

# Chapter 284-52 WAC

## CONVERSION REGULATION

### WAC

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**WAC 284-52-010 Purpose.** (1) The purpose of this chapter is to establish rules pertaining to mandated conversion plans, and their specific standards and minimum benefits, to effectuate the provisions of RCW 48.21.260, 48.21.270, 48.44.370, 48.44.380, 48.46.450, and 48.46.460 (sections 3, 4, 6, 7, 9 and 10, chapter 190, Laws of 1984).

(2) Other conversion plans in addition to those required by this chapter may also be offered.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 84-19-055 (Order R 84-4), § 284-52-010, filed 9/19/84.]

**WAC 284-52-020 Mandated conversion plans minimum standards.** (1) Every insurer and every health care service contractor which issues group hospital or medical benefit plans shall make available to covered persons a choice of three conversion benefit plans which meet the requirements of WAC 284-52-040, 284-52-050, and 284-52-060, and every health maintenance organization which issues group hospital or medical benefit plans shall make available a conversion benefit plan which meets the requirements of WAC 284-52-060.

(2) Chapter 190, Laws of 1984, permits a denial of conversion coverage "to a person who is covered under another group plan, policy, contract, or agreement providing benefits for hospital or medical care." For such denial provision to apply, such other coverage must not contain operable exclusions for preexisting conditions or waiting periods greater than those remaining under the terminated plan.

(3) Such conversion benefit plans:

(a) May provide that their benefits will be excess to any group hospital or medical plan, governmental program, or automobile medical, automobile no-fault, automobile uninsured and/or underinsured motorist or similar coverage issued to or on behalf of the covered person.

(b) Shall provide that deductible amounts will be determined on a calendar year basis.

(c) Shall provide that expenses incurred or the cost of services rendered and applied toward the annual deductible amount during the last three months of such calendar year shall be applied toward the deductible amount in the ensuing calendar year.

(d) May be rated based upon attained age.

(e) Which provide coverage for dependent children, may require evidence of insurability for newly acquired dependents except that newborn infants shall be covered from the

moment of birth without evidence of insurability provided application therefor and payment of applicable rates, if any, are made within sixty days of birth.

(f) Shall permit the covered person to pay the premium monthly.

(g) Shall provide that an insured, subscriber or enrollee may continue to renew the conversion coverage until such person fails to pay a necessary premium or fee, becomes eligible for medicare, or is covered under another group plan providing benefits for hospital and medical care, but only after preexisting conditions are covered and waiting periods have been satisfied under such plan.

(h) Which are written to cover all members of a family under one contract, shall contain a provision to assure that each member, in the event that he or she ceases to be a qualified family member for purposes of coverage, as, for example, by attaining a particular age, or through a marriage or a divorce, or by reason of death of the principal covered person, shall have the right to continue the coverage without a physical examination, statement of health, or other proof of insurability.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 84-19-055 (Order R 84-4), § 284-52-020, filed 9/19/84.]

**WAC 284-52-030 Other provisions applicable to mandated conversion plans.** Except as otherwise required or permitted by this chapter, mandated conversion plans shall:

(1) Use a format no less favorable to the covered individual than those set forth in RCW 48.20.012, with respect to insurers, or WAC 284-44-030, with respect to health care service contractors and health maintenance organizations;

(2) Contain a provision providing for the return of the contract for a refund of payment, consistent with RCW 48.20.013, 48.44.230 or 48.46.260, as appropriate;

(3) Contain provisions consistent with and no less favorable to the covered individual than the following laws and regulations thereunder:

(a) With respect to insurers, the requirements and standard provisions set forth in chapter 48.20 RCW;

(b) With respect to health care service contractors, the requirements of chapter 48.44 RCW and WAC 284-44-040, except that lifetime maximum benefits under a conversion plan are not required to be renewed or restored;

(c) With respect to health maintenance organizations, the requirements of chapter 48.46 RCW;

(4) Be administered by the carrier in full compliance with any applicable laws which prohibit denials of payments for services performed by certain licensed providers of service.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 84-19-055 (Order R 84-4), § 284-52-030, filed 9/19/84.]

**WAC 284-52-040 Basic medical plan.** A basic medical plan shall have an annual deductible amount of no less than five hundred dollars or more than one thousand dollars per person and shall provide at least the following benefits:

- (1) A lifetime maximum amount of benefits of seventy-five thousand dollars per person.
- (2) Daily hospital room and board expenses in an amount not less than one hundred eighty dollars per day for at least seventy days per calendar or contract year.
- (3) Ancillary hospital expenses up to a maximum of eighteen hundred dollars per calendar or contract year.
- (4) Surgeons' fees at the usual and customary charge up to a maximum of at least fifteen hundred dollars per surgical procedure.
- (5) Usual and customary assistant surgeons' fees.
- (6) Usual and customary anesthesiologists' and anesthesiologists' fees.
- (7) Inpatient and outpatient physician services at the usual and customary charge.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 84-19-055 (Order R 84-4), § 284-52-040, filed 9/19/84.]

**WAC 284-52-050 Major medical plan.** A major medical plan shall have an annual deductible amount of no less than one thousand dollars or more than five thousand dollars per person and shall provide at least the following benefits:

- (1) A lifetime maximum amount of benefits of two hundred fifty thousand dollars.
- (2) Payment of at least seventy-five percent of the usual and customary charges for the following:
  - (a) Daily hospital room and board expenses not less than the semi-private room rate or less than one hundred twenty days per calendar or contract year.
  - (b) Ancillary hospital expenses.
  - (c) Surgeons' fees.
  - (d) Assistant surgeons' fees.
  - (e) Anesthesiologists' and anesthesiologists' fees.
  - (f) Inpatient and outpatient physician services.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 85-03-035 (Order R 85-1), § 284-52-050, filed 1/10/85; 84-19-055 (Order R 84-4), § 284-52-050, filed 9/19/84.]

**WAC 284-52-060 Comprehensive medical plan.** Except as provided in subsection (3) of this section, a comprehensive medical plan shall have an annual deductible amount of five hundred dollars per person and shall provide at least the following benefits:

- (1) A lifetime maximum amount of benefits of five hundred thousand dollars per person.
- (2) Payment of at least eighty percent of the usual and customary charges for the following:
  - (a) Daily hospital room and board expenses not less than the semi-private room rate nor less than one hundred eighty days per calendar or contract year.
  - (b) Ancillary hospital expenses.
  - (c) Surgeons' fees.
  - (d) Assistant surgeons' fees.
  - (e) Anesthesiologists' and anesthesiologists' fees.
  - (f) Inpatient and outpatient physician services.

(3) A health maintenance organization's comprehensive medical plan may provide for no deductible amount or a deductible in any amount not exceeding five hundred dollars.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 85-03-035 (Order R 85-1), § 284-52-060, filed 1/10/85; 84-19-055 (Order R 84-4), § 284-52-060, filed 9/19/84.]

**WAC 284-52-070 Exclusions.** No policy or contract set forth in WAC 284-52-040, 284-52-050, and 284-52-060 may exclude coverage by type of illness, injury, accident, treatment, or medical condition, except with respect to the following:

- (1) Alcoholism and drug addiction.
- (2) Pregnancy, except for complications of pregnancy.
- (3) 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.
  - (4) Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows covered surgery resulting from trauma, infection or other diseases of the involved part, reconstructive breast surgery covered pursuant to RCW 48.20.395, 48.21.230, 48.44.330 and 48.46.280, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.
  - (5) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, or chronic foot strain.
  - (6) Treatment (except emergency treatment for which legal liability exists to the covered person for the costs thereof) provided in a government hospital; benefits provided under medicare or other governmental program (except medicaid), any state or federal worker's compensation, employer's liability or occupational disease law; service rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.
  - (7) Dental care or treatment.
  - (8) Eye glasses, hearing aids, and examination for the prescription or fitting thereof.
  - (9) Rest cures, custodial care, transportation, and routine physical examinations.
  - (10) Territorial limitations.
  - (11) Other exclusions commonly used by the particular carrier in group contracts providing hospital or medical benefits to employee groups.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 08-03-126 (Matter No. R 2007-14), § 284-52-070, filed 1/23/08, effective 2/23/08; 84-19-055 (Order R 84-4), § 284-52-070, filed 9/19/84.]