits on a prior institutionalization requirement.
(2)(a) A long term care insurance policy containing post confinement, post acute care, or recuperative benefits clearly must label in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits" limitations or conditions, including the required number of days of confinement.
(b) A long term care insurance policy or rider which conditions eligibility of post confinement, post acute care, or recuperative benefits on the prior receipt of institutional care may not require a prior institutional stay of more than thirty days.
(E) The following applies to the right of the policyholder to return the policy:
Long term care insurance applicants have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long term care insurance policies and certificates must have a notice prominently printed on the first page or attached to it stating in substance that the applicant has the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group as defined in Section 38 72 40(5)(a), the applicant is not satisfied for any reason.
(F)(1) An outline of coverage must be delivered to a prospective applicant for long term care insurance

SECTION 38-72-60. Continued

at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

(a) The director or his designee shall prescribe a standard format, including style, arrangement, and overall appearance, and the content of an outline of coverage.

(b) For agent solicitations, an agent shall deliver the outline of coverage before the presentation of an application or enrollment form.

(c) For direct response solicitations, the outline of coverage must be presented in conjunction with an application or enrollment form.

(2) The outline of coverage must include a:

(a) description of the principal benefits and coverage provided in the policy;

(b) statement of the principal exclusions, reductions, and limitations contained in the policy;

(c) statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including a reservation in the policy of a right to change the premium. Continuation or conversion provisions of group coverage must be described specifically.

(d) statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

(e) description of the terms under which the policy or certificate may be returned and premium refunded;

(f) brief description of the relationship of cost of care and benefits.

(G) A certificate issued pursuant to a group long term care insurance policy delivered or issued for delivery in this State must include a:

(1) description of the principal benefits and coverage provided in the policy;

(2) statement of the principal exclusions, reductions, and limitations contained in the policy; and

(3) statement that the group master policy determines governing contractual provisions.

(H) At the time of policy delivery, a policy summary must be delivered for an individual life insurance policy which provides long term care benefits within the policy or by rider. For direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request but, regardless of a request, shall make the delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary also must include:

(1) explanation of how the long term care benefit interacts with other components of the policy, including deductions from death benefits;

(2) illustration of the amount of benefits, the length of benefits, and the guaranteed lifetime benefits, if any, for each covered person;

(3) exclusions, reductions, and limitations on benefits of long term care;

(4) if applicable to the policy type:

(a) disclosure of the effects of exercising other rights under the policy;

(b) disclosure of guarantees related to long term care costs of insurance charges;

(c) current and projected maximum lifetime benefits.

(I) When a long term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report must be provided to the policyholder. The report must include:

(1) long term care benefits paid out during the month;

(2) explanation of changes in the policy, such as death benefits or cash values, due to long term care benefits being paid out;

(3) amount of long term care benefits existing or remaining.

(J) A policy or rider advertised, marketed, or offered as long term care or nursing home insurance must comply with the provisions of this chapter.

(K) All insurers issuing long term care insurance policies must offer, at time of application, an optional benefit which provides that when an insured meets the requirements under the policy that care in a nursing home or community residential care facility is necessary, the insured shall have the option of receiving necessary care in the home or community, with daily benefits at the same level that would have been paid for care in a nursing home or community residential care facility. This optional coverage may be provided by rider to the policy or included as part of the policy.

SECTION 38-72-60. Continued

Notwithstanding the foregoing, insurers issuing long term care insurance policies may offer a home health care benefit which would provide benefits when care in the home only is necessary. This home health care benefit may provide lesser benefits than that provided by the policy for care in a nursing home or community residential care facility and may be provided either by rider to the policy or included as part of the policy.

SECTION 38-72-70. Regulations.

Regulations adopted pursuant to this chapter must be in accordance with the provisions of Chapter 23, Title 1 of the 1976 Code.

SECTION 38-72-80. Application of chapter.

The requirements of this chapter apply to policies delivered or issued for delivery in this State on or after its effective date.

SECTION 38-72-90. Penalties for violation of chapter.

Any insurer violating any provision of this chapter is subject to the penalties provided for in Sections 38 5 120 and 38 5 130 of the 1976 Code.

SECTION 38-72-100. Long term care premiums excluded in determining contribution to cost of Medicaid services.

Any premiums paid for long term care insurance must be excluded in determining the amount an individual must contribute towards the cost of any Medicaid services he receives.

These Regulations apply to both group and individual policies.

Regulation 69-5.1. Minimum Standards for the Readability of Commonly Purchased Insurance Policies.

This Regulation establishes minimum standards of readability applicable to all commonly purchased personal policies, contracts and certificates of insurance delivered or issued for delivery in this State.

A. Purpose:

The purpose of this Regulation is to establish minimum standards of readability applicable to all commonly purchased personal policies, contracts and certificates of insurance delivered or issued for delivery in this State.

This Regulation is not intended to increase the risk assumed by insurance companies or other entities subject to this Act or to supersede their obligation to comply with the substance of other insurance legislation applicable to such forms of insurance policies. This Regulation is not intended to impede flexibility and innovation in the development of policy forms or content or to lead to the standardization of policy forms or content.

A policy is a legal document. Revision of the policy to make it more readable must not lead to its devaluation as a legal document. The policy must comply with all statutory and regulatory requirements.

B. Definitions:

As used in this Regulation:

(1) "Commissioner" means the Chief Insurance Commissioner of this State.

(2) "Policy" or "Policy Forms" means any policy, certificate, rider, amendment, endorsement, contract, plan or agreement of personal insurance, and any renewal thereof including homeowners, dwelling fire, automobile, accident and health, life and all other forms of personal insurance delivered or issued for delivery in this State by any company subject to this Regulation; any certificate, contract or policy issued by a fraternal benefit society, and any certificate issued pursuant to a group insurance policy delivered or issued for delivery in this State. The Commissioner may add other policies as he deems advisable.

Regulation 69-5.1 Continued

(3) "Company" or "Insurer" means any life and health, accident, property and casualty, title or marine insurance company, reciprocal, county mutuals, fraternal benefit society, nonprofit health services corporation, nonprofit hospital service corporation, nonprofit medical service corporation, prepaid health plan, dental care plan, vision care plan, pharmaceutical plan, health maintenance organization, and all similar type organizations.

C. Applicability:

(1) This Regulation shall apply to all policies delivered or issued for delivery in this State by any insurer on or after the date such forms must be approved under this Regulation, but nothing in this Regulation shall apply to:

(a) Any policy which is a security subject to Federal jurisdiction;

(b) Any group policy; however, this shall not exempt any certificate issued pursuant to a group policy delivered or issued for delivery in this State or mass marketed certificates subject to approval by this Department;

(c) Any group annuity contract which serves as a funding vehicle for pension, profit-sharing, or deferred compensation plans;

(d) Commercial, fleet vehicle and incidental personal coverages which are a part of a commercial policy;

(e) Any life, accident and health form used in connection with, as a conversion from, as an addition to, in exchange for or issued pursuant to a contractual provision for, a policy delivered or issued for delivery on a form approved or permitted to be issued prior to the date such forms must be approved under this Regulation;

(f) Renewal of a life or accident and health policy delivered or issued for delivery prior to the date such forms must be approved under this Regulation;

(g) Surety or Fidelity bonds.

D. Minimum Policy Readability Standards:

(1) In addition to any other requirements of law, no policy forms of personal insurance except as stated in Section C, shall be delivered or issued for delivery in this State on or after the dates such forms must be approved under this Regulation unless:

(a) The text achieves a minimum score of 40 on the Flesch Reading Ease Test or an equivalent score on any other comparable test as provided in subsection (3) of this Section;

(b) It is printed, except for specification pages, schedules and tables, in not less than ten point type, one point leaded;

DRAFTING NOTE: This subsection is not intended to include minor instructions concerning the preparation of an application which becomes part of the policy within the type size requirement (e. g., "Last Name," "RFD or Box Number.")

(c) The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text of the policy or to any endorsement or riders; and

(d) It contains a table of contents or an index of the principal sections of the policy, if the policy has more than 3,000 words or if the policy is printed on more than 3 pages.

(2) For the purposes of this Section, a Flesch Reading Ease Test Score shall be measured by the following method:

(a) For a policy containing 10,000 words or less of text, the entire policy shall be analyzed. For a policy containing more than 10,000 words, the readability of two 100 word samples per page may be analyzed instead of the entire form. The samples shall be separated by at least 20 printed lines.

(b) The number of words and sentences in the text shall be counted and the total number of words divided by the total number of sentences. The figure obtained shall be multiplied by a factor of 1.015.

(c) The total number of syllables shall be counted and divided by the total number of words. The figure obtained shall be multiplied by a factor of 84.6.

(d) The sum of the figures computed under (b) and (c) subtracted from 206.835 equals the Flesch Reading Ease Test Score for the policy form.

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(e) For purposes of this Section, the following procedures shall be used:

(1) A contraction, hyphenated word, numbers and letters when separated by spaces shall be counted as one word;

(2) A unit of words ending with a period, semicolon, or colon, but excluding headings and captions shall be counted as a sentence;

(3) A syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. Where the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.

(f) The term "text" as used in this Section shall include all printed matter except the following:

(1) The name and address of the insurer; the name, number or title of the policy; the table of contents or index; captions and subcaptions; specification pages, schedules or tables;

(2) Any policy language which is drafted to conform to the requirements of any federal law, regulation or agency interpretation; any policy language required by any collectively bargained agreement; any medical terminology; any words which are defined in the policy; and any policy language required by law or regulation; provided, however, the insurer identifies the language or terminology excepted by this subsection and certifies, in writing that the language or terminology is entitled to be excepted by this subsection.

(3) Any other reading test may be approved by the Commissioner for use as an alternative to the Flesch Reading Ease Test if it is comparable in result to the Flesch Reading Ease Test.

DRAFTING NOTE: The Flesch Reading Ease Test (Rudolph Flesch, The Art of Readable Writing, 1949, as revised 1974) is the basic test set forth in this Regulation.

(4)Filings subject to this Section shall be accompanied by a certificate signed by an officer of the insurer or filing organization stating that it meets the minimum reading ease score on the test used or stating that the score is lower than the minimum required but should be approved in accordance with Section F of this Regulation. To confirm the accuracy of any certification, the Commissioner may require the submission of further information to verify the certification in question. If it is necessary to alter coverage, such change must be noted and explained upon submission for filing.

(5) At the option of the insurer, riders, endorsements, and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used.

E. Powers of the Commissioner:

The Commissioner may approve a policy which does not meet the minimum Flesch Reading Ease Test Score required herein whenever, in his sole discretion, he finds such approval:

(1) will provide a more accurate reflection of the readability of a policy form;

(2) is warranted by the nature of a particular policy, or

(3) is warranted by certain policy language which is drafted to conform to the requirements of any State law, Regulation or Agency interpretation.

F. Approval of Forms:

A policy meeting the requirements of Section (D)(1) shall be approvable notwithstanding the provisions of any other law which specify the content of policies, if the policy provides the policyholders and claimants protection not less favorable than they would be entitled to under such laws.

G. Effective Dates:

(1) Except as provided in Section C, no policy shall be delivered or issued for delivery in this State on or after two years next following final promulgation of this Regulation unless approved by the Commissioner or permitted to be issued under this Regulation. Any policy which has been approved or permitted to be issued prior to and which meets the standards set by this Regulation need not be refiled for approval, but may continue to be lawfully delivered or issued for delivery in this State upon the filing with the Commissioner of a list of such policies identified by form number, edition date, previous approval date accompanied by a certificate as to each such policy in the manner provided in Section D(4).

(2) In addition to the above requirements the effective date for all property and casualty policies shall be as follows:

(a) Renewal policies or continuous policies shall be reissued using forms in compliance with this Regulation on the first anniversary or billing date which occurs after a two year period following the final promulgation of this Regulation.

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(b) The insurer shall provide, in the conversion to readable policies, generally and in overall effect, coverage which is substantially equal to or superior to that afforded by policies which they replace.

(c) If there are substantive differences in coverages, the insurer must explain in writing to the insured such differences.

(3) The Commissioner shall reserve the right to withdraw approval of all existing policies of commonly purchased insurance that do not comply with the provisions of this Regulation. The Commissioner may, in his sole discretion, extend the dates in Section G(1).

H. Penalties: Attention is directed to the penalties found in Section 5 of Act 550, "Any insurer who violates the provisions of this Act shall be deemed guilty of misdemeanor and upon conviction shall be fined not more than one thousand dollars for each offense and the Commissioner may revoke the license of any insurer who violates the provisions of this Act."

Regulation 69-44. Long Term Care Insurance.

Section 1. Definitions.

Unless the context otherwise requires, the following definitions shall apply as the terms are used in both this regulation and Act 466 of 1988 (The Long Term Care Insurance Act of 1988).

A. “Long term care insurance” means any insurance policy or rider advertised, marketed, offered or designed to provide benefits for not less than the period of time required by Act 466 of 1988 and any amendments thereto, for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual policies or riders whether issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations or any similar organization. Long term care insurance does not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

B. “Applicant” means:

(1) in the case of an individual long term care insurance policy, the person who seeks to contract for benefits, and

(2) in the case of a group long term care insurance policy, the proposed certificate holder.

C. “Certificate” means any certificate issued under a group long term care insurance policy, which policy has been delivered or issued for delivery in this State.

D. “Commissioner” means the Chief Insurance Commissioner of this State.

E. “Group long term care insurance” means a long term care insurance policy which is delivered or issued for delivery in this State and issued to:

(1) One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations; or

(2) Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:

(a) Is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and

(b) Has been maintained in good faith for purposes other than obtaining insurance; or

(3) An association or a trust or to the trustee of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing, or offering the policy within this State, the association or the insurer of the association shall file evidence with the Commissioner that the association has at the outset a minimum of one hundred persons and has been organized and maintained in good faith for purposes other than that of obtaining insurance, has been in active existence for

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at least one year, and has a constitution and bylaws which provide that the association holds regular meetings not less than annually to further the purposes of its members, except for credit unions, the association collects dues or solicits contributions from members, and the members have voting privileges and representation on the governing board and committees. Ninety days after the filing, the association is considered to have satisfied the organizational requirements unless the Commissioner makes a finding that the association does not satisfy those organizational requirements.

(4) A group other than as described in Subsections E(1), E(2) and E(3), subject to a finding by the Commissioner that:

(a) The issuance of the group policy is not contrary to the best interest of the public;

(b) The issuance of the group policy would result in economies of acquisition or administration; and

(c) The benefits are reasonable in relation to the premiums charged.

F. "Policy" means any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this State by an insurer; fraternal benefit society; nonprofit health, hospital, or medical service corporation; prepaid health plan; health maintenance organization or any similar organization.

Section 2. Policy Definitions.

No long term care insurance policy delivered or issued for delivery in this State shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

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

B. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

C. "Skilled nursing care," "intermediate care," "personal care," "home care," and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

D. All providers of services, including but not limited to "nursing homes," "community residential care facilities," and "home care providers" shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

Section 3. Policy Practices and Provisions.

A. Renewability. The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long term care insurance policy without further explanatory language in accordance with the disclosure requirements of Section 4 of this regulation.

(1) No such policy issued to an individual shall contain renewal provisions less favorable to the insured than "guaranteed renewable."

(2) The term "guaranteed renewable" means that the insured has the right to continue the long term care insurance in force by the timely payment of premiums and the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(3) The term "noncancellable" may be used only when the insured has the right to continue the long term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

B. Limitations and Exclusions. Exclusion or limitation of benefits on the basis of Alzheimer's Disease is not permitted. No policy may be delivered or issued for delivery in this State as long term care insurance if such policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

(1) Preexisting conditions or diseases.

(2) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease.

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(3) Alcoholism and drug addiction.

(4) Illness, treatment or medical condition arising out of:

(a) war or act of war (whether declared or undeclared);

(b) participation in a felony, riot or insurrection;

(c) service in the armed forces or units auxiliary thereto;

(d) suicide (sane or insane), attempted suicide or intentionally self inflicted injury; or

(e) aviation (this exclusion applies only to non fare paying passengers).

(5) Treatment provided in a federal government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.

(6) This Subsection B is not intended to prohibit exclusions and limitations by type of provider or territorial limitations or to prohibit the use of waivers or riders to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases, physical condition, or extra hazardous activity. Where waivers are required as a condition of insurance, signed acceptance by the insured is required.

C. Extension of Benefits. Termination of long term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

D. Continuation or Conversion.

(1) Group long term care insurance issued in this state on or after the effective date of this section shall provide covered individuals with a basis for continuation or conversion of coverage.

(2) For the purposes of this section, "a basis for continuation of coverage" means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due.

(3) For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

(4) For the purposes of this section, "converted policy" means an individual policy of long term care insurance providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. If the policy from which conversion is made restricts provision of benefits and services to named providers or facilities, and the circumstances of termination make continued use of these providers or facilities impossible or impractical, the converted policy shall provide coverage on an indemnity or expense incurred basis with benefits determined by the Commissioner to be substantially equivalent to the reasonable cost of services provided by the named providers or facilities, and shall not restrict provision of benefits and services to any named providers or facilities.

(5) Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than 31 days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

(6) Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which

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conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

(7) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

(a) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due, or

(b) The terminating coverage is replaced not later than 31 days after termination, by group coverage effective on the day following the termination of coverage:

(i) providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and

(ii) the premium for which is calculated in a manner consistent with the requirements of subsection (6) of this section.

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

(9) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

(10) Notwithstanding any other provision of this section, any insured individual whose eligibility for group long term care coverage is based upon his or her relationship to another person, shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage. For the purposes of this section, "continuation of coverage" means the maintenance of coverage under the existing group policy as if no terminating event had occurred, and which is subject only to the timely payment of premium when due.

(11) In cases of continuation of coverage, premium payments for coverage under the group policy may be made by the individual insured directly to the insurer, notwithstanding the provisions of Section 38 71 730(5).

E. Requirement for Home Care.

When an insured meets the requirements under the policy for a determination that care in a nursing home or community residential care facility is necessary, the insured shall have the option of receiving necessary care in the home or community, with daily benefits at the same level that would be paid for care in a nursing home or community residential care facility.

F. Option for Inflation Protection.

All insurers issuing long term care insurance policies on an indemnity basis, must offer, as an optional benefit, an inflation protection adjustment which provides for automatic future increases in the level of benefits without evidence of insurability. Adjustments must be at a level which provides reasonable protection from future increases in the costs of care for which benefits are provided.

Section 4. Required Disclosure Provisions.

A. Renewability. Individual long term care insurance policies shall contain a renewability provision. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

B. Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long term care insurance policy, all riders or endorsements added to an individual long term care insurance 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 individual insured. 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 must be agreed to

in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.
C. Payment of Benefits. A long term care insurance 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.
D. Limitations. If a long term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."
E. Other Limitations or Conditions on Eligibility for Benefits. A long term care insurance policy or certificate containing any limitations or conditions for eligibility shall set forth a description of such limitations or conditions, including any required number of days of confinement in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."
Section 5. Requirements for Solicitation and Replacement.
All individual and direct response solicited long term care insurance policies, regardless of issue age, shall be subject to compliance with the provisions of Regulations 69 34.1 and 69 34.2.
Section 6. Discretionary Powers of Commissioner.
The Commissioner may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this regulation with respect to a specific long term care insurance policy or certificate upon a written finding that:
A. The modification or suspension would be in the best interest of the insureds; and
B. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and
C.(1) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long term care; or
(2) The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or
(3) The modification or suspension is necessary to permit long term care insurance to be sold as part of, or in conjunction with, another insurance product.
Section 7. Loss Ratio.
Benefits under individual long term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent, calculated in a manner which provides for adequate reserving of the long term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:
A. Statistical credibility of incurred claims experience and earned premiums;
B. The period for which rates are computed to provide coverage;
C. Experienced and projected trends;
D. Concentration of experience within early policy duration;
E. Expected claim fluctuation;
F. Experience refunds, adjustments or dividends;
G. Renewability features;
H. All appropriate expense factors;
I. Interest;
J. Experimental nature of the coverage;
K. Policy reserves;
L. Mix of business by risk classification; and
M. Product features such as long elimination periods, high deductibles and high maximum limits.
Section 8. Filing Requirements.
Prior to an insurer or similar organization offering group long term care insurance to a resident of this

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State pursuant to Section 5 of Act 466 of 1988 (The Long Term Care Insurance Act of 1988), it shall file with the Commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long term care insurance requirements substantially similar to those adopted in this State.

Section 9. Standard Format Outline of Coverage.

This section of the regulation implements, interprets and makes specific the provisions of Section 6F of Act 466 of 1988 (The Long Term Care Insurance Act of 1988) in prescribing a standard format and the content of an outline of coverage.

A. The outline of coverage shall be a free standing document, using no smaller than 10 point type.

B. The outline of coverage shall contain no material of an advertising nature.

C. Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.

D. Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

E. Format for outline of coverage:

[COMPANY NAME]
[ADDRESS CITY & STATE]
[TELEPHONE NUMBER]
LONG TERM CARE INSURANCE
OUTLINE OF COVERAGE
[POLICY NUMBER]

(1) This policy is [an individual policy of insurance].

(2) PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual policy contains governing contractual provisions. This means that the policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY CAREFULLY!

(3) TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [Provide a brief description of the right to return ”free look” provision of the policy.]

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy. If the policy contains such provisions, include a description of them.]

(4) THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer’s Guide available from the insurance company.

(a) [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

(5) LONG TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long term care expenses, subject to policy [limitations] [waiting periods] and [co insurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

(6) BENEFITS PROVIDED BY THIS POLICY.

(a) Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.

(b) Institutional benefits, by skill level.

(c) Non institutional benefits, by skill level.

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[Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long term care, then these qualifying criteria or screens must be explained.]

(7) LIMITATIONS AND EXCLUSIONS.

Describe:

(a) Pre existing conditions.

(b) Non eligible facilities/provider.

(c) Non eligible levels of care (e.g., unlicensed providers, etc.)

(d) Exclusions/Exceptions.

(e) Limitations.

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in (6) above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

(8) RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

(a) That the benefit level will not increase over time.

(b) Any automatic benefit adjustment provisions.

(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage.

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations.

(e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

(9) TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED.

[(a) Describe the policy renewability provisions.

(b) Describe waiver of premium provisions or state that there are not such provisions.

(c) State whether or not the company has a right to change premium, and if such a right exists, describe clearly and concisely each circumstance under which premium may change.]

(10) PREMIUM.

[(a) State the total annual premium for the policy.

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

(11) ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used.

(b) Describe other important features.]

Section 10. Effective Date.

This regulation is applicable to all long term care insurance policies delivered or issued for delivery in this State on or after the effective date of this regulation which shall be one hundred eighty (180) days after final publication in the State Register.

Regulation 69-46. MEDICARE SUPPLEMENT INSURANCE.

(Statutory Authority: S.C. Code Sections 38-3-110(2), 38-71-530(b), 1-23-10 et seq. (1976), as amended)

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Regulation 69-46 Continued

Section 1. Purpose

The purpose of this regulation is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

Section 2. Authority

This regulation is issued pursuant to the authority vested in the director under S.C. Code Sections 38-3-110(2), 38-71-530(b) and 1-23-10 et seq.

Section 3. Applicability and Scope

A. Except as otherwise specifically provided in Sections 7, 13, 14, 17 and 22, this regulation shall apply to:

(1) All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this regulation; and

(2) All certificates issued under group Medicare supplement policies which certificates have been delivered or issued for delivery in this state.

B. This regulation shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

Section 4. Definitions

For purposes of this regulation:

A. "Applicant" means:

(1) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and

(2) In the case of a group Medicare supplement policy, the proposed certificate holder.

B. "Bankruptcy" means when a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

C. "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

D. "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

E. "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty three (63) days.

F.(1) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

(a) A group health plan;

(b) Health insurance coverage;

(c) Part A or Part B of Title XVIII of the Social Security Act (Medicare);

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

(e) Chapter 55 of Title 10 United States Code (CHAMPUS);

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

(g) A State health benefits risk pool;

(h) A health plan offered under chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);

(i) A public health plan as defined in federal regulation; and

(j) A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

(2) "Creditable coverage" shall not include one or more, or any combination of, the following:

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(a) Coverage only for accident or disability income insurance, or any combination thereof;
(b) Coverage issued as a supplement to liability insurance;
(c) Liability insurance, including general liability insurance and automobile liability insurance;
(d) Workers' compensation or similar insurance;
(e) Automobile medical payment insurance;
(f) Credit only insurance;
(g) Coverage for on site medical clinics; and
(h) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) "Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:
(a) Limited scope dental or vision benefits;
(b) Benefits for long term care, nursing home care, home health care, community based care, or any combination thereof; and
(c) Such other similar, limited benefits as are specified in federal regulations.

(4) "Creditable coverage" shall not include the following benefits if offered as independent, non coordinated benefits:
(a) Coverage only for a specified disease or illness; and
(b) Hospital indemnity or other fixed indemnity insurance.

(5) "Creditable coverage" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:
(a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;
(b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code; and Similar supplemental coverage provided to coverage under a group health plan.

G. "Employee welfare benefit plan" means a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

H. "Insolvency" means when an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

I. "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

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

K. "Medicare Advantage plan" means a plan of coverage for health benefits under Medicare Part C as defined in [refer to definition of Medicare Advantage plan in 42 U.S.C. 1395w 28(b)(1)], and includes:
(1) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point of service option), plans offered by provider sponsored organizations, and preferred provider organization plans;
(2) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and
(3) Medicare Advantage private fee for service plans.

L. "Medicare supplement policy" means a group or individual policy of [accident and sickness] insurance or a subscriber contract [of hospital and medical service associations or health maintenance organizations], other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et. seq.) or an issued policy under a demonstration project specified in 42 U.S.C. Section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. "Medicare supplement policy" does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under Section 1833(a)(1)(A) of the Social Security Act.

M. "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

N. "Secretary" means the Secretary of the United States Department of Health and Human Services.

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Section 5. Policy Definitions and Terms

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms which conform to the requirements of this section.

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

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

(2) The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no fault plan, unless prohibited by law.

B. "Benefit period" or "Medicare benefit period" shall not be defined more restrictively than as defined in the Medicare program.

C. "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined in the Medicare program.

D. "Health care expenses" means, for purposes of Section 14, expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

E. "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, but not more restrictively than as defined in the Medicare program.

F. "Medicare" shall be defined in the policy and certificate. 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 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.

G. "Medicare eligible expenses" shall mean expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

H. "Physician" shall not be defined more restrictively than as defined in the Medicare program.

I. "Sickness" shall not be defined to be more restrictive than the following:

"Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force." The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

Section 6. Policy Provisions

A. Except for permitted preexisting condition clauses as described in Section 7A(1) and Section 8A(1) of this regulation, no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

B. No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

C. No Medicare supplement policy or certificate in force in the state shall contain benefits which duplicate benefits provided by Medicare.

D.(1) Subject to sections 7(A)(4), (5) and (7), and 8(A)(4) and (5), a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006 shall be renewed for current policyholders who do not enroll in Part D at the option of the policyholder.

(2) A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

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(3) After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless:

(a) The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Part D plan and;

(b) Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

Section 7. Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to May 1, 1992

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

A. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

(4) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement policy shall not:

(a) Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

(b) Be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.

(5)(a) Except as authorized by the director of this state, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(b) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in Paragraph (5)(d), the issuer shall offer certificate holders an individual Medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:

(i) An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

(ii) An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in Section 8B of this regulation.

(c) If membership in a group is terminated, the issuer shall:

(i) Offer the certificate holder the conversion opportunities described in Subparagraph (b); or

(ii) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(d) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the

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period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(7) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subsection.

B. Minimum Benefit Standards.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

(3) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

(4) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

(5) Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

(6) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out of pocket amount equal to the Medicare Part B deductible [$100];

(7)Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

Section 8. Benefit Standards for Policies or Certificates Issued or Delivered on or after May 1, 1992

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after May 1, 1992. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

A. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

(4) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(5) Each Medicare supplement policy shall be guaranteed renewable.

(a) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.

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(b) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(c) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Section 8A(5)(e), the issuer shall offer certificate holders an individual Medicare supplement policy which (at the option of the certificate holder)

(i) Provides for continuation of the benefits contained in the group policy, or

(ii) Provides for benefits that otherwise meet the requirements of this subsection.

(d) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall

(i) Offer the certificate holder the conversion opportunity described in Section 8A(5)(c), or

(ii) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(e) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(f) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

(6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(7)(a) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed twenty four (24) months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

(b) If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted (effective as of the date of termination of entitlement) if the policyholder or certificate holder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period.

(c) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

(d) Reinstitution of coverages as described in Subparagraphs (b) and (c):

(i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

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(iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

B. Standards for Basic (Core) Benefits Common to Benefit Plans A J

Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

(5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

C. Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by Section 9 of this regulation.

(1) Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post hospital skilled nursing facility care eligible under Medicare Part A.

(3) Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(4) Eighty Percent (80%) of the Medicare Part B Excess Charges: Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge.

(5) One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge.

(6) Basic Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a $250 calendar year deductible, to a maximum of $1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

(7) Extended Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a $250 calendar year deductible to a maximum of $3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

(8) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the

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first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(9) Preventive Medical Care Benefit: Coverage for the following preventive health services not covered by Medicare:

(a) An annual clinical preventive medical history and physical examination that may include tests and services from Subparagraph (b) and patient education to address preventive health care measures;

(b) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

(10) At Home Recovery Benefit: Coverage for services to provide short term, at home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(a) For purposes of this benefit, the following definitions shall apply:

(i) "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self administered, and changing bandages or other dressings.

(ii) "Care provider" means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(iii) "Home" shall mean any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

(iv) "At home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a twenty four hour period of services provided by a care provider is one visit.

(b) Coverage Requirements and Limitations

(i) At home recovery services provided must be primarily services which assist in activities of daily living.

(ii) The insured's attending physician must certify that the specific type and frequency of at home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(iii) Coverage is limited to:

(I) No more than the number and type of at home recovery visits certified as necessary by the insured's attending physician. The total number of at home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;

(II) The actual charges for each visit up to a maximum reimbursement of $40 per visit;

(III) $1,600 per calendar year;

(IV) Seven (7) visits in any one week;

(V) Care furnished on a visiting basis in the insured's home;

(VI) Services provided by a care provider as defined in this section;

(VII) At home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(VIII) At home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight (8) weeks after the service date of the last Medicare approved home health care visit.

(c) Coverage is excluded for:

(i) Home care visits paid for by Medicare or other government programs; and

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(ii) Care provided by family members, unpaid volunteers or providers who are not care providers.

D. Standards for Plans K and L

(1) Standardized Medicare supplement benefit plan "K" shall consist of the following:

(a) Coverage of 100% of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

(b) Coverage of 100% of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

(c) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Medicare Part A Deductible: Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out of pocket limitation is met as described in Subparagraph (j);

(e) Skilled Nursing Facility Care: Coverage for 50% of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post hospital skilled nursing facility care eligible under Medicare Part A until the out of pocket limitation is met as described in Subparagraph (j);

(f) Hospice Care: Coverage for 50% of cost sharing for all Part A Medicare eligible expenses and respite care until the out of pocket limitation is met as described in Subparagraph (j);

(g) Coverage for 50%, under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out of pocket limitation is met as described in Subparagraph (j);

(h) Except for coverage provided in subparagraph (i) below, coverage for 50% of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out of pocket limitation is met as described in Subparagraph (j) below;

(i) Coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(j) Coverage of 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out of pocket limitation on annual expenditures under Medicare Parts A and B of $4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(2) Standardized Medicare supplement benefit plan "L" shall consist of the following:

(a) The benefits described in Paragraphs (1)(a),(b),(c) and (i);

(b) The benefit described in Paragraphs (1)(d),(e),(f),(g) and (h), but substituting 75% for 50%; and

(c) The benefit described in Paragraph (1)(j), but substituting $2000 for $4000.

Section 9. Standard Medicare Supplement Benefit Plans

A. An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core benefits, as defined in Section 8B of this regulation.

B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in Section 9(G) and in Section 10 of this regulation.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "L" listed in this subsection and conform to the definitions in Section 4 of this regulation. Each benefit shall be structured in accordance with the format provided in Sections 8B and 8C,or 8D and list the benefits in the order shown in this subsection. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of a benefit.

D. An issuer may use, in addition to the benefit plan designations required in Subsection C, other designations to the extent permitted by law.

E. Make up of benefit plans:

(1) Standardized Medicare supplement benefit plan "A" shall be limited to the basic (core) benefits common to all benefit plans, as defined in Section 8B of this regulation.

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(2) Standardized Medicare supplement benefit plan "B" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible as defined in Section 8C(1).

(3) Standardized Medicare supplement benefit plan "C" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as defined in Sections 8C(1), (2), (3) and (8) respectively.

(4) Standardized Medicare supplement benefit plan "D" shall include only the following: The core benefit (as defined in Section 8B of this regulation), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in an foreign country and the at home recovery benefit as defined in Sections 8C(1), (2), (8) and (10) respectively.

(5) Standardized Medicare supplement benefit plan "E" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined in Sections 8C(1), (2), (8) and (9) respectively.

(6) Standardized Medicare supplement benefit plan "F" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8C(1), (2), (3), (5) and (8) respectively.

(7) Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: 100% of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8C(1), (2), (3), (5) and (8) respectively. The annual high deductible plan "F" deductible shall consist of out of pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "F" deductible shall be $1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

(8) Standardized Medicare supplement benefit plan "G" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, eighty percent (80%) of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at home recovery benefit as defined in Sections 8C(1), (2), (4), (8) and (10) respectively.

(9) Standardized Medicare supplement benefit plan "H" shall consist of only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit and medically necessary emergency care in a foreign country as defined in Sections 8C(1), (2), (6) and (8) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(10) Standardized Medicare supplement benefit plan "I" shall consist of only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country and at home recovery benefit as defined in Sections 8C(1), (2), (5), (6), (8) and (10) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(11) Standardized Medicare supplement benefit plan "J" shall consist of only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess

charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at home recovery benefit as defined in Sections 8C(1), (2), (3), (5), (7), (8), (9) and (10) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(12) Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at home recovery benefit as defined in Sections 8C(1), (2), (3), (5), (7), (8), (9) and (10) respectively. The annual high deductible plan "J" deductible shall consist of out of pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve month period ending with August of the preceding year, and rounded to the nearest multiple of $10. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

F. Make up of two Medicare supplement plans mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA);

(1) Standardized Medicare supplement benefit plan "K" shall consist of only those benefits described in Section 8 D(1).

(2) Standardized Medicare supplement benefit plan "L" shall consist of only those benefits described in Section 8 D(2).

G. New or Innovative Benefits: An issuer may, with the prior approval of the director, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

Section 10. Medicare Select Policies and Certificates

A. (1) This section shall apply to Medicare Select policies and certificates, as defined in this section.

(2) No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

B. For the purposes of this section:

(1) "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

(2) "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

(3) "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

(4) "Medicare Select policy" or "Medicare Select certificate" mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.

(5) "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

(6) "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

(7) "Service area" means the geographic area approved by the director within which an issuer is authorized to offer a Medicare Select policy.

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C. The director may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the director finds that the issuer has satisfied all of the requirements of this regulation.

D. A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the director.

E. A Medicare Select issuer shall file a proposed plan of operation with the director in a format prescribed by the director. The plan of operation shall contain at least the following information:

(1) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(a) Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after hour care. The hours of operation and availability of after hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(b) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(i) To deliver adequately all services that are subject to a restricted network provision; or

(ii) To make appropriate referrals.

(c) There are written agreements with network providers describing specific responsibilities.

(d) Emergency care is available twenty four (24) hours per day and seven (7) days per week.

(e) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

(2) A statement or map providing a clear description of the service area.

(3) A description of the grievance procedure to be utilized.

(4) A description of the quality assurance program, including:

(a) The formal organizational structure;

(b) The written criteria for selection, retention and removal of network providers; and

(c) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

(5) A list and description, by specialty, of the network providers.

(6) Copies of the written information proposed to be used by the issuer to comply with Subsection I.

(7) Any other information requested by the director.

F.(1) A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the director prior to implementing the changes. Changes shall be considered approved by the director after thirty (30) days unless specifically disapproved.

(2) An updated list of network providers shall be filed with the director at least quarterly.

G. A Medicare Select policy or certificate shall not restrict payment for covered services provided by non network providers if:

(1) The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and

(2) It is not reasonable to obtain services through a network provider.

H. A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

I. A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

(1) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

(a) Other Medicare supplement policies or certificates offered by the issuer; and

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(b) Other Medicare Select policies or certificates.

(2) A description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.

(3) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out of network providers do not count toward the out of pocket annual limit contained in plans K and L.

(4) A description of coverage for emergency and urgently needed care and other out of service area coverage.

(5) A description of limitations on referrals to restricted network providers and to other providers.

(6) A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

(7) A description of the Medicare Select issuer's quality assurance program and grievance procedure.

J. Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Subsection I of this section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

K. A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

(1) The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

(2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

(3) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision makers who have authority to fully investigate the issue and take corrective action.

(4) If a grievance is found to be valid, corrective action shall be taken promptly.

(5) All concerned parties shall be notified about the results of a grievance.

(6) The issuer shall report no later than each March 31st to the director regarding its grievance procedure. The report shall be in a format prescribed by the director and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

L. At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

M. (1) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six (6) months.

(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at home recovery services or coverage for Part B excess charges.

N. Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

(1) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered

by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.
(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at home recovery services or coverage for Part B excess charges.
O. A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

Section 11. Open Enrollment

A. An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6) month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.
B.(1) If an applicant qualifies under Subsection A and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition.
(2) If the applicant qualifies under Subsection A and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this subsection.
C. Except as provided in Subsection B and Sections 12 and 23, Subsection A shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective.

Section 12. Guaranteed Issue for Eligible Persons

A. Guaranteed Issue
(1) Eligible persons are those individuals described in Subsection B who seek to enroll under the policy during the period specified in Subsection C, and who submit evidence of the date of termination, disenrollment, or Medicare Part D enrollment with the application for a Medicare supplement policy.
(2) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in Subsection E that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.
B. Eligible Persons
An eligible person is an individual described in any of the following paragraphs:
(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide substantially all such supplemental health benefits to the individual;
(2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, and any of the following circumstances apply, or the individual is 65

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years of age or older and is enrolled with a Program of All Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

(a) The certification of the organization or plan has been terminated;

(b) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(c) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the plan is terminated for all individuals within a residence area;

(d) The individual demonstrates, in accordance with guidelines established by the Secretary, that:

(i) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(e) The individual meets such other exceptional conditions as the Secretary may provide.

(3)(a) The individual is enrolled with:

(i) An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost);

(ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(iii) An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

(iv) An organization under a Medicare Select policy; and

(b) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Section 12B(2).

(4) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(a)(i) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(ii) Of other involuntary termination of coverage or enrollment under the policy;

(b) The issuer of the policy substantially violated a material provision of the policy; or

(c) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.

(5)(a) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act or a Medicare Select policy; and

(b) The subsequent enrollment under subparagraph (a) is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act); or

(6) The individual, upon first becoming eligible for benefits under part A of Medicare at age 65, enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment.

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(7) The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in Subsection E(4).

C. Guaranteed Issue Time Periods

(1) In the case of an individual described in Subsection B(1), the guaranteed issue period begins on the later of: (i) the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or (ii) the date that the applicable coverage terminates or ceases; and ends sixty three (63) days thereafter;

(2) In the case of an individual described in Subsection B(2), B(3), B(5) or B(6) whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty three (63) days after the date the applicable coverage is terminated;

(3) In the case of an individual described in Subsection B(4)(a), the guaranteed issue period begins on the earlier of: (i) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and (ii) the date that the applicable coverage is terminated, and ends on the date that is sixty three (63) days after the date the coverage is terminated;

(4) In the case of an individual described in Subsection B(2), B(4)(b), B(4)(c), B(5) or B(6) who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty three (63) days after the effective date;

(5) In the case of an individual described in Subsection B(7), the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty day period immediately preceding the initial Part D enrollment period and ends on the date that is sixty three (63) days after the effective date of the individual's coverage under Medicare Part D; and

(6) In the case of an individual described in Subsection B but not described in the preceding provisions of this Subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty three (63) days after the effective date.

D. Extended Medigap Access for Interrupted Trial Periods

(1) In the case of an individual described in Subsection B(5) (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in Subsection B(5)(a) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in Section 12B(5);

(2) In the case of an individual described in Subsection B(6) (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in Subsection B(6) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in Section 12B(6); and

(3) For purposes of Subsections B(5) and B(6), no enrollment of an individual with an organization or provider described in Subsection B(5)(a), or with a plan or in a program described in Subsection B(6), may be deemed to be an initial enrollment under this paragraph after the two year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

E. Products to Which Eligible Persons are Entitled

The Medicare supplement policy to which eligible persons are entitled under:

(1) Section 12B(1), (2), (3) and (4) is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer.

(2)(a) Subject to subparagraph (b), Section 12B(5) is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Paragraph (1);

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(b) After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with a outpatient prescription drug benefit, a Medicare supplement policy described in this subparagraph is:

(i) The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

(ii) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer;

(3) Section 12B(6) shall include any Medicare supplement policy offered by any issuer;

(4) Section 12B(7) is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

F. Notification provisions

(1) At the time of an event described in Subsection B of this section because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Subsection A. Such notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in Subsection B of this section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Section 12A. Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

Section 13. Standards for Claims Payment

A. An issuer shall comply with section 1882(c)(3) of the Social Security Act (as enacted by section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100 203) by:

(1) Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(2) Notifying the participating physician or supplier and the beneficiary of the payment determination;

(3) Paying the participating physician or supplier directly;

(4) Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

(5) Paying user fees for claim notices that are transmitted electronically or otherwise; and

(6) Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

B. Compliance with the requirements set forth in Subsection A above shall be certified on the Medicare supplement insurance experience reporting form.

Section 14. Loss Ratio Standards and Refund or Credit of Premium

A. Loss Ratio Standards

(1)(a) A Medicare Supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

(i) At least seventy five percent (75%) of the aggregate amount of premiums earned in the case of group policies; or

(ii) At least sixty five percent (65%) of the aggregate amount of premiums earned in the case of individual policies;

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(b) Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:

(i) Home office and overhead costs;

(ii) Advertising costs;

(iii) Commissions and other acquisition costs;

(iv) Taxes;

(v) Capital costs;

(vi) Administrative costs; and

(vii) Claims processing costs.

(2) All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(3) For purposes of applying Subsection A(1) of this section and Subsection C(3) of Section 15 only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

(4) For policies issued prior to May 1, 1992, expected claims in relation to premiums shall meet:

(a) The originally filed anticipated loss ratio when combined with the actual experience since inception;

(b) The appropriate loss ratio requirement from Subsection A(1)(a)(i) and (ii) when combined with actual experience beginning with [insert effective date of this revision] to date; and

(c) The appropriate loss ratio requirement from Subsection A(1)(a)(i) and (ii) over the entire future period for which the rates are computed to provide coverage.

B. Refund or Credit Calculation

(1) An issuer shall collect and file with the director by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.

(2) If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(3) For the purposes of this section, policies or certificates issued prior to May 1, 1992, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after the April 28, 2996. The first report shall be due by May 31, 1998.

(4) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for thirteen week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

C. Annual filing of Premium Rates

An issuer of Medicare supplement policies and certificates issued before or after the effective date of May 1, 1992 in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the director in accordance with the filing requirements and procedures prescribed by the director. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reason-

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able assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years.

As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the director, in accordance with the applicable filing procedures of this state:

(1)(a) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing.

(b) An issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(c) If an issuer fails to make premium adjustments acceptable to the director, the director may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this section.

(2) Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

D. Public Hearings

The director may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of [insert citation to state's regulation] if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the director.

Section 15. Filing and Approval of Policies and Certificates and Premium Rates

A. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the director in accordance with filing requirements and procedures prescribed by the director.

B. An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the director in the state in which the policy or certificate was issued.

C. An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the director in accordance with the filing requirements and procedures prescribed by the director.

D.(1) Except as provided in Paragraph (2) of this subsection, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

(2) An issuer may offer, with the approval of the director, up to four (4) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

(a) The inclusion of new or innovative benefits;

(b) The addition of either direct response or agent marketing methods;

(c) The addition of either guaranteed issue or underwritten coverage;

(d) The offering of coverage to individuals eligible for Medicare by reason of disability.

(3) For the purposes of this section, a "type" means an individual policy, a group policy, an individual

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Medicare Select policy, or a group Medicare Select policy.

E.(1) Except as provided in Paragraph (1)(a), an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this regulation that has been approved by the director. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months.

(a) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the director in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the director, the issuer shall no longer offer for sale the policy form or certificate form in this state.

(b) An issuer that discontinues the availability of a policy form or certificate form pursuant to Subparagraph (a) shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the director of the discontinuance. The period of discontinuance may be reduced if the director determines that a shorter period is appropriate.

(2) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

(3) A change in the rating structure or methodology shall be considered a discontinuance under Paragraph (1) unless the issuer complies with the following requirements:

(a) The issuer provides an actuarial memorandum, in a form and manner prescribed by the director, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

(b) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The director may approve a change to the differential which is in the public interest.

F.(1) Except as provided in Paragraph (2), the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Section 14, subsection B.

(2) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

Section 16. Permitted Compensation Arrangements

A. An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

B. The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five (5) renewal years.

C. No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

D. For purposes of this section, “compensation” includes pecuniary or non pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.

Section 17. Required Disclosure Provisions

A. General Rules.

(1) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder’s age.

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(2) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate 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 insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

(3) Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.

(4) If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

(5) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(6)(a) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Directors and CMS and in a type size no smaller than 12 point type. Delivery of the Guide shall be made whether or not the policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this regulation. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgement of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered.

(b) For the purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

B. Notice Requirements.

(1) As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the director. The notice shall:

(a) Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate, and

(b) Inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.

(2) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

(3) The notices shall not contain or be accompanied by any solicitation.

C. MMA Notice Requirements.

Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

D. Outline of Coverage Requirements for Medicare Supplement Policies.

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(1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant; and

(2) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate 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."

(3) The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than twelve (12) point type. All plans A L shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

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(4) The following items shall be included in the outline of coverage in the order prescribed below.

[COMPANY NAME]

Outline of Medicare Supplement Coverage Cover Page: 1 of 2

Benefit Plans _____[insert letters of plans being offered]

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A." Some plans may not be available in your state.

See Outlines of Coverage sections for details about ALL plans

Basic Benefits for Plans A - J:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare approved expenses) or copayments for hospital outpatient services.
Blood: First three pints of blood each year.

A	B	C	D	E	F/F*	G	H	I	J/J*
Basic	Basic	Basic	Basic	Basic	Basic	Basic	Basic	Basic	Basic
		Skilled Nursing Facility Coinsur-	Skilled Nursing Facility Coinsur-	Skilled Nursing Facility Coinsur-	Skilled Nursing Facility Coinsur-	Skilled Nursing Facility Coinsur-	Skilled Nursing Facility Coinsur-	Skilled Nursing Facility Coinsur-	Skilled Nursing Facility Coinsur-
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deducti-
		Part B Deductible			Part B Deductible				Part B Deducti-
					Part B Excess	Part B Excess		Part B Excess	Part B Excess
		Foreign Travel Emer-gency	Foreign Travel Emer-gency	Foreign Travel Emer-gency	Foreign Travel Emer-gency	Foreign Travel Emer-gency	Foreign Travel Emer-gency	Foreign Travel Emer-gency	Foreign Travel Emer-gency
			At-Home			At-Home		At-Home	At-Home
				Preventive Care NOT covered by Medicare					Preventive Care NOT covered by Medi-

* Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year [$1690] deductible. Benefits from high deductible plans F and J will not begin until out of pocket expenses exceed [$1690]. Out of pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

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[COMPANY NAME]
Outline of Medicare Supplement Coverage Cover Page: 2 of 2
Benefit Plans _____[insert letters of plans being offered]

Basic Benefits for Plans K and L include similar services as plans A - J, but cost sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A	100% of Part A
Skilled Nursing Facility	Hospitalization	Hospitalization
Part A Deductible	Coinsurance plus coverage for 365	Coinsurance plus coverage for 365
Part B Deductible	50% Hospice cost sharing	75% Hospice cost sharing
Part B Excess (100%)	50% of Medicare eligible expenses	75% of Medicare eligible expenses
Foreign Travel Emergency	50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
At-Home Recovery	50% Skilled Nursing Facility	75% Skilled Nursing Facility
Preventive Care NOT covered by Medicare	50% Part A Deductible	75% Part A Deductible
	$[4000] Out of Pocket Annual	$[2000] Out of Pocket Annual

** Plans K and L provide for different cost sharing for items and services than Plans A - J.
Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out of pocket annual limit does NOT include charges from your provider that exceed Medicare approved amounts, called “Excess Charges”. You will be responsible for paying excess charges.
***The out of pocket annual limit will increase each year for inflation.
See Outlines of Coverage for details and exceptions.

PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.
[for agents:]
Neither [insert company's name] nor its agents are connected with Medicare.
[for direct response:]
[insert company's name] is not connected with Medicare.
This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]
Review the application carefully before you sign it. Be certain that all information has been properly recorded.
[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to Section 9D of this regulation.]
[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the director.]

PLAN A
MEDICARE (PART A) - HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION *			
Semiprivate room and board, general nursing and miscellaneous			
First 60 days	All but $[876]	$0	$[876] (Part A deductible)
61st thru 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All Cost
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[109.50] a day	$0	Up to $[109.50] a day
101st day and after	$0	$0	All Cost
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long a your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have

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PLAN A
MEDICARE (PART B) - MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $[100] of Medicare approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT, such as a physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment,			
First $[100] of Medicare Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 Pints	$0	All costs	$0
Next $[100] of Medicare Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TEST FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN A
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and Medical supplies	100%	$0	$0
Durable medical equipment			
First $[100] of Medicare Approved Amounts*	$0	$0	$[100] (Part B deductible)
Reminder of Medicare Approved Amounts	80%	20%	$0

PLAN B
MEDICARE (PART A) - HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION *			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[876] (Part A deductible)	$0
61st thru 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All Cost
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[109.50] a day	$0	Up to $[109.50] a day
101st day and after	$0	$0	All Cost
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long a your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B
MEDICARE (PART B) - MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $[100] of Medicare approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT, such as a physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment,			
First $[100] of Medicare Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 Pints	$0	All costs	$0
Next $[100] of Medicare Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TEST FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN B
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and Medical supplies	100%	$0	$0
Durable medical equipment			
First $[100] of Medicare Approved Amounts*	$0	$0	$[100] (Part B deductible)
Reminder of Medicare Approved Amounts	80%	20%	$0

PLAN C
MEDICARE (PART A) - HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION *			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[876] (Part A deductible)	$0
61st thru 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All Cost
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[109.50] a day	Up to $[109.50] a day	$0
101st day and after	$0	$0	All Cost
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long a your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C
MEDICARE (PART B) - MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $[100] of Medicare approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT, such as a physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment,			
First $[100] of Medicare Approved Amounts*	$0	$[100] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 Pints	$0	All costs	$0
Next $[100] of Medicare Approved Amounts*	$0	$[100] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TEST FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN C
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and Medical supplies	100%	$0	$0
Durable medical equipment			
First $[100] of Medicare Approved Amounts*	$0	$[100] (Part B deductible)	$0
Reminder of Medicare Approved Amounts	80%	20%	$0

PLAN C
OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D
MEDICARE (PART A) - HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION *			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[876] (Part A deductible)	$0
61st thru 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All Cost
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[109.50] a day	Up to $[109.50] a day	$0
101st day and after	$0	$0	All Cost
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long a your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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PLAN D
MEDICARE (PART B) - MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $[100] of Medicare approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT, such as a physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment,			
First $[100] of Medicare Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 Pints	$0	All costs	$0
Next $[100] of Medicare Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TEST FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN D
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and Medical supplies	100%	$0	$0
Durable medical equipment			
First $[100] of Medicare Approved Amounts*	$0	$0	$[100] (Part B deductible)
Reminder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
Benefit for each visit	$0	Actual charges to $40 a visit	Balance
Number of visits covered (must be received within 8 weeks of last Medicare Approved visits)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
Calendar year maximum	$0	$1,600	

PLAN D
OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN E
MEDICARE (PART A) - HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION *			
Semiprivate room and board, general nursing and miscellaneous			
First 60 days	All but $[876]	$[876] (Part A deductible)	$0
61st thru 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All Cost
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[109.50] a day	Up to $[109.50] a day	$0
101st day and after	$0	$0	All Cost
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long a your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Regulation 69-46 Continued

PLAN E
MEDICARE (PART B) - MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $[100] of Medicare approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT, such as a physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment,			
First $[100] of Medicare Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 Pints	$0	All costs	$0
Next $[100] of Medicare Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TEST FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN E
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and Medical supplies	100%	$0	$0
Durable medical equipment			
First $[100] of Medicare Approved Amounts*	$0	$0	$[100] (Part B deductible)
Reminder of Medicare Approved Amounts	80%	20%	$0

PLAN E
OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
***PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE**			
Some annual physical and preventive test and services administered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All cost

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A) - HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$1690] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [$1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[1690] DEDUCTIBLE	[IN ADDITION TO $[1690] DEDUCTI-
HOSPITALIZATION *			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[876] (Part A deductible)	$0
61st thru 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All Cost
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[109.50] a day	Up to $[109.50] a day	$0
101st day and after	$0	$0	All Cost
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long a your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Regulation 69-46 Continued

PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART B) - MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $[100] of Medicare approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$1690] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [$1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[1690] DEDUCTIBLE **] PLAN PAYS	[IN ADDITION TO $[1690] DEDUCTIBLE.**] YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT, such as a physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment,			
First $[100] of Medicare Approved Amounts*	$0	$[100] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 Pints	$0	All costs	$0
Next $[100] of Medicare Approved Amounts*	$0	$[100] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TEST FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN F or HIGH DEDUCTIBLE PLAN F
PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[1690] DEDUCTIBLE **] PLAN PAYS	[IN ADDITION TO $[1690] DEDUCTI-BLE.**] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED			
Medically necessary skilled care services and Medical supplies	100%	$0	$0
Durable medical equipment			
First $[100] of Medicare Approved Amounts*	$0	$[100] (Part B deductible)	$0
Reminder of Medicare Approved Amounts	80%	20%	$0

PLAN F or HIGH DEDUCTIBLE PLAN F
OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[1690] DEDUCTIBLE **] PLAN PAYS	[IN ADDITION TO $[1690] DEDUCTI-BLE.**] YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G
MEDICARE (PART A) - HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION *			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[876] (Part A deductible)	$0
61st thru 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All Cost
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[109.50] a day	Up to $[109.50] a day	$0
101st day and after	$0	$0	All Cost
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long a your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Regulation 69-46 Continued

PLAN G

MEDICARE (PART B) - MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $[100] of Medicare approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as a physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment,			
First $[100] of Medicare Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	80%	20%
BLOOD			
First 3 Pints	$0	All costs	$0
Next $[100] of Medicare Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TEST FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN G
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and Medical supplies	100%	$0	$0
Durable medical equipment			
First $[100] of Medicare Approved Amounts*	$0	$0	$[100] (Part B deductible)
Reminder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
Benefit for each visit	$0	Actual charges to $40 a visit	Balance
Number of visits covered (must be received within 8 weeks of last Medicare Approved visits)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
Calendar year maximum	$0	$1,600	

PLAN G
OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN H
MEDICARE (PART A) - HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION *			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[876] (Part A deductible)	$0
61st thru 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All Cost
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[109.50] a day	Up to $[109.50] a day	$0
101st day and after	$0	$0	All Cost
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long a your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Regulation 69-46 Continued

PLAN H

MEDICARE (PART B) - MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $[100] of Medicare approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT, such as a physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment,			
First $[100] of Medicare Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All cost
BLOOD			
First 3 Pints	$0	All costs	$0
Next $[100] of Medicare Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TEST FOR DIAGNOSTIC SERVICES	100%	$0	$0

Regulation 69-46 Continued

PLAN H
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and Medical supplies	100%	$0	$0
Durable medical equipment			
First $[100] of Medicare Approved Amounts*	$0	$0	$[100] (Part B deductible)
Reminder of Medicare Approved Amounts	80%	20%	$0

PLAN H
OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN I
MEDICARE (PART A) - HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION *			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[876] (Part A deductible)	$0
61st thru 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All Cost
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[109.50] a day	Up to $[109.50] a day	$0
101st day and after	$0	$0	All Cost
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long a your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Regulation 69-46 Continued

PLAN I

MEDICARE (PART B) - MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $[100] of Medicare approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT, such as a physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment,			
First $[100] of Medicare Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 Pints	$0	All costs	$0
Next $[100] of Medicare Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TEST FOR DIAGNOSTIC SERVICES	100%	$0	$0

Regulation 69-46 Continued

PLAN I
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and Medical supplies	100%	$0	$0
Durable medical equipment			
First $[100] of Medicare Approved Amounts*	$0	$0	$[100] (Part B deductible)
Reminder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
Benefit for each visit	$0	Actual charges to $40 a visit	Balance
Number of visits covered (must be received within 8 weeks of last Medicare Approved visits)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
Calendar year maximum	$0	$1,600	

PLAN I
OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN J or HIGH DEDUCTIBLE PLAN J
MEDICARE (PART A) - HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[**This high deductible plan pays the same benefits as Plan J after one has paid a calendar year [$1690] deductible. Benefits from the high deductible Plan J will not begin until out-of-pocket expenses are [$1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[1690] DEDUCTIBLE **] PLAN PAYS	[IN ADDITION TO $[1690] DEDUCTIBLE.**] YOU PAY
HOSPITALIZATION *			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[876] (Part A deductible)	$0
61st thru 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All Cost
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[109.50] a day	Up to $[109.50] a day	$0
101st day and after	$0	$0	All Cost
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long a your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Regulation 69-46 Continued

PLAN J or HIGH DEDUCTIBLE PLAN J
MEDICARE (PART B) - MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $[100] of Medicare approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as Plan J after one has paid a calendar year [$1690] deductible. Benefits from the high deductible Plan J will not begin until out-of-pocket expenses are [$1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[1690] DEDUCTIBLE **] PLAN PAYS	[IN ADDITION TO $[1690] DEDUCTIBLE.**] YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT, such as a physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment,			
First $[100] of Medicare Approved Amounts*	$0	$[100] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 Pints	$0	All costs	$0
Next $[100] of Medicare Approved Amounts*	$0	$[100] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TEST FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN J or HIGH DEDUCTIBLE PLAN J
PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[1690] DEDUCTIBLE **] PLAN PAYS	[IN ADDITION TO $[1690] DEDUCTIBLE.**] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and Medical supplies	100%	$0	$0
Durable medical equipment			
First $[100] of Medicare Approved Amounts*	$0	$[100] (Part B deductible)	$0
Reminder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
Benefit for each visit	$0	Actual charges to $40 a visit	Balance
Number of visits covered (must be received within 8 weeks of last Medicare Approved visits)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
Calendar year maximum	$0	$1,600	

Regulation 69-46 Continued

PLAN J or HIGH DEDUCTIBLE PLAN J
OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[1690] DEDUCTIBLE **] PLAN PAYS	[IN ADDITION TO $[1690] DEDUCTIBLE.**] YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
***PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE**			
Some annual physical and preventive test and services administered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All cost

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*

PLAN K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of pocket limit of $[4000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A) - HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION *			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[438] (50% of Part A deductible)	$[438] (50% of Part A deductible) ◆
61st thru 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All Cost
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[109.50] a day	Up to $[54.75] a day	Up to $[54.75] a day ◆
101st day and after	$0	$0	All Cost
BLOOD			
First 3 pints	$0	50%	50% ◆
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long a your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for out-patient drugs and impatient	50% of coinsurance or copayment	50% of coinsurance or copayment ◆

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Regulation 69-46 Continued

PLAN K

MEDICARE (PART B) - MEDICAL SERVICES—PER CALENDAR YEAR

****Once you have been billed $[100] of Medicare approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as a physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment,			
First $[100] of Medicare Approved Amounts****	$0	$0	$[100] (Part B deductible)**** ◆
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All cost above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ◆
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All cost (and they do not count toward annual out-of-pocket limit of $[4000])*
BLOOD			
First 3 Pints	$0	50%	50% ◆
Next $[100] of Medicare Approved Amounts****	$0	$0	$[100] (Part B deductible)**** ◆
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ◆
CLINICAL LABORATORY SERVICES - TEST FOR DIAGNOSTIC SERVICES	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[4000] per year. However, the limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN K
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and Medical supplies	100%	$0	$0
Durable medical equipment			
First $[100] of Medicare Approved Amounts****	$0	$0	$[100] (Part B deductible) ◆
Reminder of Medicare Approved Amounts	80%	10%	10% ◆

****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

PLAN L

*You will pay half the cost-sharing of some covered services until you reach the annual out-of pocket limit of $[2000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A) - HOSPITAL SERVICES—PER BENEFIT PERIOD

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION *			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[657] (75% of Part A deductible)	$[219] (25% of Part A deductible) ◆
61st thru 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All Cost
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[109.50] a day	Up to $[82.13] a day	Up to $[27.37] a day ◆
101st day and after	$0	$0	All Cost
BLOOD			
First 3 pints	$0	75%	25% ◆
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long a your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for out-patient drugs and impatient	75% of coinsurance or copayment	25% of coinsurance or copayment ◆

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Regulation 69-46 Continued

PLAN L

MEDICARE (PART B) - MEDICAL SERVICES—PER CALENDAR YEAR

****Once you have been billed $[100] of Medicare approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT, such as a physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment,			
First $[100] of Medicare Approved Amounts****	$0	$0	$[100] (Part B deductible)**** ◆
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All cost above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ◆
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All cost (and they do not count toward annual out-of-pocket limit of $[2000])*
BLOOD			
First 3 Pints	$0	75%	25% ◆
Next $[100] of Medicare Approved Amounts****	$0	$0	$[100] (Part B deductible)**** ◆
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ◆
CLINICAL LABORATORY SERVICES - TEST FOR DIAGNOSTIC SERVICES	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[2000] per year. However, the limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN L
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and Medical supplies	100%	$0	$0
Durable medical equipment			
First $[100] of Medicare Approved Amounts****	$0	$0	$[100] (Part B deductible)
Reminder of Medicare Approved Amounts	80%	15%	5%

****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

Regulation 69-46 Continued

E. Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies.

(1) Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. Section 1395 et seq.), disability income policy; or other policy identified in Section 3B of this regulation, issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than twelve (12) point type and shall contain the following language:

"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

(2) Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in Subsection D(1) shall disclose, using the applicable statement in Appendix C, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

Section 18. Requirements for Application Forms and Replacement Coverage

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare supplement, Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

[Statements]

(1) You do not need more than one Medicare supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low Income Medicare Beneficiary(SLMB).

Regulation 69-46 Continued

[Questions]

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS.

[Please mark Yes or No below with an "X"]

To the best of your knowledge,

(1)(a) Did you turn age 65 in the last 6 months?

Yes____ No____

(b) Did you enroll in Medicare Part B in the last 6 months?

Yes____ No____

(c) If yes, what is the effective date? _____

(2) Are you covered for medical assistance through the state Medicaid program?

[NOTE TO APPLICANT: If you are participating in a "Spend Down Program" and have not met your "Share of Cost," please answer NO to this question.]

Yes____ No____

If yes,

(a) Will Medicaid pay your premiums for this Medicare supplement policy?

Yes____ No____

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

Yes____ No____

(3)(a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START __/__/__ END __/__/__

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

Yes____ No____

(c) Was this your first time in this type of Medicare plan?

Yes____ No____

(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

Yes____ No____

(4)(a) Do you have another Medicare supplement policy in force?

Yes____ No____

(b) If so, with what company, and what plan do you have [optional for Direct Mailers]?

_____

(c) If so, do you intend to replace your current Medicare supplement policy with this policy?

Yes____ No____

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

Yes____ No____

(a) If so, with what company and what kind of policy?

_____

_____

_____

(b) What are your dates of coverage under the other policy?

START __/__/__ END __/__/__

(If you are still covered under the other policy, leave "END" blank.)

Regulation 69-46 Continued

B. Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold which are still in force.

(2) List policies sold in the past five (5) years which are no longer in force.

C. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

D. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

E. The notice required by Subsection D above for an issuer shall be provided in substantially the following form in no less than twelve (12) point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

____Additional benefits.

____No change in benefits, but lower premiums.

____Fewer benefits and lower premiums.

____My plan has outpatient prescription drug coverage and I am enrolling in Part D.

____Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. [optional only for Direct Mailers.]

_____

_____

_____

_____

_____

_____

_____

_____

_____Other. (please specify)

Regulation 69-46 Continued

If, 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 and 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, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____

(Signature of Agent, Broker or Other Representative)*

[Typed Name and Address of Issuer, Agent or Broker]

_____

(Applicant's Signature)

_____

(Date)

*Signature not required for direct response sales.

F. Paragraphs 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

Section 19. Filing Requirements for Advertising

An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio or television medium to the Director of Insurance of this state for review or approval by the director to the extent it may be required under state law.

Section 20. Standards for Marketing

A. An issuer, directly or through its producers, shall:

(1) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

(2) Establish marketing procedures to assure excessive insurance is not sold or issued.

(3) Display prominently by type, stamp or other appropriate means, on the first page of the policy the following:

"Notice to buyer: This policy may not cover all of your medical expenses."

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.

(5) Establish auditable procedures for verifying compliance with this Subsection A.

B. In addition to the practices prohibited in [insert citation to state unfair trade practices act], the following acts and practices are prohibited:

(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy or to take out a policy of insurance with another insurer.

(2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

C. The terms "Medicare Supplement," "Medigap," "Medicare Wrap Around" and words of similar import shall not be used unless the policy is issued in compliance with this regulation.

Section 21. Appropriateness of Recommended Purchase and Excessive Insurance

A. In recommending the purchase or replacement of any Medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

B. Any sale of a Medicare supplement policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

C. An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

Section 22. Reporting of Multiple Policies

A. On or before March 1 of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one Medicare supplement policy or certificate:

(1) Policy and certificate number, and

(2) Date of issuance.

B. The items set forth above must be grouped by individual policyholder.

Section 23. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates

A. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.

B. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods.

Section 24. Separability

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

Section 25. Effective Date

This regulation shall be effective on upon publication in the State Register. Insurers are permitted to continue using current forms, or to make changes to current forms if offering Plan K or L, as appropriate through 2005. Insurers may offer any authorized plan upon approval by the Director of Insurance.

APPENDIX A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM FOR CALENDAR YEAR_____

TYPE [FN1] _____ SMSBP [FN2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number _____

Line	(a) Earned Premium	(b) Incurred Claims
1. Current Year's Experience a. Total (all policy years) b. Current year's issues c. Net (for reporting purposes = 1a-1b)	_____	_____
2. Past Years' Experience (all policy years)	_____	_____
3. Total Experience (Net Current Year + Past Year)	_____	_____
4. Refunds Last Year (Excluding Interest)		
5. Previous Since Inception (Excluding Interest)		
6. Refunds Since Inception (Excluding Interest)		
7. Benchmark Ratio Since Inception (*see worksheet for Ratio 1*)		
8. Experienced Ratio Since Inception (Ratio 2) Total Actual Incurred Claims (line 3, col. b)_____ Total Earned Prem. (line 3, col. a) Refunds Since Inception (line 6)		
9. Life Years Exposed Since Inception If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.		
10. Tolerance Permitted (obtained from credibility table)		

Medicare Supplement Credibility Table

Since Inception	Tolerance
10,000 +	0.0%
5,000 - 9,999	5.0%
2,500 - 4,999	7.5%
1,000 - 2,499	10.0%
500 - 999	15.0%

If less than 500, no credibility.

Regulation 69-46 Continued

11. Adjustment to Incurred Claims for Credibility
    Ratio 3 = Ratio 2 + Tolerance

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required.
If Ratio 3 is less than the Benchmark Ratio, then proceed.

12. Adjusted Incurred Claims
    [Total Earned Premiums (line 3, col. a) - Refunds Since Inception (line 6)]
    X Ratio 3 (line 11)

13. Refund =
    Total Earned Premiums (line 3, col. a) - Refunds Since Inception (line 6) -
    [Adjusted Incurred Claims (line 12)/Benchmark Ratio (Ratio 1)]

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund or credit against premiums to be used must be attached to this form.

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name Please Type

_____
Title Please Type

_____
Date

Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
"SMSBP" = Standardized Medicare Supplement Benefit Plan Use "P" for pre-standardized plans.
Includes Modal Loadings and Fees Charged.
Excludes Active Life Reserves.
This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

Regulation 69-46 Continued

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR GROUP POLICIES FOR CALENDAR YEAR_____

TYPE [FN1] _____ SMSBP [FN2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number _____

(a) Year	(b) Earned Premium	(c) Factor	(d) (b) x (c)	(e) Cumulative Loss Ratio	(f) (d) x (e)	(g) Factor	(h) (b) x (g)	(i) Cumulative Loss Ratio	(j) (h) x (i)	(o) Policy Year Loss Ratio
1	2.770			0.507		0.000		0.000		0.46
2	4.175			0.567		0.000		0.000		0.63
3	4.175			0.567		1.194		0.759		0.75
4	4.175			0.567		2.245		0.771		0.77
5	4.175			0.567		3.170		0.782		0.80
6	4.175			0.567		3.998		0.792		0.82
7	4.175			0.567		4.754		0.802		0.84
8	4.175			0.567		5.445		0.811		0.87
9	4.175			0.567		6.075		0.818		0.88
10	4.175			0.567		6.650		0.824		0.88
11	4.175			0.567		7.176		0.828		0.88
12	4.175			0.567		7.655		0.831		0.88
13	4.175			0.567		8.093		0.834		0.89
14	4.175			0.567		8.493		0.837		0.89
15+	4.175			0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
2 "SMSBP" = Standardized Medicare Supplement Benefit Plan Use "P" for pre standardized plans
3 Year 1 is the current calendar year - 1.
Year 2 is the current calendar year - 2 (etc.)
(Example: If the current year is 1991, then:
Year 1 is 1990; Year 2 is 1989, etc.)
4 For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
5 These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.
6 To include the earned premium for all years prior to as well as the 15th year prior to the current year.

Regulation 69-46 Continued

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR GROUP POLICIES FOR CALENDAR YEAR_____

TYPE [FN1] _____ SMSBP [FN2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number _____

(a) Year	(b) Earned Premium	(c) Factor	(d) (b) x (c)	(e) Cumulative Loss Ratio	(f) (d) x (e)	(g) Factor	(h) (b) x (g)	(i) Cumulative Loss Ratio	(j) (h) x (i)	(o) Policy Year Loss Ratio
1	2.770			0.442		0.000		0.000		0.40
2	4.175			0.493		0.000		0.000		0.55
3	4.175			0.493		1.194		0.659		0.65
4	4.175			0.493		2.245		0.669		0.67
5	4.175			0. 493		3.170		0.678		0.69
6	4.175			0.493		3.998		0.686		0.71
7	4.175			0.493		4.754		0.695		0.73
8	4.175			0.493		5.445		0.702		0.75
9	4.175			0.493		6.075		0.708		0.76
10	4.175			0. 493		6.650		0.713		0.76
11	4.175			0.493		7.176		0.717		0.76
12	4.175			0.493		7.655		0.720		0.77
13	4.175			0.493		8.093		0.723		0.77
14	4.175			0.493		8.493		0.725		0.77
15+	4.175			0.493		8.684		0.725		0.77
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
2 "SMSBP" = Standardized Medicare Supplement Benefit Plan Use "P" for pre standardized plans
3 Year 1 is the current calendar year - 1.
Year 2 is the current calendar year - 2 (etc.)
(Example: If the current year is 1991, then:
Year 1 is 1990; Year 2 is 1989, etc.)
4 For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
5 These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.
6 To include the earned premium for all years prior to as well as the 15th year prior to the current year.

APPENDIX B

FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES

Company Name: _____
Address: _____
_____
Phone Number: _____

Due March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

_____
Signature

_____
Name and Title (please type)

_____
Date

APPENDIX C

DISCLOSURE STATEMENTS

Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare

1. Section 1882 (d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.
2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).
3. State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.
4. Property/casualty and life insurance policies are not considered health insurance.
5. Disability income policies are not considered to provide benefits that duplicate Medicare.
6. Long term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.
7. The federal law does not preempt state laws that are more stringent than the federal requirements.
8. The federal law does not preempt existing state form filing requirements.
9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

Important Notice to Persons on Medicare
This Insurance Duplicates Some Medicare Benefits

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

Check the coverage in all health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department.

[Original disclosure statement for policies that provide benefits for specified limited services.]

Regulation 69-46 Continued

Important Notice to Persons on Medicare
This Insurance Duplicates Some Medicare Benefits

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

Check the coverage in **all** health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department.

[Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

Important Notice to Persons on Medicare
This Insurance Duplicates Some Medicare Benefits

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

Check the coverage in **all** health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department.

[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

Regulation 69-46 Continued

Important Notice to Persons on Medicare
This Insurance Duplicates Some Medicare Benefits

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

Check the coverage in **all** health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department.

[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long term care policies.]

Important Notice to Persons on Medicare
This Insurance Duplicates Some Medicare Benefits

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- hospice
- other approved items and services

Before You Buy This Insurance

Check the coverage in **all** health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department.

[Original disclosure statement for policies that provide benefits upon both an expense incurred and fixed indemnity basis.]

Regulation 69-46 Continued

Important Notice to Persons on Medicare
This Insurance Duplicates Some Medicare Benefits

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items & services

Before You Buy This Insurance

Check the coverage in **all** health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department.

[Original disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

Important Notice to Persons on Medicare
This Insurance Duplicates Some Medicare Benefits

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

Check the coverage in **all** health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department.

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

Regulation 69-46 Continued

Important Notice to Persons on Medicare
This Is Not Medicare Supplement Insurance

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

Check the coverage in **all** health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department.

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

Important Notice to Persons on Medicare
This Is Not Medicare Supplement Insurance

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

Check the coverage in **all** health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department.

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

Regulation 69-46 Continued

Important Notice to Persons on Medicare
This Is Not Medicare Supplement Insurance
Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

Check the coverage in **all** health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department.

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

Important Notice to Persons on Medicare
This Is Not Medicare Supplement Insurance

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

Check the coverage in **all** health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department.

[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long term care policies.]

Regulation 69-46 Continued

Important Notice to Persons on Medicare
This Is Not Medicare Supplement Insurance

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for *Medicare Supplement insurance.*

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

Check the coverage in **all** health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department.

[Alternative disclosure statement for policies that provide benefits upon both an expense incurred and fixed indemnity basis.]

Important Notice to Persons on Medicare
This Is Not Medicare Supplement Insurance

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items & services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

Check the coverage in **all** health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department.

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

Important Notice to Persons on Medicare
This Is Not Medicare Supplement Insurance

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

Check the coverage in **all** health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department.

This Regulation applies to group policies.

Regulation 69-43. Group Health Insurance Coordination of Benefits.

Section 1. Authority.

This regulation is promulgated under S. C. Code Sections 38 3 110(2) and 38 71 720 (1976), as amended.

Section 2. Purpose and Applicability.

A. The purpose of this regulation is to:

(1) Permit, but not require, plans to include a coordination of benefits (COB) provision;

(2) Establish an order in which plans pay their claims;

(3) Provide the authority for the orderly transfer of information needed to pay claims promptly;

(4) Reduce duplication of benefits by permitting a reduction of the benefits paid by a plan when the plan, pursuant to rules established by this regulation, does not have to pay its benefits first;

(5) Reduce claims payment delays; and

(6) Make all contracts that contain a COB provision consistent with this regulation.

Section 3. Definitions.

The following words and terms, when used in this regulation, shall have the following meanings unless the context clearly indicates otherwise:

A. Allowable Expenses

(1) "Allowable Expense" means the necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition.

(2) Notwithstanding the above definition, items of expense under coverages such as dental care, vision care, prescription drug or hearing aid programs may be excluded from the definition of Allowable Expense. A plan which provides benefits only for any such items of expense may limit its definition of Allowable Expenses to like items of expense.

(3) When a plan provides benefits in the form of service, the reasonable cash value of each service will be considered as both an Allowable Expense and a benefit paid.

(4) The difference between the cost of a private hospital room and the cost of a semi private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

(5) When COB is restricted in its use to specific coverage in a contract (for example, major medical or dental), the definition of "Allowable Expense" must include the corresponding expenses or services to which COB applies.

(6) When benefits are reduced under a Primary Plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements.

(a) Only benefit reductions based upon provisions similar in purpose to those described above and which are contained in the Primary Plan may be excluded from Allowable Expenses.

(b) This provision shall not be used by a Secondary Plan to refuse to pay benefits because an HMO member has elected to have health care services provided by a non HMO provider and the HMO, pursuant to its contract, is not obligated to pay for providing those services.

NOTE: This Paragraph (6) is not intended to allow a Secondary Plan to exclude expenses that are applied towards the satisfaction of the deductible, copayments or coinsurance amounts required by the Primary Plan, except for the benefit reductions expressly described in this paragraph.

B. Claim

A request that benefits of a plan be provided or paid is a claim. The benefits claimed may be in the form of:

(1) Services (including supplies);

(2) Payment for all or a portion of the expenses incurred;

(3) A combination of (1) and (2) above; or

(4) An indemnification.

Regulation 69-43 Continued

C. Claim Determination Period

This is the period of time, which must not be less than twelve consecutive months, over which Allowable Expenses are compared with total benefits payable in the absence of COB, to determine whether over insurance exists and how much each plan will pay or provide.

(1) The Claim Determination Period is usually a calendar year, but a plan may use some other period of time that fits the coverage of the group contract. A person may be covered by a plan during a portion of a Claim Determination Period if that person's coverage starts or ends during the Claim Determination Period.

(2) As each claim is submitted, each plan is to determine its liability and pay or provide benefits based upon Allowable Expenses incurred to that point in the Claim Determination Period. But that determination is subject to adjustment as later Allowable Expenses are incurred in the same Claim Determination Period.

D. Coordination of Benefits

This is a provision establishing an order in which plans pay their claims.

E. Hospital Indemnity Benefits

These are benefits not related to expenses incurred. The term does not include reimbursement type benefits even if they are designed or administered to give the insured the right to elect indemnity type benefits at the time of claim.

F. Plan

"Plan" means a form of coverage with which coordination is allowed. The definition of plan in the group contract must state the types of coverage which will be considered in applying the COB provision of that contract. The right to include a type of coverage is limited by the rest of this definition.

(1) The definition shown in the Model COB Provision, attached to this regulation as Appendix A, is an example of what may be used. Any definition that satisfies this subsection may be used.

(2) This regulation uses the term "plan." However, a group contract may, instead, use "program" or some other term.

(3) Plan may include:

(a) Group insurance and group subscriber contracts;

(b) Uninsured arrangements of group coverage;

(c) Group coverage through HMOs and other prepayment, group practice and individual practice plans;

(d) The amount by which group hospital indemnity benefits exceed $100 per day;

(e) The medical benefits coverage in group and individual automobile "no fault" and traditional automobile "fault" type contracts; and

(f) Medicare or other governmental benefits, except as provided in (4)(h) below and except as mandated by federal law. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.

(4) Plan shall not include:

(a) Individual or family insurance contracts;

(b) Individual or family subscriber contracts;

(c) Individual or family coverage through Health Maintenance Organizations (HMOs);

(d) Individual or family coverage under other prepayment, group practice and individual practice plans;

(e) Group hospital indemnity benefits of $100.00 per day or less;

(f) Blanket insurance contracts;

(g) Franchise insurance contracts; and

(h) A State plan under Medicaid, and shall not include a law or plan when, by law, its benefits are in excess of those of any private insurance plan or other non governmental plan.

G. Primary Plan

A Primary Plan is a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a Primary Plan if either of the following conditions is true:

(1) The plan either has no order of benefit determination rules, or it has rules which differ from those permitted by this regulation. There may be more than one Primary Plan; or

Regulation 69-43 Continued

(2) All plans which cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

H. Secondary Plan

A Secondary Plan is a plan which is not a Primary Plan. If a person is covered by more than one Secondary Plan, the order of benefit determination rules of this regulation decide the order in which their benefits are determined in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or plans and the benefits of any other plan which, under the rules of this regulation, has its benefits determined before those of that Secondary Plan.

I. This Plan

In a COB provision, this term refers to the part of the group contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the group contract providing health care benefits is separate from This Plan. A group contract may apply one COB provision to certain of its benefits (such as dental benefits), coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

Section 4. Model COB Contract Provision.

A. General

Appendix A contains a model COB provision for use in group contracts. That use is subject to the provisions of B and C below and to the provisions of Section 5.

B. Flexibility

A group contract's COB provision does not have to use the words and format shown at Appendix A. Changes may be made to fit the language and style of the rest of the group contract or to reflect the difference among plans which provide services, which pay benefits for expenses incurred, and which indemnify. No other substantive changes are allowed.

C. Prohibited Coordination and Benefit Design

(1) A group contract may not reduce benefits on the basis that:

(a) Another plan exists;

(b) A person is or could have been covered under another plan, except with respect to Part B of Medicare; or

(c) A person has elected an option under another plan providing a lower level of benefits than another option which could have been elected.

(2) No contract may contain a provision that its benefits are "excess" or "always secondary" to any plan as defined in this regulation, except in accord with the rules permitted by this regulation.

Section 5. Rules for Coordination of Benefits; Order of Benefits.

A. General

The general order of benefits is as follows:

(1) The Primary Plan must pay or provide its benefits as if the Secondary Plan or Plans did not exist. A Plan that does not include a coordination of benefits provision may not take the benefits of another Plan as defined in Section 3 Definitions into account when it determines its benefits. There is one exception: a contract holder's coverage that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder.

(2) A Secondary Plan may take the benefits of another plan into account only when, under these rules, it is Secondary to that other plan.

(3) The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.

B. Dependent Child/Parents Not Separated or Divorced

The rules for the order of benefits for a dependent child when the parents are not separated or divorced are as follows:

(1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;

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(2) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;

(3) The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;

(4) If the other plan does not have the rule described in B(1), (2) and (3) above, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.

C. Dependent Child/Separated or Divorced Parents

If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(1) First, the plan of the parent with custody of the child;

(2) Then, the plan of the spouse of the parent with the custody of the child; and

(3) Finally, the plan of the parent not having custody of the child.

(4) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(5) If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Section 5B, Dependent Child/ Parents Not Separated or Divorced.

D. Active/Inactive Employee

The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

E. Longer/Shorter Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member o subscriber longer are determined before those of the plan which covered that person for the shorter term.

(1) To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.

(2) The start of a new plan does not include:

(a) A change in the amount or scope of a plan's benefits;

(b) A change in the entity which pays, provides or administers the plan's benefits; or

(c) A change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

(3) The claimant's length of time covered under a plan is measured from the claimant's first date of coverage under that plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present plan has been in force.

Section 6. Procedure to be followed by Secondary Plan Total Allowable Expenses.

A. When it is determined, pursuant to Section 5, that this Plan is a Secondary Plan, it may reduce its benefits so that the total benefits paid or provided by all plans during a Claim Determination Period are not more than total Allowable Expenses. The amount by which the Secondary Plan's benefits have been reduced shall be used by the Secondary Plan to pay Allowable Expenses, not otherwise paid, which were incurred during the Claim Determination Period by the person for whom the claim is made. As each claim is submitted, the Secondary Plan determines its obligation to pay for Allowable Expenses based on all claims which were submitted up to that point in time during the Claim Determination Period.

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B. The benefits of the Secondary Plan will be reduced when the sum of the benefits that would be payable for the Allowable Expenses under the Secondary Plan in the absence of this COB provision and the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of the Secondary Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

(1) When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

(2) Paragraph B(1) above may be omitted if the plan provides only one benefit, or may be altered to suit the coverage provided.

Section 7. Miscellaneous Provisions.

A. Reasonable Cash Values of Services

A Secondary Plan which provides benefits in the form of services may recover the reasonable cash value of providing the services from the Primary Plan, to the extent that benefits for the services are covered by the Primary Plan and have not already been paid or provided by the Primary Plan. Nothing in this provision shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan which provides benefits in the form of services.

B. Excess and Other Nonconforming Provisions

(1) Some plans have order of benefit determination rules not consistent with this regulation which declare that the plan's coverage is "excess" to all others, or "always secondary." This occurs because certain plans may not be subject to insurance regulation, or because some group contracts have not yet been conformed with this regulation pursuant to Section 2.

(2) A plan with order of benefit determination rules which comply with this regulation (Complying Plan) may coordinate its benefits with a plan which is "excess" or "always secondary" or which uses order of benefit determination rules which are inconsistent with those contained in this regulation (Non-complying Plan) on the following basis:

(a) If the Complying Plan is the Primary Plan, it shall pay or provide its benefits on a primary basis;

(b) If the Complying Plan is the Secondary Plan, it shall, nevertheless, pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the Complying Plan were the Secondary Plan. In such a situation, such payment shall be the limit of the Complying Plan's liability; and

(c) If the Non-complying Plan does not provide the information needed by the Complying Plan to determine its benefits within a reasonable time after it is requested to do so, the Complying Plan shall assume that the benefits of the Non-complying Plan are identical to its own, and shall pay its benefits accordingly. However, the Complying Plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the Non-complying Plan.

(3) If the Non-complying Plan reduces its benefits so that the employee, subscriber, or member receives less in benefits than he or she would have received had the Complying Plan paid or provided its benefits as the Secondary Plan and the Non-complying Plan paid or provided its benefits as the Primary Plan, and governing State law allows the right of subrogation set forth below, then the Complying Plan shall advance to or on behalf of the employee, subscriber or member an amount equal to such difference.

However, in no event shall the Complying Plan advance more than the Complying Plan would have paid had it been the Primary Plan less any amount it previously paid. In consideration of such advance, the Complying Plan shall be subrogated to all rights of the employee, subscriber or member against the Non-complying Plan. Such advance by the Complying Plan shall also be without prejudice to any claim it may have against the Non-complying Plan in the absence of such subrogation.

C. Allowable Expense. A term such as "usual and customary," "usual and prevailing," or "reasonable and customary," may be substituted for the term "necessary, reasonable and customary." Terms such as "medical care" or "dental care" may be substituted for "health care" to describe the coverages to which the COB provisions apply.

D. Subrogation. The COB concept clearly differs from that of subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

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Section 8. Effective Date; Existing Contracts.

A. This regulation is applicable to every group contract which provides health care benefits and which is issued on or after the effective date of this regulation, which shall be ninety (90) days after final publication in the State Register.

B. A group contract which provides health care benefits and was issued before the effective date of this regulation shall be brought into compliance with this regulation by the later of:

(1) The next anniversary date or renewal date of the group contract; or

(2) The expiration of any applicable collectively bargained contract pursuant to which it was written.

APPENDIX A. MODEL COB PROVISIONS

COORDINATION OF THE GROUP CONTRACT'S BENEFITS WITH OTHER BENEFITS

I. APPLICABILITY

A. This Coordination of Benefits ("COB") provision applies to This Plan when an employee or the employee's covered dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

B. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:

(1) Shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but

(2) May be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in Section IV "Effect on the Benefits of This Plan."

II. DEFINITIONS

A. "Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

(1) Group insurance coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage.

(2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

B. "This Plan" is the part of the group contract that provides benefits for health care expenses.

C. "Primary Plan/Secondary Plan": The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

D. "Allowable Expense" means a necessary, reasonable and customary item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

The difference between the cost of a private hospital room and the cost of a semi private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

NOTE: When benefits are reduced under a Primary Plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense.

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Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements.

E. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

III. ORDER OF BENEFIT DETERMINATION RULES

A. General. When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless:

(1) The other plan has rules coordinating its benefits with those of This Plan; and

(2) Both those rules and This Plan's rules, in Subsection B below, require that This Plan's benefits be determined before those of the other plan.

B. Rules. This Plan determines its order of benefits using the first of the following rules which applies:

(1) Non Dependent/Dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.

(2) Dependent Child/Parents Not Separated or Divorced. Except as stated in Paragraph (B)(3) below, when This Plan and another plan cover the same child as a dependent of different persons, called "parents":

(a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

(b) If both parents have the same birthday, the benefits of the plan which covered a parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in (a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(3) Dependent Child/Separated or Divorced Parents. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) First, the plan of the parent with custody of the child;

(b) Then, the plan of the spouse of the parent with the custody of the child; and

(c) Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(4) Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Paragraph III B(2).

(5) Active/Inactive Employee. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (5) is ignored.

(6) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter term.

IV. EFFECT ON THE BENEFITS OF THIS PLAN

A. When This Section Applies. This Section IV applies when, in accordance with Section III "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other plans. In that event the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in B immediately below.

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B. Reduction in this Plan's Benefits. The benefits of This Plan will be reduced when the sum of:

(1) The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and

(2) The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

V. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

Certain facts are needed to apply these COB rules. [Insurer] has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. [Insurer] need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give [Insurer] any facts it needs to pay the claim.

VI. FACILITY OF PAYMENT

A payment made under another plan may include an amount which should have been paid under This Plan. If it does, [Insurer] may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. [Insurer] will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

VII. RIGHT OF RECOVERY

If the amount of the payments made by [Insurer] is more than it should have paid under this COB provision, it may recover the excess from one or more of:

A. The persons it has paid or for whom it has paid;

B. Insurance companies; or

C. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

This Regulation applies to individual policies.

Regulation 69-34. Individual Accident and Health Insurance Minimum Standards.

(Statutory Authority: 1976 Code Sections 1 23 10 et seq., 38-3-110(2), 38-71-530, 38-71-540, 38-71-550)

B. Purpose: The purpose of this regulation is to implement Section 38 71 510, et seq., so as to provide reasonable standardization and simplification of terms and coverages of individual accident and health insurance policies and individual subscriber contracts of hospital, medical and dental service corporations in order to facilitate public understanding and comparison and to eliminate provisions contained in individual accident and health insurance policies and individual subscriber contracts of hospital, medical, and dental service corporations which may be misleading or confusing in connection either with the purchase of such coverages or with the settlement of claims and to provide for full disclosure in the sale of such coverages.

C. Applicability and Scope: This Regulation shall apply to all individual accident and health insurance policies and individual subscriber contracts of hospital and medical and dental service corporations delivered or issued for delivery in this State, except that it shall not apply to individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when such group or individual policy or contract includes provisions which are inconsistent with this Regulation, nor shall it apply to Medicare Supplement policies issued in accordance with Regulation 69 46. The requirements contained in this Regulation shall be in addition to any other applicable regulations promulgated by the Commissioner.

D. Effective Date: This Regulation shall become effective July 13, 1981.

E. Policy Definitions: Except as provided hereafter, no individual accident or health insurance policy or hospital, medical, or dental service corporation subscriber contract 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.

(1) "One period of confinement" means consecutive days of in hospital service received as an in patient, or successive confinements when discharge from and re admission for the same or related causes to the hospital occurs within a period of time not more than the greater of 90 days or three times the maximum number of days of in hospital coverage provided by the policy to a maximum of 180 days.

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

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

1. be an institution operated pursuant to law; and
2. be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in patient basis for which a charge is made; and
3. provide 24 hour nursing service by or under the supervision of registered graduate professional nurses (R.N.'s).

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

1. convalescent homes, convalescent, rest, or nursing facilities; or
2. facilities primarily affording custodial, educational or rehabilitory care; or
3. facilities for the aged, drug addicts or alcoholics; or
4. 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 where a legal liability exists for charges made to the individual for such services.

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

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

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1. be operated pursuant to law;
2. be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;
3. be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;
4. provide continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and
5. maintain a daily medical record of each patient.

(b) The definition of such home or facility may provide that such term shall not be inclusive of:

1. any home, facility or part thereof used primarily for rest;
2. a home or facility for the aged or for the care of drug addicts or alcoholics; or
3. a home or facility primarily used for the care and treatment of mental diseases, or disorders, or custodial or educational care.

(4) "Accident," "Accidental Injury," "Accidental Means;" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

The definition shall not be more restrictive than the following: Injury or injuries, for which benefits are provided, means accidental bodily injury sustained by the insured person which is the direct cause of the loss, independent of disease or bodily infirmity or any other cause and which occurs while the insurance is in force. Such definition may provide that injuries shall not include injuries for which benefits are provided under workmen's compensation, employer's liability or similar laws, motor vehicle no fault plans, 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.

(5) Except as provided in F(1), "Sickness" shall not be defined to be more restrictive than the following: Sickness means sickness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period which will not exceed thirty (30) days from the effective date of the coverage of the insured person. The definition may be further modified to exclude sickness or disease for which benefits are provided under any workman's compensation, occupational disease, employer's liability or similar law.

(6) "Pre existing condition" shall not be defined to be more restrictive than (a) or (b) as stated below. (a) shall apply where the insurer uses an application form designed to elicit the complete health history of a prospective insured and, on the basis of the answers on that application, underwrites in accordance with the insurer's established standards. (b) shall apply where the insurer elects to use a simplified application, with or without a question as to the applicant's health at the time of application, or elects not to use any application.

(a) A condition misrepresented or not revealed in the application and for which symptoms existed prior to the effective date of coverage that would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which medical advice or treatment was recommended by or received from a physician.

(b) A condition for which symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a one (1) 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.

(7) "Physician" may be defined by including words such as "duly qualified physician" or "duly licensed physician." However, the use of such terms may not exclude payment or reimbursement otherwise provided by the policy which is performed by a duly licensed podiatrist, chiropractor or oral surgeon when he is acting within his legal scope of practice.

(8) "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" 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.

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(9) Total Disability:

(a) "Total Disability" shall not be defined more restrictively than the inability of the insured to engage in his own occupation during the first year of disability or for the length of the benefit period if less than one year. After the first year of disability, total disability may be defined as the complete inability of the insured to engage in any employment or occupation for which the insured is qualified by reason of education, training or experience. The definition of such word may allow the insurer to require reasonable conditions that the insured not be in fact engaged in any occupation for wage or profit.

(b) Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual's inability to: (a) Perform "any occupation whatsoever," "any occupational duty," or "any and every duty of his occupation," or (b) Engage in any training or rehabilitation program.

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

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

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

(12) "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.

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

F. Prohibited Policy Provisions and Practices.

(1) 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, tonsils, hemorrhoids and piles. However, the permissible six (6) months exception shall not be applicable where such specified diseases or conditions are treated on an emergency basis and if there is no previous medical history of the condition which predates the policy. Accident policies shall not contain probationary or waiting periods.

(2) No policy or rider for additional coverage may be issued as a dividend unless an equivalent cash payment or reduction in premium is offered to the policyholder as an alternative to such dividend policy or rider. No such dividend policy or rider shall be issued for an initial term of less than 6 months. This provision shall not be so construed as to prevent an insurer from voluntarily endorsing a policy so as to increase all future benefits without an increase in premium.

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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.

(3) A policy which is non cancellable or guaranteed renewable 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.

(4) Notwithstanding the permissible definition of hospital in Section E(2)(b)4., a hospital confinement indemnity policy shall not exclude coverage merely because of confinement in any government related hospital.

(5) A policy issued to a person eligible for Medicare by reason of age may not have limitations or exclusions more restrictive than those of Medicare for any type of coverage under such policies.

(6) No policy shall limit or exclude coverage by type of illness, accident, treatment, or medical condition more stringent than the following:

(a) Pre existing conditions or diseases, except for congenital anomalies of a covered dependent child;

(b) mental or emotional disorders, alcoholism and drug addiction;

(c) normal pregnancy and childbirth except for Disability Income policies defined in section G(6) of this regulation;

(d) illness, accident, treatment or medical condition arising out of:

1. war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the armed forces or units auxiliary thereto,
2. suicide, sane or insane, attempted suicide or intentionally self inflicted injury,
3. aviation,
4. with respect to short term nonrenewable policies, interscholastic sports;

(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 dependent child which has resulted in a functional defect;

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

(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;

(h) treatment provided in a government hospital (except a hospital confinement policy); benefits provided under Medicare or other governmental program (except Medicaid), any state or federal workmen's compensation, employers liability or occupational disease law, any motor vehicle no fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family; and services for which no charge is normally made in the absence of insurance;

(i) dental care or treatment

(j) eye glasses, hearing aids and examination for the prescription or fitting thereof;

(k) rest cures, custodial care, transportation and routine physical examinations;

(l) territorial limitations.

(7) Other provisions of this regulation 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 insurance, 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.

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(8) Policy provisions precluded in this section shall not be construed as a limitation on the authority of the Commissioner to disapprove other policy provisions in accordance with Section 38 71 530(b) which, in the opinion of the Commissioner, are unjust, unfair, misleading, or unfairly discriminatory to the policyholder, beneficiary, or any person insured under the policy.

(9) No policy shall include a provision which gives the insurer an unconditional right of non renewal.

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

G. Accident and Health Minimum Standards for Benefits.

The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. No individual policy of accident and health insurance or non profit hospital, medical or dental service corporation contract shall be delivered or issued for delivery in this state which does not meet the required minimum standards for the specified categories unless the Commissioner finds that such policies or contracts serve a valid economic and social purpose and are approvable as Limited Benefit Health Insurance and the Outline of Coverage complies with the appropriate outline in section H(11) of this Regulation. Each such policy shall contain the words “LIMITED BENEFITS” or “LIMITED OR SUPPLEMENTAL BENEFITS” prominently displayed on the first page of the policy in boldface type or contrasting color.

Nothing in this section shall preclude the issuance of any policy or contract combining two or more categories of coverage set forth in Section 38 71 540(a).

(1) General Rules

(a) A “noncancellable,” “guaranteed renewable,” or “noncancellable and guaranteed renewable” policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. The policy shall provide that in the event of the insured’s death the spouse of the insured, if covered under the policy, shall have the right to continue coverage previously afforded by the policy and exercise any rights previously vested in the insured.

(b) “Guaranteed renewable insurance” means all individual insurance which grants an insured the right to continue the policy in force by the timely payment of premiums until at least age 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 except that the Commissioner may disapprove such increase in rates if he determines that the benefits provided in such policies are unreasonable in relation to the premium to be charged after the increase.

(c) “Noncancellable insurance” or “noncancellable and guaranteed renewable insurance” means all individual insurance which gives the insured the right to continue the insurance in force by the timely payment of premiums set forth in the policy until at least age 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 it is in force.

(d) “Nonrenewable for stated reasons only” or “Conditionally Renewable” means all individual insurance which limits the insurer’s right of nonrenewal to reasons stated in the policy. The following are acceptable reasons, except that reasons 2 and 3 shall not be included in the same policy:

1. over insurance in accordance with insurer’s standards on file with the Commissioner;
2. discontinuance of all policies in the same class;
3. discontinuance of all policies issued on the same form in this State;
4. change of the insured’s occupation to an occupation classified as more hazardous than the original occupation.
5. any other factor which would qualify as a valid and generally accepted insurance underwriting basis.

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

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

(g) 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 persons on a pro rata basis.

(h) In the event the insurer cancels, or refuses to renew, policies providing pregnancy benefits, the 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.

(i) 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.

(j) 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 31 days of such date the company receive due proof of such incapacity in order for the insured to elect to continue the policy in force with respect to such child, or that a separate converted policy be issued at the option of the insured or policyholder.

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

(l) 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.

(m) 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 due to accident, 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.

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

(o) A company may not refuse to refund unearned premiums during a term for which premiums are paid. It may, however, base the amount of refund on a mode of premium payment more frequent than that of the term paid.

(p) 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.

(q) Termination of the policy shall be without prejudice to losses incurred for "one period of confinement", as defined, or 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, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

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

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(a) daily hospital room and board in an amount not less than the lesser of 80% of the charges for semi private room accommodations or $30.00 per day;

(b) 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 the lesser of (i) 80% of the charges incurred up to at least $1,000.00 or (ii) ten times the daily hospital room and board benefits;

(c) hospital outpatient services consisting of hospital services on the day surgery is performed, hospital services rendered within 72 hours after accidental injury, in an amount not less than $50, and X ray and laboratory tests to the extent that benefits for such services would have been provided if rendered to an in patient of the hospital in an amount not less than $100; and

(d) benefits provided under (a) and (b) of (2) above, may be provided subject to a combined deductible amount not in excess of $100.00.

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

(a) Surgical Services:

1. in amounts not less than those provided on a fee schedule based on the relative values contained in the state of New York certified surgical fee schedule, or the 1964 California Relative Value Schedule or other acceptable relative value scale or surgical procedures, up to a maximum of at least $500.00 for any one procedure; or

2. not less than 80% of the reasonable charges.

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

1. in an amount not less than 80% of the reasonable charges; or

2. 15% of the surgical service benefit.

(c) In hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than 80% of the reasonable charges; or $5.00 per day for not less than twenty one (21) days during one period of confinement.

(4) Hospital Confinement Indemnity Coverage: "Hospital Confinement Indemnity Coverage" is a policy of accident and health insurance which provides daily benefits for hospital confinement on an indemnity basis in an amount not less than $30.00 per day and not less than thirty one (31) days during any one period of confinement for each person insured under the policy.

(5) Major Medical Expense Coverage: "Major Medical Expense Coverage" is an accident and health insurance policy which provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than $20,000.00; copayment by the covered person not to exceed 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 5% of the aggregate maximum limit under the policy, unless the policy is written to complement underlying hospital and medical insurance in which case such deductible may be increased to the amount of the benefits provided by such underlying insurance, for each covered person for at least:

(a) Daily hospital room and board expenses, prior to application of the copayment percentage, for not less than $70.00 daily (or in lieu thereof the average daily cost of semiprivate room rate in the area where the insured resides) for a period of not less than 31 days during continuous hospital confinement;

(b) miscellaneous hospital services, prior to application of the copayment percentage, for an aggregate maximum of not less than $1,500 or 15 times the daily room and board rate if specified in dollar amounts;

(c) surgical services, prior to application of copayment percentage to a maximum of not less than $600 for the most severe operation with the amounts provided for other operations reasonably related to such maximum amount;

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

(e) in hospital medical services, prior to application of the copayment percentage, as defined in subdivision (3)(c) of G.

(f) out of hospital care prior to application of the copayment percentage, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, and diagnostic X ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician; and

(g) not fewer than three of the following additional benefits, prior to application of the copayment percentage, for an aggregate maximum of such covered charges of not less than $1,000:

1. In hospital private duty graduate registered nurse services.
2. Convalescent nursing home care.
3. Diagnosis and treatment by a radiologist or physiotherapist.
4. Rental of special medical equipment, as defined by the insurer in the policy.
5. Artificial limbs or eyes, casts, splints, trusses or braces.
6. Treatment for functional nervous disorders, and mental and emotional disorders.
7. Out of hospital prescription drugs and medications.

(6) Disability Income Protection Coverage This section does not apply to those policies providing business buyout coverage.

"Disability Income Protection Coverage" is a policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination thereof which:

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

(b) Contains an elimination period no greater than:

1. Ninety (90) days in the case of a coverage providing a benefit of one (1) year or less;
2. One hundred and eighty (180) days in the case of coverage providing a benefit of more than one year but not greater than two (2) years; or
3. Three hundred sixty five (365) days in all other cases during the continuance of disability resulting from sickness or injury.

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

(7) Accident Only Coverage: "Accident Only Coverage" is a policy of accident insurance which provides coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under such a policy shall be at least $1,000.00 and a single dismemberment amount shall be at least $500.00.

(8) Specified Disease and Specified Accident Coverage

(a) "Specified disease coverage" pays benefits for the diagnosis and/or treatment of a specifically named disease or diseases. Any such policy must meet the following general rules of subsection 1. In addition, policies providing coverage on an expense incurred basis must meet the standards of subsection 2, while policies providing coverage on an indemnity basis must meet the standards of subsection 3.

1. General Rules.

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

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

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

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

(iv) Policies containing specified disease coverage shall be at least Guaranteed Renewable.

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

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

(vii) Except for the uniform provision regarding other insurance with this insurer, benefits for specified disease coverage shall be paid regardless of other coverage.

(viii) After the effective date of the coverage (or applicable waiting period, if any) benefits shall begin with the first day of care or confinement if such care or confinement is for a covered disease even though the diagnosis is made at some later date. The retroactive application of such coverage may not be less than forty five (45) days prior to such diagnosis.

2. Expense Incurred Policies.

(i) Coverage must be provided for each person insured under the policy for a specifically named disease (or diseases) with a deductible amount not in excess of $250.00 and an overall aggregate benefit limit of no less than $10,000 and a benefit period of not less than two (2) years for at least the following incurred expenses with no unreasonable inside limits:

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

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

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

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

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

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

(G) Drugs and medicines prescribed by a physician;

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

(I) Braces, crutches and wheel chairs as are deemed necessary by the attending physician for the treatment of the disease;

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

(ii) The policy may include coverage of any other expenses necessarily incurred in the treatment of the disease.

3. Indemnity Policies.

Coverage must be provided for each person insured under the policy for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than $25,000 payable at a daily rate not expected to produce a claim payment less than that which would be produced by a policy paying $50 a day while confined in a hospital with a benefit period of 500 days.

(b) "Specified Accident Coverage" is an accident insurance policy which provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment, combined with a benefit amount not less than $1,000.00 for accidental death, $1,000.00 for double dismemberment and $500.00 for single dismemberment.

(9) Limited Benefit Health Insurance Coverage: "Limited Benefit Health Insurance Coverage" is any policy or contract, other than a policy or contract covering only a specified disease or diseases, which provides benefits that are less than the minimum standards for benefits required under G(2), (3), (4), (5), (6), (7), and (8). A policy covering a single specified disease or combination of diseases shall meet the requirements of Section G(8) and shall not be offered for sale as a "Limited Coverage."

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Limited benefit policies or contracts may be delivered or issued for delivery in this state only if the outline of coverage required by Section H(11) of this Regulation is completed and delivered as required by Section H(2) of this Regulation.

H. Required Disclosure Provisions.

(1) General Rules

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

(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 in writing signed by the insured, unless the increased benefits or coverage is required by law.

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

(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.

(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."

(f) Each accident only policy or a policy providing benefits for a specified disease only shall contain an appropriate prominent statement on the first page of the policy in boldface type or in contrasting color similar to the following, whichever is appropriate:

1. This is an accident only policy which does not pay benefits for a loss from sickness.
2. This is a specified disease policy which only provides benefits for a loss due to _____. It does not provide benefits for any other sickness or condition.

(g) All policies, except trip or travel ticket policies and as otherwise provided in this paragraph, shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy within ten (10) days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. With respect to policies issued pursuant to a direct response solicitation, the policy shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.

(h) If age is to be used as a 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.

(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.

(j) Insurers issuing policies which provide hospital or medical expense coverage on either an expense incurred or indemnity basis to person(s) eligible for Medicare by reason of age, shall provide to the policyholder a Medicare supplement buyer's guide in a form approved by the Commissioner.

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Delivery of the buyer's guide shall be made whether or not the policy qualifies as a Medicare supplement coverage under Regulation 69 46. Except in the case of direct response insurers, delivery of the buyer's guide shall be made at the time of application, and acknowledgment of receipt or certification of delivery of the buyer's guide shall be provided to the insurer. Direct response insurers shall deliver the buyer's guide upon prior request but not later than at the time the policy is delivered. (NOTE: The NAIC Model Buyer's Guide is acceptable. Any substantially equivalent Buyer's Guide which has been approved by the Insurance Department of any other state may be used upon prior approval by the Commissioner.)

(k) Outlines of coverage delivered in connection with policies defined in this Regulation as Hospital Confinement Indemnity (G(4)), Specified Disease (G(8)), or Limited Benefit Health Insurance Coverages (G(9)) to persons eligible for Medicare by reason of age shall contain, in addition to the requirements of subsections H(6), H(10), and H(11), 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 furnished by the company.

(2) Outline of Coverage Requirements for Individual Coverages: No individual accident and health insurance policy or non profit hospital, medical or dental service corporation subscriber contract subject to this regulation shall be delivered or issued for delivery in this State unless an appropriate outline of coverage, as prescribed in Section H(3) through (11) is completed as to such policy or contract, and the outline is either: (a) delivered with the policy; or (b) delivered to the applicant at the time application is made and acknowledgment of receipt or certification of delivery of such outline of coverage is provided to the insurer.

(a) 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, acknowledgment of receipt or certification of delivery of such outline of coverage is provided to the insurer; and

(b) for all other policies, the outline is either:

1. delivered with the policy; or
2. delivered to the applicant at the time application is made and acknowledgment of receipt or certification of delivery of such outline of coverage is provided to the insurer.

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

The appropriate outline of coverage for policies or contracts providing hospital coverage which only meets the standards of section G(2) shall be that statement contained in section H(3). The appropriate outline of coverage for policies providing coverage which meets the standards of both sections G(2) and (3) shall be the statement contained in section H(5). The appropriate outline of coverage for policies providing coverage which meets the standards of both sections G(2) and (5) or sections G(3) and (5) or sections G(2), (3), and (5) shall be the statement contained in section H(7).

An appropriate outline of coverage will be filed with each policy submitted for approval. In any case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or contract, an alternate outline of coverage shall be submitted to the Commissioner for prior approval.

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(3) 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 G(2) of this Regulation. The items included in the outline of coverage must appear in the sequence prescribed:

COMPANY NAME AND ADDRESS

LOCAL TELEPHONE NUMBER: _____ (if available) _____

BASIC HOSPITAL EXPENSE COVERAGE

Policy Form Number _____

OUTLINE OF COVERAGE

(a) 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!

(b) 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 out patient services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for physicians or surgeons fees or unlimited hospital expenses.

(c) (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:
1. daily hospital room and board;
2. miscellaneous hospital services;
3. hospital out patient services; and
4. other benefits, if any.)
(Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.)

(d) (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 (c) above.)

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

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(4) 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 G(3) of this Regulation. The items included in the outline of coverage must appear in the sequence prescribed:

COMPANY NAME AND ADDRESS

LOCAL TELEPHONE NUMBER: _____ (if available) _____

BASIC MEDICAL SURGICAL EXPENSE COVERAGE

Policy Form Number _____

OUTLINE OF COVERAGE

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

(b) Basic Medical Surgical Expense Coverage Policies of this category are designed to provide, to persons insured, coverage for medical surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services, and in hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for hospital expenses in unlimited medical surgical expenses.

(c) (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:
1. surgical services;
2. anesthesia services;
3. in hospital medical services; and
4. other benefits, if any.)
(Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described.)

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

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

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(5) Basic Hospital and Medical Surgical Expense Coverage (Outline of Coverage): An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of section G(2) and (3) of this Regulation. The items included in the outline of coverage must appear in the sequence prescribed.

COMPANY NAME AND ADDRESS

LOCAL TELEPHONE NUMBER: _____ (if available) _____

BASIC HOSPITAL AND MEDICAL SURGICAL

EXPENSE COVERAGE

Policy Form Number _____

OUTLINE OF COVERAGE

(a) 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 YOU POLICY CAREFULLY!

(b) Basic Hospital and Medical Surgical Expense Coverage Policies of this category are designed to provide, to persons insured, coverage for hospital and medical surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital out patient services, surgical services, anesthesia services, and in hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for unlimited hospital or medical surgical expenses.

(c) 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:
1. daily hospital room and board;
2. miscellaneous hospital services;
3. hospital out patient services;
4. surgical services;
5. anesthesia services;
6. in hospital medical services; and
7. other benefits, if any.)

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

(d) (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 (c) above.)

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

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(6) 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 G(4) of this Regulation. The items included in the outline of coverage must appear in the sequence prescribed:

COMPANY NAME AND ADDRESS LOCAL TELEPHONE NUMBER: _____ (if available) _____

HOSPITAL CONFINEMENT INDEMNITY COVERAGE

Policy Form Number _____

OUTLINE OF COVERAGE

(a) 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!

(b) 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.

(c) (A brief specific description of the benefits contained in this policy, in the following order:
1. daily benefit payable during hospital confinement; and
2. duration of benefit described in (a).)
(Note: The above description of benefits shall be stated clearly and concisely.)

(d) (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 (c) above.)

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

(f) (Any benefits provided in addition to the daily hospital benefit.)

Regulation 69-34 Continued

(7) 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 G(5) of this Regulation. The items included in the outline of coverage must appear in the sequence prescribed:

COMPANY NAME AND ADDRESS

LOCAL TELEPHONE NUMBER _____ (if available) _____

MAJOR MEDICAL EXPENSE COVERAGE

Policy Form Number _____

OUTLINE OF COVERAGE

(a) 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!

(b) Major Medical Expense Coverage Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in hospital medical services, and out of hospital care, subject to any deductibles, copayment provisions, or other limitations which may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.

(c) (A brief specific description of the benefits, including dollar amount, contained in this policy, in the following order:
1. daily hospital room and board;
2. miscellaneous hospital services;
3. surgical services;
4. anesthesia services;
5. in hospital medical services;
6. out of hospital care;
7. maximum dollar amount for covered charges; and
8. other benefits, if any.)

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

(d) (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 (c) above.)

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

Regulation 69-34 Continued

(8) 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 G(6) of this Regulation. The items included in the outline of coverage must appear in the sequence prescribed:

COMPANY NAME AND ADDRESS

LOCAL TELEPHONE NUMBER: _____ (if available) _____

DISABILITY INCOME PROTECTION COVERAGE

Policy Form Number _____

OUTLINE OF COVERAGE

(a) 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!

(b) 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.

(c) (A brief specific description of the benefits contained in this policy).
(Note: The above description of benefits shall be stated clearly and concisely.)

(d) (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 (c) above.)

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

Regulation 69-34 Continued

(9) 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 G(7) of this Regulation. The items included in the outline of coverage must appear in the sequence prescribed:

COMPANY NAME AND ADDRESS LOCAL TELEPHONE NUMBER: _____ (if available) _____

ACCIDENT ONLY COVERAGE

Policy Form Number _____

OUTLINE OF COVERAGE

(a) 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!

(b) 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 due to sickness.

(c) (A brief specific description of the benefits contained in this policy.)
(Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with subsection (1)(o) of section G of this Regulation.)

(d) (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 (c) above.)

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

Regulation 69-34 Continued

(10) 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 G(8) of this Regulation. The coverage shall be identified by the appropriate bracketed title. The items included in the outline of coverage must appear in the sequence prescribed:

COMPANY NAME AND ADDRESS

LOCAL TELEPHONE NUMBER: _____ (if available) _____

(SPECIFIED DISEASE) (SPECIFIED ACCIDENT) COVERAGE

Policy Form Number _____

OUTLINE OF COVERAGE

(a) 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!

(b) (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.

(c) (A brief specific description of the benefits, including dollar amounts, contained in this policy.)
(Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with subsections (1)(o) of section G of this Regulation.)

(d) (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 (c) above.)

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

Regulation 69-34 Continued

(11) Limited Benefit Health Coverage (Outline of Coverage): An outline of coverage, in the form prescribed below, shall be issued in connection with policies which do not meet the minimum standards of section G(2), (3), (4), (5), (6), (7), and (8) of this Regulation. The items included in the outline of coverage must appear in the sequence prescribed:

COMPANY NAME AND ADDRESS

LOCAL TELEPHONE NUMBER: _____ (if available) _____

LIMITED BENEFIT HEALTH COVERAGE

Policy Form Number _____

OUTLINE OF COVERAGE

(a) 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!

(b) Limited Benefit Health Coverage Policies of this category are designed to provide, to persons insured, limited or supplemental coverage.

(c) (A brief specific description of the benefits, including dollar amounts, contained in this policy.)
(Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with subsection (1)(o) of section G of this Regulation.)

(d) (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 (c) above.)

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

Regulation 69-34 Continued

(12) Limited Benefit Health Coverage (Outline of Coverage): An outline of coverage, in the form prescribed below, shall be issued in connection with policies which do not meet the minimum standards of section G(2), (3), (4), (5), (6), (7), and (8) of this Regulation. The items included in the outline of coverage must appear in the sequence prescribed:

COMPANY NAME AND ADDRESS

LOCAL TELEPHONE NUMBER: _____ (if available) _____

LIMITED BENEFIT HEALTH COVERAGE

Policy Form Number _____

OUTLINE OF COVERAGE

(a) 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!

(b) Limited Benefit Health Coverage Policies of this category are designed to provide, to persons insured, limited or supplemental coverage.

(c) (A brief specific description of the benefits, including dollar amounts, contained in this policy.)
(Note: The above description of benefits shall be stated clearly 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 (1)(o) of section G of this Regulation.)

(d) (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 (c) above.)

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

Regulation 69-34 Continued

I. Severability: Each provision of this Regulation is deemed to be severable and the determination that any provision is invalid for any reason shall not invalidate the remaining provisions of the Regulation.

Bulletin 1989-1

FROM: John G. Richards
Chief Insurance Commissioner

DATE: January 31, 1989

RE: EFFECTIVE DATE OF CONTRACT AND INCONTESTABILITY CLAUSE

Group policies issued outside of this state which extend coverage to residents of this state

South Carolina Code SECTIONS 38-65-60 and 38-71-750 set out the requirements for group life and group accident and health insurance policies, respectively, issued outside of South Carolina which extend coverage to residents in South Carolina. These statutes clearly provide that while such policies need not receive approval to be used in South Carolina, they must nevertheless conform to South Carolina's requirements for group life, accident and health insurance and must be made available to the Department on an informational basis.

Effective immediately, all group life, accident and health insurance policies and certificates, other than "mass marketed" policies and certificates as defined under SECTIONS 38-65-50 and 38-71-740, issued outside of this State which cover residents of this State must be filed in duplicate with the South Carolina Department of Insurance on an informational basis. All such filings, whether pending or new filings, must be accompanied by a sworn certification executed by an officer of the insurer that the policy forms fully comply with SECTION 38-65-210 in the case of group life insurance or with Article 5 of Chapter 71 of Title 38 in the case of group accident and health insurance. The certification should also state that the insurer will comply with the requirements of this State relating to advertising and to claims settlement practices with respect to the insurance. A postage paid return envelope should also be enclosed with the filing. All "mass-marketed" forms must be filed for approval prior to use in this State.

If it is determined, notwithstanding the certification as required in the second paragraph of this Bulletin, that the policy form does not comply with South Carolina's group life, accident and health insurance laws, appropriate disciplinary action will be instituted.

This document is supplemented by 2-2001
See SCOPE for more information.

SOUTH CAROLINA INSURANCE BULLETINS AND RELATED MATERIALS
BULLETINS

Bulletin 1-97
June 11, 1997

TO: All Insurers Licensed to Transact Accident and Health Insurance Business within the State of South Carolina and all Licensed State of South Carolina Health Maintenance Organizations

FROM: Lee P. Jedziniak

Director of Insurance

DATE: June 11, 1997

RE: STATE HIPAA COMPLIANCE LEGISLATION--1997 S. C. ACT NUMBER 0005

The purpose of this Bulletin is to advise all insurers licensed to transact accident and health insurance business within this State and all licensed State of South Carolina health maintenance organizations of the enactment of State legislation necessary to bring this State's insurance laws into compliance with the provisions of the Health Insurance Portability and Accountability Act of 1996, [P.L. 104-191, August 21, 1996, 110 Stat 1936] [FN1] commonly-known as HIPAA. This Bulletin includes notice of the applicability and scope and effective dates of State HIPAA Compliance Legislation, as well as policy form filing requirements. The Bulletin considers not only newly-enacted State law, but also the interim rules published by the United States Departments of Treasury, Labor, and Health and Human Services. This Department may issue future bulletins to further address State law, interim Federal rule changes, or final Federal regulations which differ from the interim rules.

I. APPLICABILITY AND SCOPE

State HIPAA Compliance Legislation, which became law on March 31, 1997, addresses limitations on preexisting condition exclusions, certifications of creditable coverage, special enrollment periods, anti-discrimination, guaranteed renewability of group and individual health insurance coverage, guaranteed availability in the small group market, minimum hospital stays for mothers and newborns, and mental health coverage parity.

The group market rules include provisions on limitations on preexisting condition exclusions, certifications of creditable coverage, special enrollment periods, anti-discrimination, guaranteed renewability of coverage in the group market, guaranteed availability in the small group market, and mental health coverage parity. The individual market rules include provisions on guaranteed renewability of coverage in the individual market and certifications of creditable coverage. Minimum hospital stay requirements for mothers and newborns apply both to individual and group health insurance coverage.

The group market rules apply to health insurance coverage offered by issuers in connection with a group health plan. For purposes of the group market rules, a group health plan is defined to be an employee welfare benefit plan

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which provides medical care to employees and, or, their dependents. The individual market rules apply to health insurance coverage offered by issuers which is not offered in connection with a group health plan.

Health insurance coverage means benefits consisting of medical care -- provided directly through insurance or reimbursement or otherwise -- under any hospital or medical service plan contract issued by any entity licensed to transact the business of insurance in this State or under any health maintenance organization contract. Health insurance coverage does not include excepted benefits listed in Section 38-71-670(6) and Section 38-71-840(14).

An issuer is defined as any entity that provides health insurance coverage in this State. An issuer specifically includes insurers, health maintenance organizations, and all other entities licensed to engage in the business of insurance subject to State insurance regulation providing health insurance coverage.

II. EFFECTIVE DATES

Group market provisions on limitations on preexisting condition exclusions, special enrollment periods, anti-discrimination, guaranteed renewability of coverage in the group market, and guaranteed availability in the small group market are effective for plan years beginning on, or after, July 1, 1997.

The provision requiring guaranteed renewability of coverage in the individual market applies to individual health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market in this State on, or after, July 1, 1997.

Plan year means the year which is designated as the plan year in the group health plan's plan document. Provided, however, that if the plan document does not designate a plan year, or if there is no plan document, then the plan year is the deductible or limit year used under the plan. If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year. If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year. In any other case, the plan year is the calendar year.

The requirement that an issuer provide certificates to evidence creditable coverage applies to terminations occurring on, or after, July 1, 1996, except that in no case is a certificate required to be provided before June 1, 1997, or to reflect coverage before July 1, 1996. For terminations occurring on, or after, July 1, 1996, but before October 1, 1996, a certificate is required to be provided only upon written request by, or on behalf of, the individual to whom the certificate applies. For terminations occurring on, or after, October 1, 1996, and before June 1, 1997, a certificate must be furnished no later than June 1, 1997. For terminations occurring before June 1, 1997, an issuer is deemed to satisfy the automatic certificate requirements if a special notice is provided no later than June 1, 1997. The notice must be in writing, and it must be substantially similar to the model notice authorized by the interim rules of the United States Secretaries of Treasury, Labor, and Health and Human Services.

Minimum hospital stay requirements for mothers and newborns apply to group health insurance coverage for plan years beginning on, or after, January 1, 1998, and to individual health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market in this State on, or after, January 1, 1998.

Group market provisions related to mental health coverage parity are effective for plan years beginning on or after January 1, 1998.

III. FILING REQUIREMENTS

A. Individual Market Rules

1. Form Filings. All form filings for individual health insurance coverage must incorporate the provisions of

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Section 38-71-675 concerning guaranteed renewability of individual health insurance coverage.

South Carolina Regulation 69-34, Binder 25A, Section H(1)(a), requires that the renewability provision must be detailed upon the first page of the policy and must be appropriately captioned. Examples of appropriate captions are: "Guaranteed Renewable Except for Stated Reasons" or "Guaranteed Renewable Except for Specified Reasons".

Overinsurance and eligibility for Medicare by reason of age or otherwise may no longer be used as reasons for termination or nonrenewal of an individual's health insurance coverage in the individual market. However, South Carolina Regulation 69-34, Binder 25A, Section F(6)(h), allows a provision which permits a reduction of benefits to the extent benefits are provided under Medicare.

2. Existing Contracts and Certificates. The guaranteed renewability provisions of Section 38-71-675 apply to all existing contracts and certificates for individual health insurance coverage as of July 1, 1997. All contracts and certificates must be administered according to the provisions of Section 38-71- 675 as of July 1, 1997, regardless of whether or not these provisions have been incorporated into the existing contracts or certificates as of this date.

If an existing contract or certificate is no longer being issued, then the contract or certificate must be amended to conform with the guaranteed renewability provisions of Section 38-71-675. Amendments incorporating Section 38-71-675 must be filed for approval prior to January 1, 1998.

An issuer may file an amendment to an existing contract or certificate to reduce benefits to the extent benefits are provided under Medicare only if the existing contract or certificate currently contains a provision which terminates or nonrenews the contract once a person becomes eligible for Medicare by reason of age or otherwise. However, this amendment must be filed in conjunction with an amendment to conform to the renewability provisions of Section 38-71-675.

If an existing contract or certificate is currently being issued, then the contract or certificate must be re-filed in its entirety to conform with the provisions of Section 38-71-675 by January 1, 1998.

B. Group Market Rules

1. Form Filings. Group health insurance coverage form filings must incorporate the following provisions:

Sections 38-71-850(A)(1) through (3), limitations on preexisting condition exclusions. Further, pursuant to Section 38-71-840(28), the definition of preexisting condition exclusion must include notice that genetic information may not be treated as a preexisting condition in the absence of a diagnosis of the condition related to the information. If a health maintenance organization uses an affiliation period in lieu of a preexisting condition exclusion, then the contract or certificate must not contain preexisting condition exclusions. However, the contract or certificate must contain provisions consistent with Section 38-71-850(F);

Sections 38-71-850(B)(1) through (2), creditable coverage;

Section 38-71-850(B)(3)(a) or (b), use of the alternative or standard method of crediting coverage. Since this choice may vary by plan, an issuer may incorporate both provisions with the use of brackets to indicate the variable language;

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Section 38-71-850(C)(1) through (4), limitations on preexisting condition exclusions for pregnancy, adopted children, and newborns;

Section 38-71-850(E), special enrollment periods; and

Section 38-71-870(B) through (D), renewability of group health insurance coverage.

An "actively at work" or "non-confinement" provision may not contain language which establishes rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the plan based on the health-status related factors detailed within Section 38-71-860.

2. Existing Contracts and Certificates. All plans must be administered in accordance with the group market rules -- except for the provisions related to mental health coverage parity and the changes to the provision relating to minimum hospital stays for mothers and newborns -- for plan years beginning on or after July 1, 1997. Existing contracts must be re-filed or amended to conform with the provisions listed above by January 1, 1998.

IV. GENERAL ISSUES

A. References in contract or certificate language to code sections under Federal law or State law will not be allowed.

B. To help reduce the administrative burden upon issuers which will result from the re-filing of existing contracts, expedited review will be afforded issuers re-filing currently issued contracts or certificates to comply with the provisions of State HIPAA Compliance Legislation if each such re-filing includes a certification signed by an executive officer of the issuer stating that the only changes made to the contract or certificate are changes necessary to bring that contract or that certificate into compliance.

C. If an existing contract or certificate is no longer being issued, then the Department will consider alternative approaches of notifying policyholders of their rights under the new law in lieu of amending the contract or certificate to conform. Issuers must submit their proposals, in writing, to the Department for approval and must indicate whether or not the contract or certificate at issue contains a "Conformity with State Statute" provision which clearly ensures that any provision in the contract or certificate which conflicts with current State law is amended to conform with the minimum requirements of current State law.

D. South Carolina law now includes two noteworthy differences from the Federal provisions on limitations on preexisting condition exclusions:

1. Under South Carolina law, an exclusion may not extend for more than 12 months without medical care, treatment, or supplies related to the preexisting condition ending after the effective date of the coverage, or 12 months after the enrollment date, whichever occurs first, or 18 months after the enrollment date in the case of a late enrollee. Under Federal law, the exclusion may not extend for more than 12 months after the enrollment date, or, in the case of a late enrollee, 18 months after the enrollment date.

2. Under South Carolina law, an issuer may not impose any preexisting condition exclusion in the case of a newborn or a child who is adopted or placed for adoption before attaining 18 years of age who, as of the last day of the 31 day period beginning on the date of birth, adoption, or placement for adoption, is covered under any creditable coverage. Federal law describes a "thirty day period".

[FN1] Citation editorially supplied. Text of P.L. 104-191 is available in the US-PL-OLD database. For classification to the United States Code, see "Health Care Insurance Portability and Accountability Act of 1996" in the USCA-POP database.

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MARK SANFORD
Governor

ERNST N. CSISZAR
Director of Insurance

BULLETIN NUMBER 2003-13

(Issued Upon November 24, 2003)

To: All Insurers Licensed to Transact Life and/or Accident and Health Insurance Business within the State of South Carolina and All South Carolina Licensed Health Maintenance Organizations

From: Ernst N. Csiszar
Director of Insurance

Re: List of "Exempt" Policy Forms, Filing Procedures for "Exempt" and "Prior Approval" Forms and Rate Filings, Establishing Audit Procedures and Withdrawal of Bulletin 93-2

I. PURPOSE

The purpose of this bulletin is to streamline the exemption standards and procedures for filing life, accident and health insurance policy forms. This bulletin does not exempt rates that are subject to prior approval from prior approval. Accordingly, the exemption standards and filing procedures previously established by this Department have been revised. Specifically, this bulletin will:

1. List the "exempt" policy forms from the requirements of prior approval in accordance with S.C. Code Ann. §38-61-20 (D);
2. Establish filing procedures for filing "Exempt" and "Prior Approval" Forms and Rate Filings;
3. Establish audit procedures for "Exempt" filings; and
4. Withdraw and replace Bulletin 93-2.

II. LIST OF "EXEMPT" POLICY FORMS

Section 38-61-20(D), as amended, permits the Director of Insurance or his designee to exempt from prior approval those policy forms for which, in his opinion, prior approval is not necessary to protect the public. Accordingly, the Department has carefully reviewed the forms currently subject to prior approval to determine which are appropriate for exemption. Based upon this review the following categories of forms have been exempted from prior approval because policy language is somewhat standard and the

Department receives few, if any, consumer complaints related to these policy forms. Until further notice, the following types of forms are hereby exempt from prior approval by this Department unless the circumstances warranting their exemption change:

1. Individual life insurance policies. This applies to both fixed and variable life.
2. Individual annuity policies. This applies to both fixed and variable annuities.
3. Group life insurance policies. Mass-marketed policies as defined in S.C. Code § 38-65-50 will be subject to prior approval as outlined in S.C. Code § 38-65-60 (3).
4. Group annuity policies. This applies to both fixed and variable annuities. (NOTE: Group annuity policies/certificates etc are exempted from filing under any filing procedure including the annual exemption list.)
5. Individual accident and health insurance policies [other than health insurance coverage as defined in Section 38-71-670 (6) (i.e. policies subject to HIPAA of 1996), long term care insurance policies, and Medicare Supplement insurance policies].
6. Group accident and health insurance policies [other than health insurance as defined in Section 38-71-840 (14) (i.e. policies subject to HIPAA of 1996), long term care insurance policies, and Medicare Supplement insurance policies.] Mass-marketed policies as defined in S.C. Code § 38-71-740 will be subject to prior approval as outlined in S.C. Code § 38-71-750 (3).
7. Certificates, applications, riders, endorsements and amendments issued in conjunction with 1 through 6 above.

III. FILING REQUIREMENTS FOR "EXEMPT" FILING (S)

Although the forms specified above are exempt from prior approval, insurers must continue to file such forms with the Department and must continue to follow the procedures outlined in Section IV of this bulletin. The cover letter of each filing (SERFF and paper) must be prominently captioned to indicate the exempt status of the filing and must state that the forms filed are exempt from prior approval. In addition, all forms contained within the filing must be listed in the cover letter or in a separate attachment. If the filing contains certificates, applications, riders, endorsements and/or amendments, the cover letter must state the specific types of policies with which these forms will be used.

Upon the insurer's receipt of an "Exempt" status from the Department, the insurer may issue or sell the forms in the State. If the filing contains the information required by this bulletin, including the certification required by Section IV (10) below, the Department will, for paper filings, stamp the cover letter "Exempt" and return a copy to the insurer. For SERFF filings, the Department will send a final "Closed Exempt" disposition to the insurer indicating that the forms included in the cover letter are "Exempt". See Section V of this bulletin for audit procedures.

Each insurer shall submit to the Department an annual list including all the policy forms it issues or sells in South Carolina and which had been accepted as "Exempt" from having to be filed and approved by the Director or his designee. The annual list should cover a 12-month period of filings, as determined by the insurer (example: a January 1 to December 31 period or a July 1 to June 30 period, etc.). The annual list must be submitted to the Department as soon as reasonably possible after the end of the reporting period elected by the insurer. An officer of the insurer shall certify to the best of his knowledge and belief that all policy forms comply fully with the applicable statutes, regulations, and bulletins of the State of South Carolina.

NOTE: Domestic insurers may request a formal full review of "Exempt" filings in order to provide proof of domiciliary approval to other states. Please request this exception via the cover letter.

IV. FILING PROCEDURES FOR "EXEMPT" and "PRIOR APPROVAL" FORMS AND RATE FILINGS

In general the only forms subject to prior approval are individual and group Long Term Care insurance policies, Medicare Supplement insurance policies and health insurance coverage as defined in Sections 38-71-670 (6) and 38-71-840 (14). Mass marketed policies as defined in Section 38-65-50 and 38-71-740 are also subject to prior approval.

1. All paper filings must be directed to the attention of the Life, Accident and Health Section. The submission should include two copies of the cover letter and only one copy of the forms. For SERFF filings, one copy of the cover letter and one copy of the form must be submitted.

2. All submissions must include one self-addressed, stamped return envelope large enough to return the filing(s). This does not apply to SERFF filings.

3. The cover letter must be prominently captioned to indicate the status of the filing (i.e., filing for approval, exempt from prior approval). In addition, all form numbers contained within the filing must be listed on the cover letter or in a separate attachment. The cover letter must describe the filing, including the type of forms, any unusual aspects of the forms, and how and to whom the forms will be marketed. If the filing contains certificates, applications, riders, endorsements and/or amendments, the cover letter must state the specific types of policies with which these forms will be used.

4. All forms must be accompanied by a Certificate of Readability signed by an officer of the insurer as required under Regulation 69-5.1, except those forms excluded under SECTION C of that regulation.

5. A Form SCID 1504 must be furnished with all individual accident and health insurance forms and rate filings pursuant to Bulletin #8-84.

6. All individual accident and health and group Medicare supplement filings must include the premium rates and supporting actuarial memorandum.

7. If a detailed statement of the method of computation of reserves, nonforfeiture values and benefits available under the policy is not incorporated in each life policy submitted for approval, such a statement must accompany the submitted form.

8. Life and annuity filings must include all applicable disclosure materials such as the Statement of Policy Cost and Benefit Information required for individual life policies under Regulation 69-30, the Contract Summary required for individual annuities under Regulation 69-39 and Life Insurance Illustrations required under Regulation 69-40. If the policy is illustrated in accordance with Regulation 69-40, insurers do not need to furnish the Statement of Policy Cost and Benefit Information.

9. Group life and group accident and health insurance policies (other than long term care insurance as provided in Section 38-72-50) issued outside of this State that extend coverage to residents of this State must also be filed for informational purposes only in accordance with Bulletin 89-1. This does not apply to group annuity filings. Upon the insurer's receipt of an "Exempt" status from the Department, the insurer may issue or sell the forms in the State. All exempt form filings may be subject to audit.

10. To ensure that insurers review their forms prior to submission and to ascertain their compliance with South Carolina statutes, regulations and bulletins, the filing must include the following certification by an officer of the insurer:

> "I have reviewed or supervised the review of the policy forms contained in this filing and hereby certify to the best of my knowledge and belief that they are in compliance with the applicable statutes, regulations and bulletins of the State of South Carolina. I further certify that the forms will be revised and/or discontinued as appropriate in the event of future changes in the statutes, regulations or bulletins."

V. AUDIT PROCEDURES FOR "EXEMPT" FILING (S)

All forms that are exempt from prior approval may be subject to audit by this Department. SCDOI checklists and supplemental checklists will be used to conduct audits of policy forms and certificates.

Life, Accident and Health Analysts will be required to utilize a statute, regulation, bulletin, and/or a legal opinion with every criteria point and should not submit disapproval points that cannot be referenced by the aforementioned.

If a form is found to be in violation of South Carolina statutes, regulations or bulletins, the insurer must, within fifteen calendar days of notification of the violation, advise the Department if the form has been issued or sold in South Carolina:

- If the form has not been issued, the insurer may revise the form to be in compliance with South Carolina statutes, regulations and bulletins and resubmit the form to the Department in accordance with this Bulletin. If the insurer does not wish to resubmit the form, the insurer must notify the Department within fifteen calendar days from the date it is notified of the violation that it is withdrawing the form.

- If the form has been issued, the insurer should:

  - Submit a plan to the Department within thirty calendar days of date of the violation notification letter detailing the action plan that will be taken to correct the violations. The action plan should address whether steps are necessary to notify current insureds of the revisions to their coverage. These steps may include issuing revised forms and/or explanation letters.
  - Submit any forms necessary to correct the violation(s).
  - The Department will review the action plan and any forms to redress the violations within 30 calendar days of receipt. If acceptable, the cover letter will be stamped "Exempt" and the insurer must implement the action plan within 30 calendar days.

If a filed form is certified to be in compliance with South Carolina statutes, regulations and bulletins, and the director or his designee finds that not to be the case, he may disqualify that insurer from using the "Exempt" certification process provided under this bulletin.

VI. WITHDRAWAL OF BULLETIN 93-2

Bulletin 93-2 previously issued by this Department is hereby withdrawn. This bulletin supersedes and replaces any and all bulletins addressing exemption standards and procedures for filing Life, Accident and Health Insurance Policy Forms, except Bulletin 89-1.

VII. EFFECTIVE DATE

This Bulletin is effective upon the issuance date of November 17, 2003.

VIII. QUESTIONS

Please direct any questions that you may have about this bulletin to the attention of June DuBard, Manager, Life, Accident and Health Section at (803) 737-6230 or jdubard@doi.state.sc.us.