CHAPTER 88. INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS

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Authority

The provisions of this Chapter 88 issued under The Insurance Company Law of 1921 (40 P. S. §§ 341—961); The Insurance Department Act of 1921 (40 P. S. §§ 1—321); and sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412), unless otherwise noted.

Source

The provisions of this Chapter 88 adopted June 23, 1978, effective June 24, 1978, 8 Pa.B. 1677, unless otherwise noted.

Notes of Decisions

A determination of whether the provisions of 31 Pa. Code Chapter 88 are a product of an unconstitutional delegation of legislative power must first be sought through administrative procedures before a court may exercise its equity jurisdiction in the matter. *American Family Life Assurance Company of Columbus v. Insurance Department*, 414 A.2d 166 (Pa. Cmwlth. 1980).

GENERAL PROVISIONS

§ 88.1. Purpose.

(a) The purpose of this chapter is to implement the act of May 18, 1976 (P. L. 123, No. 54) (40 P. S. §§ 776.1—776.7) so as to provide for reasonable standardization of terms and coverages contained in individual accident and health insurance policies, nongroup subscriber contracts issued by health plan corporations and nonprofit health service plans and certificates issued by fraternal benefit societies. This chapter does not apply to credit accident and health insurance.

(b) In addition, it is the purpose of this chapter to facilitate public understanding and comparison of the terms, benefits and conditions of individual policies or contracts, to eliminate provisions which may be misleading or unreasonably confusing in connection either with purchase of the coverage or with the settlement of claims and to provide for full disclosure of these matters in the sale of policies or contracts.

§ 88.2. Applicability and scope.

This chapter applies to, and the term ''policy'' includes, all individual accident and health insurance policies, nongroup subscriber contracts of health plan corporations and nonprofit health service plans, and certificates issued by fraternal benefit societies delivered or issued for delivery in this Commonwealth on and after the effective date hereof. This chapter does not apply to credit accident and health insurance nor to individual policies or contracts issued pursuant to a conversion privilege under a group policy as required by section 621.2 of the act of May 17, 1921 (P. L. 682, No. 284) (40 P. S. § 756.2). The requirements contained in this chapter are in addition to any statutory requirements and any chapters previously adopted, except to the extent that the previous chapters are expressly inconsistent herewith, in which case the terms of this chapter are controlling.

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POLICY PROVISIONS

§ 88.11. Terms of renewability.

Each policy of accident and health insurance covered by this chapter shall include a renewal, continuation or nonrenewal provision. The language or specifications of the provision must be consistent with the type of contract to be issued such as noncancellable and guaranteed renewable, guaranteed renewable, renewable at the option of the insurer, single term nonrenewable, and the like. Such provision must be appropriately captioned and commence or be referenced on the first page of the policy and on the filing back, if any, and must 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. Policies which allow for a change in premiums shall specify the conditions under which rate changes may be made by insurer.

§ 88.12. Noncancellable and guaranteed renewable policy.

(a) All such policies must be renewable to at least age 60, subject to the timely payment of premiums, and shall provide that the company cannot cancel the policy and that the company cannot increase the premium.

(b) In a family policy covering both husband and wife the age of the younger spouse must be used as the basis for meeting the age and durational requirements of the definitions of ''noncancellable'' and ''guaranteed renewable.'' However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age limit, such as age 60, 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.

§ 88.13. Guaranteed renewable policy.

All such policies must be renewable to at least age 65, subject to the timely payment of premiums, and shall provide that the company cannot cancel the policy. However, the insurer may reserve the right to change the premium on a class basis. Such right shall be clearly expressed within the renewal provision and referenced in the caption of such provision. The insurer may include a policy provision for termination or nonrenewal of disability income policies prior to age 65 when the insured is no longer subject to the risk of loss of income as a result of accident or sickness.

§ 88.14. Renewable subject to consent of company and variants thereof.

(a) The renewal provision of a policy characterized as renewable subject to the consent of the company shall be appropriately captioned as one of the following:

(1) ''Renewable Subject to Consent of Company.''

(2) ''Renewable Subject to Company Consent.''

(3) ''Renewable at Option of Company.''

(b) The designated captions are without prejudice to the right of the insurer to submit another caption, subject to the approval of the Commissioner, which it believes is equally clear or more definitive as to the subject matter of said provision.

(c) The provision shall clearly declare that renewal of the policy is subject to the consent of the insurer and that the premium rate applicable to such policy shall be that currently in use on each renewal date of the policy.

(d) Policy nonrenewal shall be limited to the renewal date occurring on, or after and nearest, each anniversary of the policy. Nonrenewal shall not be based on the deterioration of mental or physical health of any individual covered under the policy.

(e) If the insurer reserves the right of cancellation, notice of the existence of the provision shall be cross-referenced in the renewal provision.

§ 88.15. Qualified right of renewal.

(a) A renewal provision, other than enumerated in this chapter, may grant to the insured the right of renewal by timely payment of premiums up to a stated age, if any, subject to the reserved right of the insurer to terminate all such policies on a specified basis upon the giving of a specified period of notice, which shall be set forth in the appropriate provision of the policy.

(b) The right of the insured to renew the policy may be conditioned upon the continuation of a specified status, such as an employee of a named employer, member of a named organization, while engaged in a specific occupation associated with such employment of such organization, residence in a given state or geographic area, insured under a given form of insurance having like form number identification.

(c) The rights of the insured and of the insurer shall be clearly set forth in the renewal provision. Such shall include the specified age limit, if any, requirements as to the professional or occupational status, if any, and requirements as to the continuing relationship, if any, of the employe or member.

(d) Continuance of insurance after the insured ceases to be eligible for coverage under the plan may be at the option of the insurer. In the event a different table of premium rates is to be applicable with respect to renewals occurring thereafter, such fact shall be declared in the renewal provision.

§ 88.16. Single term nonrenewable policy.

A policy characterized as a single term nonrenewable policy shall include a provision appropriately captioned, for example, ''this policy is not renewable'' or words of similar import. Such provision must identify or reference the proper part of the contract within which the term or duration of the coverage is specified.

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§ 88.17. Renewable at the option of the insured.

Policies which may not be characterized as noncancellable and guaranteed renewable or guaranteed renewable under existing definitional requirements solely because such policy may not be continuable to age 60 or for a minimum period of five years, may use a renewal provision caption, subject to the approval of the Commissioner, which states that the right of renewal is vested in the insured for a stated period of years, to a stated age, to the occurrence of a stated event or during the continuance of a given status such as employment or membership.

§ 88.18. Conditional or limited continuance.

Policies which provide a qualified right of continuance after expiration of the period during which such policy is noncancellable and guaranteed renewable or guaranteed renewable must clearly specify the conditions, such as continued gainful employment, which must be fulfilled to permit continuance of the policy. If premiums are to be based on an attained age or on a step rate basis, such must be declared in the renewal provision. The age limit, if any, to which any policy may be renewed shall be declared in the renewal provision.

CONDITIONS OF ELIGIBILITY

§ 88.31. Family members.

A family policy providing hospital, surgical, medical expense, hospital confinement indemnity, or accident only insurance shall include provisions which specify the identity and qualifications applicable to those family members who may become insured under the policy initially or by subsequent addition.

Cross References

This section cited in 31 Pa. Code § 88.35 (relating to accidental injuries).

§ 88.32. Eligibility.

Eligible family members may include the insured, the insured's spouse, children of the insured, and of the insured's spouse who are under a specified age not to exceed 19, unless a dependency test is specified, and any other person dependent upon the insured. However, newborn children of any insured shall be covered pursuant to act of August 1, 1975 (P.L. 157, No. 81) (40 P. S. §§ 771—774).

Cross References

This section cited in 31 Pa. Code § 88.35 (relating to accidental injuries).

§ 88.33. Subsequent eligibility.

The provisions concerning eligibility shall, for persons who may become insured subsequent to policy issuance, state the condition under which such coverage may become effective. Such conditions may include:

(1) qualifications for automatic coverage and the duration thereof;

(2) required evidence of insurability;

(3) the necessity of application or notice from the insured;

(4) any requirements as to the payment of premiums as to such addition; and

(5) the time within which action is to be taken by the insured.

Cross References

This section cited in 31 Pa. Code § 88.35 (relating to accidental injuries).

§ 88.34. Time limit on defenses.

In family policies providing for the addition of newly eligible family members, the Time Limit on Certain Defenses provision, section 618(A)(2) of the Insurance Company Law (40 P. S. § 753(A)(2)) may be modified to provide for a new contestable period for each new member so added, but shall not provide for a new contestable period for the policy.

Cross References

This section cited in 31 Pa. Code § 88.35 (relating to accidental injuries).

§ 88.35. Accidental injuries.

A family policy providing benefits for accidental injuries such as accidental death, dismemberment, loss of sight, indemnity for fractures or dislocations, and the like shall provide an option to include all insureds under the contract and not just the principal insured. The level of benefits for covered dependents may be different than the benefits for the principal insured. Provisions decribing eligibility of family members, the adding of family members and the termination of insurance as to such family members will generally follow the pattern specified in §§ 88.31—88.41 (relating to conditions of eligibility and termination of insurance). Generally, causes of termination of coverage of individual family members will be predicated on age, cessation of dependency which would include legal separation, termination of marriage by divorce and similar occurrences.

TERMINATION OF INSURANCE

§ 88.41. Family policy provisions.

A family policy providing hospital, surgical, medical expense, hospital confinement indemnity or accident only insurance shall include provisions which shall specify the following:

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(1) As to the insured, the age or event, if any, upon which coverage under the policy will terminate such as age 65, eligibility for Medicare.

(2) As to the spouse, the age or event, if any, upon which coverage under the policy will terminate such as age 65, eligibility for Medicare, legal separation, divorce, or annulment.

(3) As to child, the age or event upon which coverage under the policy will terminate such as age 19, marriage of the child, cessation of dependency. The policy shall provide that coverage of an unmarried dependent child shall not terminate if that child is incapable of self-sustaining employment by reason of mental retardation or physical handicap, under section 617(A)(9) of the Insurance Company Law of 1921 (40 P. S. § 752(A)(9)).

(4) For other family members, the age or event, if any, or such other reasons as are appropriate for termination of coverage as to persons not coming within paragraph (1), (2) or (3).

(5) A noncancellable and guaranteed renewable or guaranteed renewable policy may not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. The provisions 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.

(6) The provisions shall provide that if the insurer accepts the premium for coverage extending beyond the date, age, or event specified for termination as to an insured family member, then coverage as to such person shall continue during the period for which an identifiable premium was accepted, except where such acceptance was predicated on a misstatement of age.

(7) The provisions shall provide that, in the event of cancellation or refusal to renew by the insurer, where permitted by law, except for nonpayment of premium, of a policy providing pregnancy benefits, such policy shall provide for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy continued in force.

(8) The provisions shall provide that termination of the policy by the insurer shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period the policy was in force may be predicated upon the continuous disability of the insured person, limited to the duration of the policy benefit period or to the payment of the maximum benefits.

(9) The termination provision may provide for the termination or suspension of coverage if the insured individual becomes eligible for Medicare under the Social Security Act (42 U.S.C.A. § 1395 et seq).

Cross References

This section cited in 31 Pa. Code § 88.35 (relating to accidental injuries).

PREEXISTING CONDITIONS

§ 88.51. Applicability of conditions.

The policy must clearly disclose the intent of the insurer as to the applicability or nonapplicability of coverage relating to preexisting conditions. If coverage of the policy is not to be applicable to preexisting conditions, the policy shall specify, in substance, that coverage pertains solely to accidental bodily injuries resulting from accidents occurring after the effective date of coverage, and that sickness is limited to that which is diagnosed or treated subsequent to the effective date of coverage or expiration of the probationary period, if any.

Source

The provisions of this § 88.51 amended June 27, 1980, effective June 28, 1980, 10 Pa.B. 2591. Immediately preceding text appears at serial page (36604).

§ 88.52. Definitions.

The following words and terms, when used in these §§ 88.51—88.53, have the following meanings, unless the context clearly indicates otherwise:

Preexisting condition—A condition for which medical advice or treatment was recommended by a physician or received from a physician within a 5-year period preceding the effective date of the coverage of the insured person.

Notes of Decisions

Construction; Ambiguity

The fact that State insurance regulations contain a definition of ''preexisting condition'' that is virtually identical to that contained in an insured's policy does not conclusively demonstrate that the policy definition is unambiguous. *Lawson v. Fortis Insurance Co.*, 146 F. Supp.2d 737 (E.D. Pa. 2001); affirmed 301 F.3d 159 (3rd Cir. Pa. 2002).

§ 88.53. Simplified application form.

Notwithstanding the provisions of section 618 (A)(2) of The Insurance Company Law of 1921 (40 P. S. § 753 (A)(2)), if an insurer elects to use a simplified application form, with or without a question as to the health of the applicant at the time of application, but without any questions concerning the health history or medical treatment history of the insured, the policy must cover any loss occurring after 12 months from the effective date of the insured person's coverage from any preexisting condition not specifically excluded from coverage by terms of the policy, and, except as so provided, the policy or contract shall not include wording that would permit a defense based upon preexisting conditions. Changes to policies or contracts required under this section, including changes to premium rates applicable thereto, shall be permitted by endorsement or rider.

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PROBATIONARY OR WAITING PERIODS

§ 88.61. Period of time.

Probationary or waiting periods shall relate to that period of time which may be specified in the policy and which must follow the date a person is initially insured under the policy, or following reinstatement of a policy, before the coverage or coverages of the policy shall become effective as to such person. A probationary or waiting period shall not be used with respect to any loss resulting

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from accidental injuries as defined in the policy. However, as to loss resulting from sickness a policy may specify a probationary or waiting period which shall not exceed 30 days, except as follows:

(1) For normal pregnancy and childbirth, 30 days where the probationary or waiting period is expressed in terms of the inception of the pregnancy.

(2) For elective surgery, not to exceed six months. The following is a list of surgical procedures which may be considered elective surgery:

(i) Cataract operations.
(ii) Strabismus operations.
(iii) Tonsilectomies, adenoidectomies.
(iv) Herniotomies.
(v) Arthrotomies.
(vi) Hemorrhoidectomies.
(vii) Laminectomies.
(viii) Varicose veins.
(ix) Gall bladder.
(x) Appendectomies concurrent with gall bladder operation.

LIMITATIONS

§ 88.71. Clarity.

The limitations on the risk undertaken, whether applicable to amounts, duration of benefits, or age or other matters, must be specified with clarity and certainty in the appropriate provision of the contract.

EXCEPTIONS, EXCLUSIONS AND REDUCTIONS

§ 88.81. Exception or exclusion.

An exception or exclusion is any provision in a policy whereby coverage for a specific hazard is entirely eliminated. It is statement of a risk not assumed under the terms and provisions of the contract.

§ 88.82. Reduction.

A reduction is a provision which takes away some portion, but not all, of the coverage of the policy under certain specific conditions. Such reduction relates to a risk, which although assumed by the insurer, payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction clause not been used.

§ 88.83. Clear expression.

Exceptions, exclusions, and reductions must be clearly expressed as a part of the benefit provision to which such applies, or if applicable to more than one benefit provision, shall be set forth as a separate provision and appropriately cap-

tioned. The use of general policy exclusions and the scope thereof will, of necessity, vary with the type of benefits afforded in a given policy, subject to the requirement that said exclusions are reasonable in light of the nature of benefits afforded.

§ 88.84. Listing of exclusions.

The following is a list of the exclusions which shall be permitted in addition to those specified under § 618 of The Insurance Company Law of 1921 (40 P. S. § 753). The wording of the exclusions is illustrative and is intended to indicate the general intent of the Department. Alternate wording is permissible as long as the meaning preserves the general intent of the exclusions, as follows:

(1) General exclusions shall conform with the following:

(i) Loss sustained or expenses incurred while on active duty as a member of the armed forces of any nation, or losses sustained or expenses incurred as a result of act of war whether declared or undeclared.

(ii) Suicide or intentionally self-inflicted injuries.

(iii) Sickness or injury covered by any Workmen's Compensation Act or Occupational Disease Law or by United States Longshoreman's Harbor Worker's Compensation Act (33 U.S.C.A. §§ 901—950).

(iv) Mental, nervous, or emotional disorders.

(v) Aviation hazards except while flying as a fare-paying passenger on a commercial airline.

(vi) Participation in a riot or insurrection.

(vii) Cosmetic surgery, except when necessitated by covered sickness or injury.

(viii) Named hazardous occupations.

(ix) Named hazardous sports or hobbies.

(x) Normal pregnancy, childbirth, and miscarriage.

(xi) Exclusions which, in the opinion of the Commissioner, are justified by special circumstances or the particular coverage of the policy.

(2) Exclusions pertaining to hospital or basic coverage and major medical policies may include the following:

(i) Eye examinations, refractions, eye glasses, contact lenses or hearing aids, or hearing examinations.

(ii) Any services, use of a facility, or supply which is not recommended or approved by a licensed medical or dental practitioner practicing within the scope of the practitioner's license.

(iii) Charges for services, use of facilities, or supplies that neither the insured nor any other covered person is legally obligated to pay.

(iv) Routine physical examinations.

(v) Dentistry, dental x-rays or dental services, dental prosthetic appliances, except expenses otherwise covered on account of accidental bodily injury to sound natural teeth.

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(vi) Expenses of a covered person for cosmetic surgery, except expenses otherwise covered which are necessary for repair of an accidental bodily injury.

(vii) Expenses for transportation except local ambulance services for the insured or covered person.

(viii) Sickness or injuries to the extent that any covered person under the policy is eligible to receive benefits under ''Medicare'' for the expenses incurred. This exclusion may include other specifically enumerated national, state, or other governmental plans. It may not include or be interpreted to include plans which may possibly be enacted at some future time.

(ix) Services performed by the insured's spouse, child, parent, brother, or sister or persons who ordinarily reside in the household of the insured.

(x) Medical care of members of the armed forces in a United States Government facility.

(xi) Specified foot conditions.

Cross References

This section cited in 31 Pa. Code § 88.86 (relating to waivers).

§ 88.85. Unusual limitations, reductions, restrictions.

Any policy which contains unusual limitations, reductions, or conditions of such a restrictive nature that the payment of benefits under such policies is limited in frequency or in amounts shall carry the legend ''This Is A Limited Policy—Read It Carefully'' imprinted in not less than 18-point outline type of contrasting color diagonally across the face and filing back, if any, of the policy.

§ 88.86. Waivers.

The listing of specified exclusionary subjects set forth in § 88.84 (relating to listing of exclusions) may not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical condition or extra hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required unless on initial issuance the full text of the waiver is contained either on the first page or specification page of the policy or unless notice of the waiver appears on the first page or specification page.

§ 88.87. Military service exclusions.

If a policy contains a military service exclusion or a provision suspending coverage during military service, and if the premiums are either reduced or refunded for the period of the military service, the policy shall clearly so state the following:

(1) As to policies other than noncancellable and guaranteed renewable and guaranteed renewable policies, the following provisions apply:

(i) If the policy contains a ''status'' type of exclusion which excludes all coverages applicable to an insured person while in military service on full time active duty, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to such person on a pro rata basis.

(ii) If the policy contains a ''causation'' type exclusion, that is loss resulting from military service while an insured person is on full time active duty, refund of premium is not required since the policy would be operative as to any other loss not resulting from military service causes.

(iii) A provision for voluntary suspension of coverage as to an insured person during military service may be used and if an identifiable premium is charged as to such person, then upon written request for suspension a pro rata premium must be refunded.

(2) As to noncancellable and guaranteed renewable and guaranteed renewable policies, the following provisions apply:

(i) The policy may provide for refund of the entire premium for the period of military service or for a partial refund of the premium from the date the insurer receives notice and it may adjust the refund for a change in reserves during the period of suspension.

(ii) The policy may contain a military service exclusion or may provide for suspension of coverage upon entry into military service with the right of reinstatement upon termination of service within a specified period of not less than 60 days without evidence of insurability.

(iii) The insurer may charge a partial premium during the period of suspension which will anticipate accumulation of reserves required by law or regulation and related cost factors.

ELIMINATION PERIOD

§ 88.91. Definition.

(a) ''Elimination period'' means the initial period of time, during the continuance of a condition insured against and specified in respect to a particular benefit, for which the benefit will not be paid.

(b) The periods shall be clearly expressed in the policy schedule or benefits page and referenced in the benefit provision to which the elimination period applies.

REQUIREMENTS FOR REPLACEMENT

§ 88.101. Application form.

Application forms shall contain a question to elicit information as to whether the insurance to be issued is to replace any other accident and health insurance presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

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Cross References

This section cited in 31 Pa. Code § 88.102 (relating to delivery to applicant); and 31 Pa. Code § 90c.3 (relating to replacement questions for life insurance).

§ 88.102. Delivery to applicant.

Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer or its agent, shall furnish the applicant at the time of completing the application, the notice described in § 88.103 (relating to notice form). One copy of such notice shall be furnished to 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 § 88.104 (relating to notice form for direct response insurer). In no event, however, will §§ 88.101—88.104 (relating to requirements for replacement) apply to the solicitation of single premium nonrenewable policies and accident only policies.

Cross References

This section cited in 31 Pa. Code § 88.103 (relating to notice form); and 31 Pa. Code § 88.104 (relating to notice form for direct response insurer).

§ 88.103. Notice form.

The notice required by § 88.102 of this title (relating to delivery to applicant) 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. Your new policy provides 10 days after receipt of the policy within which you may decide whether you desire to keep the policy. For your own information and protection you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have, (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.

(This subsection may be modified if pre-existing conditions are covered under the new policy).

(2) Even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.

(3) 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 is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(4) 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.

above Notice to Applicant' was delivered to me on:

____
(Date)

____
(Applicant's Signature)

Cross References

This section cited in 31 Pa. Code § 88.102 (relating to delivery to applicant).

§ 88.104. Notice form for direct response insurer.

The notice required by § 88.102 (relating to delivery to applicant) for 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 the policy delivered herewith issued by (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 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.

(This section may be modified if pre-existing conditions are covered under the new policy.)

(2) Even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.

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

(4) (To be included only if the application is attached to the policy.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (Company Name and Address) within 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)

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Cross References

This section cited in 31 Pa. Code § 88.104 (relating to delivery to applicant).

RECURRENT CONDITIONS

§ 88.111. Confinements or disabilities.

A policy may contain provisions relating to recurrent confinements or recurrent disabilities; provided however, a recurrent confinement or recurrent disability provision may not specify that such confinement or such disabilities be separated by a period greater than 6 months.

GENERAL RULES

§ 88.121. Applications.

(a) Opinion-type questions regarding the past or present health of the applicant should provide that the applicant is to answer to the best of his knowledge and belief.

(b) No provision shall be permitted in an application which changes the terms of the policy to which it is attached.

§ 88.122. Assessable policy.

The words ''This Is An Assessable Policy'' shall be printed prominently on the policy face and filing back, if any, of each assessable policy in at least 16-point type.

§ 88.123. Use of certain words and terms.

(a) A policy containing, as part of its title, words such as ''special'' or ''preferred'' which are used in a misleading fashion, or words such as ''Union,'' ''Labor,'' ''Miner,'' and the like in its title which could associate it with a particular organization, association, or business will not be approved.

(b) Policies which are to be issued to supplement Medicare shall not have policy titles or headings which could in any way confuse them with the Federal Medicare Program.

§ 88.124. Suspension and termination.

No policy shall contain a provision for its automatic termination upon the happening of any loss, except a loss which has exhausted all possible benefits under the policy.

§ 88.125. Multiple benefits.

Policies which contain multiple benefit provisions shall not limit the payment of a specific benefit based on the fact that another benefit is paid under the same policy.

§ 88.126. Miscellaneous policy provisions.

(a) If the policy provides for any reduction in benefits because of the attainment of a specified age limit, reference thereto shall be set forth on the first or specifications page. For this purpose, a reduction in a benefit period is a reduction in benefits requiring such reference.

(b) No reduction of benefits by reason of a change in employment status or change in income of the insured shall be permitted, unless clearly set forth in the policy under an appropriate caption.

(c) Dependency status may not be defined by sex.

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

DEFINITION OF TERMS

§ 88.131. Hospital.

(a) The term 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 or the American Osteopathic Association. No definition of the term ''hospital'' shall be more restrictive than one requiring that the hospital:

(1) Be an institution operated pursuant to law which is licensed or approved as a hospital by the responsible state agency.

(2) Be primarily engaged in providing medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made.

(3) Provide 24 hour nursing service by or under supervision of registered graduate professional nurses (R.N.'s).

(b) The definition of the term ''hospital'' may state that the term shall not be inclusive of:

(1) Any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces.

(2) Convalescent homes, convalescent, rest or nursing facilities.

(3) Facilities primarily for the aged, drug or alcoholic rehabilitation, and those primarily affording custodial or educational care.

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§ 88.132. Convalescent nursing home, extended care facility or skilled nursing facility.

(a) The terms ''convalescent nursing home,'' ''extended care facility'' or ''skilled nursing facility'' may be defined in relation to their status, facilities and available services. No definition of the home or facility shall be more restrictive than one requiring that it:

(1) Be operated pursuant to law.

(2) Be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested.

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

(4) Provide continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.).

(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 or treatment of drug and alcohol abuse.

(3) A home or facility primarily used for the care and treatment of mental disease or disorders or custodial or educational care.

§ 88.133. Accident, accidental injury.

(a) The definition of accident, accidental injury shall employ ''result'' language and shall not include words which establish an accidental means test or use words such as ''external, violent, visible wounds'' or similar words of description or characterization.

(b) No definition shall be more restrictive than the following: Injury or injuries, for which benefits are provided, means accidental bodily injuries sustained by the insured person which are the direct and independent cause of the loss and occur while the insurance is in force. The definition may provide that injuries shall not include injuries for which benefits are provided under any workmen's compensation, employer's liability or similar law.

§ 88.134. Sickness.

No definition of ''sickness'' shall be more restrictive than the following: ''sickness'' shall mean sickness or disease of an insured person which is diagnosed or treated after the effective date of insurance and while the insurance is in force. Such definition may provide for a probationary period which shall not exceed 30 days. However, the definition shall clearly state that illnesses diagnosed or treated during the probationary period shall be covered subject to the Time Limit on

Certain Defenses. The definition may be further modified to exclude sickness or disease for which benefits are provided under any workmen's compensation, occupational disease, employer's liability, or similar law.

§ 88.135. Physician.

The insurer may define ''physician'' or the policy may include words such as qualified physician'' or ''duly licensed physician.'' The use of such words requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

§ 88.136. Nurses.

The definition or description of ''nurse'' may be restricted to a type of nurse, such as registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the words ''nurse,'' ''trained nurse,'' or ''registered nurse'' are used without a specific definition, 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.

§ 88.137. Total disability.

(a) For the first 24 months after the commencement of a loss, ''total disability'' shall be defined as the inability of the insured to perform all the substantial and material duties of his regular occupation. After 24 months of continuous disability, total disability may be defined as the inability of the insured to perform all of the substantial and material duties of any occupation for which he is reasonably suited by reason of education, training, or experience. The definition may require that the insured not in fact be 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 such inability may not be based solely upon the ability of an individual to:

(1) Perform ''any occupation whatsoever'' or ''any occupational duty.''

(2) Engage in any training or rehabilitation program.

(c) The definition may require regular care and attendance by a physician, other than the insured or a member of the insured's immediate family. The definition may require that the total disability be ''continuous'' or ''uninterrupted'' for a specified period of time or to a specified age which shall be consistent with the type of coverage afforded.

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§ 88.138. Partial disability.

Partial disability may be defined in relation to one's inability to perform one or more but not all of the ''major,'' ''important,'' or ''essential'' duties of his 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.

§ 88.139. Residual disability.

Residual disability shall be defined in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the ''major,'' ''important,'' or ''essential duties'' of employment or occupation, or 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.

§ 88.140. Medicare.

A hospital, surgical, or medical expenses policy which relates its coverage to eligibility for Medicare or Medicare benefits shall include a definition of Medicare. Such 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.

§ 88.141. Mental or nervous disorders.

Mental, nervous, or emotional disorder means a neurosis, psychoneurosis, psychopathy, or psychosis. The definition may include mental, nervous or emotional disorders without demonstrable organic origin.

§ 88.142. Debit plan policies.

These policies are those which are issued on a weekly premium paying basis and in which the premiums are collectible weekly by an agent of the insurance company.

§ 88.143. One period of confinement.

One period of confinement means one or more separate or combined periods of confinement in a hospital, for the same or related causes not separated by an interval of at least 6-consecutive months between the end of one such period and the beginning of the succeeding period. When succeeding confinements for the same or related causes are separated by such a 6-month interval, the second confinement will be considered a new period of confinement and any applicable benefit limits will be restored.

CONVERSION PRIVILEGES

§ 88.151. Compliance.

If a policy contains a conversion privilege, it shall comply, in substance, with the following:

(1) 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, shall be described in the provision. The provision may indicate that the privilege is subject to the underwriting standards of the insurer relating to overinsurance.

(2) A business overhead expense policy issued on a guaranteed renewable basis, on a noncancellable basis, or a renewable at the option of the insurer basis may, at the option of the insurer, provide for continuation as a loss of time policy upon termination of the business interest.

(3) When a policy is issued pursuant to the exercise of a conversion privilege the converted policy or a rider attached thereto shall reflect the relative rights of each person covered under the converted policy.

MINIMUM STANDARDS FOR BENEFITS

§ 88.161. Minimum standards.

The following minimum standards for benefits are prescribed for the categories of coverage noted in the following sections.

Cross References

This section cited in 31 Pa. Code § 88.169 (relating to specified disease and specified accident coverage); and 31 Pa. Code § 88.171 (relating to supplemental insurance coverage).

§ 88.162. Basic hospital expense coverage.

(a) A policy which provides ''Basic Hospital Expense Coverage'' is defined as providing coverage for a period of not less than 31 days, during any one period

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of confinement for each person insured under the policy for the expense incurred for necessary treatment and services rendered as a result of an injury or sickness for at least the following:

(1) Daily hospital room and board in an amount not less than the average semi-private room rate in the community in which theinsured resides or $30 per day.

(2) Miscellaneous hospital service up to ten times the daily hospital room and board benefit for the expense incurred for the charges made by the hospital for services and supplies rendered by the hospital and provided for use only during the period of confinement.

(3) Hospital outpatient services consisting of the following:

(i) Hospital services on the day surgery is performed.

(ii) Hospital services rendered within 72 hours after accidental injury, in an amount not less than $50.

(iii) X-ray and laboratory tests to the extent that benefits for these services would have been provided to an extent not less than $100 if rendered to an inpatient of the hospital.

(b) Benefits provided under subsections (a)(1) and (a)(2) may be provided subject to a combined deductible amount not in excess of $100.

Cross References

This section cited in 31 Pa. Code § 88.169 (relating to specified disease and specified accident coverage); 31 Pa. Code § 88.171 (relating to supplemental insurance coverage); 31 Pa. Code § 88.186 (relating to basic hospital expense coverage form); and 31 Pa. Code § 88.188 (relating to basic hospital and medical-surgical expense form).

§ 88.163. Basic medical-surgical expense coverage.

A policy which provides ''Basic Medical-Surgical Expense Coverage'' is defined as providing coverage for each person insured under the policy for the expense incurred for the necessary services rendered by a physician for treatment of an injury or sickness for at least the following:

(1) Surgical services on a fee schedule basis with a maximum of $350 based on an acceptable relative value scale of surgical procedures.

(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, to a minimum of 15% on an expense incurred basis of the surgical service benefit provided.

(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 $5.00 per call, one call per day, for at least 21 such calls during ''one period of confinement.''

(4) Surgical schedules contained in the policy shall include a provision providing coverage for procedures not specifically listed in the schedules and not otherwise excluded by the policy, and benefits therefore, shall be consistent with the benefits for comparable procedures.

(5) Two or more surgical procedures performed on the same surgical occasion and through the same incisions shall be covered to the extent that payment is provided for the most expensive procedure. Operations performed during the same surgical session, but not through the same incision, shall be covered to the extent that 100% payment is provided for the most expensive operation and 50% payment for the remaining total.

(6) Whenever a policy is written that provides at least the coverages required for both basic hospital expense coverage and basic medical-surgical expense coverages, the allowable deductible may be applied to the combined coverage.

Cross References

This section cited in 31 Pa. Code § 88.169 (relating to specified disease and specified accident coverage); 31 Pa. Code § 88.171 (relating to supplemental insurance coverage); 31 Pa. Code § 88.187 (relating to basic medical-surgical expense coverage form); and 31 Pa. Code § 88.188 (relating to basic hospital and medical-surgical expense form).

§ 88.164. Hospital confinement indemnity coverage.

A policy of ''Hospital Confinement Indemnity Coverage'' provides daily benefits for hospital confinement on an indemnity basis in an amount not less than $10 per day and for not less than 31 days during any one period of confinement for each person insured under the policy.

Cross References

This section cited in 31 Pa. Code § 88.169 (relating to specified disease and specified accident coverage); 31 Pa. Code § 88.171 (relating to supplemental insurance coverage); and 31 Pa. Code § 88.189 (relating to hospital confinement indemnity coverage form).

§ 88.165. Major medical expense coverage.

A policy of ''Major Medical Expense Coverage'' provides hospital, medical, and surgical coverage as follows:

(1) The aggregate maximum is not less than $10,000 per covered person.

(2) The copayment by a covered person is not more than 25% of covered charges except that the copayment percentage applicable to paragraph (7) of § 88.166 of this title (relating to coverage of each covered person) may not be more than 50%.

(3) The deductible shall be stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of such bases. The deductible shall be not more than 5% of the maximum limit under the coverage unless the policy is written to complement underlying hospital and medical insurance in which case such deductible may be increased by the amount of the benefits provided by such underlying insurance. If the deductible includes benefits provided by underlying hospital and medical insurance, it shall be known as a variable deductible and shall be subject to the following requirements:

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(i) The sales material and policy forms for this type of coverage shall clearly and fully describe the variable deductible provision.

(ii) Sales material describing the variable deductible shall be left with the applicant at the time the application is executed.

(iii) The policy shall contain a provision which will permit the insured to increase or decrease his basic deductible to reflect his changing needs and changes in his other medical coverage. Such change will be permitted on any policy whenever subject to an appropriate adjustment of premiums. No evidence of insurability shall be required in connection with a decrease in the basic deductible.

(iv) The minimum basic dollar deductible shall be $750.

(v) Policies shall provide for claim payments on a pro rata basis in the event that other policies of the insured contain similar deductible provisions.

(vi) The insurance company shall remind the insured of his right to adjust the deductible with each renewal notice. This may be accomplished by a question or questions on the renewal notice. These questions would concern themselves with any changes in the basic benefits of the policyholder.

(vii) An explanation of the variable deductible provision shall be included in the outline of coverage and shall be worded substantially similar to the following:

Your Major Medical Expense Policy is designed to coordinate its coverage with benefits provided under other medical expense coverage. This is done by a deductible amount' which is the flat amount of the Basic Deductible shown on page ____of your policy or the amount of benefits paid under other medical expense coverage if that is greater. *If this feature of your policy is not understood contact your agent* or the company immediately.

In the application attached to your policy, you were asked to furnish details of any other medical expense coverage applicable to Covered Persons under your policy so that your choice of the flat amount Basic Deductible could be an appropriate one under the circumstances. If the extent of such other coverage changes in the future, it may be that you should consider a change in the Basic Deductible amount in accordance with the provision of your policy entitled Privilege of Changing Basic Deductible.' In such event, we suggest that you get in touch with your agent or company, who will be glad to assist you.

(4) The maximum benefit period for an ''each cause'' type of policy, where a separate deductible is required for each sickness and accident, is not less than 18 months. The maximum benefit period for an ''all cause'' type of policy, where separate deductibles are not required for each sickness or accident, is not less than the number of days remaining in the calendar or policy year after the deductible has been met.

(5) The period allowed to satisfy the deductible shall be at least 90 days.

Cross References

This section cited in 31 Pa. Code § 88.169 (relating to specified disease and specified accident coverage); 31 Pa. Code § 88.171 (relating to supplemental insurance coverage); and 31 Pa. Code § 88.190 (relating to major medical expense coverage form).

§ 88.166. Coverage for each covered person.

Major Medical Expense Coverage must provide for each covered person the following:

(1) Hospital room and board expenses, prior to application of the copayment percentage, for not less than $50 daily or in lieu thereof the average daily

cost of a semi-private room rate in the area where the insured resides for a period of not less than 31 days for any period of continuous hospital confinement.

(2) 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.

(3) Surgical fees, prior to application of the copayment percentage, to a maximum of not less than $600 for the most severe operation with the amounts provided for other operations reasonably related to such maximum amount.

(4) Anesthesia services, prior to application of the copayment percentage, for a maximum of not less than 15% of the covered surgical fees or, alternatively, if the surgical schedule is based on relative values, not less than the amount provided therein for anesthesia services at the same unit value as used for the surgical schedule.

(5) Doctor visits, in or out of the hospital, with minimum dollar amounts per visit, prior to application of the copayment percentage, equal to not less than $10 per visit, covering not less than one visit per day and for an aggregate maximum of such covered charges of not less than $600.

(6) Out-of-hospital diagnostic X-rays and tests, prior to application of the copayment percentage, for an aggregate maximum of such covered charges of not less than $600.

(7) Not fewer than three of the following additional benefits prior to application of the copayment percentage, for an aggregate maximum of such covered charges of not less than $1,000:

(i) In-hospital private duty registered nurse services.

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

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

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

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

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

Cross References

This section cited in 31 Pa. Code § 88.165 (relating to major medical expense coverage); 31 Pa. Code § 88.169 (relating to specified disease and specified accident coverage); and 31 Pa. Code § 88.171 (relating to supplemental insurance coverage).

§ 88.167. Disability income protection coverage.

(a) A policy of ''Disability Income Protection Coverage'' 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.

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This section does not apply to those policies providing business buyout coverage. Disability Income Protection Coverage must:

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

(2) Contain an elimination period no greater than:

(i) 90 days in the case of a coverage providing a benefit of 1 year or less.

(ii) 180 days in the case of coverage providing a benefit of more than one year but not greater than 2 years.

(iii) 365 days in all other cases during the continuance of disability resulting from sickness or injury.

(3) Have a maximum period of time for which it is payable during disability of at least 6 months.

(b) The coverage shall not require a loss from accidental injury to commence within less than 30 days after the date of an accident, nor may any such accident policy which the insurer may cancel or refuse to renew require that it be in force at the time the loss commences, if the accident occurred while the policy was in force.

(c) Benefits for specific injury due to accident shall not be in lieu of sickness benefits, unless the specific benefit exceeds the sickness benefit.

(d) No policy which contains a disability income benefit or a similar type benefit may require an insured person to be confined to his residence due to sickness or injury as a condition for any such benefit, any change in the amount of such benefit or any change in duration of coverage of such benefit.

(e) No policy of accident and health insurance will be approved which contains a provision that the disability period shall be considered to commence with the date on which written notice is actually received by the company.

(f) Policies which limit benefits for loss of time to specified items, such as business overhead policies, shall provide for a premium refund in accordance with a short rate table in the event that none of the items to be indemnified exist at the time the policy is cancelled, for example, where a professional person discontinues his office, but only if the insured requests cancellation of the policy and gives timely notice. Any premium refund may be limited to one year's premium.

Cross References

This section cited in 31 Pa. Code § 88.169 (relating to specified disease and specified accident coverage); 31 Pa. Code § 88.171 (relating to supplemental insurance coverage); and 31 Pa. Code § 88.191 (relating to disability income protection coverage form).

§ 88.168. Accident only coverage.

(a) ''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.

(b) ''Accident Only'' policies shall provide continuous 24-hour coverage. The amount of benefits payable shall not vary with respect to when, where, or how the accident occurs except with respect to benefits for the general classifications of ''Common Carrier'' and ''Private Passenger Automobile.''

(c) Accidental death and dismemberment benefits shall be payable irrespective of total disability. Disability income benefits, if provided, shall not require the loss to commence less than 30 days after the date of the accident, nor may any policy which the insurer may cancel or refuse to renew require that it be in force at the time disability commences if the accident occurred while the policy was in force.

(d) The amount of the accidental death benefit shall not be less than $1,000.

(e) The amount of the dismemberment benefit shall not be less than:

(1) $500 in the case of a single dismemberment; and

(2) $1,000 in the case of a double dismemberment.

Cross References

This section cited in 31 Pa. Code § 88.169 (relating to specified disease and specified accident coverage); 31 Pa. Code § 88.171 (relating to supplemental insurance coverage); and 31 Pa. Code § 88.192 (relating to accident only coverage form).

§ 88.169. Specified disease and specified accident coverage.

(a) ''Specified Disease Coverage'' is a policy which provides coverage for each person insured under the policy for specifically named diseases with a deductible amount not in excess of $250 and an overall aggregate benefit limit of not less than $5,000 and a benefit period of not less than 2 years for at least the following incurred expenses:

(1) Hospital room and board for semi-private accommodations and other hospital furnished medical services or supplies.

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

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

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

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

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

(7) Drugs and medicines prescribed by a physician.

(8) The rental of an iron lung or similar mechanical apparatus. Braces, crutches and wheel chairs as deemed necessary by the attending physician for the treatment of the disease.

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(9) 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.

(10) Policies may contain no ''inside limits.''

(b) ''Specified disease coverage'' is a policy which provides benefits for each person insured under the policy for specifically named diseases for the following:

(1) Hospital confinement in an amount of at least $100 per day for at least 500 days.

(2) Surgical expenses equal to reasonable and customary charges not to exceed an overall lifetime maximum of $3,500.

(3) Radium, cobalt, chemotherapy or X-ray therapy expenses while not hospital confined to at least $1,000. The therapy benefit shall be restored after an insured is treatment or hospitalization free for at least 12 months.

(c) A policy of ''Specified Accident Coverage'' provides coverage for a specifically identified kind of accident for each person insured under the policy for accidental death or accidental death and dismemberment combined, and may include coverage for disability or hospital and medical care with a benefit amount of no less than $1,000 for accidental death, $1,000 for double dismemberment and $500 for single dismemberment. Benefit amounts may not be so limited as to be unjust, unfair or misleading to the public. Benefits for disability, hospital or medical care shall be subject to the limits set forth in §§ 88.161—88.171 (relating to minimum standards for benefits).

Cross References

This section cited in 31 Pa. Code § 88.193 (relating to specified disease or specified accident coverage form).

§ 88.170. [Reserved].

Source

The provisions of this § 88.170 amended September 18, 1981, effective September 20, 1982, 11 Pa.B. 3214; reserved September 15, 1989, effective September 16, 1989, 19 Pa.B. 3945. Immediately preceding text appears at serial pages (65162) to (65166).

Cross References

This section cited in 31 Pa. Code § 88.169 (relating to specified disease and specified accident coverage).

§ 88.171. Supplemental insurance coverage.

A policy of ''Supplemental Insurance Coverage'' provides benefits that are less than the minimum standards for benefits required under §§ 88.161—88.168. The policies or contracts may be delivered or issued for delivery in this Commonwealth only if the outline of coverage is completed and delivered as required by §§ 88.181—88.195 (relating to outline of coverage). Supplemental policies shall

clearly state that the coverage provided is intended only to supplement other basic coverages. This disclosure shall be part of the policy title, policy description or schedule page.

Cross References

This section cited in 31 Pa. Code § 88.169 (relating to specified disease and specified accident coverage); and 31 Pa. Code § 88.195 (relating to supplemental insurance coverage form).

OUTLINE OF COVERAGE

§ 88.181. Prohibition.

No policy may be delivered or issued for delivery in this Commonwealth unless an appropriate outline of coverage, as prescribed by this chapter, either accompanies the policy or contract or is delivered at the time application is made.

Authority

The provisions of this § 88.181 issued under The Insurance Company Law of 1921 (40 P. S. §§ 341—991); amended under sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and sections 354 and 616 of The Insurance Company Law of 1921 (40 P. S. §§ 477b and 751).

Source

The provisions of this § 88.181 amended September 18, 1981, effective September 20, 1982, 11 Pa.B. 3214; amended September 15, 1989, effective September 16, 1989, 19 Pa.B. 3945. Immediately preceding text appears at serial page (65167).

Cross References

This section cited in 31 Pa. Code § 88.171 (relating to supplemental insurance coverage).

§ 88.182. Disclosure statement.

In the event that a policy or contract is issued on a basis other than that applied for, a disclosure statement properly describing the policy or contract must accompany the policy or contract when it is delivered and contain the following statement, in no less than 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.''

Cross References

This section cited in 31 Pa. Code § 88.171 (relating to supplemental insurance coverage).

§ 88.183. Changes in terminology.

Appropriate changes in terminology shall be made in outlines of coverage in the case of contracts of hospital plan corporations, or professional health service corporations. In any other case where the prescribed outline is inappropriate for

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the coverage provided by the policy or contract, an alternate outline shall be submitted to the Commissioner for prior approval.

Cross References

This section cited in 31 Pa. Code § 88.171 (relating to supplemental insurance coverage).

§ 88.184. Print.

The outlines of coverage required by this chapter shall be plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lower-case unspaced alphabet length not less than 120-point.

Cross References

This section cited in 31 Pa. Code § 88.171 (relating to supplemental insurance coverage).

§ 88.185. Text.

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

Cross References

This section cited in 31 Pa. Code § 88.171 (relating to supplemental insurance coverage).

§ 88.186. Basic hospital expense coverage form.

An outline of coverage, in the form prescribed in this section, shall be issued in connection with policies meeting the standards of § 88.162 (relating to basic hospital expense coverage). The items included in the outline must appear in the sequence prescribed:

(COMPANY NAME)
(HOME OFFICE ADDRESS)
BASIC HOSPITAL EXPENSE COVERAGE
REQUIRED OUTLINE OF COVERAGE

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

(2) *Basic Hospital Expense Coverage*—Policies of this category are designed to provide, to persons covered, 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 set forth in the policy. Coverage

is *not* provided for physicians or surgeons fees or *unlimited* hospital expenses. (*NOTE: Immediately preceding sentence may be appropriately modified, if necessary, to reflect coverage provided.)

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

(a) Daily hospital room and board;

(b) Miscellaneous hospital services;

(c) Hospital out-patient services; and

(d) Other benefits, if any.

*NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of benefit amounts; durations or limits, elimination periods, inner limits, deductible or co-payment provisions and any other items appropriate to the coverage provided.)

(4) (A description of the exceptions, reductions, and limitations contained in the policy or contract, including the pre-existing conditions provisions, if any, and the circumstances under which any reduction becomes operative.)

(5) (A description of the terms and conditions of renewability of the policy or contract, including any limitation by age, time or event, rights to change premium, status requirements and any other matters appropriate to the terms and conditions of renewability (including any rights of cancellation reserved to the insured).)

Cross References

This section cited in 31 Pa. Code § 88.171 (relating to supplemental insurance coverage).

§ 88.187. Basic medical-surgical expense coverage form.

An outline of coverage, in the form prescribed in this section, shall be issued in connection with policies meeting the standards of § 88.163 (relating to basic medical-surgical expense coverage). The items included in the outline must appear in the sequence prescribed:

(COMPANY NAME)
(HOME OFFICE ADDRESS)
BASIC MEDICAL-SURGICAL EXPENSE COVERAGE
REQUIRED OUTLINE OF COVERAGE

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

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

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provided for surgical services, anesthesia services, and in-hospital medical services, subject to any limitations set forth in the policy. Coverage is *not* provided for hospital expenses or *unlimited* medical-surgical expenses. (*NOTE: Immediately preceding sentence may be appropriately modified, if necessary, to reflect coverage provided.)

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

(a) Surgical services;

(b) Anesthesia services;

(c) In-hospital medical services; and

(d) Other benefits, if any.

*NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of benefit amounts, durations or limits, elimination periods, inner limits, deductible or co-payment provisions and any other items appropriate to the coverage provided.)

(4) (A description of the exceptions, reductions and limitations contained in the policy or contract, including the pre-existing conditions provisions, if any, and the circumstances under which any reduction becomes operative.)

(5) (A description of the terms and conditions of renewability of the policy or contract, including any limitation by age, time or event, rights to change premium, status requirements and any other matters appropriate to the terms and conditions of renewability (including any rights of cancellation reserved to the insured).)

Cross References

This section cited in 31 Pa. Code § 88.171 (relating to supplemental insurance coverage).

§ 88.188. Basic hospital and medical-surgical expense form.

An outline of coverage, in the form prescribed in this section, shall be issued in connection with policies meeting the standards of §§ 88.162 and 88.163 (relating to basic hospital expense coverage; and basic medical-surgical expense coverage). The items included in the outline must appear in the sequence prescribed:

(COMPANY NAME)
(HOME OFFICE ADDRESS)

BASIC HOSPITAL AND MEDICAL-SURGICAL EXPENSE COVERAGE
REQUIRED OUTLINE OF COVERAGE

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

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

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

(a) Daily hospital room and board;

(b) Miscellaneous hospital services;

(c) Hospital out-patient services;

(d) Surgical services;

(e) Anesthesia services;

(f) In-hospital medical services; and

(g) Other benefits, if any.

*NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of benefit amounts; durations or limits, elimination periods, inner limits, deductible or co-payment provisions and any other items appropriate to the coverage provided.)

(4) (A description of the exceptions, reductions, and limitations contained in the policy or contract, including the pre-existing conditions provisions, if any, and the circumstances under which any reduction becomes operative.)

(5) (A description of the terms and conditions of renewability of the policy or contract, including any limitation by age, time or event, rights to change premium, status requirements and any other matters appropriate to the terms and conditions of renewability (including any rights of cancellation reserved to the insured).)

Cross References

This section cited in 31 Pa. Code § 88.171 (relating to supplemental insurance coverage).

§ 88.189. Hospital confinement indemnity coverage form.

An outline of coverage, in the form prescribed in this section, shall be issued in connection with policies meeting the standards of § 88.164 of this title (relating to hospital confinement indemnity coverage). The items included in the outline must appear in the sequence prescribed:

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(COMPANY NAME)
(HOME OFFICE ADDRESS)
HOSPITAL CONFINEMENT INDEMNITY COVERAGE
REQUIRED OUTLINE OF COVERAGE

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

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

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

(a) Daily benefit payable during hospital confinement; and

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

(c) Any other benefits provided by the policy.

*NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of benefit amounts, durations or limits, elimination periods, inner limits, deductible or co-payment provisions and any other items appropriate to the coverage provided.)

(4) (A description of the exceptions, reductions and limitations contained in the policy or contract, including the pre-existing conditions provisions, if any, and the circumstances under which any reduction becomes operative.)

(5) (A description of the terms and conditions of renewability of the policy or contract, including any limitation by age, time or event, rights to change premium, status requirements and any other matters appropriate to the terms and conditions of renewability (including any rights of cancellation reserved to the insured).)

Cross References

This section cited in 31 Pa. Code § 88.171 (relating to supplemental insurance coverage).

§ 88.190. Major medical expense coverage form.

An outline of coverage, in the form prescribed in this section, shall be issued in connection with policies meeting the standards of § 88.165 of this title (relating to major medical expense coverage). The items included in the outline must appear in the sequence prescribed:

(COMPANY NAME)
(HOME OFFICE ADDRESS)
MAJOR MEDICAL EXPENSE COVERAGE
REQUIRED OUTLINE OF COVERAGE

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

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

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

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

*NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of benefit amounts, durations or limits, elimination periods, inner limits, deductible or co-payment provisions and any other items appropriate to the coverage provided.)

(4) (A description of the exceptions, reductions and limitations contained in the policy or contract, including the pre-existing conditions provisions, if any, and the circumstances under which any reduction becomes operative.)

(5) (A description of the terms and conditions of renewability of the policy or contract, including any limitation by age, time or event, rights to change premium, status requirements and any other matters appropriate to the terms and conditions of renewability (including any right of cancellation reserved to the insured).)

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Cross References

This section cited in 31 Pa. Code § 88.171 (relating to supplemental insurance coverage).

§ 88.191. Disability income protection coverage form.

An outline of coverage, in the form prescribed in this section, shall be issued in connection with policies meeting the standards of § 88.167 (relating to disability income protection coverage). The items included in the outline must appear in the sequence prescribed:

(COMPANY NAME)
(HOME OFFICE ADDRESS)
DISABILITY INCOME PROTECTION COVERAGE
REQUIRED OUTLINE OF COVERAGE

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

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

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

*NOTE: The description of benefits shall be stated clearly and concisely, and shall include a description of benefit amounts, durations or limits, elimination periods, inner limits, deductible or co-payment provisions and any other items appropriate to the coverage provided.)

(4) (A description of the exceptions, reductions and limitations contained in the policy or contract, including the pre-existing conditions provisions, if any, and the circumstances under which any reduction becomes operative.)

(5) (A description of the terms and conditions of renewability of the policy or contract, including any limitation by age, time or event, rights to change premium, status requirements and any other matters appropriate to the terms and conditions of renewability (including any rights of cancellation reserved to the insured).)

Cross References

This section cited in 31 Pa. Code § 88.171 (relating to supplemental insurance coverage).

§ 88.192. Accident only coverage form.

An outline of coverage, in the form prescribed in this section, shall be issued in connection with policies meeting the standards of § 88.168 (relating to accident only coverage). The items included in the outline must appear in the sequence prescribed:

(COMPANY NAME)
(HOME OFFICE ADDRESS)
ACCIDENT ONLY COVERAGE
REQUIRED OUTLINE OF COVERAGE

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

(2) *Accident Only Coverage*—Policies of this category are designed to provide, to persons insured, payment for certain losses resulting from a covered accident *ONLY,* subject to any limitations contained in the policy. Coverage is *not* provided for any loss due to sickness. Coverage is *not* provided for basic hospital, basic medical-surgical, or major-medical expenses.

(*NOTE: Immediately preceding sentence may be appropriately modified, if necessary, to reflect coverage provided.)

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

*NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of benefit amounts, durations or limits, elimination periods, inner limits, deductible or co-payment provisions and any other items appropriate to the coverage provided.)

(4) (A description of the exceptions, reductions and limitations contained in the policy or contract, including the pre-existing conditions provisions, if any, and the circumstances under which any reduction becomes operative.)

(5) (A description of the terms and conditions of renewability of the policy or contract, including any limitation by age, time or event, rights to change premium, status requirements and any other matters appropriate to the terms and conditions of renewability (including any rights of cancellation reserved to the insured).)

Cross References

This section cited in 31 Pa. Code § 88.171 (relating to supplemental insurance coverage).

§ 88.193. Specified disease or specified accident coverage form.

An outline of coverage, in the form prescribed in this section, shall be issued in connection with policies meeting the standards of § 88.169 (relating to speci-

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fied disease or specified accident coverage). The coverage shall be identified by the appropriate bracketed title. The items included in the outline must appear in the sequence prescribed:

(COMPANY NAME)
(HOME OFFICE ADDRESS)
(SPECIFIED DISEASE) (SPECIFIED ACCIDENT) COVERAGE
REQUIRED OUTLINE OF COVERAGE

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

(2) *(Specified Disease) (Specified Accident) Coverage*—Policies of this category are designed to provide, to persons insured, 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. (*NOTE: Immediately preceding sentence may be appropriately modified, if necessary, to reflect coverage provided.)

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

*NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of benefit amounts, durations or limits, elimination periods, inner limits, deductible or co-payment provisions and any other items appropriate to the coverage provided.)

(4) (A description of the exceptions, reductions and limitations contained in the policy or contract, including the pre-existing conditions provisions, if any, and the circumstances under which any reduction becomes operative.)

(5) (A description of the terms and conditions of renewability of the policy or contract, including any limitation by age, time or event, rights to change premium, status requirements and any other matters appropriate to the terms and conditions of renewability (including any rights of cancellation reserved to the insured).)

Cross References

This section cited in 31 Pa. Code § 88.171 (relating to supplemental insurance coverage).

§ 88.194. [Reserved].

Source

The provisions of this § 88.194 amended September 18, 1981, effective September 20, 1982, 11 Pa.B. 3214; reserved September 15, 1989, effective September 16, 1989, 19 Pa.B. 3945. Immediately preceding text appears at serial pages (65169) to (65171).

Cross References

This section cited in 31 Pa. Code § 88.171 (relating to supplemental insurance coverage).

§ 88.195. Supplemental insurance coverage form.

An outline of coverage, in the form prescribed in this section, shall be issued in connection with policies meeting the standards of § 88.171 (relating to supplemental insurance coverage). The coverage shall be identified by the appropriate bracketed title. The items included must appear in the sequence prescribed:

(COMPANY NAME)
(HOME OFFICE ADDRESS)
SUPPLEMENTAL INSURANCE COVERAGE
REQUIRED OUTLINE OF CONTRACT

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

(2) *(Supplemental Insurance Coverage)*—Policies of this category are designed to provide, to persons insured, limited or supplemental coverage.

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

*NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of benefit amounts, durations or limits, elimination periods, inner limits, deductible or co-payment provisions and any other items appropriate to the coverage provided. Proper disclosure of benefits which vary according to accidental cause shall be made.)

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

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

Cross References

This section cited in 31 Pa. Code § 88.171 (relating to supplemental insurance coverage).

[Next page is 89-1.]

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