TITLE 365. INSURANCE DEPARTMENT
CHAPTER 10. LIFE, ACCIDENT AND HEALTH

SUBCHAPTER 5. MINIMUM STANDARDS; CONTRACT GUIDELINES
PART 1. MINIMUM STANDARDS AND BENEFITS FOR ACCIDENT AND HEALTH INSURANCE

365:10-5-1. Purpose

The purpose of this Part is to implement 36 O.S. §3611 so as to provide reasonable standardization and simplification of terms and coverages of individual accident and health insurance policies in order to facilitate public understanding and comparison and to eliminate provisions contained in individual accident and health insurance policies 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.

365:10-5-2. Applicability and scope

This Part shall apply to all individual accident and health insurance policies delivered or issued for delivery in this state, on and after the effective date hereof, except it shall not apply to individual policies issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when such group or individual policy or contract includes provisions which are inconsistent with the requirements of this section, nor shall it apply to policies being issued to employees or members as additions to franchise plans in existence on the effective date of this section. The requirements contained in this section shall be in addition to any other applicable regulations previously adopted.

365:10-5-3. Policy definitions

Except as provided in this Part, no individual accident or sickness insurance policy 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 inpatient, or successive confinements when the insured is discharged from and then re-admitted to the hospital within a period of time not more than 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:

(i) be an institution operated pursuant to law; and

(ii) be primarily and continuously engaged in providing and operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of fully 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

(iii) 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:

(i) convalescent homes, convalescent, rest, or nursing facilities; or

(ii) facilities primarily affording custodial, educational or rehabilitative care; or

(iii) facilities for the aged, drug addicts, or alcoholic; or

(iv) any military or veterans hospital or soldiers home or any hospital contracted for or operated by a national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

(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:

(i) be operated pursuant to law;

(ii) be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;

(iii) be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

(iv) provide continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and

(v) maintain a daily medical record of each patient.

(B) The definitions of such home or facility may provide that such term shall not be inclusive of:

(i) any home, facility or part thereof, used primarily for rest;

(ii) a home or facility for the aged or for the care of drug addicts or alcoholics; or

(iii) a home or facility primarily used for the care and treatment of mental diseases, or disorders, or custodial or educational care.

(4) **"Ambulatory surgical center"** shall be defined as any licensed public or private establishment with an organized medical staff of physicians with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures and continuous physician services and registered professional nursing services whenever a patient is in the facility and which does not provide services or other accommodations for patients to stay overnight.

(5) **"Accident", "Accidental Injury", "Accidental Means"** shall be defined to employ "result" language and shall not include words which establish an accidental cause test or use words such as "external, violent, visible wounds" or similar words

of description or characterization. The definition shall not be more restrictive than the following: Injury or injuries, for which benefits are provided, means accidental bodily injury sustained by the insured person which are the direct cause, independent of disease or bodily infirmity or any other cause, and which occur while the insurance is in force. Such definition may provide that injuries shall not include injuries for which benefits are provided under workmen's compensation, employer's liability or similar law, motor vehicle no fault plan, unless prohibited by law, or injuries occurring while the insured person is engaged in any activity pertaining to any trade, business, employment, or occupation for wage or profit.

(6) **"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 workers' compensation, occupational disease, employer's liability or similar law".

(7) **"Pre-existing condition"** shall not be defined to be more restrictive than the following: Pre-existing condition means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a five (5) year period preceding the effective date of the coverage of the insured person or a condition for which medical advise 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.

(8) **"Nurses"** may be defined so that the description of a nurse is restricted to a type of nurse, such as a 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.

(9) **"Total disability"**

(A) A general definition of total disability cannot be more restrictive than one requiring the individual to be totally disabled from engaging in any employment or occupation for which he is or becomes qualified by reason of education, training or experience, and

requiring that the insured not be engaged in any employment or 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:

(i) Perform "any occupation whatsoever", "any occupational duty", or "any and every duty of his occupation", or

(ii) 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 material duties of this 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 are payable. The total disability before 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 The 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 disorder"** shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

(14) **"Other health plans"** shall include any plan which provides insurance, reimbursement, or service benefits for hospital, surgical, or medical expenses; this shall include coverage under group or individual insurance policies, non-profit health service plans, subscriber contracts, and pre-payment plans.

(A) It shall not include:

(i) Medicaid; or

(ii) Medicare; or

(iii) Workers' compensation coverage; or

(iv) Automobile or homeowners medical pay plans; or

(v) Hospital daily indemnity plans; or

(vi) Specified diseases only policies; or

(vii) Limited occurrence policies which provide only for intensive care or coronary care at a hospital, first aid out-patient medical expenses resulting from accidents, or specified accidents such as travel accidents.

(B) Any insurer or non-profit health service plan issuing a policy or contract which coordinates or integrates benefits with "other health plans" must disclose this provision in its point of sale, in its advertising material, in its application, asking the applicant whether any proposed insured has existing medical insurance. The definition of what constitutes "other health plans" must be clearly stated in these point of sale materials and set forth on the first page of the policy or contract. Every policy shall set forth, imprinted or stamped in red ink on the first page thereof, in ten point type the following text:

THIS POLICY CONTAINS A NON-DUPLICATION PROVISION WHICH MAY REDUCE THE BENEFITS OF THIS POLICY TO THE EXTENT THAT THERE ARE BENEFITS UNDER OTHER HEALTH PLANS, AS DEFINED ON PAGE .

If the insurer fails to comply with these disclosure requirements, said insurer may not coordinate or integrate benefits with other health plans.

365:10-5-4. Prohibited policy provisions

(a) **Probationary or waiting period.** Except as provided in 365:10-5-3(6), 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, exception shall not be applicable where such specified diseases or conditions are treated on an emergency basis. Accident policies shall not contain probationary or waiting periods.

(b) **Policy or rider for dividend.** No policy or rider for additional coverage may be issued as a dividend unless an equivalent cash payment is offered to the policyholder as an alternative to such dividend policy or rider. No such dividend policy or rider shall be issued for an initial term of less than 6 months. The initial renewal subsequent to the issuance of any policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that such renewal is optional with the policyholder.

(c) **Pre-existing conditions.** No policy shall exclude coverage for a loss due to a pre-existing condition or 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 condition or prior medical care and treatment and such pre-existing condition is not specifically excluded by the terms of the policy.

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

(e) **Policy limits or exclusions, Exceptions.** No policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:

(1) Pre-existing conditions or diseases, except for congenital anomalies of a covered dependent child. This paragraph shall apply to:

(A) policies of accident and health insurance, and

(B) limited benefit insurance policies;

(2) Mental or emotional disorders, alcoholism and drug addiction;

(3) Pregnancy, except for complications of pregnancy, other than for policies defined in 365:10-5-5(g);

(4) Illness, treatment or medical condition arising out of:

(A) war or act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer; participation in a felony, riot or insurrections, service in the armed forces or units auxiliary thereto;

(B) suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;

(C) aviation;

(D) with respect to short-term non-renewable policies, interscholastic sports;

(5) cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted, if a functional defect;

(6) foot care in connection with corns, calluses, flat feet, fallen arches, weak fee, chronic foot strain, or symptomatic complaint of the feet;

(7) treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employers liability or occupational disease law, or any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

(8) dental care or treatment;

(9) eye glasses, hearing aids and examination for the prescription or fitting thereof;

(10) rest cures, custodial care, transportation and routine physical examinations;

(11) territorial limitations;

(12) cost containment:

(A) pre-admission certification;

(B) second surgical opinion and third surgical opinion if the first two conflict;

(C) one-hundred percent coverage for generic drugs while hospital confined, or on a physician's prescription;

(D) insured self audit of hospital bills.

(f) **Use of waiver.** Except with respect to Medicare Supplement Coverages as defined in 365:10-5-5(b), other provisions of this section 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 or issuance, renewal or reinstatement, signed

acceptance by the insured is required unless on initial issuance the full text of the waiver is contained either on the first page or specification page. Waivers to exclude, limit or reduce coverage or benefits for specifically named or described pre-existing diseases or physical conditions shall not be used in Medicare Supplement Coverages.

(g) **Use of the terms "Medicare Supplement" and "Medigap".** Except as otherwise provided in 365:10-5-6(a)(11) the terms "Medicare Supplement", "Medigap" and words of similar import shall not be used unless the policy is issued in compliance with 365:10-5-5(b).

(h) **Policy provisions.** Policy provisions precluded in this section shall not be constructed as a limitation on the authority of the Commissioner to disapprove other policy provisions which, in the opinion of the Commissioner, are unjust, unfair, or unfairly discriminatory to the policyholder, beneficiary, or any person insured under the policy, pursuant to the Oklahoma Insurance Code.

(i) **Policy limitations.** A policy issued as a "Medicare Supplement Coverage" pursuant to 365:10-5-5(b) shall not include, when issued, limitations or exclusions of the type enumerated in 365:10-5-4(e)(6), (7), (11) and (12) if such limitations or exclusions are more restrictive than those of medicare for any type of care covered under such policy.

[**Source:** Amended at 22 Ok Reg 1954, eff 7-14-05; Amended at 28 Ok Reg 1960, eff 7-14-11]

365:10-5-5. Accident and sickness minimum standards for benefits

(a) **Minimum standards.** The following minimum standards for benefits are prescribed for categories of coverage noted in the following subsections. No individual policy or accident and sickness insurance shall be delivered or issued for delivery in this site which does not meet the required minimum standards for the specified categories unless the Commissioner finds that such policies or contracts are approvable as Limited Benefit Health insurance and the Outline of Coverage complied with the appropriate outline in 365:10-5-5(j). Nothing in this section shall preclude the issuance of any policy or contract combining two or more categories of coverage.

(b) **General rules.**

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

(2) The terms "noncancellable", "guaranteed renewable" or "noncancellable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of 365:10-5-6(a)(1). The terms "noncancellable" or "noncancellable and guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of sixty-five (65) or to eligibility for medicare, during which period the insurer has no right to make unilaterally any change in a provision of the policy while the policy is in force;

provided, however, any accident and health or accident and health only policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness, may provide that the insured has the right to continue the policy only to age sixty (60) if, at age sixty (60), the insured has the right to continue the policy in force at least to age sixty-five (65) while actively or regularly employed. Except as provided above, the term "guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums until the age of sixty-five (65) or to eligibility for medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes. Provided however, any accident and health or accident only policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age sixty (60) if, at age sixty (60), the insured has the right to continue the policy in force at least to age sixty-five (65) while actively and regularly employed.

(3) In a family policy covering both husband and wife the age of the younger spouse must be used as the basis for meeting the age and duration 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 duration period as specified in said definition.

(4) When accident health and dismemberment coverage is part of the insurance coverage offered under the contract, the insured shall have the option to include all insureds under such coverage and not just the principal insured.

(5) If a policy contains a status type military service exclusion or a provision which suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to such person on a pro rata basis.

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

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

(8) Family coverage shall continue for any dependent child who is incapable of self sustaining employment due to mental retardation or physical handicap on the date that such child's coverage would otherwise terminate under the policy due to the attainment of a specified age limit for children, if the child 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.

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

(10) A policy may contain a provision relating to recurrent disabilities, provided however, that no such provision shall specify that a recurrent disability be separated in a period greater than six (6) months.

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

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

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

(14) Termination of the policy shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period the policy was in force may be predicated upon the continuous total disability of the insured,

limited to the duration of the policy benefit period, if any, of payment of the maximum benefits.

(15) Any policy which does not meet the prescribed minimum standards stated in this section which in the opinion of the Department, is either experimental in nature or is demonstrated to be of a type of coverage that will fulfill a reasonable need of the person or persons insured, may be approved only as to categories prescribed by the Department.

(16) Nothing in this regulation shall preclude the issuance of any policy or outline of coverage that combines two or more of the categories of coverage enumerated in (c) through (i) of this paragraph.

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

(1) daily hospital room and board in an amount not less than the lesser of:

(A) 80% of the charges for semi-private room accommodations; or

(B) $30.00 per day;

(2) miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during any one period of confinement in an

amount not less than either 80% of the charges incurred up to at least $1,000.00 or ten times the daily hospital room and board benefits;

(3) hospital outpatient services consisting of:

(A) hospital services on the day surgery is performed, and

(B) hospital services rendered within 72 hours after accidental injury, in an amount not less than $50.00, and

(C) X-ray and laboratory tests to the extent that benefits for such services would have been provided to an extent not less than $100.00 if rendered to an in- patient of the hospital;

(4) benefits provided under (1) and (2) of this section, may be provided subject to a combined deductible amount not in excess of $100.00.

(d) **Basic medical-surgical expense coverage.** "Basic Medical-Surgical Expense Coverage" is a policy of accident and sickness insurance which provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered in a physician for treatment of an injury or sickness for at least the following:

(1) Surgical services:

(A) in amounts not less than those provided on a fee schedule based on the relative values contained in the State of New York certified surgical fee schedule, or the 1964 California Relative Value Schedule or other acceptable relative value scale or surgical procedures, up to a maximum of at least $500.00 for any one procedure; or

(B) not less than 80% of the reasonable charges.

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

(A) in an amount not less than 80% of the reasonable charges; or

(B) 15% of the surgical service benefit.

(3) In-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than 80% of the reasonable charges; or $5.00 per day for not less than twenty-one (21) days during one period of confinement.

(e) **Hospital confinement indemnity coverage.** "Hospital Confinement Indemnity Coverage" is a policy of accident and sickness insurance which provides daily benefits for hospital confinement
on an indemnity basis in an amount not less that $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.

(f) **Major medical expense coverage.** "Major Medical Expense Coverage" is an accident and sickness insurance policy which provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than $10,000.00; co-payment 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 basis not to exceed 5% of the aggregate maximum limit under the policy, unless the policy is written to complement "other health plans" as defined in 365:10-5-3, in which

case such deductible may be increased by the amount of the benefits provided by such "other health plans". However, if the covered person is insured by two or more policies containing such a non-duplication of benefits feature, only the policy which has covered the person for the longest time may apply such non-duplication provision. To be classified as "major Medical Expense Coverage", a policy must provide for each covered person for at least:

(1) Daily hospital room and board expense, prior to application of the co-payment percentage, for not less than $50.00 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;

(2) miscellaneous hospital services, prior to application of the co-payment 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;

(3) surgical services, prior to application of co-payment percentage to a maximum of not less than $600 for the most severe operation with the amounts provided for other operations related to such maximum amount;

(4) anesthesia services prior to application of the co-payment 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 to the surgical schedule;

(5) in hospital medical services, prior to application of the co-payment percentage, as defined in 365:10-5-3(c) of this subsection.

(6) Out of hospital care prior to application of the co-payment percentage consisting of physicians' services rendered on an ambulatory basis where coverage is not provided

elsewhere in the policy for diagnosis and treatment of sickness or injury, and diagnostic X-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician; and

(7) no fewer than three of the following additional benefits, prior to application of the co-payment percentage, for a aggregate maximum of such covered charges of not less than $1,000:

(A) In hospital private duty graduate registered nurse services.

(B) Convalescent nursing home care.

(C) Diagnosis and treatment by a radiologist or physiotherapist.

(D) Rental of special medical equipment, as defined by the insurer in the policy.

(E) Artificial limbs or eyes, casts, splints, trusses or braces.

(F) Treatment for functional nervous disorders, and mental emotional disorders.

(G) Out-of-hospital prescription drugs and medications.

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

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

(2) Contains an elimination period no greater than:

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

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

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

(3) Has a maximum period of time for which it is payable during disability of at least six (6) months, except in the case of a policy covering disability arising out of pregnancy, childbirth, or miscarriage, in which case the period for such disability may be one (1) month. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period. 365:10-5-5(g) does not apply to these policies providing business buy out coverage.

(h) **Accident only coverage.** "Accident only coverage" is a policy of accident insurance which provides coverage, singularly 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.

(i) **Specified disease and specified accident coverage.**

(1) "Specified Disease Coverage" is a policy which meets one of the following definitions:

(A) A policy which provides coverage for each person insured under the policy for a specifically named disease (or diseases) with a deductible amount not in excess of $250.00 and an overall aggregate benefit limit of not less than $5,000.00 and a benefit period of not less than two (2) years for at least the following incurred expenses:

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

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

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

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

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

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

(vii) Drugs and medicines prescribed by a physician;

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

(ix) Braces, crutches and wheel chairs as are deemed necessary by the attending physician for the treatment of the disease;

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

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

(B) A policy which provides coverage for each person insured under the policy for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than $25,000 payable at the rate of not less than $50 a day while confined in a hospital and a benefit period of not less than 500 days.

(2) "Specified Accident Coverage" is an accident insurance policy which provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment, combined with a benefit amount not less than $1,000.00 for accidental death, $1,000.00 for double dismemberment and $500.00 for single dismemberment.

(j) **Medicare supplement coverage.** "Medicare Supplement Coverage" is a policy of accident and sickness insurance which is designed primarily to supplement Medicare, or is advertised, marketed, or otherwise proposed to be a supplement to Medicare and which meets the requirements of the following rules and standards applicable to any such policy sold to a person eligible for Medicare by reason of age:

(1) The following shall be applicable to "Medicare Supplement Coverage" and shall be in addition to other requirements of this regulation. These are minimum standards and do not preclude the inclusion of additional benefits in such coverage:
(A) Notwithstanding 365:10-5-3(6), 365:10-5-4(c) and (g), pre-existing condition limitations shall not exclude coverage for more than six months after the effective date of coverage under the policy for 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 the coverage;

(B) The term "Medicare benefit period" shall mean the unit of time used in the Medicare program to measure use of services and availability of benefits under Part A Medicare hospital insurance;

(C) The term "Medicare eligible expenses" shall mean health care expenses of the kinds covered by Medicare to the extent recognized as reasonable by Medicare. Payment of benefits by insurers for Medicare eligible expenses may be conditioned upon the same
or less restrictive payment conditions, including determinations of medical necessity as are applicable to Medicare claims;

(D) Coverage, when issued, shall not be subject to any exclusions, limitations, or reductions (other than as permitted in this section and other applicable laws and regulations) which are inconsistent with the exclusions, limitations or reductions permissible under Medicare, other than a provision that coverage is not provided for any expenses to the extent of any benefit available to the insured person under Medicare;

(E) Coverage shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents; and

(F) Coverage 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 co-payment percentage factors. Premiums may be changed to correspond with such changes.

(2) Minimum Benefit Provisions, Medicare Supplement Coverages shall provide at least the following benefits to an insured person:

(A) Coverage of Part A Medicare eligible for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit period;

(B) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

(C) Upon exhaustion of all Medicare hospital impatient coverage, including the lifetime reserve days coverage of 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.

(D) Coverage of 20% of the amount of Medicare eligible expenses under Part B, regardless of hospital confinement, subject to a maximum calendar year out-of-pocket deductible of $200 of such expenses and to a maximum benefit of at least $5000 per calendar year.

(k) **Limited Benefit Health Insurance Coverage.** "Limited Benefit Health Insurance Coverage" is any policy or contract which provides benefits that are less than the minimum standards for benefits required under (c), (d), (e), (f), (h), (i), and (j) of this paragraph. Such policies or contracts may be delivered or issued for delivery in this state only if the outline coverage required by 365:10-5-6(h) is completed and delivered by 365:10-5-6(b).

365:10-5-6. Required disclosure provisions

(a) **General rules.**

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

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

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

(4) A policy which provides for the payment of benefits based on standards described as "usual and customary", "reasonable and customary" or words of

similar import, shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.
(5) If a policy contains any limitations with respect to pre-existing conditions, such limitations must appear as a separate paragraph of the policy and be labeled as "Pre-existing Condition Limitations."
(6) All "accident only" policies shall contain a prominent statement on the first page of the policy or attached thereto, in either contrasting color or in boldface type at least equal to the size of type used for policy captions, a prominent statement as follows: "This is an accident only policy and it does not pay benefits for loss from sickness"
(7) All policies, except single premium nonrenewable policies and as otherwise provided in this paragraph, shall have a notice prominently printed on the first page of the policy or attached thereto, stating in substance that the policyholder shall have the right to return the policy within ten (10) days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. If the insurer does not return any premiums or moneys paid therefore within thirty (30) days from the date of cancellation, the insurer shall pay interest on the proceeds which shall be the same rate of interest as the average United States Treasury Bill rate of the preceding calendar year as certified to the State Insurance Commissioner by the State Treasurer on the first regular business day in January of each year, plus two percentage points which shall accrue from the date of cancellation until the premiums or moneys are returned. In such event, the policy shall be deemed to have been cancelled on the date the policy was placed in the United States mails in a properly addressed post paid envelope; or, if not so posted, on the date of delivery of such
policy to the insurer. With respect to policies issued pursuant to a direct response solicitation to persons eligible for Medicare 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. If the insurer does not return any premiums or moneys paid therefor within thirty (30) days from the date of cancellation, the insurer shall pay interest on the proceeds which shall be the same rate of interest as the average United States Treasury Bill rate of the preceding calendar year as certified to the State Insurance Commissioner by the State Treasurer on the first regular business day in January of each year, plus two percentage points which shall accrue from the date of cancellation until the premiums or moneys are returned. In such event, the policy shall be deemed to have been cancelled on the date the policy was placed in the United States mails in a properly addressed post paid envelope; or, if not so posted, on the date of delivery of such policy to the insurer.
(8) If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy as originally issued, such fact must be prominently set forth in the outline of coverage.
(9) If a policy contains a conversion privilege, it shall comply, in substance with the following: the caption of the provision shall be "Conversion Privilege", or words of

similar import. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

(10) Insurers issuing policies which provide hospital or medical expense coverage on an expense incurred or indemnity basis other than incidentally, to a person's eligible for Medicare by reason of age, shall provide to the policyholder, a Medicare supplement buyer's guide in a form prescribed by the Commissioner. Delivery of the buyer's guide shall be made whether or not the policy qualified as a "Medicare Supplement Coverage" in accordance with this Chapter. 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 of certificate of delivery of the buyer's guide shall be provided to the insurer. Direct response insurers shall deliver the buyer's guide upon request but not later than at the time the policy is delivered.

(11) Outlines of coverage delivered in connection with policies defined as Hospital Confinement Indemnity in 365:10-5-6(i), Specified Disease in 365:10-5-6(i), or Limited Benefit Health Insurance Coverage in 365:10-5-6(k) to persons eligible for Medicare by reason of age shall contain in addition to the requirements of 365:10-5-6(f), (j) and (k), the following language which shall be printed on or attached to the first page of the outline coverage: This policy IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare review the Medicare Supplement Buyer's Guide available from the company.

(b) **Outline of coverage requirements for individual coverages.**

(1) No individual or family accident and health insurance policy, shall be delivered, or issued for delivery, in this state unless:

(A) Accompanied by an appropriate outline of coverage in plain and simple language, in no less than 10 point type and provided further, that in case of limited or substandard policies, as described herein, the outline of coverage shall state, in no less than 11 point type that said policy is of limited nature or other appropriate information, as prescribed by the State Insurance Commissioner.

(B) Or, an appropriate outline of coverage is compiled and delivered to the applicant at the same time application is made, and an acknowledgment of receipt or certificate of delivery of such outline is provided to the insurer with the application.

(2) In the case of a direct response, such as a written application to the insurance company from an application the outline of coverage shall accompany the policy when issued.

(3) Such outline of coverage shall contain:

(A) A statement identifying the applicable category of coverage afforded by the policy as based on the minimum basic standards set forth in these regulations.

(B) A brief description of the principal benefits and coverage provided in the policy.

(C) A summary statement of the principal exclusions and limitations or reductions contained in the policy, including, but not limited to, pre-existing conditions, probationary periods, elimination periods, and any age limitations or reductions.

(D) A summary statement of the renewal provision, including any reservation of the insurer of a right to change premiums.

(E) A statement that the outline contains a summary only of the details of the policy as issued or of the policy as applied for and that the issued policy should be referred to for the actual contractual governing provisions.

(c) **Basic hospital expense coverage.** An outline of coverage, in the form prescribed, shall be issued in connection with policies meeting the standards of 365:10-5-5(c). The items included in the outline of coverage must appear in the sequence prescribed.

(d) **Basic medical surgical expense coverage.** An outline of coverage, in the form prescribed, shall be issued in connection with policies meeting the standards of 365:10-5-5(d). The items included in the outline of coverage must appear in the sequence prescribed.

(e) **Basic hospital and medical surgical expense coverage.** An outline of coverage, in the form prescribed, shall be issued in connection with policies meeting the standards of 365:10-5-5(c) and (d). The items included in the outline of coverage must appear in the sequence prescribed.

(f) **Hospital confinement indemnity coverage.** An outline of coverage, in the form prescribed, shall be issued in connection with policies meeting the standards of 365:10-5-5(e). The items included in the outline of coverage must appear in the sequence prescribed.

(g) **Major medical expense coverage.** An outline of coverage, in the form prescribed, shall be issued in connection with policies meeting the standards of 365:10-5-5(f). The items included in the outline coverage must appear in the sequence prescribed.

(h) **Disability income protection coverage.** An outline of coverage, in the form prescribed, shall be issued in connection with policies meeting the standards of 365:10-5-5(g). The items include in the outline of coverage must appear in the sequence prescribed.

(i) **Accident only coverage.** An outline of coverage, in the form prescribed, shall be issued in connection with policies meeting the standards of 365:10-5-5(h). The items included in the outline of coverage must appear in the sequence prescribed.

(j) **Specified disease or specified accident coverage.** An outline of coverage, in the form prescribed, shall be issued in connection with policies meeting the standards of 365:10-5-5(i). The coverage shall be identified by the appropriate bracketed title. The items included in the outline of coverage must appear in the sequence prescribed.

(k) **Medicare supplement coverage.** An outline of coverage, in the form prescribed, shall be issued in connection with policies that meet the standards of 365:10-5-5(b). The items included in the outline of coverage must appear in the sequence prescribed.

(l) **Limited benefit health coverage.** An outline of coverage, in the form prescribed, shall be issued in connection with policies which do not meet the minimum standards of 365:10-5-5(c), (d), (e), (f), (g), (h), (i) and (j). The items included in the outline of coverage must appear in the sequence prescribed.

[**Source:** Amended at 11 Ok Reg 1839, eff 5-15-94]

365:10-5-7. Requirements for replacement

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

(b) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in 365:10-5-7(c). One (1) copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in 365:10-5-7(d). In no event, however, will such a notice be required in the solicitation of the following types of policies: accident only and single premium nonrenewable policies.

(c) The notice required by (2) of this paragraph for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS INSURANCE

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

1. Health conditions which you may presently have, (pre- existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

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

_____
(date)

_____
(Applicant's Signature)

(d) The notice required by 365:10-5-7(b) for a direct response insurer shall be as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with the policy delivered herewith issued by (insert Company Name) Insurance Company. Your new policy provides 10 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection you should be aware of and seriously consider certain factors which may affect the insurance protection you should be aware of an seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have, (pre- existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. (To be included only if the application is attached to the policy.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (insert Company Name and Address) within 10 days if any information is not correct and complete, or if any past medical history has been left out of the application.

_____
(Company Name)

[**Source:** Amended at 11 Ok Reg 1839, eff 5-15-94]

365:10-5-8. Separability provision

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

365:10-5-9. Disclosure of reasonable charge determination

(a) Any contract or certificate of insurance issued by an insurance company, not-for-profit hospital service and medical indemnity plan, health insurance service organization or preferred provider organization which bases its payment for health care services, procedures, or supplies on a determination of average area charges for health care services, procedures, or supplies shall disclose that information to the contract purchaser and certificate holder at the time that the policy or certificate is delivered.

(b) "Average area charge" means any determination of a charge for health care services, procedures, or supplies on a basis other than the billed rate or contracted rate of the health care provider. For example, average area charge includes, but is not limited to, the terms "customary and reasonable," "usually and customary," "usual, customary, and reasonable," or other similar terms.

(c) The disclosure shall be located on the first page or in a separate document affixed to the front page of the contract or certificate. The disclosure shall:

(1) Be appropriately captioned and printed in font size at least two (2) points larger than the other text of the policy.

(2) Reference the applicable section of the contract or certificate that specifies how average area charges are determined and provide an example of how this determination will affect the payment for services, procedures, or supplies of a health care provider. This example shall provide an explanation of the liability for charges of the insured that exceed the average area charge.

(3) Advise the insured of the provisions of 36 O.S. § 6571 and provide a point of contact for health care providers to request the information used to determine the average area charge.

(4) Include language advising the insured that noncompliance with 36 O.S. § 6571 should be reported to the Oklahoma Insurance Department.

[**Source:** 27 Ok Reg 1531, eff 7-14-10]