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# TITLE 230 – DEPARTMENT OF BUSINESS REGULATION

## CHAPTER 20 – INSURANCE

## SUBCHAPTER 30 – HEALTH INSURANCE

Part 1 – Minimum Standards for Health Benefit Plans

## 1.1 Purpose and Scope

A. The purpose of this Part is to:

1. Provide reasonable standardization and simplification of coverages under health benefits plans, as defined in R.I. Gen. Laws § 42-62-4;

2. Facilitate consumer understanding and comparisons;

3. Eliminate provisions which may be misleading or unreasonably confusing to the consumer in connection with the purchase of such coverages or with the settlement of claims;

4. Eliminate deceptive practices in connection with the sale of such coverages;

5. Eliminate provisions which may be contrary to the health needs of the public; to make available qualified plans to persons residing in the state who apply therefor regardless of age, sex, race, occupational status, or medical condition;

6. Eliminate coverages which are so limited in scope as to be of no substantial economic value to the holders thereof; and

7. Add coverages, the sale of which is required by the public interest to protect the health of persons residing in the State.

B. This Part applies to all health benefits plans issued, delivered or offered for sale in Rhode Island to the extent that such plans cover Rhode Island residents and is not limited to plans described under R.I. Gen. Laws § 42-62-10. This Part does not apply to that portion of any such plans covering participating employers, associations and/or their members located outside this state. This Part applies to all advertisements for health benefits plans intended for presentation, distribution or dissemination in the state.

## 1.2 Authority

This Part is promulgated pursuant to R.I. Gen. Laws § 42-62-12.

## 1.3 Definitions

A. "Accident and sickness insurance" means Accident and sickness insurance as defined in R.I. Gen. Laws Chapter 27-18.

B. "Agent" means an insurance agent, broker or solicitor as defined in R.I. Gen. Laws Chapters 27-2.4. 27-2.4 and 27-3 or any person who acts or aids in negotiation for a Health Benefits Plan on behalf of an insurer, as defined herein. Where this Part requires notices or printed statements referring to "your agent," such notice may refer to the agent as a "sales representative" or use other appropriate terms.

C. "Approval by the Director of Business Regulation" means personal approval by the Director or approval by any duly authorized deputy acting on behalf of the Director.

D. "Blanket health benefit contract" means any health benefit contract which is issued or intended to be issued in at least one of the following manners:

1. Under any contract issued to any railroad, steamship, motorbus or airplane carrier of passengers, which shall be deemed the contractholder, to provide health benefits for a group defined as all persons who become such passengers, insuring them while being such passengers;

2. Under a contract issued to an employer, who shall be deemed the contractholder, to provide health benefits for any group of employees defined by reference to exceptional hazards incident to such employment insuring such employees with respect to such exceptional hazards;

3. Under a contract issued to a college, school or other institution of learning, a school district or districts, or school jurisdictional unit, or to the head, principal or governing board of any such educational unit, who or which shall be deemed the contractholder, covering students, teachers or employees.

4. Under a contract issued to any religious, charitable, recreational, educational, or civic organization, or branch thereof, which shall be deemed the contractholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such contractholder.

5. Under a contract issued to a sports team, camp or sponsor thereof, which shall be deemed the contractholder, covering members, campers, employees, officials or supervisors.

6. Under a contract issued to any volunteer fire department, first aid, civil defense, or other such volunteer organization, which shall be deemed the contractholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such contractholder.

7. Under a contract issued to a newspaper or other publisher, which shall be deemed the contractholder, covering its carriers.

8. Under a contract issued to an association of persons having a common interest or calling which shall have a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance and which shall be deemed the contractholder to provide health benefits for such persons with respect to specific hazards arising out of such common interest or calling.

E. "Director" means the Director of Business Regulation.

F. "Direct response insurance" means insurance issued to an applicant who has himself completed the application and forwarded it directly to the insurer in response to a solicitation coming into his possession by any means of mass communication.

G. "Expense incurred benefits" means a health benefit which promises to pay all or part of the actual expenses incurred by a person insured for covered services.

H. "Group health benefit contract" means that form of health benefit contract covering groups of persons in one of the manners described below, with or without one or more members of their families or one or more dependents, or covering one or more members of the families or one or more dependents of such groups or persons:

1. Benefits are offered under any contract issued to an employer or trustees of a fund established by an employer, who shall be deemed the master contractholder, insuring employees of such employer for the benefit of persons other than the employer. The term "employees as used herein may include the officers, managers, and employees of the employer, the individual proprietor or partner if the employer is an individual proprietor or partnership, the officers, managers, and employees of subsidiary or affiliated corporations, the individual proprietors, partners and employees of individuals and firms, if the business of the employer and such

individual or firm is under common control through stock ownership, contract, or otherwise. The term "employees" as used herein may include retired employees. The term "employees" as used with respect to a contract issued to insure employees of a public body may include elected or appointed officials. The term "employees" may include the trustees or their employees, or both, if their duties are principally connected with such trusteeship.

2. Benefits are offered under any contract issued to an association, including a labor union, which shall have a constitution and bylaws insuring members, employees, or employees of members of the association for the benefit of persons other than the association or its officers or trustees. The term "employees" as used herein may include retired employees.

3. Benefits are offered under any contract issued to the trustees of a fund established by two or more employers or by one or more labor unions or by one or more employers and one or more labor unions or by an association as defined in § 1.3(H)(2) of this Part which trustees shall be the master contractholder, to insure employees of the employers or members of the unions or of such association, or employees of members of such association for the benefit of persons other than the employers or the unions or such association. The term "employees" as used herein may include the officers, managers and employees of the employer, and the individual proprietor or partners if the employer is an individual proprietor or partnership. The term "employees" as used herein may include retired employees. The term "employees" may include the trustees or their employees, or both, if their duties are principally connected with such trusteeship.

4. Benefits are offered under any contract issued to cover any other group which in the Director's judgment is substantially similar to those described in § 1.3(H)(1) through (3) of this Part.

I. "Group-type basis" means a health benefit plan, other than "salary budget" plans utilizing individual contracts, which meets the following conditions:

1. Coverage is provided through health benefit contracts to classes of employees or members defined in terms of conditions pertaining to employment or membership.

2. The coverage is not available to the general public and can be obtained and maintained only because of the covered person's membership in or connection with the particular organization or group.

3. There are arrangements for bulk payment of premiums or subscription charges to the insurer.

4. There is sponsorship of the plan by the employer, union or association.

J. "Health benefit contract" means any policy or other contract issued, delivered or available for issue or delivery in Rhode Island by an insurer, as defined herein, which provides health benefits, as defined in R.I. Gen. Laws § 42-62-4 including both contracts which determine benefits in recognition of actual services or actual charges for services and contracts which determine benefits based on the status of hospitalization or receipt of medical treatment. Where this Part requires notices or printed statements referring to "this contract," such notice may refer to the contract as a "policy" whenever such term appropriately describes such contract. "Health benefit contract" shall also mean that portion of an accident and sickness insurance policy or life and accident and sickness insurance policy that provides health benefits, if such health benefits account for one- third (1/3) or more of the pure premium (i.e., that portion of the total premium needed for payment of benefits, exclusive of all portions of the premium intended to pay sales and administrative costs.) for accident and sickness insurance in such policy.

K. "Health maintenance organization" shall have the same meaning as that given such term in R.I. Gen. Laws § 42-62-4(d).

L. "Indemnity basis" means, with respect to Hospital Confinement Indemnity Coverage, that basis for determining benefits which depends solely on the insured person's being confined in a hospital and provides for payment of a stated amount per day of hospital confinement without regard to actual services rendered or expenses incurred during such confinement.

M. "Individual health benefit contract" means any health benefit contract that is not a group health benefit contract or a blanket health benefit contract.

N. "Insured" means any resident of the State of Rhode Island who is entitled to receive benefits in the form of cash or services under a health benefit contract.

O. "Insurance" means the benefits provided by any health benefit contract, as defined herein.

P. "Insurer" shall have the same meaning as that given such term in R.I. Gen. Laws § 42- 62-4(c).

Q. "Premium" means the consideration for any health benefit contract, including, but not limited to, the premium for an accident and sickness insurance policy and the

subscription fee charged by a hospital service corporation, physicians service corporation or health maintenance organization.

R. "Qualified plan" means a qualified health program as defined in R.I. Gen. Laws § 42-62-10.

S. "Replacement" means any transaction wherein a new health benefit contract is to be purchased, and it is known to the agent or insurer at the time of application that as part of the transaction, an existing health benefit contract has been or is to be lapsed or the benefits thereof substantially reduced.

T. "Service benefit" means a health benefit which promises to defray the cost of health services provided to a person insured but which reserves the right to make payments directly to the provider and may reserve the right to negotiate the amount of payment for such services with the provider.

## 1.4 Availability of Qualified Plans

The Director shall from time to time consider whether a sufficient number of qualified plans is available to persons residing in the state regardless of age, sex, race, occupational status or medical condition. If he determines that a sufficient number of such plans is not available he may promulgate regulations requiring all insurers or all of a class of insurers to offer qualified plans as a condition of doing business in the state.

## 1.5 Coverage of Newborn Children

A. All health benefit contracts which provide coverage for a family member of the insured or subscriber shall, as to such family member's coverage, also provide that the health benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth. In the event that no other children are covered under the contract, benefits for the newborn must be provided to the same extent as those provided to the insured.

B. The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. This provision is not intended to imply, and should not be construed so as to imply, the inclusion of coverages for routine well-baby care services.

C. If payment of a specific premium is required to provide coverage for a child, the contract may require that notification of birth of a newly born child and payment of the required premium must be furnished to the insurer within thirty-one (31)

days after the date of birth in order to have the coverage continue beyond such thirty-one (31) day period.

## 1.6 Statements in the Application for Health Benefit Contracts

A. No application designed to elicit information regarding the applicant's physical condition or that of his dependents shall be used in this state in connection with any health benefit contract which by its terms permits the insurer to reduce or deny a claim or avoid the contract on the grounds that misstatements were made by the insured in the application unless a statement is made which satisfies the requirements of § 1.6(A)(1) or (2) of this Part.

1. A statement contained in the application to be signed by the applicant which states that he has read or has had read to him all questions and answers contained in the application and that any misstatements made by him may allow the insurer to reduce or deny a claim or avoid the contract within the contestable period.

    a. The following statement is acceptable:

        (1) I hereby certify that I have read the above statements or that they have been read to me and that the above statements are true and complete to the best of my knowledge and belief. I understand that any misrepresentation contained herein relied on by the Company may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of the risk.

    b. The Director may approve any other statement that clearly expresses the same intent as the above statement.

2. A statement furnished to the applicant, within ten (10) days of the issuance of a contract or amendment of a contract, in the form of a sticker to be attached to the first page of the contract, a letter or other form containing substantially the following:

    a. Please read the copy of the application attached to this notice or to your contract. Omissions or misstatements in the application could cause an otherwise valid claim to be denied or cause your contract to be voided or reformed. Carefully check the application and write to the insurer within ten (10) days if any information shown on the application is not correct and complete or if any medical history has not been included. The application is part of the insurance contract.

The insurance contract was issued on the basis that the answers to all questions and any other material information shown on the application are correct and complete.

B. Each insurer shall instruct its agents that such agents must ascertain whether each applicant is able to read and understand the English language. When questions or answers on such application are written in English and the applicant is unable to read and/or understand English, the agent must read or interpret or have someone else interpret all questions and answers in such manner that they could reasonably be expected to be understood by the applicant.

1. Each insurer shall file with the Director a description of the procedure it will follow and the form or forms it will use to meet the requirements of § 1.6 of this Part.

## 1.7 Individual Health Benefit Contracts

### 1.7.1 Purpose, Applicability, and Definitions

A. The purpose of this part is to provide reasonable standardization and simplification of terms and coverages of individual health benefit contracts in order to facilitate public understanding and comparison and to eliminate provisions contained in individual health benefit contracts which may be misleading or confusing in connection either with the purchase of such coverages or with the settlement of claims and to provide for full disclosure in the sale of such coverages.

B. This part shall apply to all individual health benefit contracts delivered or issued for delivery in this state on or after the effective date hereof, except it shall not apply to individual health benefit contracts issued pursuant to a conversion privilege under a group health benefit contract or individual health benefit contract when such group or individual contract includes provisions which are inconsistent with the requirements of this Part, nor to health benefit contracts being issued to employees or members as additions to franchise plans in existence on the effective date of this Part. Neither shall this part apply to health benefit contracts issued by a health maintenance organization which has been certified as a health maintenance organization by the United States Secretary of Health, Education and Welfare for purposes of compliance with Section 1310 of Public Law 93-222 nor shall it apply to health benefit contracts issued by a health maintenance organization which has been certified as a health maintenance organization by the State of Rhode Island Director of Health for purposes of compliance with R.I. Gen. Laws § 42-62-9. The requirements contained in this Part shall be in addition to any other applicable laws and regulations.

C. Except as provided hereafter, no individual health benefit contract delivered or issued for delivery to any person in this State shall contain definitions respecting the matters set forth below unless such definitions comply with the requirements of § 1.7.1 of this Part.

1. "Accident," "Accidental Injury," "Accidental Means," shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

a. The definition shall not be more restrictive than the following: Injury or injuries, for which benefits are provided, means accidental bodily injury sustained by the insured person which is the direct cause, independent of disease or bodily infirmity or any other cause and occurs while the insurance is in force.

b. Such definition may provide that injuries shall not include injuries for which benefits are provided under any workmen's compensation, employer's liability or similar law, motor vehicle no fault plan, unless prohibited by law, or injuries occurring while the insured person is engaged in any activity pertaining to any trade, business, employment or occupation for wage or profit.

2. "Convalescent Nursing Home," "Extended Care Facility," or "Skilled Nursing Facility" shall be defined in relation to its status, facilities and available services and, only with respect to insurers permitted to contract with convalescent nursing homes, extended care facilities or skilled nursing facilities under R.I. Gen. Laws Chapter 27-19 such facilities may be defined to include only "contracting" facilities with which the insurer or another insurer with similar powers in another state has made a contract for the provision of services to its subscribers.

a. A definition of such home or facility shall not be more restrictive than one requiring that it:

(1) Be operated pursuant to law and, with respect to insurers permitted to contract with such facilities, be a contracting facility;

(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 twenty-four (24) hour 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 of facility for the aged or for the care of drug addicts or alcoholics; or

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

3. "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals and, only with respect to insurers permitted to contract with hospitals under R.I. Gen. Laws § 27-19-5 "hospital" may be defined to include only "contracting" hospitals with which the insurer or another insurer with similar powers in another state has made a contract for the provision of services to its subscribers.

a. The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

(1) Be an institution operated pursuant to law and, with respect to insurers permitted to contract with hospitals, be a contracting hospital; and

(2) Be primarily and continuously engaged in providing or operating either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and

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

b. The definition of the term "hospital" may state that such term shall not be inclusive of:

(1) Convalescent homes, convalescent, rest or nursing facilities; or

(2) Facilities primarily affording custodial, educational or rehabilitory care; or

(3) Facilities for the aged, drug addicts, or alcoholics; or

(4) Any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services, except that, with respect to "Hospital Confinement Indemnity Coverage," the same benefits must be provided for the first thirty five (35) days of any one confinement in any of the above government hospitals as is provided for confinement in any other hospital. Benefits for confinement in any of the above government hospitals may be reduced after the 35th day of confinement to no less than 2/3 of the benefit payable for confinement in any other hospital.

4. "Medicare" may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or later Amended," or "Title I, Part I of Public Laws 89- 97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof" or words of similar import.

5. "Mental or Nervous Disorders" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

6. "Nurses" may be defined so that the description of nurse is restricted to a type of nurse, such as a registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the words "nurse," "trained nurse," or "registered nurse" are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualifies under such

terminology in accordance with R.I. Gen. Laws Chapter 5-34 and any administrative rules of the Board of Nursing Registration and Nursing Education or in accordance with similar laws or rules of other states.

7. "One period of confinement" means consecutive days of in-hospital service received as an in-patient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time not more than ninety (90) days or three (3) times the maximum number of days of in-hospital coverage provided by the policy to a maximum of one hundred eighty (180) days.

8. "Physician" may be defined by including words such as "legally qualified physician" or "legally licensed physician." The use of such terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws, except to the extent provided to the contrary in R.I. Gen. Laws Title 27.

9. "Pre-Existing Condition" shall not be defined to be more restrictive than the following: Pre-existing condition means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a thirty six (36) month period preceding the effective date of the coverage of the insured person; or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a thirty six (36) month period preceding the effective date of coverage of the insured person.

    a. This definition does not prohibit an insurer, using an application form designed to elicit the complete health history of a prospective insured and on the basis of the answers on that application, from underwriting in accordance with that insurer's established standards. It is assumed that an insurer that elicits a complete health history of a prospective insured will act on the information and if the review of the health history results in a decision to exclude a condition, the policy will be endorsed or amended by including the specific exclusion. This same requirement of notice to the prospective insured of the specific exclusion will also apply to insurers which elect to use simplified application forms containing questions relating to the prospective insured's health.

    b. This definition does, however, prohibit an insurer that elects to use a simplified application, with or without a question as to the applicant's health at the time of application, from reducing or

denying a claim on the basis of the existence of a pre-existing condition that is defined more restrictively than above.

10. "Sickness" shall not be defined to be more restrictive than the following: Sickness means sickness or disease of an insured person which first manifests itself after the effective date of the insurance and while the insurance is in force. A definition of sickness may provide for a probationary period which will not exceed thirty (30) days from the effective date of the coverage of the insured person. The definition may be further modified to exclude sickness or accident for which benefits are provided under any workman's compensation, occupational disease, employer's liability or similar law.

### 1.7.2 Prohibited Contract Provisions

A. Except as provided in § 1.7.1(C)(10) of this Part, no contract shall contain provisions establishing a probationary or waiting period during which no coverage is provided under the contract subject to the further exception that a contract may specify a probationary or waiting period not to exceed six (6) months for losses resulting from hernia, disorder of reproduction organs, varicose veins, adenoids, appendix and tonsils. However, the permissible six (6) months exception shall not be applicable where such specified diseases or conditions are treated on an emergency basis. Accident contracts shall not contain probationary or waiting periods.

B. No contract or rider for additional coverage may be issued as a dividend unless an equivalent cash payment is offered to the contractholder as an alternative to such dividend contract or rider. No such dividend contract or rider shall be issued for an initial term of less than six (6) months.

1. The initial renewal subsequent to the issuance of any contract or rider as a dividend shall clearly disclose that the contractholder is renewing the coverage that was provided as a dividend for the previous term and that such renewal is optional with the contractholder.

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

D. No contract shall limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:

1. Pre-existing conditions or diseases, except for congenital anomalies of a covered dependent child; [This exclusion shall not be interpreted so as to reduce any benefits required to be provided for newborn children in § 1.5 of this Part]

2. Mental or emotional disorders, alcoholism and drug addiction;

3. Pregnancy, except for complications of pregnancy;

4. Illness, treatment or medical condition arising out of:

    a. war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the armed forces or units auxiliary thereto,

    b. suicide (sane or insane), attempted suicide or intentionally self-inflicted injury,

    c. aviation,

    d. with respect to short-term non-renewable contracts, interscholastic sports;

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

6. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;

7. Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof where such interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;

8. Treatment provided in a government hospital, however, contracts providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the Federal Government; benefits provided under Medicare or other governmental program (except Medicaid), any state or federal workmen's compensation, employers liability or occupational disease law,

or any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institution; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.

a. Benefits provided by R.I. Gen. Laws Chapter 42-62, are, by their nature, supplemental to all health benefit contracts and are not to be treated as benefits provided under a governmental program for purposes of this exclusion.

9. Dental care or treatment;

10. Eye glasses, hearing aids and examination for the prescription or fitting thereof;

11. Rest cures, custodial care, transportation and routine physical examinations;

12. Territorial limitations.

E. Other provisions of § 1.7 of this Part shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described pre-existing diseases, physical condition or extra hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required unless on initial issuance the full text of the waiver is contained either on the first page or specification page of the contract or unless notice of the waiver appears on the first page or specification page.

F. Contract provisions precluded in § 1.7.2 of this Part shall not be construed as a limitation on the authority of the Director to disapprove other contract provisions which, in the opinion of the Director, are unjust, unfair or unfairly discriminatory to the contractholder, beneficiary or any person insured under the contract; nor shall such provisions be construed as a limitation on the authority of the director to approve other exclusions which he finds to be in the interest of the public.

### 1.7.3 Minimum Standards for Benefits

A. The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. Except as provided in § 1.7.3(H) of this Part no individual health benefit contract shall be delivered or issued for delivery in this state which does not meet the required minimum standards for the specified categories unless the Director finds that such contracts are approvable as Limited Benefit Health Contracts and the Outline of Coverage complies with the appropriate outline in § 1.7.4 (H) of this Part.

B. Nothing in § 1.7.3 of this Part shall preclude the issuance of any contract combining two (2) or more categories of coverage defined in § 1.7.3 of this Part or combining one (1) or more categories of coverage defined in § 1.7.3 of this Part with life insurance or with any form of policy of Accident and Sickness insurance or health benefit contract that may legally be issued in this State.

C. General Rules

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

2. The terms "non-cancelable," "guaranteed renewable" or "non-cancelable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of § 1.7.4(A)(1) and (2) of this Part. The terms "non-cancelable" or "Non-cancelable and guaranteed renewable" may be used only in a health benefit contract which the insured has the right to continue in force by the timely payment of premiums set forth in the contract until the age of sixty-five (65) or to eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the contract while the contract is in force. The term "guaranteed renewable" may be used only in a contract which the insured has the right to continue in force by the timely payment of premiums until the age of sixty-five (65) or to eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the contract while the contract is in force, except that the insurer may make changes in premium rates by classes.

3. In a family contract covering both husband and wife, the age of the younger spouse must be used as the basis for meeting the age and durational requirements of the definitions of "non-cancelable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age limit (e.g., age 65) so long as the contract may be continued in force as to the younger spouse to the age or for the duration period as specified in said definition.

4. If a contract contains a status type military service exclusion or a provision which suspends coverage during military service, the contract shall

provide, upon receipt of written request, for refund of premiums as applicable to such person on a pro rata basis.

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

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

7. Family coverage shall continue for any dependent child who is incapable of self-sustaining employment due to mental retardation or physical handicap on the date that such child's coverage would otherwise terminate under the contract due to the attainment of a specified age limit for children and is chiefly dependent on the insured for support and maintenance. The contract may require that within thirty-one (31) days of such date the insurer receive due proof of such incapacity in order for the insured to elect to continue the contract in force with respect to such child, or that a separate converted contract be issued at the option of the insured or contractholder.

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

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

10. Any accident only contract providing benefits which vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits are payable which are lesser than the maximum amount payable under the contract.

11. No contract that provides in-hospital benefits only shall be represented in any manner to be a supplement to Medicare unless it shall include in its provided benefits the initial Part A Medicare deductible as established from time to time by the Social Security Administration. Premiums may be reduced or raised to correspond with changes in the covered deductible,

subject to approval by the Director of each proposed reduction or increase.

12. Termination of the contract shall be without prejudice to any continuous loss which commenced while the contract was in force, but the extension of benefits beyond the period the contract was in force may be predicated upon the continuous disability of the insured, limited to the duration of the benefit period, if any, or payment of the maximum benefits.

D. Basic Hospital Expense Coverage

1. "Basic Hospital Expense Coverage" is a health benefit contract which provides coverage for a period of not less than thirty-one (31) days during any one period of confinement for each person insured under the contract, for expense incurred for necessary treatment and services rendered as a result of accident or sickness or which provides service benefits of equivalent value to the insured for at least the following:

a. Daily hospital room and board in an amount not less than the lesser of:

(1) eighty percent (80%) of the charges for semi-private room accommodations or

(2) fifty dollars ($50) per day.

b. Miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use during any period of confinement in an amount not less than either eighty percent (80%) of the charges incurred up to at least one thousand eight hundred ($1,800) or ten times the daily hospital room and board benefits; and

c. Hospital outpatient services consisting of (a) hospital services on the day surgery is performed, and (b) hospital services rendered within 24 hours after accidental injury, in an amount not less than nine hundred dollars ($900).

d. Benefits provided § 1.7.3(D)(1)(a) and (b) of this Part above may be provided subject to a combined deductible amount not in excess of one hundred fifty ($150).

e. The above benefits may be provided in the form of equivalent services in lieu of reimbursement of actual expenses.

E. Basic Medical-Surgical Expense Coverage

1. "Basic Medical-Surgical Expense Coverage" is a health benefit contract which provides coverage for each person insured under the contract for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness or which provides service benefits of equivalent value to the insured for at least the following:

    a. Surgical services;

        (1) In amounts not less than those provided on a fee schedule based on the relative values contained in the State of New York certified surgical fee schedule, except that each relative value shall be multiplied by four dollars and fifty cents ($4.50) instead of the two dollars and fifty cents ($2.50) specified in the New York certified fee schedule; or other acceptable relative value scale of surgical procedures, up to a maximum of at least nine hundred dollars ($900) for any one procedure; or

        (2) Not less than eighty percent (80%) of the usual and customary charges.

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

        (1) In an amount not less than eighty percent (80%) of the usual and customary charges; or

        (2) fifteen percent (15%) of the surgical service benefit.

    c. In-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than eighty (80%) of the reasonable charges; or eight dollars ($8.00) per day for not less than twenty-one (21) days during one continuous hospital confinement.

F. Hospital Confinement Indemnity Coverage

1. "Hospital Confinement Indemnity Coverage" is a health benefit contract which provides daily benefits for hospital confinement on an indemnity

basis in an amount not less than fifty dollars ($50) per day and not less than thirty-one (31) days during any one period of confinement for each person insured under the contract.

G. Major Medical Expense Coverage

1. "Major Medical Expense Coverage" is a health benefit contract which provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than $10,000; copayment by the covered person not to exceed twenty five percent (25%), fifty percent (50%) in the case of the expense of diagnosis and treatment of mental and nervous disorders, of covered charges, a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of such bases not to exceed five percent (5%) of the aggregate maximum limit under the contract, unless the contract 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 (In no event, however, may the deduction of benefits of an underlying plan be applied to reduce the aggregate maximum.), for each covered person for at least:

   a. Daily hospital room and board expense, prior to application of the co- payment percentages, for not less than ninety dollars ($90) daily (or in lieu thereof the average daily cost of semi-private room rate in the State of Rhode Island) for a period of not less than thirty-one (31) days during continuous hospital confinement;

   b. Miscellaneous Hospital Services, prior to application of co-payment percentage, for an aggregate maximum of not less than two thousand six hundred dollars ($2,600) or fifteen (15) times the daily room and board rate if specified in dollar amounts;

   c. Surgical Services, prior to application of co-payment percentage to a maximum of not less than one thousand one hundred dollars ($1,100) for the most severe operation with the amounts provided for other operations reasonably related to such maximum amount;

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

e. In-Hospital Medical Services, prior to application of the co-payment percentage, as defined in § 1.7.5(E)(1)(c) of this Part.

f. Out of Hospital Care, prior to application of the co-payment percentage, consisting of usual and customary charges for physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the contract, for diagnosis and treatment of sickness or injury, and for diagnostic x-ray, laboratory services, radiation therapy and hemodialysis ordered by a physician; and

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

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

(2) Convalescent nursing home care.

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

(4) Rental of special medical equipment, as defined by the insurer in the contract.

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

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

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

H. Limited Health Benefit Coverage

"Limited Health Benefit Coverage" is any contract which provides benefits that are less than the minimum standards for benefits required under § 1.7.3(D), (E), (F) and (G) of this Part or any other health benefit contract which does not satisfy the requirements of § 1.7.3(D), (E), (F) and (G) of this Part. Such policies or contracts may be issued or issued for delivery in this state only if the outline of coverage required by § 1.7.4(H) of this Part is completed and delivered as required by § 1.7.4(B) of this Part.

### 1.7.4 Required Disclosure Provisions

A. General Rules

1. Each individual health benefit contract shall include a renewal, continuation, or nonrenewal provision. The language or specifications of such provision must be consistent with the type of contract to be issued. Such provision shall be appropriately captioned, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the contract is issued and for which it may be renewed.

2. No health benefit contract shall be delivered or issued for delivery to any person in this state unless provisions respecting renewability or cancellability by the insurer shall appear on the first page of the contract or reference shall be made thereto in a brief description of the first page. For purposes of this requirement, the "first page" shall include any parts of other pages which are visible at the same time as the first page through a cut out section of the first page or below a shortened first page.

3. The following texts for the brief description are considered as among those which would be acceptable:

    a. Cancelable at Option of Company

    b. Renewal Subject to Consent of Company

    c. Renewal Subject to Company Consent

    d. Renewal at Option of Company

4. A more general statement such as the following is not acceptable:

    a. SEE SPECIAL RENEWAL PROVISION

    b. The above captions are recommended without prejudice to the right of an insurer to submit another caption, subject to approval by the Director, which it believes is equally clear or more definite as to the subject matter.

5. If a contract contains a cancellation provision, the existence of the cancellation provisions must be referred to in the renewal provision by a specific cross reference to the cancellation provision in the Renewal Provision on the first page of the contract.

6. Except for riders or endorsements by which the insurer effectuates a request made in writing by the contractholder or exercises a specifically reserved right under the contract, all riders or endorsements added to a contract after date of issue or at reinstatement or renewal which reduce or

eliminate benefits or coverage in the contract shall require signed acceptance by the contractholder. After date of contract issue, any rider or endorsement which increases benefits or coverage with concomitant increase in premium during the contract term must be agreed to in writing signed by the insured, unless the increased benefit or coverage is required by law.

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

8. A contract which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

9. If a contract contains any limitations with respect to pre-existing conditions such limitations must appear as a separate paragraph of the contract and be labeled as "Pre-existing Condition Limitation".

10. All accident only contracts shall contain a prominent statement on the first page of the contract or attached thereto in either contrasting color or in boldface type at least equal to the size of type used for policy captions, a prominent statement as follows: "This is an accident only contract and it does not pay benefits for loss from sickness."

11. All contracts, except single premium nonrenewable contracts, shall have a notice prominently printed on the first page of the contract or attached thereto stating in substance that the contractholder shall have the right to return the contract within ten (10) days of its delivery and to have the premium refunded if after examination of the contract the contractholder is not satisfied for any reason.

12. If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the contract as originally issued, such fact must be prominently set forth in the outline of coverage.

13. If a contract contains a conversion privilege, it shall comply, in substance, with the following: The caption of the provision shall be "Conversion Privilege," or words of similar import. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised. The provision shall specify the benefits to be provided on conversion or may state that

the converted coverage will be as provided on a contract form then being used by the insurer for that purpose.

B. Outline of Coverage Requirements for Individual Coverages

1. No individual health benefit contract subject to this Part shall be delivered or issued for delivery in this State unless an appropriate outline of coverage, as prescribed in § 1.7.4 (C) through (H) of this Part is completed as to such contract; and

   a. Is either delivered with the contract; or

   b. Delivered to the applicant at the time application is made and acknowledgement of receipt or certification of delivery of such outline of coverage is provided to the insurer.

2. If an outline of coverage was delivered at the time of application and the contract is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the contract must accompany the contract when it is delivered and contain the following statement, in no less than twelve (12) point type, immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

3. The appropriate outline of coverage for contracts providing hospital coverage which only meets the standards of § 1.7.3(D) of this Part shall be that statement contained in § 1.7.4(G) of this Part. The appropriate outline of coverage for contracts providing coverage which meets the standards of both § 1.7.3(D) and (E) of this Part shall be the statement contained in § 1.7.4(E) of this Part. The appropriate outline of coverage for contracts providing coverage which meets the standards of both §§ 1.7.3(D) and (G) or § 1.7.3(D), (E) and (G) of this Part shall be the statement contained in § 1.7.4(G) of this Part.

4. Appropriate changes in terminology may be made in outlines of coverages in the case of contracts of nonprofit hospital, medical, or dental service corporations as defined in R.I. Gen. Laws Title 27. In any other case where the prescribed outline of coverage is inappropriate for the coverage provided by the contract, an alternate outline of coverage shall be submitted to the Director for prior approval.

C. Basic Hospital Expense Coverage (Outline of Coverage).

1. An outline of coverage, in the form prescribed below, shall be issued in connection with contracts meeting the standards of § 1.7.3(D) of this Part. The items included in the outline of coverage must appear in the sequence prescribed:

   a. (INSURER'S NAME)

   b. BASIC HOSPITAL EXPENSE COVERAGE

   c. OUTLINE OF COVERAGE

   d. Read Your Contract Carefully -- This outline of coverage provides a very brief description of the important features of your contract. This is not the insurance contract and only the actual contract provisions will control.

      (1) The contract itself sets forth in detail the rights and obligations of both you and your insurer. It is, therefore, important that you READ YOUR CONTRACT CAREFULLY! (Instead of the word "contract," the word "policy" may be used where appropriate).

   e. Basic Hospital Expense Coverage -- Contracts of this category are designed to provide to persons insured coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, and hospital out-patient services, subject to any limitations, deductibles and co-payment requirements set forth in the contract. Coverage is not provided for physicians or surgeons fees or unlimited hospital expenses.

   f. A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this contract, in the following order;

      (1) Daily hospital room and board;

      (2) Miscellaneous hospital services;

      (3) Hospital outpatient services; and

      (4) Other benefits, if any.

      (5) (Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any

deductible or co-payment provision applicable to the benefits described.)

g. (A description of any contract provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in § 1.7.4(C)(1)(f) of this Part.)

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

D. Basic Medical-Surgical Expense Coverage (Outline of Coverage) –

1. An outline of coverage, in the form prescribed below, shall be issued in connection with contracts meeting the standards of § 1.7.3(E)of this Part. The items included in the outline of coverage must appear in the sequence prescribed:

a. (INSURER'S NAME)

b. BASIC MEDICAL-SURGICAL EXPENSE COVERAGE

c. OUTLINE OF COVERAGE

d. Read Your Contract Carefully -- This outline of coverage provides a very brief description of the important features of your contract. This is not the insurance contract and only the actual contract provisions will control. The contract itself sets forth in detail the rights and obligations of both you and your insurer. It is, therefore, important that you READ YOUR CONTRACT CAREFULLY! (Instead of the word "contract," the word "policy" may be used where appropriate.)

e. Basic Medical-Surgical Expense Coverage -- Contracts of this category are designed to provide to persons insured coverage for medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services, and in-hospital medical services, subject to limitations, deductibles and co-payment requirements set forth in the contract. Coverage is not provided for hospital expenses or unlimited medical surgical expenses.

f. A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this contract in the following order:

(1) Surgical services;

(2) Anesthesia services;

(3) In-hospital medical services; and

(4) Other benefits, if any.

(5) (Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.)

g. (A description of any contract provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in § 1.7.4(D)(1)(f) of this Part.)

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

E. Basic Hospital and Medical Surgical Expense Coverage (Outline of Coverage) –

1. An outline of coverage, in the form prescribed below, shall be issued in connection with contracts meeting the standards of § 1.7.3(D) and (E) of this Part. The items included in the outline of coverage must appear in the sequence prescribed:

a. (INSURER'S NAME)

b. BASIC HOSPITAL AND MEDICAL SURGICAL EXPENSE

c. COVERAGE OUTLINE OF COVERAGE

d. Read Your Contract Carefully -- This outline of coverage provides a very brief description of the important features of your contract. This is not the insurance contract and only the actual contract provisions will control. The contract itself sets forth in detail the rights and obligations of both you and your insurer. It is, therefore, important that you READ YOUR CONTRACT CAREFULLY! (Instead of the word "contract," the word "policy" may be used where appropriate.)

e. Basic Hospital and Medical Surgical Expense Coverage -- Contracts 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 outpatient services, surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and co-payment requirements set forth in the contract. Coverage is not provided for unlimited hospital or medical surgical expenses.

f. A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this contract, in the following order:

(1) Daily hospital room and board;

(2) Miscellaneous hospital services;

(3) Hospital outpatient services;

(4) Surgical services;

(5) Anesthesia services;

(6) In-hospital medical services; and

(7) Other benefits, if any.

g. (Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.)

h. (A description of any contract provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in § 1.7.4(E)(1)(f) of this Part.)

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

F. Hospital Confinement Indemnity Coverage (Outline of Coverage) –

1. An outline of coverage, in the form prescribed below, shall be issued in connection with contracts meeting the standards of § 1.7.3(F) of this Part. The items included in the outline of coverage must appear in the sequence prescribed:

a. (INSURER'S NAME)

b. HOSPITAL CONFINEMENT INDEMNITY COVERAGE

c. OUTLINE OF COVERAGE

d. Read Your Contract Carefully -- This outline of coverage provides a very brief description of the important features of your contract. This is not the insurance contract and only the actual contract provisions will control. The contract itself sets forth in detail the rights and obligations of both you and your insurer. It is, therefore, important that you READ YOUR CONTRACT CAREFULLY! (Instead of the word "contract," the word "policy" may be used where appropriate.)

e. Hospital Confinement Indemnity Coverage -- Contracts 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 and any additional benefit described below, subject to any limitations set forth in the contract. Such contracts do not provide any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.

f. (A brief specific description of the benefits in this contract, in the following order:

(1) Daily benefit payable during hospital confinement; and

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

(3) (Note: The above description of benefits shall be stated clearly and concisely.)

g. (A description of any contract provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in § 1.7.4(F)(1)(f) of this Part.)

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

i. (Any benefits provided in addition to the daily hospital benefit.)

G. Major Medical Expense Coverage (Outline of Coverage) –

1. An outline of coverage, in the form prescribed below, shall be issued in connection with contracts meeting the standards of § 1.7.3(G) of this Part. The items included in the outline of coverage must appear in the sequence prescribed:

   a. (INSURER'S NAME)

   b. MAJOR MEDICAL EXPENSE COVERAGE

   c. OUTLINE OF COVERAGE

   d. Read Your Contract Carefully -- This outline of coverage provides a very brief description of the important features of your contract. This is not the insurance contract and only the actual contract provisions will control. The contract itself sets forth in detail the rights and obligations of both you and your insurer. It is, therefore, important that you READ YOUR CONTRACT CAREFULLY! (Instead of the word "contract," the word "policy" may be used where appropriate.)

   e. Major Medical Expense Coverage -- Contracts of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in- hospital medical services, and out of hospital care, subject to any deductibles, co-payment provisions, or other limitations which may be set forth in the contract. Basic hospital or basic medical insurance coverage is not provided. (If, in accordance with § 1.7.4(B)(3) of this Part this form of outline is used for coverage which meets the standards of § 1.7.3(D) and (G) or § 1.7.3(D), (E) and (G) of this Part the preceding sentence shall be omitted and an appropriate description in accordance with §§ 1.7.4(C)(3) or (E)(3) of this Part shall be included.)

   f. (A brief specific description of the benefits, including dollar amounts, contained in this contract, in the following order:

      (1) Daily hospital room and board;

      (2) Miscellaneous hospital services;

      (3) Surgical services;

      (4) Anesthesia services;

(5) In-hospital medical services;

(6) Out of hospital care;

(7) Maximum dollar amount for covered charges; and

(8) Other benefits, if any.)

(9) (Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.)

g. (A description of any contract provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in §1.7.4(G)(1)(f) of this Part above.)

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

H. Limited Benefit Health Coverage (Outline of Coverage) –

1. An outline of coverage, in the form prescribed below, shall be issued in connection with contracts which do not meet the minimum standards of §1.7.4(D), (E), (F) and (G) of this Part. The items included in the outline of coverage must appear in the sequence prescribed:

a. (INSURER'S NAME)

b. LIMITED BENEFIT HEALTH COVERAGE

c. OUTLINE OF COVERAGE

d. Read Your Contract Carefully -- This outline of coverage provides a very brief description of the important features of your contract. This is not the insurance contract and only the actual contract provisions will control. The contract itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR CONTRACT CAREFULLY! (Instead of the word "contract," the word "policy" may be used where appropriate.)

e. Limited Benefit Health Coverage -- Contracts of this category are designed to provide, to persons insured, limited or supplemental coverage.

f. (A brief specific description of the benefits, including dollar amounts, contained in this policy.)

g. (Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with § 1.7.3(C)(10) of this Part.

h. (A description of any contract provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in in § 1.7.4(H)(1)(f) of this Part.)

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

### 1.7.5 Replacement of Individual Health Benefit Contracts

A. Application forms, except applications designed exclusively for use with accident only and single premium non-renewable contracts, shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any health benefit contract presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

B. Upon determining that a sale will involve replacement, an insurer, other than an insurer offering direct response insurance or its agent shall furnish the applicant, prior to issuance or delivery of the contract, the notice described in § 1.7.5(C) of this Part. One (1) copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. An insurer offering direct response insurance shall deliver to the applicant upon issuance of the contract, the notice described in § 1.7.5(D) of this Part. In no event, however, will such a notice be required in the solicitation of the following types of contracts: accident only and single premium non-renewable contracts.

C. The notice required by § 1.7.5(B) of this Part for an insurer, other than an insurer offering direct response insurance, shall provide, in substantially the following form:

1. NOTICE TO APPLICANT REGARDING REPLACEMENT OF HEALTH BENEFIT CONTRACTS

2. According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing health benefits and replace them with a contract to be issued by (Insurer's Name). 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 contract.

   a. Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present contract.

   b. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present contract. 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.

   c. If, after due consideration, you still wish to terminate your present contract and replace it with new coverage, be certain to answer truthfully and completely 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 contract 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.

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

      (1) (Date)

      (2) (Applicant's Signature)

   e. Note: The term "accident and sickness insurance" may be used instead of "health benefits" or "health benefit contracts." "Policy" may be used instead of "contract."

D. The notice required by § 1.7.5(B) of this Part for an insurer offering direct response insurance shall be as follows:

1. NOTICE TO APPLICANT REGARDING REPLACEMENT OF HEALTH BENEFIT CONTRACTS

2. According to (your application) (information you have furnished) you intend to lapse or otherwise terminate existing health benefits and replace them with the contract delivered herewith issued by (Insurer's Name). Your new contract provides 10 days within which you may decide without cost whether you desire to keep the contract. 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 contract.

    a. Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present contract.

    b. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present contract. 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 contract.

    c. (To be included only if the application is attached to the contract.) If, after due consideration, you still wish to terminate your present contract and replace it with new coverage, read the copy of the application attached to your new contract 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 (Insurer's 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.

    d. (Insurer's Name)

    e. Note: The term "accident and sickness insurance" may be used instead of "health benefits" or "health benefit contract." "Policy" may be used instead of "contract."

### 1.7.6 Violation

Notwithstanding anything to the contrary in R.I. Gen. Laws Chapters 27-19 and 27-20 a violation of this section shall be prima facie evidence of a

misrepresentation for the purpose of inducing a person to purchase insurance. A person guilty of such violation shall be subject to R.I. Gen. Laws § 27-29-4.

## 1.8 Group and Blanket Health Benefit Contract Standard Provisions

### 1.8.1 General Provisions

A. No group or blanket health benefit contract shall be delivered or issued for delivery in the state unless it contains in substance the following provisions, or provisions which in the opinion of the Director are more favorable to the persons covered; or at least as favorable to the persons covered and more favorable to the master contractholder. PROVIDED; HOWEVER, that:

1. the standard provisions required for individual health benefit contracts shall not apply to group health benefit contracts;

2. if any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of contract, the insurer, with the approval of the Director, shall omit from such contract any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of a provision in such a manner as to make the provision as contained in the contract consistent with the coverage provided by the contract;

3. § 1.8.1(A)(6)(g) of this Part, below, shall be optional with respect to blanket contracts;

4. if the group contract (but not a blanket contract) provides hospital, surgical, or major medical benefits or any combination of these coverages for other than specified diseases or accidental injuries only, it shall also contain a conversion privilege conforming to the requirements of § 1.8.2 of this Part;

5. if a contract subject to this section shall contain other benefits in addition to health benefits, some or all of the provisions required in this section may be restricted so as to apply to health benefits only, and other appropriate provisions may be included which apply to non-health benefit portions of the contract.

6. The text of all master contract, certificate and subscriber contract forms, including any riders or endorsements to be attached to such forms shall be plainly printed in light-face type of a style in general use, the size of which shall be uniform and not less than ten (10) point with a lower-case unspaced alphabet length not less than one hundred and twenty (120) point (the "text" shall include all printed matter except the name and

address of the insurer, any specific information required by law or regulation to be in some other type, the name or title of the contract, certificate, etc., and captions and subcaptions). The effective date of this § 1.8 of this Part shall be the same as that generally provided in § 1.11 of this Part for filing of forms.

a. A provision that the master contractholder is entitled to a grace period of thirty-one (31) days or, at the option of the insurer, one month for the payment of any premium due except the first, during which grace period the contract shall continue in force, unless the master contractholder shall have given the insurer written notice of discontinuance of the coverage in advance of the date of discontinuance and in accordance with the terms of the contract. The contract may provide that the master contractholder shall be liable to the insurer for the payment of a pro rata premium for the time the coverage was in force during such grace period.

b. A provision that validity of the contract shall not be contested, except for non-payment of premiums, after it has been in force for two years from its date of issue; and that no statement made for the purpose of effecting insurance coverage under the contract with respect to a person shall be used to avoid the insurance with respect to which such statement was made or to reduce benefits thereunder after such insurance has been in force for a period of two (2) years during such person's lifetime, nor unless such statement is contained in a written instrument signed by the person making such statement and a copy of that instrument is or has been furnished to him.

c. A provision that a copy of the application, if any, of the master contractholder shall be attached to the master contract when issued, and that all statements made by the master contractholder or by the persons covered shall be deemed representations and not warranties.

d. A provision that no agent has authority to change the contract or waive any of its provisions and that no change in the contract shall be valid unless approved by an officer of the insurer and evidenced by an endorsement on the contract, or by rider or amendment to the contract signed by the insurer, provided that any such amendment which reduces or eliminates coverage was either requested in writing by the master contractholder or signed by the master contractholder.

e. A provision specifying the additional exclusions or limitations, if any, applicable under the contract with respect to a disease or physical condition of a person, not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss, which existed prior to the effective date of the person's coverage under the contract. Any such exclusion or limitation may only apply to a disease or physical condition for which medical advice or treatment was received by the person during the twelve (12) months prior to the effective date of his coverage. In no event shall such exclusion or limitation apply to loss incurred after the earlier of (a) the end of a continuous period of twelve (12) months commencing on or after the effective date of the person's coverage during all of which the person has received no medical advice or treatment in connection with such disease or physical condition and (b) the end of the two (2) year period commencing on the effective date of the person's coverage.

f. A provision specifying the ages, if any, to which the insurance provided shall be limited; and the ages, if any, for which additional restrictions are placed on benefits, and the additional restrictions placed on the benefits at such ages. If the premiums or benefits vary by age, there shall also be a provision specifying an equitable adjustment of premiums or of benefits, or both, to be made in the event the age of a covered person has been misstated, such provision to contain a clear statement of the method of adjustment to be used. In no event, however, shall coverage be required for any person during any period when, according to his correct age, coverage would otherwise not be provided for him under the contract.

g. (Optional with respect to blanket contracts) A provision that the insurer will issue to the master contractholder for delivery to each person insured, a certificate or subscriber contract, which may be in summary form, setting forth the essential features of the coverage and to whom the benefits are payable. If family members or dependents are included in the coverage, only one certificate or subscriber contract need be issued for each family unit.

h. A provision that written notice of claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the contract. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

i. A provision that the insurer will furnish to the person making the claim, or to the master contractholder for delivery to such person, such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of fifteen (15) days after the insurer received notice of any claim under the contract, the person making such claim shall be deemed to have complied with the requirements of the contract as to proof of loss, upon submitting within the time fixed in the contract for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

j. A provision that, in the case of claim for loss, written proof of such loss must be furnished to the insurer within ninety (90) days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one (1) year from the time proof is otherwise required.

k. A provision that all benefits payable under the contract will be payable not more than sixty (60) days after receipt of such proof.

l. A provision that all indemnities of the contract are payable to the insured, except that the master contract may provide that all or any portion of any benefits on account of hospital, medical, surgical or other services may, at the insurer's option, be paid directly to the hospital or person rendering such services. Any payment made by the insurer in good faith pursuant to the foregoing provisions shall discharge an insurer's obligation with respect to the extent of such payment.

m. A provision that the insurer shall have the right and opportunity to examine the person of the individual for whom claim is made when and so often as it may reasonably require during the pendency of claim under the contract.

n. A provision that no action at law or in equity shall be brought to recover on the contract prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of the contract and that no such action shall be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by the contract.

### 1.8.2 Conversion Privilege

A. A group health benefit contract delivered or issued for delivery in the state which provides hospital, surgical, or major medical expense benefits, or any combination of these coverages, but not a contract which provides benefits for specified disease or for accidental injuries only, shall provide that an employee or member whose insurance under the group contract has been terminated for any reason other than discontinuance of the group contract in its entirety or with respect to an insured class, and who has been continuously covered under the group contract (and under any group contract providing similar benefits which it replaces) for at least three months immediately prior to termination, shall be entitled to have issued to him by the insurer a health benefit contract (hereafter referred to as the converted contract).

B. An employee or member shall not be entitled to have a converted contract issued to him if termination of his insurance under the group contract occurred because:

1. he failed to pay any required contribution, or

2. any discontinued group coverage was replaced by similar group coverage within thirty-one days.

C. Issuance of a converted contract shall be subject to the following conditions:

1. Written application for the converted contract shall be made and the first premium therefor paid to the insurer not later than thirty-one (31) days after such termination.

2. The converted contract shall be issued without evidence of insurability.

3. The premium for the converted contract shall be determined in accordance with the insurer's table of premium rates applicable to the age and class of risk of each person to be covered under the converted contract and to the type and amount of insurance provided.

4. The effective date of the converted contract shall be the day following the termination of coverage under the group contract.

5. The converted contract shall cover the employee or member and his dependents who were covered by the group contract on the date of termination of coverage. At the option of the insurer, a separate converted contract may be issued to cover any dependent.

6. The insurer shall not be required to issue a converted contract covering any person if such person is or could be covered by Medicare (Title XVIII

of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded).

a. Furthermore, the insurer shall not be required to issue a converted contract covering any person if

(1) such person is covered for similar benefits by another hospital, surgical, medical or major medical expense contract; or

(2) such person is eligible for similar benefits (whether or not covered therefor) under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis, or

(3) similar benefits are provided for or available to such person, pursuant to or in accordance with the requirement of any state or federal law (benefits under R.I. Gen. Laws § 42-62-6 shall not be deemed "similar benefits" for purposes of this subsection), and

b. The benefits provided under the sources referred to in § 1.8.2(C)(6)(a)(1) of this Part for such person or benefits provided or available under the sources referred to in §1.8.2(A)(6)(a)(2) and (3) of this Part for such person, together with the benefits provided by the converted contract would result in overinsurance according to the insurer's standards. The insurer's standards must bear some relationship to actual health care costs in the area in which the insured lives at the time of conversion and must be filed with the Director of Business Regulation prior to their use in denying coverage.

7. A converted contract may include a provision whereby the insurer may request information in advance of any premium due date of such contract of any person covered thereunder as to whether:

a. he is covered for similar benefits by another health benefit contract,

b. he is covered for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis or

c. similar benefits are provided for or available to such person, pursuant to or in accordance with the requirements of any state or federal law.

d. The converted contract may provide that the insurer may refuse to renew the contract or the coverage of any person insured thereunder for the following reasons only:

(1) either the benefits provided under the sources referred to in §§ 1.8.2(C)(7)(a) and (b) of this Part above for such person or benefits provided or available under the sources referred to in 1.8.2(C)(7)(c) of this Part above for such person, together with the benefits provided by the converted contract, would result in overinsurance according to the insurer's standards on file with the Director of Business Regulation, or the converted contractholder fails to provide the requested information.

(2) fraud or material misrepresentation in applying for any benefits under the converted contract;

(3) eligibility of the insured person for coverage under Medicare (Title XVIII of the United States Social Security Act as amended by the Social Security Amendments of 1965 or as later amended or superseded) or under any other state or federal law providing for benefits similar to those provided by the converted contract;

(4) other reasons approved by the Director of Business Regulation.

8. An insurer shall not be required to issue a converted contract which provides benefits in excess of those provided under the group contract form which conversion is made.

9. The converted contract shall not exclude a pre-existing condition not excluded by the group contract. However, the converted contract may provide that any hospital, surgical or medical benefits payable thereunder may be reduced by the amount of any such benefits payable under the group contract after termination of the individual's insurance thereunder. The converted contract may also include provisions so that during the first contract year the benefits payable under the converted contract, together with the benefits payable under the group contract, shall not exceed those that would have been payable had the individual's insurance under the group contract remained in force and effect.

10. Subject to the provisions and conditions of § 1.8 of this Part, if the group health benefit contract from which conversion is made insured the

employee or member for basic hospital or surgical expense insurance, the employee or member shall be entitled to obtain a converted contract providing, at his option, coverage on an expense incurred basis or equivalent service benefits under any one of the plans meeting the following requirements:

a. Plan A

(1) hospital room and board daily expense benefits in a maximum dollar amount approximately the average semi-private rate charged in this state, for a maximum duration of at least seventy days,

(2) miscellaneous hospital expense benefits of a maximum amount of ten times the hospital room and board daily expense benefits, or, at the insurer's option, full benefits for ancillary services for the period covered § 1.8.2(C)(10)(a)(1) of this Part, and,

(3) surgical operation expense benefits according to a surgical schedule consistent with those customarily offered by the insurer under group or individual health benefit contracts and providing a maximum benefit of nine hundred dollars, or, at the insurer's option, full coverage of the usual and customary fee for surgical operations, or

b. Plan B

(1) hospital room and board daily expense benefits in a maximum amount equal to seventy five percent (75%) of the maximum dollar amount determined for Plan A, for a maximum duration of at least seventy (70) days,

(2) miscellaneous hospital expense benefits of a maximum amount of ten times the hospital room and board daily expense benefits, or, at the insurer's option, benefits covering seventy five percent (75%) of the ancillary services for the period covered by § 1.8.2(C)(10)(b)(1) of this Part, and

(3) surgical operation expense benefits according to a surgical schedule consistent with those customarily offered by the insurer under group or individual health benefit contracts and providing a maximum benefit of six hundred seventy-five

dollars, or, at the insurer's option, benefits equivalent to 75% of the usual and customary fee for surgical operations, or

c. Plan C

(1) hospital room and board daily expense benefits in a maximum dollar amount equal to fifty percent (50%) of the maximum dollar amount determined for Plan A, for a maximum duration of at least seventy days,

(2) miscellaneous hospital benefits of a maximum amount of ten times the hospital room and board daily expense benefits, or, at the insurer's option, benefits covering fifty percent (50%) of the ancillary services for the period covered by § 1.8.2(C)(10)(c)(1) of this Part, and

(3) surgical operation expense benefits according to a surgical schedule consistent with those customarily offered by the insurer under group or individual health benefit contracts and providing a maximum benefit of four hundred fifty dollars, or at the insurer's option, benefits equivalent to seventy five percent (75%) of the usual and customary fee for surgical operations.

d. The maximum dollar amount in Plan A shall be determined by the Director of Business Regulation and may be redetermined by him from time to time as to converted contracts issued subsequent to such redetermination. Such redetermination shall not be made more often than once in three (3) years. The maximum dollar amounts in Plans A, B and C shall be rounded to the nearest multiple of ten dollars ($10).

(1) Note: As of December 14, 1978, it has been determined that the maximum dollar amounts, rounded as required, are as follows:

(AA) Plan A$130.00

(BB) Plan B$100.00

(CC) Plan C $70.00

(2) This determination shall be effective until October 9, 1981, and it shall remain in effect thereafter until a redetermination shall be made by the Director.

11. Subject to the provisions and conditions of § 1.8 of this Part, if the group health benefit contract from which conversion is made insures the employee or member for major medical expense insurance, the employee or member shall be entitled to obtain a converted contract providing catastrophic or major medical coverage under a plan meeting the following requirements:

    a. A maximum benefit at least equal to either, at the option of the insurer, § 1.8.2(C)(11)(a)(1) or (2) of this Part below:

        (1) The smaller of the following amounts:

            (AA) The maximum benefit provided under the group contract.

            (BB) A maximum payment of ten thousand dollars ($10,000) per covered person for all covered medical expenses incurred during the covered person's lifetime.

        (2) The smaller of the following amounts:

            (AA) The maximum benefit provided under the group contract.

            (BB) A maximum payment of ten thousand dollars ($10,000) for each unrelated injury or sickness.

    b. Payment of benefits at the rate of eighty percent (80%) of covered medical expenses which are in excess of the deductible. Payment of benefits for outpatient treatment of mental illness, if provided in the converted contract, may be at a lesser rate but not less than fifty percent (50%) and may be subject to a maximum of no more than one thousand dollars ($1,000) in any one benefit period.

    c. A deductible for each benefit period which, at the option of the insurer, shall be:

        (1) the sum of the benefits deductible and one hundred dollars ($100), or

        (2) the corresponding deductible in the group contract. The term "benefits deductible," as used herein, means the value of any benefits provided on an expense incurred or a service benefit basis which are provided with respect to covered

medical expenses by any other health benefit contract, or any other plan or program whether on an insured or uninsured basis, or in accordance with the requirements of any state or federal law except that benefits provided under R.I. Gen. Laws § 42-62-6 shall not be included in the "benefits deductible", and, if pursuant to § 1.8.2(C)(12) of this Part, the converted contract provides both basic hospital or surgical coverage and major medical coverage, the value of such basic benefits. If the maximum benefit is determined by § 1.8.2(C)(11)(a)(2) of this Part, the insurer may require that the deductible be satisfied during a period of not less than three months if the deductible is one hundred dollars ($100) or less, and not less than six months if the deductible exceeds one hundred dollars ($100).

d. The benefit period shall be each calendar year when the maximum benefit is determined by § 1.8.2(C)(11)(a)(1) of this Part or twenty-four months when the maximum benefit is determined § 1.8.2(C)(11)(a)(2) of this Part.

e. The term "covered medical expenses," as used above, shall include at least, in the case of hospital room and board charges, the lesser of the dollar amount in Plan A and the average semi-private room and board rate for the hospital in which the individual is confined and twice such amount for charges in an intensive care unit. Any surgical schedule shall be consistent with those customarily offered by the insurer under group or individual health insurance contracts and must provide at least a one thousand two hundred dollar ($1,200) maximum benefit.

12. The conversion privilege required by § 1.8 of this Part shall, if the group health benefit contract insures the employee or member for basic hospital or surgical expense insurance as well as major medical expense insurance, make available the plans of benefits set forth in conditions 10 and 11 hereof. At the option of the insurer, such plans of benefits may be provided under one contract. Instead of the plans of benefits set forth in § 1.8.2(C)(10) and (11) of this Part the insurer may provide a contract of comprehensive benefits without first-dollar coverage. Such a contract shall conform to the requirements of § 1.8.2(C)(11), except that the maximum payment shall be two hundred fifty thousand dollars ($250,000), where ten thousand dollars ($10,000) is established in § 1.8.2(C)(11) of this Part.

13. The insurer may, at its option, also offer alternative plans for group health conversion in addition to those required by § 1.8 of this Part.

14. In the event coverage would be continued under the group contract on an employee following his retirement prior to the time he is or could be covered by Medicare, he may elect, in lieu of such continuation of group insurance, to have the same conversion rights as would apply had his insurance terminated by reason of termination of employment or membership.

15. The converted contract may provide for reduction of coverage on any person upon his eligibility for coverage under Medicare (Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded) or under any other state or federal law providing for benefits similar to those provided by the converted contract, except that benefits provided under R.I. Gen. Laws § 42-62-6 shall not be considered to be "similar" for purposes of such reduction.

16. Subject to the conditions set forth above, the conversion privilege shall also be available:

    a. to the surviving spouse, if any, at the death of the employee or member, with respect to the spouse and such children whose coverage under the group contract terminates by reason of such death, otherwise to each surviving child whose coverage under the group contract terminates by reason of such death, or, if the group contract provides for continuation of dependents coverage following the employee's or members' death, at the end of such continuation,

    b. to the spouse of the employee or member upon termination of coverage of the spouse, while the employee or member remains covered under the group contract, by reason of ceasing to be a qualified family member under the group contract, with respect to the spouse and such children whose coverage under the group contract terminates at the same time, or

    c. to a child solely with respect to himself upon termination of his coverage by reason of ceasing to be a qualified family member under the group contract, if a conversion privilege is not otherwise provided above with respect to such termination.

17. If the benefit levels required in § 1.8.2(C)(10) of this Part above exceed the benefit levels provided under the group contract, the conversion may offer benefits which are substantially similar to those provided under the group contract in lieu of those required in § 1.8.2(C)(10) of this Part.

18. The insurer may elect to provide group insurance coverage in lieu of the issuance of a converted individual contract.

19. A notification of the conversion privilege shall be included in each certificate of coverage or group subscriber contract.

20. The insurer may elect to issue a converted contract itself, or it may arrange with another appropriately licensed insurer for such other insurer to issue the converted contract required by § 1.8 this Part.

21. A converted contract which is delivered outside this state must be on a form which could be delivered in such other jurisdiction as a converted contract had the group contract been issued in that jurisdiction. Except for this requirement, converted contracts issued outside this state shall not be required to be in accordance with § 1.8.2 of this Part.

### 1.8.3 Notice of Group Health Conversion

A. An employee or member who is entitled to make application for a converted health benefit contract in accordance with the provision of § 1.8.2 of this Part shall be given written notice of the existence of the conversion privilege at least fifteen (15) days prior to the expiration of the thirty-one (31) day conversion period established by the group contract. If the employee or member is not given notice of his conversion rights as provided above, the employee or member shall have an additional period within which to exercise such conversion privilege. This additional period shall expire fifteen (15) days after the employee or member has been given such notice, or ninety (90) days after termination of his coverage under the group contract, whichever comes earlier.

B. Written notice presented to the employee or member by his employer, the master contractholder or insurer or mailed by his employer, the master contractholder or insurer to the last known address of the employee or member, as furnished by the master contractholder, shall constitute the giving of notice for the purpose of this provision. If an employee or member is permitted an additional period for conversion, as provided herein, and if written application for the converted contract, accompanied by the initial premium, is made within the additional period, the effective date of the converted contract shall be the day following his termination of insurance under the group contract.

## 1.9 Group or "Group-Type" Coverage Discontinuance and Replacement

### 1.9.1 Scope

§ 1.9 of this Part is applicable to all health benefit contracts issued or provided by an insurance company or a non-profit service corporation on a group or group-type basis covering persons as employees of employers or as members of unions or associations.

### 1.9.2 Effective Date of Discontinuance for Non-Payment of Premium or Subscription Charges

A. If a contract subject to § 1.9 of this Part provides for automatic discontinuance of the contract after a premium or subscription charge has remained unpaid through the grace period allowed for such payment, the insurer shall be liable for valid claims for covered losses incurred prior to the end of the grace period.

B. If the actions of the insurer after the end of the grace period indicate that it considers the contract as continuing in force beyond the end of the grace period (such as, by continuing to recognize claims subsequently incurred except to the extent that specific limited coverage may be provided after termination by the terms of the contract), the insurer shall be liable for valid claims for losses beginning prior to the effective date of written notice of discontinuance to the master contractholder or other entity responsible for making payments or submitting subscription charges to the insurer. The effective date of discontinuance shall not be prior to midnight at the end of the third scheduled work day after the date upon which the notice is delivered.

### 1.9.3 Requirements for Notice of Discontinuance

A. Any notice of discontinuance so given by the insurer, shall include a request to the group master contractholder or other entity involved to notify employees covered under the contract of the date as of which the group contract will discontinue and to advise that, unless otherwise provided in the contract, the insurer shall not be liable for claims for losses incurred after such date. Such notice of discontinuance shall also advise that, in any instance in which the plan involves employee contributions, that if the master contractholder or other entity continues to collect contributions for the coverage beyond the date of discontinuance, the master contractholder or other entity may be held solely liable for the benefits with respect to which the contributions have been collected.

B. The insurer will prepare and furnish to the master contractholder or other entity at the same time a supply of notice forms to be distributed to the employees or members concerned indicating such discontinuance and the effective date thereof, and urging the employees or members to refer to their certificates of contracts in order to determine what rights, if any, are available to them upon such discontinuance. Instead of furnishing such notice to the master contractholder, the insurer may mail such notice to the employees or members.

### 1.9.4 Extension of Benefits

A. Every group contract subject to § 1.9 of this Part hereafter issued, or under which the level of benefits is hereafter altered, modified, or amended, must provide a reasonable provision for extension of benefits in the event of total disability at the date of discontinuance of the group contract, as required by the following paragraphs of § 1.9.4 of this Part.

B. In the case of a group plan providing specific indemnity during hospital confinement, discontinuance of the contract during a disability shall have no effect on benefits payable for that confinement.

C. In the case of hospital or medical expense coverages other than dental and maternity expense, a reasonable extension of benefit or accrued liability provision is required. Such a provision will be considered "reasonable" if it provides an extension of at least twelve (12) months under "major medical" and "comprehensive medical" type coverages, and under other types of hospital or medical expense coverages provides either an extension of at least ninety (90) days or an accrued liability for expenses incurred during a period of disability or during a period of at least ninety (90) days starting with a specific event which occurred while coverage was in force (e.g., an accident).

D. Any applicable extension of benefits or accrued liability shall be described in any master contract as well as in group insurance certificates or subscriber contracts. The benefits payable during any period of extension or accrued liability may be subject to the contract's regular benefits limits (e.g., benefits ceasing at exhaustion of a benefit period or of maximum benefits).

### 1.9.5 Continuance of Coverage in Situations Involving Replacement of One Insurer by Another

A. § 1.9.5 of this Part shall indicate the insurer responsible for liability in those instances in which one insurer's contract replaces a plan of similar benefits of another.

B. Liability of Prior Insurer. The prior insurer remains liable only to the extent of its accrued liability and extensions of benefits. The position of the prior insurer shall be the same whether the group master contractholder or other entity secures replacement coverage from a new insurer, self-insures, or foregoes the provision of coverage.

C. Liability of Succeeding Insurer

1. Each person who is eligible for coverage in accordance with the succeeding insurer's plan of benefits (in respect of classes eligible and

activity at work and non-confinement rules) shall be covered by that insurer's plan of benefits.

2. Each person not covered under the succeeding insurer's plan of benefits in accordance with § 1.9.5(C)(1) of this Part, must nevertheless be covered by the succeeding insurer in accordance with the following rules if such individual was validly covered (including benefit extension) under the prior plan on the date of discontinuance and if such individual is a member of the class or classes of individuals eligible for coverage under the succeeding insurer's plan. Any reference in the following rules to an individual who was or was not totally disabled is a reference to the individual's status immediately prior to the date the succeeding insurer's coverage becomes effective.

    a. The minimum level of benefits to be provided by the succeeding insurer shall be the applicable level of benefits of the prior insurer's plan reduced by any benefits payable by the prior plan.

    b. Coverage must be provided by the succeeding insurer until at least the earliest of the following dates:

        (1) the date the individual becomes eligible under the succeeding insurer's plan as described in § 1.9.5(C)(1) of this Part.

        (2) for each type of coverage, the date the individual's coverage would terminate in accordance with the succeeding insurer's plan provisions applicable to individual termination of coverage (e.g., at termination of employment or ceasing to be an eligible dependent, as the case may be.)

        (3) in the case of an individual who was totally disabled, and in the case of a type of coverage for which § 1.9.5 of this Part requires an extension of accrued liability, the end of any period of extension or accrued liability which is required of the prior insurer by § 1.9.5 of this Part or, if the prior insurer's contract is not subject to § 1.9.5 of this Part, would have been required of that insurer had its contract been subject to § 1.9.5 of this Part at the time the prior plan was discontinued and replaced by the succeeding insurer's plan.

3. In the case of a pre-existing conditions limitation included in the succeeding insurer's plan, the level of benefits applicable to pre-existing conditions of persons becoming covered by the succeeding insurer's plan

in accordance with this subsection during the period of time this limitation applies under the new plan shall be the lesser of:

a. the benefits of the new plan determined without application of the pre-existing conditions limitation; and

b. the benefits of the prior plan.

4. The succeeding insurer, in applying any deductibles or waiting periods in its plan, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. In the case of deductible provisions, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible provisions of the prior insurer's plan during the ninety (90) days preceding the effective date of the succeeding insurer's plan but only to the extent these expenses are recognized under the terms of the succeeding insurer's plan and are subject to a similar deductible provision.

5. In any situation where a determination of the prior insurer's benefits is required by the succeeding insurer, at the succeeding insurer's request the prior insurer shall furnish a statement of the benefits available or pertinent information, sufficient to permit verification of the benefit determination or the determination itself by the succeeding insurer. For the purpose of § 1.9.5 of this Part, benefits of the prior plan will be determined in accordance with all of the definitions, conditions, and covered expense provisions of the prior plan rather than those of the succeeding plan. The benefit determination will be made as if coverage has not been replaced by the succeeding insurer.

## 1.10 Group Anti-Duplication Provision

A. If a group health benefit contract contains a provision restricting benefit payments on account of the benefit paid by another plan, such provision shall be at least as favorable to the insured as the following:

1. Provision for Co-Ordination Between This Contract and Other Benefits

a. Benefits Subject to This Program

(1) All of the benefits provided under this contract are subject to this provision.

(2) (Note: When contract provides both integrated Major Medical Expense Benefits and the underlying Basic Benefits, but

provision applies to Major Medical only, use the following alternate wording: Only the Major Medical Expense Benefits under this contract are subject to this provision).

b. Definitions

(1) (Note: Include here the definition of a Plan, that is, the benefits, including those provided by this contract, that are to be co-ordinated. The following definition is illustrative only, except that “plan” may not be defined to include individual health benefit contracts. If government programs are excluded, language substantially equivalent to that at (iv) must be used.)

(AA) “Plan” means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by:

(i) group, blanket or franchise insurance coverage,

(ii) Blue Cross, Blue Shield, group practice, individual practice and other prepayment coverage,

(iii) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans, and

(iv) any coverage under governmental programs, and any coverage required or provided by any statute; except that “plan” shall not include benefits provided under R.I. Gen. Laws §§ 42-62-5, 6, 7 and 8.

(BB) The term “plan” shall be construed separately with respect to each contract or other arrangement for benefits or services and separately with respect to that portion of any such contract or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

(2) “This Plan” means that portion of this contract which provides the benefits that are subject to this provision.

(3) “Allowable Expense” means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one the Plans covering the person for whom claim is made.

(AA) When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

(4) “Claim Determination Period” means (Note: Insert here an appropriate period of time such as, “calendar year” or “Benefit Period as defined elsewhere in this contract.”)

c. Effective on Benefits

(1) This provision shall apply in determining the benefits as to a person covered under this Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such person during such period, the sum of

(AA) the benefits that would be payable under this Plan in the absence of this provision, and

(BB) the benefits that would be payable under all other Plans in the absence therein of provision of similar purpose to this provision would exceed such Allowable Expenses.

(2) As to any Claim Determination Period with respect to which this provision is applicable, the benefits that would be payable under this Plan in the absence of this provision for the Allowable Expenses incurred as to such person during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other Plans except as provided in § 1.10(A)(1)(c)(3) of this Part, shall not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made therefor.

(3) If:

(AA) another Plan which is involved in § 1.10(A)(1)(c)(2) of this Part and which contains a provision co-ordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined, and

(BB) the rules set forth in § 1.10(A)(1)(c)(4) of this Part would require this Plan to determine its benefits before such other Plan which the benefits of such other Plan will be ignored for the purposes of determining the benefits under this Plan.

(4) For the purposes of item § 1.10(A)(1)(c)(3) of this Part, the rules establishing the order of benefit determination are:

(AA) The benefits of Plan which cover the person on whose expenses claim is based other than as a dependent shall be determined before the benefits of a Plan which covers such person as a dependent;

(BB) Dependent Child/Parents Not separated or Divorced. Except as stated in § 1.10(A)(1)(c)((4))((BB))((iii)) of this Part below, when this Plan and another Plan cover the same child as a dependent of different persons, called “parents”:

(i) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

(ii) if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

(iii) However, if the other Plan does not have the rule described in § 1.10(A)(1)(c)((4))((BB))((i)) of this Part immediately above but instead has a rule based upon the gender of the parents, and if, as a result, the Plans do not agree on

the order of benefits, the rule in the other Plan will determine the order of benefits.

(CC) Dependent Child/Separated or Divorced Parents, If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order;

(i) first, the Plan of the parent with custody of the child;

(ii) then, the Plan of the spouse of the parent with the custody of the child; and

(iii) finally, the plan of the parent not having custody of the child.

(iv) However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period of plan year during which any benefits are actually paid or provided before the entity has that actual knowledge

(DD) Active/Inactive Employee. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule § 1.10(A)(1)(c)((4))((DD)) of this Part is ignored.

(EE) When rules § 1.10(A)(1)(c)((4))(AA) and (BB) of this Part do not establish an order of benefits determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period of time shall be

determined before the benefit of a Plan which has covered such person the shorter period of time.

(FF) This amendment is effective immediately. However, it shall apply to all claims incurred on or after January 1, 1988.

(5) (Note: This item (5) may be omitted if the Plan provides only one benefit. The wording shown is illustrative.)

(AA) When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any Claim Determination period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charges against any applicable benefit limit of this Plan.

d. Right to Receive and Release Necessary Information

(1) For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provision of similar purpose of any other Plan, the insurer may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which the insurer deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the insurer such information as may be necessary to implement this provision.

e. Facility of Payment

(1) Whenever payment which should have been made under this Plan is accordance with this provision have been made under any other Plans, the insurer shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the insurer shall be fully discharged form liability under this Plan.

f. Right of Recovery

(1) Whenever payments have been made by the insurer with respect to Allowable Expenses in a total amount, in excess of the maximum amount or payment necessary at that time to satisfy the intent of this provision, the insurer shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the insurer shall determine: any persons to or for or with respect to whom such payments were made, any other insurers, any other organizations.

## 1.11 Filing of Forms and Rates

### 1.11.1 Approval of Director

A. No health benefit contract shall be issued or delivered to any person in this state nor shall any application, rider, endorsement, individual certificate, subscriber contract or group master contract to be used in connection therewith be issued or delivered until a copy of the form thereof and of the classification of risks and the premium rates or the rating formula have been approved by the Director of Business Regulation. This requirement shall take effect two hundred seventy (270) days after promulgation of this Part, subject to the following conditions and exceptions:

1. No forms submitted to the Director for approval after the promulgation of this Part shall be approved unless such forms are in compliance with this Part.

2. Forms filed and approved under R.I. Gen. Laws Chapters 27-18 and 27-2 or otherwise approved in writing by the Director of Business Regulation may be issued or delivered without re-filing, provided that such forms are in compliance with this Part.

3. Forms filed and approved under R.I. Gen. Laws Chapter 27-18 or otherwise approved in writing by the Director of Business Regulation but which are not in compliance with this Part may be issued or delivered provided that such forms are amended by appropriate riders or endorsements designed to bring them into compliance. Such amendment forms must be approved by the Director of Business Regulation prior to use.

4. Forms filed and approved under R.I. Gen. Laws Chapter 27-18 or otherwise approved in writing by the Director of Business Regulation may

be issued or delivered for up to three hundred sixty (360) days after promulgation of this Part provided that appropriate riders endorsements or revisions designed to bring such forms into compliance have been submitted to the Director for approval within two hundred seventy (270) days after promulgation of this Part.

5. Rates not previously submitted for approval and rates "received for filing" and not affirmatively approved by the Director may not be used in connection with contracts issued or delivered and placed in force in the state more than two hundred seventy (270) days after promulgation of this Part.

6. Rates affirmatively approved by the Director under R.I. Gen. Laws §§ 27-2-10, 27-19-6, 27-20-6, 27-20.1-3 or 42-16-13 remain approved without re-filing, subject to the terms and conditions of such approval.

### 1.11.2 Filing and Approval

No such contract shall be issued, nor shall any application, rider, endorsement, individual certificate, subscriber contract, or group master contract be used in connection therewith, until the expiration of sixty (60) days after it has been so filed unless the Director of Business Regulation shall sooner give his written approval thereto, except that with respect to forms submitted within two hundred seventy (270) days after promulgation of this Part, no such forms shall be issued until the expiration of ninety (90) days unless the Director shall sooner give his written approval.

### 1.11.3 Hearing

A. The Director of Business Regulation may, with or without a public hearing as provided for in R.I. Gen. Laws § 42-62-13, within sixty (60) days, except that ninety (90) days shall apply to forms submitted for approval within two hundred seventy (270) days after promulgation of this Part, after filing of any such form disapprove such form:

1. if the benefits provided therein are unreasonable in relation to the premium charged, or

2. if it contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of such contract. If the Director of Business Regulation shall notify the insurer which has filed any such form that it does not comply with all applicable laws and regulations, it shall be unlawful thereafter for such insurer to issue such form or use it in connection with any contract. In such notice the Director of Business Regulation shall specify the reasons for his disapproval.

### 1.11.4 Withdrawal of Approval

The director of Business Regulation may at any time, after a hearing of which not less than twenty (20) days written notice shall have been given to the insurer, withdraw his approval of any such form on any of the grounds stated § 1.11 of this Part. The insurer may not issue such form or use it in connection with any contract after the effective date of such withdrawal of approval.

### 1.11.5 Form of Contracts

A. The style, arrangement and over-all appearance of the contract shall give no undue prominence to any portion of the text, and every printed portion of the text of the contract and of any endorsements or attached papers 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 one hundred and twenty (120) point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the contract, the brief description if any, and captions and subcaptions); and

B. The exceptions and reductions of indemnity shall be set forth in the contract and, except those which are set forth in R.I. Gen. Laws §§ 27-18-3 to 27-18-10 inclusive, if such sections are applicable to such contract, are printed at the insurer's option, either included with the benefit provisions to which they apply, or under an appropriate caption such as "EXCEPTIONS," or "EXCEPTIONS AND REDUCTIONS," provided that if an exception or reduction specifically applies only to a particular benefit of the contract, a statement of such exception or reduction shall be included with the benefit provision to which it applies; and

C. Each form shall bear a unique form number printed in the lower left-hand corner of such form. All numbers, letters and other symbols appearing in the lower left-hand corner shall together constitute the entire form number, and any change in that number shall require filing as a separate form.

D. Each form shall contain no provision purporting to make any portion of the charter, rules, constitution, or by-laws of the insurer a part of the contract unless such portion is set forth in full in the contract, except in the case of the incorporation of, or reference to a statement of rates or classification of risks, or short-rate table filed with the insurance commissioner.

### 1.11.6 Submission Instructions

A. Forms submitted for approval in accordance with § 1.11 of this Part must be submitted as follows:

1. A letter in triplicate must be included with each submission which:

a. specifies the form number and title of each form being submitted;

b. generally describes the purpose of each form;

c. states whether the form is new or a replacement of any existing form and describes by title and form number any forms being replaced;

d. with respect to applications and other forms which have been previously approved and are submitted in support of such filing, states the date(s) of approval of such form(s).

2. One specimen copy of each form in final printed form including a specimen of the application, if any, to be used with such form, whether or not such application has been previously approved (two copies if the insurer wishes to have a stamped copy returned for its records) with all blanks in the printed form filled in with hypothetical information, except that no hypothetical information is required on application forms. With respect to rider, endorsement or other amendment forms for use with individual health benefit contracts, one specimen copy of each contract form to which it will be attached, whether or not such contract form has been previously approved.

3. One specimen copy of each rate schedule or rating formula together with all required actuarial data as outlined in § 1.11.7(A)(1) and (2) of this Part.

4. A stamped, self-addressed envelope.

**1.11.7 Rates**

A. To the extent appropriate, rates submitted in accordance with § 1.11 of this Part should be submitted in duplicate, including complete rate schedules accompanied by the following supporting data:

1. For rates applied to new individual contract forms - A signed statement from an actuary giving the methods and assumptions used to determine the proposed premium rates including the formulas used to calculate gross premiums. The statement as to the assumptions used should give the exact source of the claim costs or other experience data on which the premium calculations are based and the source of any multipliers or other factors used to adjust such claim costs or other experience data to reflect the benefits provided.

a. If published experience is used, state the page and table number of the source. Unless published, the basic experience data (for

example, claim costs) and adjustment factors should be included with such description. When the basic claim costs or other data are shown for age groupings, for example, quinquennial or decennial ages, state the method used to obtain the required values at intermediate ages.

b. Indicate where judgment is used to determine any adjustment factors applied to basic experience data.

c. Indicate any modifications used to reflect the effect of selection or to allow for future increases in claim costs.

d. A statement as to the contract termination rates used.

e. A statement of the methods used to incorporate margins for profit and contingencies in the premium rates.

f. If the contract is participating, give a statement as to the methods used to determine anticipated dividends.

g. A detailed statement of all expense assumptions including commissions, taxes, claims handling, and administrative expenses made in the premium calculations, and indicating allowances for future increase in expenses.

h. A statement of the expected benefit loss ratios at representative issue ages and an estimated composite benefit loss ratio indicating the distribution of issue ages for both males and females used to determine such composite loss ratio.

i. A statement summarizing the type of benefit provided, the range of benefits offered, and the average size of the benefits assumed.

j. A statement as to how gross premiums were calculated including the formula used.

2. For changes in rates that apply to presently-approved individual contract forms;

a. A statement of all premiums (both received and earned), and claims (both paid and incurred) and expenses incurred for each of the previous five (5) years;

b. A statement of the actual benefit loss ratio on both a cash basis and on an incurred claim to earned premium basis;

c. A statement of the approval date of the rate currently in use and the anticipated benefit loss ratio at the time the rate was approved;

d. A statement of the total number of contracts in force, to which the above rates will apply;

e. A statement of the total number of contracts in force, to which the above rates will apply, in Rhode Island.

f. A copy of the contract, rider, and/or endorsements for which the rates apply.

g. A copy of the rate schedule now in use and the rate schedule which reflects the proposed rate increase.

3. For rates that apply to new group and blanket contract forms and changes in rates that apply to presently-approved group and blanket contract forms;

a. One copy of each rate schedule, rating formula or formulas, or manual must be submitted. Upon receipt of manuals, formulas, or rate schedules, the Director of Business Regulation may request actuarial data and other pertinent information.

b. An outline of the essential benefits, coverages, limitations and exclusions to which such rates shall apply.

4. The Director may approve, disapprove or modify rates, with or without a public hearing, as provided in R.I. Gen. Laws § 42-62-13.

5. With respect to insurers, as defined in R.I. Gen. Laws § 42-62-4(c) that are not insurance companies subject to R.I. Gen. Laws Chapter 27-1 and R.I. Gen. Laws Chapter 27-2 the Director may waive any or all of the requirements of § 1.11.7 of this Part and establish, through written correspondence or in the course of the review of filings and the conduct of public hearings, other statements or exhibits which he deems more appropriate to the review of rates proposed by such insurers.

## 1.12 Advertising Rules and Guidelines for Interpretation

### 1.12.1 Purpose

A. The purpose of § 1.12 of this Part is to assure truthful and adequate disclosure of all material and relevant information in the advertising of health benefits. This purpose is to be accomplished by the establishment of, and adherence to, certain

minimum standards and guidelines of conduct in the advertising of health benefits in a manner which prevents unfair competition among insurers and is conducive to the accurate presentation and description to the public of such benefits offered through various advertising media.

B. Guideline 1

1. Disclosure is one of the principal objectives of these rules and § 1.12.1 of this Part states specifically that the rules shall assure "truthful and adequate disclosure of all material and relevant information". These rules specifically prohibit some previous advertising techniques.

**1.12.2 Applicability**

A. § 1.12 of this Part shall apply to any health benefits "advertisement," as that term is hereinafter defined in § 1.12.3(A), (F), (G), (H) of this Part unless otherwise specified in § 1.12 of this Part, intended for presentation, distribution or dissemination in the State of Rhode Island where such presentation, distribution or dissemination is made either directly or indirectly by or on behalf of an insurer or agent, as defined in this Part.

B. Guideline 2-A

1. These rules apply to any "advertisement" as that term is defined in § 1.12.3(A), (F), (G), (H) of this Part unless otherwise specified in the rules.

2. These rules apply to group and blanket as well as individual health benefit contracts. Certain distinctions, however, are applicable to these categories.

3. Among them is the level of conversance with insurance, a factor which is covered by § 1.12.5(A) of this Part.

C. Every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its health benefit contracts. All such advertisements, regardless of by whom written, created, designed, or presented, shall be the responsibility of the insurer whose health benefit contracts are so advertised.

D. Guideline 2-B

1. Advertising materials which are reproduced in quantity shall be identified by form numbers or other identifying means in the case of advertisements not subject to the requirements of § 1.12.13 of this Part. Such identification shall be sufficient to distinguish an advertisement from other

advertising materials, health benefit contracts, applications or other materials used by the insurer.

**1.12.3 Definitions**

A. An advertisement for the purpose of § 1.12 of this Part shall include:

1. printed and published material, audio visual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio scripts, TV scripts, billboards, and similar displays;

2. descriptive literature and sales aids of all kinds issued by an insurer or agent, as defined in this Part for presentation to members of the insurance buying public, including but not limited to circulars, leaflets, booklets, depictions, illustrations, and form letters; and

3. prepared sales talks, presentations, and material for use by agents and other sales representatives.

B. Guideline 3-A

1. The scope of the term "advertisement" extends to the use of all media for communication to the general public § 1.12.3(A)(1) of this Part to the use of all media for communication to specific members of the general public § 1.12.3(A)(2) of this Part and to the use of all media for communication by agents, brokers, and solicitors.

2. The definition of "advertisement" includes advertising material included with a contract when the contract is delivered and material used in the solicitation of renewals and reinstatements.

3. The definition of "advertisement" does not include:

a. material to be used solely for the training and education of an insurer's employees, agents, or brokers;

b. material in house organs or insurers;

c. communications within an insurer's own organization not intended for dissemination to the public;

d. individual communications of a personal nature with current contract holders other than material urging such contract holders to increase or expand coverages;

e. correspondence between a prospective group or blanket contractholder and an insurer in the course of negotiating a group or blanket contract;

f. court approved material ordered by a court to be disseminated to contract holders; or

g. a general announcement from a group or blanket contractholder to eligible individuals on an employment or membership list that a contract or program has been written or arranged; provided, the announcement clearly indicates that it is preliminary to the issuance of a booklet.

C. "Exception" for the purpose of § 1.12 of this Part means any provision in a contract whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the contract.

D. "Reduction" for the purpose of § 1.12 of this Part means any provision which reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction not been used.

E. "Limitation" for the purpose of § 1.12 of this Part means any provision which restricts coverage under the contract other than an exception or a reduction.

F. "Institutional Advertisement" for the purpose of § 1.12 of this Part means an advertisement having as its sole purpose the promotion of the Reader's or viewer's interest in the concept of health benefits, or the promotion of the insurer.

G. "Invitation to Inquire" for the purpose of § 1.12 of this Part means an advertisement having as its objective the creation of a desire to inquire further about the product and which is limited to a brief description of the loss for which the benefit is payable, and which may contain:

1. The dollar amount of benefit payable, and/or

2. The period of time during which the benefit is payable, provided the advertisement does not refer to cost. An advertisement which specifies either the dollar amount of benefit payable or the period of time during which the benefit is payable shall contain a provision in effect as follows:

a. "For costs and further details of the coverage, including exclusions, any reductions or limitations and the terms under which the health benefit contract may be continued in force, see your agent or write to the company."

H. "Invitation to Contract" for the purpose of § 1.12 of this Part means an advertisement which is neither an invitation to inquire nor an institutional advertisement.

### 1.12.4 Method of Disclosure of Required Information

A. All information required to be disclosed by § 1.12 of this Part shall be set out conspicuously and in close conjunction with the statements to which such information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisement so as to be confusing or misleading.

B. Guideline 4

1. This rule permits the use of either of the following alternative methods of disclosure:

a. The first alternative provides for the disclosure of exceptions, limitations, reductions and other restrictions conspicuously and in close conjunction with the statements to which such information relates. This may be accomplished by disclosure in the description of the related benefits or in a paragraph set out in close conjunction with the description of contract benefits.

b. The second alternative provides for the disclosure of exceptions, limitations, reductions and other restrictions not in conjunction with the provisions describing contract benefits but under appropriate captions of such prominence that the information shall not be minimized, rendered obscure or otherwise made to appear unimportant. The phrase "under appropriate captions" means that the title must be accurately descriptive of the captioned material. Appropriate captions include the following: "Exceptions," "Conditions Not Covered," and "Exceptions and Reductions." The use of captions such as, or similar to, the following are not acceptable because they do not provide adequate notice of the significance of the material: "Extent of Coverage," "Only These Exclusions," or "Minimum Limitations".

c. In considering whether an advertisement complies with the disclosure requirements of this rule, the rule must be applied in conjunction with the form and content standards contained in § 1.12.5 of this Part.

### 1.12.5 Form and Content of Advertisements

A. The format and content of an advertisement of a health benefit contract shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the Director of Business Regulation or his designee from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence, within the segment of the public to which it is directed.

1. Guideline 5-A

a. This rule must be applied in conjunction with §§ 1.12.1 and 1.12.4 of the rules. This rule refers specifically to "format and content" of the advertisement and the "overall" impression created by the advertisement. This involves factors such as, but not limited to, the size, color and prominence of type used to describe benefits. The word "format" means the arrangement of the text and the captions.

b. This rule requires distinctly different advertisements for publication in newspapers or magazines of general circulation as compared to scholarly, technical or business journals or newspapers. Where an advertisement consists of more than one piece of material, each piece of material must, independent of all other pieces of material, conform to the disclosure requirements applicable to the appropriate form of advertisement as defined in § 1.12.3(F) through (H) of this Part.

B. Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used.

1. Guideline 5-B

a. This rule prohibits the use of incomplete statements and words or phrases which have the tendency or capacity to mislead or deceive because of the reader's unfamiliarity with insurance terminology. Therefore, words, phrases and illustrations used in an advertisement must be clear and unambiguous and, if the advertisement uses insurance terminology, sufficient description of a word, phrase or illustration shall be provided by definition or description in the context of the advertisement. As implied in § 1.12.5(A) of this Part, distinctly different levels of comprehension may be anticipated of the subscribers of various publications.

**1.12.6 Advertisements of Benefits Payable, Losses Covered or Premiums Payable**

A. Deceptive Words, Phrases, or Illustrations Prohibited.

1. No advertisement shall omit information or use words, phrases, statements, references or illustrations if the omission of such information or use of such words, phrases, statements, references, or illustrations has the capacity, tendency, or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any health benefit payable, loss covered or premium payable. The fact that the health benefit contract is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.

2. Guideline 6-A(1)

a. This rule prohibits words, phrases or illustrations which create deception to the reader by omission or commission. The following examples are illustrations of the prohibitions created by the rule.

(1) An advertisement which describes any benefits that vary by age must disclose that fact.

(2) An advertisement which uses a phrase such as "no age limit," if benefits or premiums vary by age or if age is an underwriting factor, must disclose that fact.

(3) Advertisements, applications, requests for additional information and similar material are unacceptable if they state or imply that the recipient has been individually selected to be offered insurance or has had his eligibility for such insurance individually determined in advance when the advertisement is directed to all persons in a group or to all persons whose names appear on a mailing list.

(4) Advertisements which indicate that a particular coverage or health benefit contract is exclusively for "preferred risks" or a particular segment of the population are acceptable risks, when such distinctions are not maintained in the issuance of health benefit contracts, are not acceptable.

(5) Advertisements for group and franchise group plans which provide a common benefit or a common combination of benefits shall not imply that the insurance coverage is tailored or designed specifically for that group, unless such is the fact.

(6) It is unacceptable to use terms such as "enroll" or "join" to imply group or blanket insurance coverage when such is not the fact.

(7) Any advertisement which contains statements such as "anyone can apply," or "anyone can join" other than with respect to a guaranteed issue health benefit contract for which administrative procedures exist to assure that the health benefit contract is issued within a reasonable period of time after the application is received by the insurer is unacceptable.

(8) An advertisement which states or implies immediate coverage or guaranteed issuance of a health benefit contract is unacceptable unless suitable administrative procedures exists so that the health benefit contract is issued within a reasonable period of time after the application is received by the insurer.

(9) Any advertisement which uses any phrase or term such as "here is all you do to apply," "simply" or "merely" to refer to the act of applying for a health benefit contract which is not a guaranteed issue health benefit contract is unacceptable, unless it refers to the fact that the application is subject to acceptance or approval by the insurer.

(10) Applications, request forms for additional information and similar related materials are unacceptable if they resemble paper currency, checks, bonds, stock certificates, etc.

(11) No advertisement shall employ devices which are designed to create undue fear or anxiety in the minds of those to whom they are directed. Unacceptable examples of such devices are:

(AA) The use of phrases such as "cancer kills somebody every two minutes" and "total number of accidents" without reference to the total population from which such statistics are drawn. (As an example of a permissible device, data prepared by the American Cancer Society are acceptable provided their source is noted and they are not overemphasized),

(BB) The use of phrases such as "the finest kind of treatment," implying that such treatment would be unavailable without insurance;

(CC) The reproduction of newspaper articles, etc., containing irrelevant facts and figures;

(DD) The use of illustrations which unduly emphasize automobile accidents, crippled persons or persons confined in beds who are in obvious distress or receiving hospital or medical bills or persons being evicted from their homes due to their inability to pay hospital bills;

(EE) The use of phrases such as "financial disaster," "financial distress," "financial shock," or other phrases implying that financial ruin is likely without insurance, where used in an advertisement which comes within § 1.12.6(A)(2)(a)(7) of this Part relating to contracts covering specified illnesses or specified accidents only.

(12) An advertisement which uses the word "plan" without identifying it as an "insurance plan" is not permissible unless such plan is in fact, not an insurance plan or unless specific provisions in the General Laws of Rhode Island declare that it is not an insurance plan.

(13) An advertisement which implies in any manner that the prospective insured may realize a profit from obtaining hospital, medical, or surgical coverage is not acceptable.

(14) An advertisement shall not state or imply by word, phrase, or illustration that the benefits being offered will supplement any other insurance policy, insurance-type concept, or governmental plan if such is not the fact.

(15) An advertisement of a hospital or other similar facility confinement benefit that makes reference to the benefit being paid directly to the insured is misleading unless, in making such a reference, the advertisement includes a statement that the benefits may be paid directly to the hospital or other health care facility if an assignment of benefits is made by the insured. An advertisement of

medical and surgical expense benefits shall comply with this § 1.12 of Part in regard to the disclosure of assignments of benefits to providers of services. Phrases such as "you collect," "you get paid," "pays you," or other words or phrases of similar import are acceptable so long as the advertisement indicates that it is payable to the insured or someone designated by the insured.

(16) An advertisement which refers to "hospitalization for injury or sickness" omitting the word "covered" when the health benefit contract excludes certain sicknesses or injuries is unacceptable. Continued reference to "covered injury or sickness" is not necessary where this fact has been prominently disclosed in the advertisement and where the descriptions of sicknesses or injuries not covered are prominently set forth.

(17) An advertisement which refers to "whenever you are hospitalized" or "while you are confined in the hospital" omitting the phrase "for covered injury or sickness," if the health benefit contract excludes certain injuries or sickness, is unacceptable. Continued reference to "covered injury or sickness" is not necessary where this fact has been prominently disclosed in the advertisement and where the description of sicknesses or injuries not covered are prominently set forth.

(18) Advertisements which state that benefits are provided when "you go to the hospital" are unacceptable unless the advertisement clearly sets forth the extent of the coverage.

(19) An advertisement which fails to disclose any waiting or elimination periods for specific benefits is unacceptable.

(20) An advertisement for a limited health benefit contract, or hospital indemnity contract, or a plan of insurance which covers only certain causes of loss (such as dread disease) or which covers only a certain type of loss (such as hospital confinement) is unacceptable if:

(AA) the advertisement refers to a total benefit maximum limit payable under the health benefit contract in any headline, lead-in or caption without also in the same

headline, lead-in or caption specifying the applicable daily limits and other internal limits;

(BB) the advertisement states any total benefit limits without stating the periodic benefit payment, if any, and the length of time the periodic benefit would be payable to reach the total benefit limit;

(CC) the advertisement prominently displays a total benefit limit which would not, as a general rule, be payable under an average claim.

(21) Advertisements which emphasize total amounts payable under hospital, medical, or surgical coverage or other benefits in a health benefit contract, such as benefits for private duty nursing, are unacceptable unless the actual amounts payable per day for such indemnity or benefits are stated.

(22) Examples of what benefits may be paid under the health benefit contract shall not disclose only maximum benefits unless such maximum benefits are paid for loss from common and probable illnesses or accidents rather than exceptional or rare illnesses or accidents or periods of confinement for such exceptional or rare accidents or illnesses.

(23) When a range of benefit levels is set forth in an advertisement, it must be made clear that the insured will receive only the benefit level written or printed in the health contract selected and issued. Language which implies that the insured may select the benefit level at the time of filing claims is unacceptable.

(24) Advertisements for health benefit contracts whose premiums are modest because of their limited coverage or limited amount of benefits shall not describe premiums as "low," "low cost," "budget," or use qualifying words of similar import. § 1.12 of this Part also prohibits the use of words such as "only" and "just" in conjunction with statements of premium amounts when used to imply a bargain.

(25) Advertisements which state or imply that premiums will not be changed in the future are not acceptable unless the advertised health benefit contracts so provide.

(26) An advertisement which does not require the premium to accompany the application must not over-emphasize that fact and must make the effective date of the coverage clear.

(27) An advertisement which exaggerates the effect of statutorily mandated benefits or required health benefit contract provisions or which implies that such provisions are unique to the advertised health benefit contract is unacceptable. For example, the phrase, "Money Back Guarantee" is an exaggerated description of the ten-day right to examine the health benefit contract and is not acceptable.

(28) An advertisement which implies that a common type of health benefit contract or a combination of common benefits is "new," "unique," "a bonus," "a break- through," or is otherwise unusual is unacceptable. Also, the addition of a novel method of premium payment to an otherwise common plan of insurance does not render it "new."

(29) An advertisement which is an invitation to contract which fails to disclose the amount of any deductible and/or the percentage of any coinsurance factor is unacceptable.

(30) An advertisement which fails to state clearly the type of coverage being offered is not acceptable.

(31) Language which states or implies that each member under a "family" contract is covered as to the maximum benefits advertised, where such is not the fact, is unacceptable.

(32) The importance of diseases rarely or seldom found in the class of person to whom the health benefit contract is offered shall not be exaggerated in an advertisement.

(33) A television, radio, mail, or newspaper advertisement which is designed to produce leads either by use of a coupon or a request to write to the company or a subsequent advertisement prior to contact must include information disclosing that an agent may contact the applicant if such is the fact.

(34) Advertisements for health benefit contracts designed to supplement Medicare or which are otherwise designed for issue to the elderly shall not employ devices which are designed to create undue anxiety in the minds of such persons. Such phrases as "here is where most people over 65 learn about the gaps in Medicare," or "Medicare is great, but…" or which otherwise exaggerate the gaps in Medicare coverage are unacceptable. Phrases or devices which unduly excite fear of dependence upon relatives or charity are unacceptable. Phrases or devices which imply that long sicknesses or hospital stays are common among the elderly are unacceptable.

(35) An advertisement implying that the coverage is supplemental to Medicare, if it does not explain the manner in which it is supplemental to Medicare coverage, is not acceptable.

(36) An advertisement for a health benefit contract designed to supplement benefits under Medicare is unacceptable if the advertisement:

(AA) fails to disclose in clear language which of the Medicare benefits the health benefit contract is designed to supplement and which of the Medicare benefits the health benefit contract is not designed to supplement or if it otherwise implies that Medicare provides only those benefits which the health benefit contract is designed to supplement;

(BB) describes the in-patient hospital coverage of Medicare as "hospital Medicare" or "Medicare Part AA" when the health benefit contract does not supplement the non-hospital or the psychiatric hospital benefits of Medicare Part A (phrases to the effect of "the in-hospital portion of Medicare Part A" are acceptable);

(CC) fails to clearly describe the operation of the Part of Parts of Medicare which the health benefit contract is designed to supplement;

(DD) describes those Medicare benefits not supplemented by the health benefit contract in such a way as to minimize their importance relative to the Medicare benefits which are supplemented.

3. No advertisement shall contain or use words or phrases such as "all;" "full;" "complete;" "comprehensive;" "unlimited;" "up to;" "as high as;" "this policy will help fill some of the gaps that Medicare and your present insurance leave out;" or similar words and phrases, in a manner which exaggerates any benefits beyond the terms of the health benefit contract

4. Guideline 6-A(2)

    a. This rule recognizes that certain words and phrases in advertising may have a tendency to mislead the public as to the extent of benefits under an advertised contract. Consequently, such terms (and those specified in the rule do not represent a comprehensive list but only examples) must be used with caution to avoid any tendency to exaggerate benefits and must not be used unless the statement is literally true in every instance. The use of the following phrases based on such terms or having the same effect must be similarly restricted: "pays hospital, surgical, etc., bills," "pays dollars to offset the cost of medical care," "safeguards your standard of living," "pays full coverage," "pays complete coverage," or "pays for financial needs." Other phrases may or may not be acceptable depending upon the nature of the coverage being advertised. For example, the phrase "this policy will help to replace your income" is unacceptable in advertising for hospital confinement (including "hospital indemnity") coverage.

    b. This rule also prohibits words or phrases which exaggerate the effect of benefit payment on the insured's general well-being, such as "worryfree savings plan," "guaranteed savings," "financial peace of mind," and "you will never have to worry about hospital bills again".

    c. Advertisements for contracts designed to supplement Medicare benefits are unacceptable if they fail to disclose that no hospital confinement benefits will be payable for that portion of a Medicare benefit period for which Medicare pays all hospital confinement expenses, currently sixty (60) days, other than the initial deductible if the contract so provides. The length of said period must be stated in days.

5. An advertisement shall not contain descriptions of a health benefit contract limitation, exception, or reduction, worded in a positive manner to imply that it is a benefit, such as, describing a waiting period as a "benefit builder," or stating "even pre-existing conditions are covered after two years." Words and phrases used in an advertisement to describe such

health benefit contract limitations, exceptions and reductions shall fairly and accurately describe the negative features of such limitations, exceptions, and reductions of the health benefit contract offered.

6. Guideline 6-A(3)

   a. Explanations must not minimize nor describe restrictive provisions in a positive manner. Negative features must be accurately set forth. Any limitations on benefits precluding pre-existing conditions must also be restated under a caption concerning exclusions or limitations, notwithstanding that the pre-existing condition exclusion has been disclosed elsewhere in the advertisement. (See Guideline 6-C(1) for additional comments on pre-existing conditions.)

   b. No advertisement of a benefit for which payment is conditional upon confinement in a hospital or similar facility shall use words or phrases such as "tax free," "extra cash," "extra income," "extra pay," or substantially similar words or phrases because such words and phrases have the capacity, tendency or effect of misleading the public into believing that the health benefit contract advertised will, in some way, enable them to make a profit from being hospitalized.

7. Guideline 6-A(4)

   a. The words, phrases, illustrations and concepts listed are illustrations of the words, phrases, illustrations, and concepts prohibited by the rule which create the impression of a profit or gain to be realized by the insured when hospitalized.

   b. Illustrations which depict paper currency or checks showing an amount payable are deceptive and misleading and are not permissible.

   c. A hospital indemnity advertisement shall not include language such as "pay for a trip to Florida," "buy a new television," or otherwise imply that the insured will make a profit on hospitalization.

   d. An advertisement which uses words such as "extra," "special," or "added" to describe any benefit in the contract is unacceptable.

   e. Although the rule prohibits the use of the phrase "tax free," it does not prohibit the use of complete and accurate terminology explaining the Internal Revenue Service rules applicable to the taxation of accident and sickness benefits. The IRS rules provide that the premiums paid for and the benefits received from hospital

indemnity policies are subject to the same rules as loss of time premiums and benefits and are not afforded the same favorable tax treatment as premiums for expense incurred hospital, medical, and surgical benefit coverages. (Rev. Rule. 68-451 and Rev. Rule. 69-154.) Prominence either to caption, lead-in, boldface, or large type shall not be given in any manner to any statements relating to the tax status of such benefits.

8. No advertisement of a hospital or other similar facility confinement benefit shall advertise that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is based upon a daily pro rata basis relating to the number of days of confinement. When the health benefit contract contains a limit on the number of days of coverage provided, such limit must appear in the advertisement.

9. Guideline 6-A(5)

   a. This rule requires that benefits payable on a daily basis be stated as such and not on the basis of weekly or monthly equivalents. The rule also requires disclosure of the period of coverage provided by the contract.

      (1) No advertisement of a health benefit contract covering only one disease or a list of specified diseases shall imply coverage beyond the terms of the health benefit contract. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact.

      (2) An advertisement for a health benefit contract providing benefits for specified illnesses only, such as cancer, or for specified accidents only, such as automobile accidents, shall clearly and conspicuously, in prominent type, state the limited nature of the health benefit contract. The statement shall be worded in language identical to or substantially similar to the following: "THIS IS A LIMITED CONTRACT;" "THIS IS A CANCER ONLY CONTRACT;" "THIS IS AN AUTOMOBILE ACCIDENT ONLY CONTRACT."

      (3) An advertisement of a direct response insurance product shall not imply that because "no insurance agent will call and no commissions will be paid to agents that it is "a low cost plan," or use other similar words or phrases.

10. Guideline 6-A(8)

a. This rule should be applied in conjunction with § 1.12.11 of this Part. Phrases such as "we cut cost to the bone" or "we deal direct with you so our costs are lower" shall not be used.

B. Exceptions, Reductions, and Limitations.

1. When an advertisement which is an invitation to contract refers to either a dollar amount, or a period of time for which any benefit is payable, or the cost of the health benefit contract, or specific health benefit, or the loss for which such benefit is payable, it shall also disclose those exceptions, reductions, and limitations affecting the basic provisions of the health benefit contract without which the advertisement would have the capacity or tendency to mislead or deceive.

2. Guideline 6-B(1)

a. The extent of disclosure required by this rule depends upon the type of advertisement. An institutional advertisement as defined in § 1.12.3(F) of this Part is not subject to this rule. An advertisement which is an invitation to inquire as defined in § 1.12.3(G) of this Part which mentions either the dollar amount of benefit payable or the period of time during which the benefit is payable must include a reference to the existence of exceptions, reductions, and limitations in the manner required by § 1.12.3(G) of this Part. An advertisement which is an invitation to contract as defined in § 1.12.3(H) of this Part must recite the exceptions, reductions, and limitations as required by the rule and in a manner consistent with § 1.12.4 of this Part.

b. If an exception, reduction, or limitation is important enough to use in a contract, it is of sufficient importance that its existence in the contract should be referred to in the advertisement regardless of whether it may also be subject matter of a provision of the Uniform Individual Accident and Sickness Policy Provision Law.

c. Some Advertisements disclose exceptions, reductions, and limitations as required, but the advertisement is so lengthy as to obscure the disclosure. Where the length of an advertisement has this effect, special emphasis must be given by changing the format to show the restrictions in a manner which does not minimize, render obscure or otherwise make them appear unimportant.

3. When a health benefit contract contains a waiting, elimination, probationary, or similar time period between the effective date of the

health benefit contract and the effective date of coverage under the health benefit contract or a time period between the date loss occurs and the date benefits begin to accrue for such loss, an advertisement which is subject to the requirements of the preceding paragraph shall disclose the existence of such periods.

4. Guideline 6-B(2)

    a. This rule imposes the same disclosure standards as the preceding with respect to contract provision providing for waiting, elimination, probationary, or similar time periods, between the effective date of the contract and the effective date of coverage under the contract or a time period between the date a loss occurs and the date benefits begin to accrue from such loss. The comments under § 1.12.6(B)(1) of this Part are equally applicable to this Subsection. Where a contract has waiting, elimination, probationary, or other such time periods, such provisions must be stated in negative terms. This requirement is comparable to that contemplated in § 1.12.6(A)(5) of this Part as to exceptions, reductions, and limitations.

    b. An advertisement for a contract designed to supplement Medicare benefits is unacceptable if it fails to disclose that no hospital confinement benefits will be payable for that portion of a Medicare benefit period, currently 60 days, for which Medicare pays all hospital confinement expenses other than the initial deductible, if the contract so provides. The length of said period must be stated in days.

5. An advertisement shall not use the words "only;" "just;" "merely;" "minimum;" or similar words or phrases to describe the applicability of any exceptions and reductions, such as: "This contract is subject to the following minimum exceptions and reductions”

6. Guideline 6-B (3)

    a. This rule is similar to § 1.12.6(A)(5) of this Part and requires a fair and accurate description of exceptions, limitations, and reductions in a manner which does not minimize, render obscure or otherwise make them appear unimportant.

    b. Advertisements must state exceptions, limitations, and reductions in the negative and must not understate any exception, limitation, or reduction or qualify any exception, limitation, or reduction to

emphasize coverage described elsewhere (e.g., "Does not pay for_____, however, Medicare pays this" is not acceptable, nor is "Does not pay for the first four days in hospital for sickness, but pays for accident from first day"). (Underscoring indicates the manner in which statements are sometimes emphasized.)

c. This rule prohibits the use of any term, such as "just," "only," "merely," "necessary," or "minimum" to describe any exclusion, limitation, reduction, or exception.

C. Pre-Existing Conditions.

1. An advertisement which is subject to the requirements of Section 6(B) shall, in negative terms, disclose the extent to which any loss is not covered if the cause of such loss is traceable to a condition existing prior to the effective date of the health benefit contract. The use of the term "pre-existing condition" without an appropriate definition or description shall not be used.

2. Guideline 6-C (1)

a. This rule imposes the same disclosure standards with respect to pre-existing conditions provisions as noted in § 1.12.6(B)(2) of this Part. The comments under that Guideline are equally applicable to this subsection of the rules since the pre- existing conditions provision is an exception under the rules.

b. This rule implements the objective of § 1.12.6(A)(3) of this Part by requiring in negative terms a description of the effect of a pre-existing condition exclusion because such an exclusion is a restriction on coverage. The subdivision also prohibits the use of the phrase "pre-existing condition" without an appropriate definition or description of the term and prohibits stating a reduction in the statutory time limit (such as a reduction from three years to two years or to one year) as an affirmative benefit. The words "appropriate definition or description" mean that the term "pre-existing condition" must be defined as it is used by the company's claims department.

3. When a health benefit contract does not cover losses resulting from pre-existing conditions, no advertisement of the health benefit contract shall state or imply that the applicant's physical condition or medical history will not affect the issuance of the health benefit contract or payment of a claim thereunder. § 1.12 of this Part prohibits the use of the phrase "no medical

examination required" and phrases of similar import, but does not prohibit explaining "automatic issue." If an insurer requires a medical examination for a specified health benefit contract, the advertisement, if it is an invitation to contract, shall disclose that a medical examination is required.

4. Guideline 6-C (2)

   a. The phrase "no health questions" or words of similar import shall not be used if the contract excludes pre-existing conditions.

   b. Use of a phrase such as "guaranteed issue" or "automatic issue," if the contract excludes pre-existing conditions for a certain period, must be accompanied by a statement disclosing that fact in a manner which does not minimize, render, obscure, or otherwise make it appear unimportant and is otherwise consistent with § 1.12.4 of this Part.

5. When an advertisement contains an application form to be completed by the applicant and returned by mail for a direct response insurance product, such application form shall contain a question or statement which reflects the pre-existing condition provisions of the health benefit contract immediately preceding the blank space for applicant's signature. For example, such an application form shall contain a question or statement substantially as follows:

   a. Do you understand that this health benefit contract will not pay benefits for any loss incurred during the first ____ year(s) after the issue date for a disease or physical condition which you now have or have had in the past? ____ YES.

   b. Or substantially the following statement:

      (1) I understand that the health benefit contract applied for will not pay benefits for any loss incurred during the first ____ year(s) after the issue date on account of disease or physical condition which I now have or have had in the past.

### 1.12.7 Necessity for Disclosing Health Benefit Contract Provisions Relating to Renewability, Cancellability, and Termination

A. When an advertisement which is an invitation to contract refers to either a dollar amount or a period of time for which any benefit is payable, or the cost of the health benefit contract, or specific health benefit contract benefit, or the loss for which such benefit is payable, it shall disclose the provisions relating to renewability, cancellability, and termination and any modification of benefits,

losses covered, or premiums because of age or for other reasons, in a manner which shall not minimize or render obscure the qualifying conditions.

1. Guideline 7

    a. This rule imposes the same disclosure standards with respect to contract provisions relating to renewability, cancellability, and termination, modification of benefits, losses or premiums because of age or otherwise as stated in § 1.12.6(B)(2) of this Part. The comments in that Guideline are equally applicable to § 1.12.7 of this Part.

    b. Advertisements of cancelable contracts must state that the contract is cancelable or renewable at the option of the company as the case may be. For example, the following represent illustrations: A contract which is cancelable shall be advertised in a manner similar to "This contract can be cancelled by the company at any time"; A contract which is renewable at the option of the insurance company shall be advertised in a manner similar to "This contract is renewable at the option of the company" or "The company has the right to refuse renewal of this contract" or "Renewable at the option of the insurer". Advertisements of such contracts must indicate that the insurer has the right to increase premium rates.

    c. With respect to non-cancelable contracts and guaranteed renewable contracts, the rule requires that a summary of the contract provisions with respect to renewability must be set forth and defined where appropriate. The disclosure of provisions relating to renewability requires the use of language such as "non-cancelable", "non-cancelable and guaranteed renewable", or "guaranteed renewable". Unless otherwise modified by law or regulation, the use of those terms and the definitions provided shall be consistent with the definitions of those terms adopted by the National Association of Insurance Commissioners (1960 Proc. Vol. 1, P. 153).

    d. The rule also requires a statement of the qualifying conditions which constitute limitations on the permanent nature of the coverage. These customarily fall into three categories:

        (1) age limits,

        (2) reservation of a right to increase premiums, and

(3) the establishment of aggregate limits. For example, "non-cancelable and guaranteed renewable" does not fulfill the requirement of the rule if the contract contains a terminal age of 65. In such a case, a proper statement would be "Non-cancelable and guaranteed renewable to age 65". If a guaranteed renewable contract reserves the right to increase premiums, the statement must be expanded into language similar to "guaranteed renewable to age 65 but the company reserves the right to increase premium rates on a class basis". If the contract contains an aggregate limit after which no further benefits are payable, the above statement must be amplified with the phrase "subject to a maximum aggregate amount of $50,000" or similar language. A contract may have one or more or the three basic limitations and an advertisement must describe each of those which the contract contains. The fact that a contract is guaranteed renewable shall not be exaggerated.

e. This rule also requires the disclosure of any modification of benefits or losses covered because of age or for other reasons. Provisions for reduction of benefits at stated ages must be set forth. For example, a contract may contain a provision which reduces benefits fifty percent (50%) after age sixty (60) although it is renewable to age sixty-five (65). Such a reduction would have to be set forth.

f. Also, a provision for the elimination of certain hazards at any specific ages or after the contract has been in force for a specified time would have to be set forth.

g. An advertisement for a contract which provides for step-rated premium rates based upon the contract year or the insured's attained age must disclose such rate increases and the time or ages at which such premiums increase.

h. This rule requires that the qualifying conditions of renewability must be disclosed in a manner which does not minimize or render obscure the qualifying conditions of renewal.

### 1.12.8 Testimonials or Endorsements by Third Parties

A. Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the health benefit contract advertised and be accurately reproduced. The insurer, in using a testimonial, makes as its own

all of the statements contained therein, and the advertisement, including such statement, is subject to all the provisions of § 1.12 of this Part.

1. Guideline 8-A

    a. This rule must be applied in conjunction with § 1.12.9 of this Part and requires that all such statements must be genuine and not fictitious. Under this rule, the manufacturing, substantive editing or "doctoring up" of a testimonial is clearly prohibited as being false and misleading to the insurance-buying public. However, language which would be unacceptable under these rules must be edited out of a testimonial.

    b. A testimonial must also represent the current opinion of the author. While an insurer is not required in each instance to check with the author each time the testimonial is used to ascertain that the views expressed have not altered, a testimonial should be checked before use in those instances when a change in views might be probable or reasonable to assume. When a testimonial is used more than one year after it was originally given, a confirmation must be obtained. The rule does not prohibit testimonials of a general nature in which the author expresses appreciation for courteous treatment received or prompt payment of claims.

B. If the person making a testimonial, an endorsement or an appraisal has a financial interest in the insurer or a related entity, as a stockholder, director, officer, employee, or otherwise, such fact shall be disclosed in the advertisement. If a person is compensated for making a testimonial, endorsement or appraisal, such fact shall be disclosed in the advertisement by language substantially as follows: "Paid Endorsement." This rule does not require disclosure of union "scale" for TV or radio performances. The payment of substantial amounts, directly or indirectly, for "travel and entertainment" for filming or recording of TV or radio advertisements removes the filming or recording from the category of an unsolicited testimonial and requires disclosure of such compensation. This rule does not apply to an institutional advertisement which has as its sole purpose the promotion of the insurer.

1. Guideline 8-B

    a. This rule requires the disclosure of any financial interest of a person making a testimonial, endorsement, or appraisal. Any payment, direct or indirect, whether specifically for the testimonial or endorsement or for any other services or relationship, is required to be disclosed. Reimbursement for substantial travel and

entertainment expenses is also required to be disclosed; however, union scale wages required by union rules are not required to be disclosed. Travel away from the home of the person giving the testimonial or endorsement to a distant location involving transportation expenses, lodging expenses or expenses for meals constitutes payment and must be reflected as a paid endorsement. The requirement of disclosure may be fulfilled by use of the phrase "Paid Endorsement" or words of similar import in a type style and size that is identical to the endorser's name. In the case of television or radio advertising, the paid nature of the advertisement must be given prominence.

C. An advertisement shall not state or imply that an insurer or a health benefit contract has been approved or endorsed by any individual group of individuals, society, association or other organizations, unless such is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, such fact shall be disclosed in the advertisement.

1. Guideline 8-C

a. This rule requires both that approval or endorsement of a contract by an individual, group of individuals, society, association, or other organization be factual and that any proprietary relationship between the sponsoring or endorsing organization and the insurer be disclosed. For example, if the dividend under an association group case is payable to the association, disclosure of that fact is required. Also, if the insurer or an officer of the insurer formed or controls the association, that fact must be disclosed.

D. When a testimonial refers to benefits received under a health benefit contract, the specific claim data, including claim number, date of loss, and other pertinent information shall be retained by the insurer for inspection for a period of four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

1. Guideline 8-D

a. This rule provides the means to verify the authenticity of testimonials used in advertising efforts.

b. The use of testimonials which do not correctly reflect the present practices of the insurer or which are not applicable to the contract or benefit being advertised is not permissible.

### 1.12.9 Use of Statistics

A. An advertisement relating to the dollar amount of claims paid, the number of persons insured, or similar statistical information relating to any insurer or health benefit contract shall not use irrelevant facts, and shall not be used unless it accurately reflects all of the relevant facts. Such an advertisement shall not imply that such statistics are derived from the health benefit contract advertised unless such is the fact, and when applicable to other health benefit contracts or plans, shall specifically so state.

1. Guideline 9-A

a. This rule prohibits the use of statistics in a manner which is misleading and deceptive. It requires the disclosure of all relevant facts and prohibits the use of irrelevant facts. An advertisement shall specifically identify the contract to which statistics relate and, where statistics are given which are applicable to a different contract; it must be stated clearly that the data do not relate to the contract being advertised.

b. Statistics which describe the insurer, such as assets, corporate structure, financial standing, age, product lines or relative position in the insurance business, may be irrelevant and, if used at all, must be used with extreme caution because of their potential for misleading the public. As a specific example, an advertisement for a health benefit contract which refers to the amount of life insurance which the company has in force or the amounts paid out in life insurance benefits is not permissible unless the advertisement clearly indicates the amount paid out for each line of insurance.

c. An advertisement which states the dollar amount of claims paid must also indicate the period over which such claims have been paid.

d. If the term "loss ratio" is used, it shall be properly explained in the context of the advertisement and, it shall be calculated on the basis of premiums earned to losses incurred and shall not be on a yearly run-off basis.

B. An advertisement shall not represent or imply that claim settlements by the insurer are "liberal" or "generous," or use words of similar import, or that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for a unique claim for the health benefit contract advertised is misleading and shall not be used.

1. Guideline 9-B

a. This rule prohibits deceptive or misleading statements in an advertisement regarding an insurer's claim settlement practices. It also prohibits the use of an unusual amount paid for a unique claim or an unusual claim whether actual or hypothetical.

C. The source of any statistics used in an advertisement shall be identified in such advertisement.

1. Guideline 9-C

a. This rule requires any advertisement which uses statistics to cite the source. The rule does not require that statistics for a state be used since such statistics as hospital charges and average stays may vary from state to state. When nationwide statistics are used such fact should be noted unless the statistics on the particular point are substantially the same in a state to which the advertisement is directed. Statistics may be used only if they are credible.

**1.12.10 Identification of Plan or Number of Health Benefit Contracts**

A. When a choice of the amount of benefits is referred to, an advertisement which is an invitation to contract shall disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of the benefits selected.

B. When an advertisement which is an invitation to contract refers to various benefits which may be contained in two or more health benefit contracts, other than group master health benefit contracts, the advertisement shall disclose that such benefits are provided only through a combination of such health benefit contracts.

1. Guideline 10

a. This rule imposes the same disclosure standards as stated in § 1.12.6(B)(2) of this Part. The comments in that Guideline are equally applicable to § 1.12.10 of this Part.

### 1.12.11 Disparaging Comparisons and Statements

A. An advertisement shall not directly or indirectly make unfair or incomplete comparisons of health benefit contracts or benefits or comparisons of noncomparable health benefit contracts of other insurers, and shall not disparage competitors, their health benefit contracts, services or business methods, and shall not disparage or unfairly minimize competing methods of marketing insurance.

1. Guideline 11

a. This rule prohibits unfair or incomplete comparisons of products, insurers or business methods. It specifically prohibits comparisons of noncomparable contracts and provides that advertisements shall not unfairly minimize nor disparage competing types of health benefit coverages or competing methods of marketing health benefits.

b. An advertisement should not contain statements such as "no red tape" or "here is all you do to receive benefits".

c. Advertisements which state or imply competing insurance contracts customarily contain certain exceptions, reductions, or limitations not contained in the advertised contracts are unacceptable unless such exceptions, reductions, or limitations are contained in a substantial majority of such competing contracts.

d. Advertisements which state or imply that an insurer's premiums are lower or that its loss ratios are higher because of its organizational structure differs from that of competing insurers are unacceptable.

### 1.12.12 Jurisdictional Licensing and Status of Insurer

A. An advertisement which is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

1. Guideline 12-A

a. This rule prohibits advertisements which imply that an insurer is licensed beyond the limits of those jurisdictions where it is actually licensed. An advertisement which contains testimonials from persons who reside in a state in which the insurer is not licensed or which refers to claims of persons residing in states in which the insurer is not licensed implies licensing in those states and

therefore is in violation of this rule unless the advertisement states that the insurer is not licensed in those states.

B. An advertisement shall not create the impression directly or indirectly that the insurer, its financial condition or status, or the payment of its claims, or the merits, desirability, or advisability of its contract forms or kinds or plans of insurance are approved, endorsed, or accredited by any division or agency of this State or the United States Government.

1. Guideline 12-B

a. This rule prohibits advertisements implying that approval, endorsement, or accreditation of contract forms or advertising has been granted by any division or agency of the state or federal government. "Approval" of either contract forms or advertising shall not be used by an insurer to imply or state that a governmental agency has endorsed or recommended the insurer, its contracts, advertising or its financial condition.

b. Although the rule permits a reference to an insurer being licensed in a state when the advertisement appears, it does not allow exaggeration of the fact of such licensing nor does it permit the suggestion that competing insurers may not be so licensed because, in most states, an insurer must be licensed in the state to which it directs its advertising.

c. Terms such as "official," or words of similar import, used to describe any contract or application form are not permissible because of the potential for deceiving or misleading the public.

### 1.12.13 Identity of Insurer

A. The name of the actual insurer shall be stated in all of its advertisements. The form number or numbers of the health benefit contract advertised shall be stated in an advertisement which is an invitation to contract. An advertisement shall not use a trade name, any insurance group designation, name of the parent company of the insurer, name of the particular division of the insurer, service mark, slogan, symbol or other device which, without disclosing the name of the actual insurer, would have the capacity and tendency to mislead or deceive as to the true identity of the insurer.

B. No advertisement shall use any combination of words, symbols, or physical materials which by their content, phraseology, shape, color or characteristics are so similar to any combination of words, symbols, or physical materials used by agencies of the federal government or of this State, or otherwise appear to be of

such a nature that it tends to confuse or mislead prospective insureds into believing that the solicitation is in some manner connected with an agency of the municipal, state, or federal government.

1. Guideline 13

    a. This rule prohibits the use of an advertisement which has the capacity or tendency to mislead or deceive as to the true identity of the insurer. The rule recognizes the existence of holding companies. The requirement that the advertisement refer to the contract form number is applicable to individual and franchise contracts only. However, the requirement of the contract form number is not applicable to those advertisements for individual and franchise contracts not required to disclose information under §§1.12.6(B)(1) and 1.12.7 of this Part. § 1.12.13(A) and (B) of this Part prohibit misleading practices of insurers in connection with the sale of insurance to supplement federal Medicare benefits and confusion of insurance companies with advertising material used by hospital service corporations or pre-paid health plans.

    b. This rule prohibits advertisements, envelopes, or stationery which employ words, letters, initials, symbols, or other devices which are so similar to those used by governmental agencies or other insurers, including hospital service corporations and pre-paid health plans, that the public may be confused into believing:

        (1) that the advertised coverages are somehow provided by or are endorsed by such governmental agencies or such other insurers;

        (2) that the advertised coverages are the same as those provided by such governmental agencies or such other insurers;

        (3) that the advertiser is the same as, is connected with or is endorsed by such governmental agencies or such other insurers.

    c. It is unacceptable for an advertisement to use the name of a state or a political subdivision thereof in a contract name or description. For example, "XYZ insurance company's (name of state) hospital confinement contract" is unacceptable.

    d. This rule prohibits an insurer from using envelopes or stationery which have printed thereon any name, service mark, slogan,

symbol, or using any device in such a manner that it implies that the insurer or the contract advertised is connected with a governmental agency such as the Social Security Administration or the Veterans Administration.

e. Contracts advertised to supplement Medicare benefits are unacceptable if they incorporate the word "Medicare" in the title of the contract being advertised unless, wherever it appears, said word is qualified by language differentiating it from Medicare. Such phrases as "Medicare Insurance Supplement" or "insurance to supplement Medicare" are acceptable. Such an advertisement, however, shall not use the phrase "Medicare Department of the XYZ Insurance Company," or language of similar import.

f. Advertisements for contracts designed to supplement Medicare benefits are unacceptable if they fail to contain a disclaimer to the effect of "Not connected with or endorsed by the U.S. Government or the federal Medicare program".

g. This rule prohibits an advertisement which implies that the reader may lose a right, privilege or benefit under federal, state or local law if he fails to respond to the advertisement.

h. If the use of letters, initials, or symbols of the corporate name or trademark would have the capacity or tendency to mislead or deceive the public as to the true identity of the insurer, § 1.12.13 of this Part prohibits the use of such letters, initials, or symbols without disclosing in a close conjunction the true and correct complete name of the insurer which will issue the contract.

i. This rule prohibits the use of the name of an agency or "_____ Underwriters" or "_____ Plan" in type, size, and location so as to have the capacity and tendency to mislead or deceive as to the true identity of the insurer and also prohibits an insurer from using an address so as to mislead or deceive as to its true identity, location, or licensing status.

### 1.12.14 Group or Quasi-Group Implications

A. An advertisement of a particular health benefit contract shall not state or imply that prospective insureds become group or quasi-group members covered under a group health benefit contract and as such enjoy special rates or underwriting privileges, unless such is the fact.

1. Guideline 14

a. This rule prohibits the use of representations to any segment of the population that a particular contract or coverage is available only to that or similar segments of the population as preferred risks when actually such contract or coverage is available to members of the public at large at the same rates. This rule prohibits an advertisement labeled "Now for Readers of X Magazine".

b. This rule prohibits the solicitation of a particular class, such as governmental employees, by use of advertisements which state or imply that their occupational status entitles them to reduced rates on a group or other basis when, in fact, the contract being advertised is sold only on an individual basis at regular rates.

### 1.12.15 Introductory, Initial, or Special Offers

A. An advertisement of an individual health benefit contract shall not directly or by implication represent that a contract or combination of contracts is an introductory, initial, or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such is the fact. An advertisement shall not contain phrases describing an enrollment period as "special," "limited," or similar words or phrases when the insurer uses such enrollment periods as the usual method of advertising health benefits.

1. Guideline 15-A (1)

a. This rule prohibits advertising representing that a product is offered on an introductory, initial, special offer basis or otherwise which:

(1) will not be available later; or

(2) is available only to certain individuals unless such is the fact.

b. This rule prohibits repetitive use of such advertisements. Where an insurer uses enrollment periods as the usual method of advertising these contracts, the rule prohibits describing an enrollment period as a special opportunity or offer for the applicant.

B. An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this State unless there has been a lapse of not less than 6 months between the close of the immediately preceding enrollment for the same product and the opening of the new enrollment period. The advertisement shall indicate the date by which the applicant must mail the application, which shall not be less than ten days and not more than forty days from the date that such enrollment period is advertised for

the first time. This rule applies to all advertising media, i.e., mail, newspapers, radio, television, magazines, and periodicals, by any one insurer. The phrase "any one insurer" includes all the affiliated companies of a group of insurers under common management or control.

1. Guideline 15-A (2)

    a. This rule restricts the repetitive use of enrollment periods. The requirement of reasonable closing dates and waiting periods between enrollment periods was adopted to eliminate the abuses which formerly existed. This rule does not limit just the use of enrollment periods. It requires that a particular insurance product offered in an enrollment period through any advertising media, including the prepared presentations of agents, cannot be offered again in the entire state until 6 months from the close of the enrollment period have expired. Thus, an insurer must choose whether to use enrollment period or open enrollment for a product. (See § 1.12.15(D) of this Part for definition of "a particular insurance product".)

    b. This rule does not prohibit multiple advertising during an enrollment period through any and all media published or transmitted within this state as long as the enrollment periods for all such advertisements have the same expiration date.

    c. This rule does not prohibit the solicitation of members of a group or association for the same product even though there has not been a lapse of 6 months since the close of a preceding enrollment period which was open to the general public for the same product.

    d. This rule does not require separation by 6 months of enrollment periods for the same insurance product in this state if the advertising material is directed by an admitted insurer to persons by direct mail on the basis that a common relationship exists with an entity, such as a bank and its depositors, a department store to its charge account customers or an oil company to its credit card holders, and more than one of such organizations is sponsoring such insurance product at different times if providing such insurance under such a method is not otherwise prohibited by law; provided, however, the 6 month rule does not apply to one specific sponsor to the same persons in this state on the basis of their status as customers of that one specific entity only.

C. § 1.12 of this Part prohibits any statement or implication to the effect that only a specific number of health benefit contracts will be sold or that a time is fixed for the discontinuance of the sale of the particular health benefit contract advertised because of the special advantages available in the health benefit contract, unless such is the fact.

D. The phrase "a particular insurance product" in § 1.12.15(B) of this Part means a health benefit contract which provides substantially different benefits than those contained in any other health benefit contract. Different terms of renewability; an increase or decrease in the dollar amounts of benefits; an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another health benefit contract shall not be sufficient to constitute the product being offered as a different product eligible for concurrent or overlapping enrollment periods.

1. Guideline 15-A (4)

a. This rule defines the meaning of "a particular insurance product" in § 1.12.15(B) of this Part and prohibits advertising of products having minor variations, such as different elimination periods or different amounts of daily hospital indemnity benefits, in a succession of enrollment periods.

E. An advertisement shall not offer a health benefit contract which utilizes a reduced initial premium rate in a manner which overemphasizes the availability and the amounts of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial reduced premium and the renewal premium must be stated in juxtaposition in each portion of the advertisement where the initial reduced premium appears.

1. Guideline 15-B

a. This rule prohibits advertising which over-emphasizes an initial premium. The rule requires the renewal premium to appear as frequently as, as prominently as and in juxtaposition with the initial reduced premium wherever and as often as it appears. The term "juxtaposition" means side by side or immediately above or below.

F. Special awards, such as a "safe drivers' award" shall not be used in connection with advertisements of health benefits.

1. Guideline 15-C

a. This rule prohibits the use in advertisements of so-called awards as an inducement to the purchase of insurance.

### 1.12.16 Statements About an Insurer

A. An advertisement shall not contain statements which are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendations.

1. Guideline 16

a. This rule is closely related to the requirements of § 1.12.9 of this Part concerning the use of statistics. The rule prohibits insurers which have been organized for only a brief period of time advertising that they are "old" and also prohibits the use of illustrations of a "home office" building in a manner which is misleading with respect to the actual size and magnitude of the insurer. Also, the occupations of the persons comprising the insurer's board of directors or the public's familiarity with their names or reputations is irrelevant and must not be emphasized. The preponderance of a particular occupation or profession among the board of directors of an insurer does not justify the advertisement of a plan of insurance offered to the general public as insurance designed or recommended by members of that occupation or profession. For example, it is unacceptable for an insurance company to advertise a policy offered to the general public as "the physicians' policy" or "the doctors' plan" simply because there is a preponderance of physicians or doctors on the board of directors of the insurer. The rule prohibits the use of a recommendation of a commercial rating system unless the purpose, meaning and limitations of the recommendation are clearly indicated.

### 1.12.17 Enforcement Procedures

A. Advertising File. Each insurer shall maintain at its home or principal office a complete file containing every printed, published, or prepared advertisement of its individual health benefit contracts and typical printed, published, or prepared advertisements of its blanket and group contracts and contracts on a "group-type" basis as defined in § 1.3 of this Part thereafter disseminated in this or any other state, whether or not licensed in such other state, with a notation attached

to each such advertisement which shall indicate the manner and extent of distribution and the form number of any health benefit contract advertised. Such file shall be subject to regular and periodical inspection by the Director. All such advertisements shall be maintained in said file for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

B. Certificate of Compliance. Each insurer required to file an Annual Statement which is now or which hereafter becomes subject to the provisions of § 1.12 of this Part must file with the Director, with its Annual Statement, a Certificate of Compliance executed by an authorized officer of the insurer wherein it is stated that, to the best of his knowledge, information and belief, the advertisements which were disseminated by the insurer during the preceding statement year complied or were made to comply in all respects with the provisions of § 1.12 of this Part and the Laws of this State as implemented and interpreted by § 1.12 of this Part. With respect to the year in which this Part is promulgated, such certification shall cover only that portion of the year during which this Part is effective.

### 1.12.18 Filing for Prior Review

The Director of Business Regulation may, at his or her discretion, require the filing by any insurer with this Department, for review prior to use, of all of its advertisements or all of a class of its advertisements which the Director shall describe which are printed or published "Invitations to Contract" and all prepared sales presentations to be used by agents, brokers and solicitors. Such advertising material must be filed by the insurer with this Department not less than ninety (90) days prior to the date the insurer desires to use the advertisement.

## 1.13 Review of Approvals or Disapprovals

Notwithstanding anything to the contrary in R.I. Gen. Laws Chapter 27-18 any request for a review of any approval or disapproval by the Director under this Part shall be treated as a contested case and shall be subject to the rules and procedures set forth in R.I. Gen. Laws Chapter 42-35 for the handling of contested cases and to all other rules and regulations appropriate thereto.

## 1.14 Severability

If any provisions of this Part, or the application thereof to any person or circumstance, is held invalid, such invalidity shall not affect other provisions or applications of this Part which can be given effect without the invalid provision or application, and to that end the provisions of this Part are severable.

## 1.15 Insurance Coverage for Serious Mental Illness

### 1.15.1 Statutory Authority

This addition of § 1.15 of this Part is promulgated pursuant to RI. Gen. Laws §§ 42-14-17 and 42-62-12 to implement R.I. Gen. Laws Chapter 27-38.2 (“Insurance Coverage for Serious Mental Illness” referred to herein as the "Act").

### 1.15.2 Definitions

A. Unless otherwise defined in the Act, for purposes of the Act and this § 1.15 of this Part, the following terms shall have the following meanings:

1. "Director" means the Director of the Department.

2. "ERISA" means the Employee Retirement Income Security Act of 1974 (including but not limited to Section 514 thereof, 29 U.S.C. § 1144), as amended from time to time.

3. "Health care insurers" shall have the meaning given to "Health insurers" in R.I. Gen. Laws § 27-38.2-2(a).

4. "Plan" means a health benefits plan as defined in R.I. Gen. Laws § 42-62-4(d) provided, however, that the term does not include federal employee health benefit programs or services provided to self-insured employers subject to ERISA.

5. "Serious Mental Illness" shall have the meaning given to "Serious Mental Illness" in R.I. Gen. Laws § 27-38.2-2(b).

### 1.15.3 Department's Jurisdiction -- Limits on Applicability

A. Certain Plans may:

1. be governed by contracts formed under laws of other states or of the United States and may, therefore, not be subject to the provisions of the Act or this § 1.15 of this Part; and

2. not be subject to the Act or this § 1.15 of this Part because of the pre-exemption of all or a portion of the Act and this § 1.15 of this Part by ERISA.

### 1.15.4 Time Limitation of Coverage

R.I. Gen. Laws § 27-38.2-4 requires that "inpatient coverage in cases where continuous hospitalization is medically necessary shall be limited to ninety (90)

consecutive days." As used in the Act, the phrase "ninety (90) consecutive days" shall constitute a reference to a time limit per hospitalization of the patient, and not to a lifetime or annual time limit.

### 1.15.5 Enforcement and Penalties

The Director shall have all of the enforcement powers granted or described in R.I. Gen. Laws § 27-42-14 and this Part to enforce the provisions of the Act and this § 1.15 of this Part. The Director may consider as part of the exercise of such enforcement powers any information the Director deems relevant, including but not limited to, decisions, rulings or orders of any agency of the State of Rhode Island.

### 1.15.6 Severability

If any section, term or provision of this § 1.15 of this Part shall be adjudged invalid for any reason, that judgment shall not affect, impair, or invalidate any remaining section, term or provision, which shall remain in full force and effect.

**230-RICR-20-30-1**

# TITLE 230 - DEPARTMENT OF BUSINESS REGULATION (INCLUDES THE OFFICE OF THE HEALTH INSURANCE COMMISSIONER)

## CHAPTER 20 - INSURANCE

## SUBCHAPTER 30 - HEALTH INSURANCE

PART 1 - Minimum Standards for Health Benefit Plans (230-RICR-20-30-1)

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Editorial Note: This Part was filed with the Department of State prior to the launch of the Rhode Island Code of Regulations. As a result, this digital copy is presented solely as a reference tool. To obtain a certified copy of this Part, contact the Administrative Records Office at (401) 222-2473.