

WAC 284-50-350 Major medical expense coverage. (1) "Major medical expense coverage" is a disability insurance policy which provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than \$10,000; copayment by the covered person not to exceed 25% of covered charges; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of such bases not to exceed 5% of the aggregate maximum limit under the policy, unless the policy is written to complement underlying hospital and medical insurance in which case such deductible may be increased by the amount of the benefit provided by such underlying insurance, provided the policy containing such deductible meets the criteria of subsection (3) of this rule.

(2) The coverage for each covered person shall be for at least:

(a) Daily hospital room and board expenses, prior to application of the copayment percentage, for not less than \$50 daily (or in lieu thereof the average daily cost of semiprivate room rate in the area where the insured resides) for a period of not less than 31 days during continuous hospital confinement;

(b) Miscellaneous hospital services, prior to application of the copayment percentage, for an aggregate maximum of not less than the greater of \$1,500 or 15 times the daily room and board rate if specified in dollar amounts;

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

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

(e) In-hospital medical services, prior to application of the copayment percentage, as defined in WAC 284-50-340(3).

(f) Out of hospital care, prior to application of the copayment percentage, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, and diagnostic X-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician; and

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

(i) In-hospital private duty graduate registered nurse services;

(ii) Convalescent nursing home care;

(iii) Diagnosis and treatment by a radiologist or physio-therapist;

(iv) Rental of special medical equipment, as defined by the insurer in the policy;

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

(vi) Treatment for functional nervous disorders, and mental and emotional disorders;

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

(3) The "variable deductible" permitted by subsection (1) of this rule will not be approved unless the following conditions are met:

(a) The policy containing such deductible shall be either guaranteed renewable as defined in WAC 284-50-330 or be a policy which would

otherwise be so guaranteed renewable except that the insurer has reserved the right to terminate all such policies in this state.

(b) The policy containing such deductible shall provide that the policyholder shall have the right to increase the stated or specified deductible on any policy anniversary date or upon the establishment of a benefit period, as defined in the policy.

(c) An insurer intending to market such policies in this state shall provide the commissioner, as part of its filing of policy forms, the following information and assurances:

(i) The outline of coverage used in connection with the policy shall contain a clear and prominent explanation of the effect of the variable deductible with respect to other coverages;

(ii) In the event a claim situation arises where the operation of the deductible provision would result in payment to the insured of an amount less than the total covered expenses for which the insured has not been reimbursed under other policies, the variable deductible feature of the deductible provision will be disregarded to the extent necessary to provide payment for such nonreimbursed expenses, subject to the variable deductible policy's coinsurance percentage;

(iii) An annual notice will be given to the policyholder recommending a review of the policy and the deductible feature in light of any change in the policyholder's other coverage which might affect the policy. A copy of such notice shall be filed with the commissioner prior to use.

[Order R-76-4, § 284-50-350, filed 10/29/76, effective 3/1/77.]