

Chapter 284-50 WAC

WASHINGTON DISABILITY INSURANCE REGULATIONS

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		DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER	
			ADVERTISING
			WAC 284-50-010 Title and purpose. (1) This regulation, WAC 284-50-010 through 284-50-230, shall be known and may be cited as the "Washington disability insurance advertising regulation."
			(2) The purpose of this regulation is to assure truthful and adequate disclosure of all material and relevant information in the advertising of disability insurance (as defined in RCW 48.11.030), health care service contractors' agreements (as defined in RCW 48.44.020), and health maintenance agreements (as defined in RCW 48.46.020). This purpose is intended to be accomplished by the establishment of, and adherence to, certain minimum standards and guidelines of conduct in the advertising of disability insurance and health care agreements in a manner which prevents unfair competition among insurers and is conducive to the accurate presentation and description to the insurance buying public of a policy or agreement of such insurance offered through various advertising media. RCW 48.30.040, 48.44.110 and 48.46.130 prohibit false, deceptive or misleading advertising in the conduct of the business of insurance and in the conduct of the business of a health care service contractor and a health maintenance organization. Because those statutes establish only general standards, this regulation establishes specific stan-

dards for advertisements relating to individual, group, blanket, and franchise disability, insurance and individual and group health care service contractors' agreements and health maintenance agreements.

[Order R-76-2, § 284-50-010, filed 3/4/76; Order R-73-1, § 284-50-010, filed 2/28/73, effective 4/1/73.]

WAC 284-50-020 Applicability. (1) These rules shall apply to every "advertisement," as that term is hereinafter defined, in WAC 284-50-030, subsections (1), (7), (8) and (9), unless otherwise specified in these rules, intended for presentation distribution, or dissemination in this state when such presentation, distribution, or dissemination is made either directly or indirectly by or on behalf of an insurer, or insurance producer as those terms are defined in the insurance code of this state and these rules.

(2) 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 policies. All such advertisements, regardless of by whom written, created, designed, or presented, shall be the responsibility of the insurer for whom such advertisements are prepared.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.010(5). WSR 11-01-159 (Matter No. R 2010-09), § 284-50-020, filed 12/22/10, effective 1/22/11; Order R-76-2, § 284-50-020, filed 3/4/76; Order R-73-1, § 284-50-020, filed 2/28/73, effective 4/1/73.]

WAC 284-50-030 Definitions. (1) An advertisement for the purpose of these rules shall include:

(a) Printed and published material, audio visual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio scripts, television scripts, billboards, and similar displays; and

(b) Descriptive literature and sales aids of all kinds issued by an insurer, or insurance producer for presentation to members of the insurance buying public, including but not limited to circulars, leaflets, booklets, depictions, illustrations, and form letters; and

(c) Prepared sales talks, presentations, and material for use by insurance producers.

(2) "Policy" for the purpose of these rules shall include any policy, plan, certificate, contract, agreement, statement of coverage, rider, or endorsement which provides disability benefits, or medical, surgical, or hospital expense benefits, whether on an indemnity, reimbursement, service, or prepaid basis, except when issued in connection with another kind of insurance other than life and except disability, waiver of premium, and double indemnity benefits included in life insurance and annuity contracts.

(3) "Insurer" for the purposes of these rules shall include any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds, fraternal benefit society, health care service contractor, health maintenance organization, and any other legal entity which is defined as an "insurer" in the insurance code of this state and is engaged in the advertisement of a policy as "policy" is defined in this regulation.

(4) "Exception" for the purpose of these rules shall mean any provision in a policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy.

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(5) "Reduction" for the purpose of these rules shall mean 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.

(6) "Limitation" for the purpose of these rules shall mean any provision which restricts coverage under the policy other than an exception or a reduction.

(7) "Institutional advertisement" for the purpose of these rules shall mean an advertisement having as its sole purpose the promotion of the reader's or viewer's interest in the concept of accident and sickness insurance, or the promotion of the insurer.

(8) "Invitation to inquire" for the purpose of these rules shall mean 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:

(a) The dollar amount of benefit payable, and/or

(b) 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:

"For costs and further details of the coverage, including exclusions, any reductions or limitations and the terms under which the policy may be continued in force, see your insurance producer or write to the company."

(9) "Invitation to contract" for the purpose of these rules shall mean an advertisement which is neither an invitation to inquire nor an institutional advertisement.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.010(5). WSR 11-01-159 (Matter No. R 2010-09), § 284-50-030, filed 12/22/10, effective 1/22/11; Order R-76-2, § 284-50-030, filed 3/4/76; Order R-73-1, § 284-50-030, filed 2/28/73, effective 4/1/73.]

WAC 284-50-040 Method of disclosure of required information. All information required to be disclosed by these rules shall be set out conspicuously and in close conjunction with the statement 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.

[Order R-73-1, § 284-50-040, filed 2/28/73, effective 4/1/73.]

WAC 284-50-050 Form and content of advertisements. (1) The format and content of an advertisement to which these rules apply 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 insurance commissioner 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.

(2) 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.

[Order R-73-1, § 284-50-050, filed 2/28/73, effective 4/1/73.]

WAC 284-50-060 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 policy benefit payable, loss covered, or premium payable. The fact that the policy offered 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) 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 pay your hospital and surgical bills"; "this policy will help fill some of the gaps that medicare and your present insurance leave out"; "this policy will help to replace your income" (when used to express loss of time benefits); or similar words and phrases, in a manner which exaggerates any benefits beyond the terms of the policy.

(3) An advertisement shall not contain descriptions of a policy 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 preexisting conditions are covered after two years." Words and phrases used in an advertisement to describe such policy limitations, exceptions, and reductions shall fairly and accurately describe the negative features of such limitations, exceptions, and reductions of the policy offered.

(4) 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 "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 policy advertised will, in some way, enable them to make a profit from being hospitalized.

(5) 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 policy contains a limit on the number of days of coverage provided, such limit must appear in the advertisement.

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

(7) An advertisement for a policy 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 policy. The statement shall be worded in language identical to, or substantially similar to the following: "THIS IS A LIMITED POLICY"; "THIS IS A CANCER ONLY POLICY"; "THIS IS AN AUTOMOBILE ACCIDENT ONLY POLICY."

(8) 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 because the cost of advertising and servicing such policies is a substantial cost in the marketing of a direct response insurance product.

(9) The phrase "tax free" shall not be used in or as a heading, caption, or title in any advertisement and shall not be unduly or deceptively emphasized, but it may be used in connection with a reasonably complete explanation of the Internal Revenue Service rules applicable to the particular benefits afforded by the policy or policies advertised.

[Order R-73-1, § 284-50-060, filed 2/28/73, effective 4/1/73.]

WAC 284-50-070 Exceptions, reductions, and limitations to be disclosed. (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 policy, or specific policy 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 policy without which the advertisement would have the capacity or tendency to mislead or deceive.

(2) When a policy contains a waiting, elimination, probationary, or similar time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for such loss, an advertisement which is subject to the requirements of the preceding subsection (1) shall disclose the existence of such periods.

(3) An advertisement shall not use the words "only"; "just"; "merely"; "minimum"; or similar words or phrases to deceptively describe or unfairly minimize the applicability of any exceptions and reductions contained in the policy advertised.

(4) When a policy contains a provision permitted by RCW 48.20.192, 48.20.202, or 48.20.212 (Optional standard provisions No. 15, 16, and 17), an advertisement which is subject to the requirements of WAC 284-50-070(1) shall disclose clearly the effect of such provisions.

[Order R-76-2, § 284-50-070, filed 3/4/76; Order R-73-1, § 284-50-070, filed 2/28/73, effective 4/1/73.]

WAC 284-50-080 Preexisting conditions. (1) An advertisement which is subject to the requirements of WAC 284-50-070 shall, in negative terms, disclose the extent to which any loss is traceable to a condition existing prior to the effective date of the policy. The use of the term "preexisting condition" without an appropriate definition or description shall not be used.

(2) When a policy does not cover losses resulting from preexisting conditions, no advertisement of the policy shall state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim thereunder. This rule 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 policy, the advertisement if it is an invitation to contract shall disclose that a medical examination is required.

(3) 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 requiring a response by the applicant or a statement in prominent type, all in capital letters, which reflects the preexisting condition provisions of the policy immediately preceding the blank space for the applicant's signature. For example, such an application form shall contain a question substantially as follows:

"Do you understand that this policy will not pay benefits 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

Or a statement in prominent type, all capitalized, substantially as follows:

"I UNDERSTAND THAT THE POLICY 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."

[Order R-76-2, § 284-50-080, filed 3/4/76; Order R-73-1, § 284-50-080, filed 2/28/73, effective 4/1/73.]

WAC 284-50-090 Disclosure of provisions relating to renewability, cancellability, and termination. 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 policy, or specific policy 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.

[Order R-76-2, § 284-50-090, filed 3/4/76; Order R-73-1, § 284-50-090, filed 2/28/73, effective 4/1/73.]

WAC 284-50-100 Testimonials or endorsements by third parties. (1) Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy 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 these rules.

(2) 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" wages required by union rules if the payment is actually for such "scale" for television or radio performance. The

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payment of substantial amounts, directly or indirectly for "travel and entertainment" for filming or recording of television or radio advertisements removes the filming or recording from the category of an unsolicited testimonial and requires disclosure of such compensation. This subsection (2) does not apply to an institutional advertisement which has as its sole purpose the promotion of the insurer.

(3) An advertisement shall not state or imply that any insurer or a policy has been approved or endorsed by an 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.

(4) When a testimonial refers to benefits received under a policy, 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.

[Order R-76-2, § 284-50-100, filed 3/4/76; Order R-73-1, § 284-50-100, filed 2/28/73, effective 4/1/73.]

WAC 284-50-110 Use of statistics. (1) An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy 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 policy advertised unless such is the fact, and when applicable to other policies or plans shall specifically so state.

(2) 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 an uncommon claim for the policy advertised is misleading and shall not be used.

(3) The source of any statistics used in an advertisement shall be identified in such advertisement.

[Order R-73-1, § 284-50-110, filed 2/28/73, effective 4/1/73.]

WAC 284-50-120 Identification of plan or number of policies. (1) 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.

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

[Order R-76-2, § 284-50-120, filed 3/4/76; Order R-73-1, § 284-50-120, filed 2/28/73, effective 4/1/73.]

WAC 284-50-130 Disparaging comparisons and statements. An advertisement shall not directly or indirectly

make unfair or incomplete comparisons of policies or benefits or comparisons of non-comparable policies of other insurers, and shall not disparage competitors, their policies, services, or business methods, and shall not disparage or unfairly minimize competing methods of marketing insurance.

[Order R-73-1, § 284-50-130, filed 2/28/73, effective 4/1/73.]

WAC 284-50-140 Jurisdictional licensing and status of insurer. (1) An advertisement which reasonably is expected to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

(2) 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 policy 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.

[Order R-73-1, § 284-50-140, filed 2/28/73, effective 4/1/73.]

WAC 284-50-150 Identity of insurer. (1) The full legal name (and, where required by RCW 48.30.050, the home office) of the actual insurer shall be shown in each advertisement. The form number or numbers of any specific policy or policies advertised shall be stated in each 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 a particular division of the insurer, service mark, slogan, symbol, or other device in a manner which would have the capacity and tendency to mislead or deceive as to the true identity of the insurer.

(2) No advertisement shall use any combination of words, symbols, or physical materials which by their content, phraseology, shape, color, or other characteristics are so similar to 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.

[Order R-76-2, § 284-50-150, filed 3/4/76; Order R-73-1, § 284-50-150, filed 2/28/73, effective 4/1/73.]

WAC 284-50-160 Group or quasi-group implications. An advertisement of a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and as such enjoy special rates or underwriting privileges, unless such is the fact.

[Order R-73-1, § 284-50-160, filed 2/28/73, effective 4/1/73.]

WAC 284-50-170 Introductory, initial, or special offers. (1) An advertisement of an individual policy 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

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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 disability insurance or health care service contractors' agreements.

(2) 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 three months between the close of the immediately preceding enrollment period 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 be not 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 insurance companies under common management or control. This rule is inapplicable to solicitations of employees or members of a particular group or association which solicitations are being made under specific provisions of the insurance code for group, blanket, or franchise insurance.

(3) This rule prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless such is the fact.

(4) The phrase "a particular insurance product" in subsection (2) of this rule means an insurance policy which provides substantially different benefits than those contained in any other policy. 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 policy shall not be sufficient to constitute the product being offered as a different product eligible for the concurrent or overlapping enrollment periods.

(5) Special awards, such as a "safe driver's award" shall not be used in connection with advertisements of disability insurance.

[Order R-73-1, § 284-50-170, filed 2/28/73, effective 4/1/73.]

WAC 284-50-180 Reduced initial premium rates. An advertisement shall not offer a policy which utilizes a reduced initial premium rate in a manner which over-emphasizes the availability and the amount 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.

[Order R-73-1, § 284-50-180, filed 2/28/73, effective 4/1/73.]

WAC 284-50-190 Statements about an insurer. An advertisement shall not contain statements which are untrue in fact, or by implication misleading, with respect to the

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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 recommendation.

[Order R-73-1, § 284-50-190, filed 2/28/73, effective 4/1/73.]

WAC 284-50-200 Advertising file to be maintained.

Each insurer shall maintain at its home or principal office a complete file containing every printed, published, or prepared advertisement of its individual policies and typical printed, published, or prepared advertisements of its blanket, franchise, and group policies hereafter disseminated in this or any other state whether or not licensed in such state, with a notation attached to each such advertisement which shall indicate the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to regular and periodical inspection by the insurance commissioner. 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.

[Order R-73-1, § 284-50-200, filed 2/28/73, effective 4/1/73.]

WAC 284-50-210 Violation defined as unfair practice. A violation of these rules, WAC 284-50-010 through 284-50-230, is hereby defined to be an unfair method of competition and an unfair or deceptive act or practice in the conduct of the business of insurance, pursuant to RCW 48.30.010.

[Order R-73-1, § 284-50-210, filed 2/28/73, effective 4/1/73.]

WAC 284-50-220 Severability provision. If any section or portion of a section of these rules, or the applicability thereof to any person or circumstances is held invalid by a court, the remainder of the rules, or the applicability of such provision to other persons or circumstances, shall not be affected thereby.

[Order R-73-1, § 284-50-220, filed 2/28/73, effective 4/1/73.]

WAC 284-50-230 Effective date. The effective date of this regulation, WAC 284-50-010 through 284-50-230, shall be April 1, 1973.

[Order R-73-1, § 284-50-230, filed 2/28/73, effective 4/1/73.]

MISCELLANEOUS

WAC 284-50-260 PKU formula coverage requirements and exceptions. (1) The purpose of this section is to effectuate the provisions of sections 1 and 2, chapter 173, Laws of 1988, by establishing the requirements and exceptions with respect to coverage for the formulas necessary for the treatment of phenylketonuria (PKU).

(2) Every group disability insurance contract, which is delivered or issued for delivery or renewed in this state on or after September 1, 1988, that insures for hospital or medical expenses shall provide coverage for the formulas necessary for the treatment of phenylketonuria, with the exception of

the following contracts, which need not provide such coverage:

(a) A contract of "blanket disability insurance" as defined in RCW 48.21.040;

(b) A group contract designed to provide benefits on an "accident only" or "specified disease only" basis;

(c) A group contract subject to chapter 48.66 RCW and providing medicare supplemental insurance;

(d) A group contract subject to chapter 48.84 RCW and providing long-term care insurance; and

(e) A group contract as to which the commissioner, in writing, consents to the exclusion of PKU formula coverage, upon a finding that such coverage would be inappropriate to the contract.

(3) Every individual disability insurance contract, including a contract of "family expense disability insurance" as defined in RCW 48.20.340 and a contract on a "franchise plan" as defined in RCW 48.20.350, delivered or issued for delivery or renewed in this state on or after September 1, 1988, that insures for hospital or medical expenses, shall provide coverage for the formulas necessary for the treatment of phenylketonuria, subject to the following exceptions:

(a) A contract providing only hospital confinement indemnity coverage, as such coverage is defined in WAC 284-50-345, need not provide the PKU formula coverage;

(b) A contract limited to providing accident only coverage, as such coverage is defined in WAC 284-50-360, need not provide the PKU formula coverage;

(c) A contract providing only specified disease or specified accident coverage, as such coverage is defined in WAC 284-50-365, need not provide the PKU formula coverage;

(d) A contract providing limited benefit health insurance coverage, as such coverage is defined in WAC 284-50-370, need not provide the PKU coverage to the extent that the commissioner allows an exception;

(e) A contract providing basic hospital expense coverage, as such coverage is defined in WAC 284-50-335, may limit the coverage for PKU formulas to a benefit that is based on the cost of formula consumed during a covered hospital stay;

(f) A contract that is subject to chapter 48.66 RCW and provides medicare supplemental insurance need not provide the PKU formula coverage;

(g) A contract that is subject to chapter 48.84 RCW and provides long-term care insurance need not provide the PKU formula coverage; and

(h) A contract as to which the commissioner, in writing, consents to the exclusion of PKU formula coverage, upon a finding that such coverage would be inappropriate to the contract.

(4) Coverage for the formulas necessary for the treatment of phenylketonuria may be limited to the usual and customary charge for such formulas, and may be made subject to deductibles, copayments, coinsurance or other reductions only to the extent that deductibles, copayments, coinsurance or other reductions are applied to general expenses incurred for common sicknesses or disorders under the provisions of the particular contract. (Relating the PKU formula to a special expense benefit, such as a prescription drug benefit, is not acceptable unless it results in the PKU formula benefit being paid at an amount no less than the amount that would

be produced by application of the reimbursement formula for medically necessary treatment for common sicknesses or disorders.)

(5) Premiums for an insured receiving benefits under the PKU formula coverage shall be no greater, by reason thereof, than the premiums for anyone else who is covered under the same form and who is not receiving such benefits.

(6) Preexisting condition provisions shall not be used with respect to PKU formula coverage, and no insurer shall cancel or decline to renew any contract, or restrict, modify, exclude or reduce the amount of benefits payable or type of coverage provided in any contract, because an applicant or insured has phenylketonuria.

(7) For purposes of sections 1 and 2, chapter 173, Laws of 1988, and this section, a contract is "renewed" when it is continued beyond the earliest date, after September 1, 1988, upon which, at the insurer's sole option:

(a) The contract's termination could have been effectuated, for other than nonpayment of premium; or

(b) The contract could have been amended to add the PKU formula coverage, with, if justified, an appropriate rate increase for any increased cost in providing the PKU formula coverage under the contract.

The failure of the insurer to take any such steps does not prevent the contract from being "renewed." The intent of this subsection is to bring the PKU formula benefits under the maximum number of contracts possible at the earliest possible time, by permitting the insurer to exclude such coverage from only those contracts as to which there exists a right of renewal on the part of the insured without any change in any provision of the contract.

[Statutory Authority: RCW 48.02.060 (3)(a), 48.44.050 and 48.46.200. WSR 88-16-065 (Order R 88-7), § 284-50-260, filed 8/1/88.]

WAC 284-50-270 Mammograms—Coverage requirements and exceptions. (1) The purpose of this regulation is to effectuate the provisions of RCW 48.20.393 and 48.21.225, by establishing definitions for the exceptions to coverage for mammograms. This regulation shall apply to every group and individual disability insurance contract, which is delivered or issued for delivery or renewed in this state on or after September 1, 1992, that provides coverage for hospital or medical expenses.

(2) For the purposes of RCW 48.20.393 and 48.21.225 and this regulation, supplemental contracts covering specified disease shall be defined to mean and include only those contracts or policies which provide benefits to a policyholder only in the event that the policyholder contracts the disease or diseases specifically named in the policy. Also for the purposes of RCW 48.20.393 and 48.21.225 and this regulation, supplemental contracts covering limited benefits shall be defined to mean and include only those contracts providing only one of the following benefits: Hospital indemnity, accident only coverage, dental care, vision care, mental health care, chemical dependency care, pharmaceutical care, and podiatric care.

(3) Coverage of mammograms may be subject to standard policy provisions applicable to other diagnostic X-ray benefits such as deductible or copayment provisions.

(4) For purposes of RCW 48.20.393 and 48.21.225 and this regulation, a contract is "renewed" when it is continued

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beyond the earliest date, after September 1, 1992, upon which, at the insurer's sole option:

(a) The contract's termination could have been effectuated, for other than nonpayment of premium; or

(b) The contract could have been amended to add the mammogram coverage, with, if justified, an appropriate rate increase for any increased cost in providing mammogram coverage under the contract.

The failure of the insurer to take any such steps does not prevent the contract from being "renewed." The intent of this section is to bring the mammogram coverage under the maximum number of contracts possible at the earliest possible time, by permitting the insurer to exclude such coverage from only those contracts as to which there exists a right of renewal on the part of the insured without any change in any provision of the contract.

[Statutory Authority: RCW 48.02.060 (3)(a). WSR 92-19-061 (Order R 92-13), § 284-50-270, filed 9/11/92, effective 10/12/92.]

MINIMUM STANDARDS FOR INDIVIDUAL POLICIES

WAC 284-50-300 Purpose. The purpose of this regulation, WAC 284-50-300 through 284-50-435, is to implement RCW 48.20.450 through 48.20.470 so as to provide reasonable standardization and simplification of terms and coverages of individual disability insurance policies in order to facilitate public understanding and comparison and to eliminate provisions contained in individual disability insurance policies which may be misleading or confusing in connection either with the purchase of such coverages or with the settlement of claims and to provide for full disclosure in the sale of such coverages.

[Order R-76-4, § 284-50-300, filed 10/29/76, effective 3/1/77.]

WAC 284-50-305 Applicability and scope. This regulation shall apply to all individual disability insurance policies delivered or issued for delivery in this state on and after the effective date hereof, except it shall not apply to individual policies issued pursuant to a conversion privilege under a policy of group or individual insurance when such group or individual policy includes provisions which are inconsistent with the requirements of this regulation, nor to policies being issued to employees or members as additions to franchise plans in existence on the effective date of this regulation. The requirements contained in this regulation shall be in addition to any other applicable regulations previously adopted. This regulation shall not apply to medicare supplement insurance policies, as such policies are defined in the Medicare Supplemental Health Insurance Act, chapter 153, Laws of 1981. This regulation shall not apply to long-term care insurance policies or contracts, as such policies or contracts are defined in the Long-Term Care Insurance Act, chapter 48.84 RCW.

[Statutory Authority: RCW 48.02.060(3), 48.20.450 through 48.20.470 and chapter 48.84 RCW. WSR 87-15-028 (Order R 87-8), § 284-50-305, filed 7/9/87, effective 1/1/88. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. WSR 82-01-017 (Order R 81-7), § 284-50-305, filed 12/9/81; Order R-76-4, § 284-50-305, filed 10/29/76, effective 3/1/77.]

WAC 284-50-310 Effective date. This regulation shall be effective on March 1, 1977, and shall be applicable to all

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individual disability insurance policies (except those specifically excluded from the scope of this regulation) delivered or issued for delivery in this state on and after such date: Provided, however, That policies which have been approved prior to January 1, 1977, and which are not in compliance with this regulation may be issued until May 1, 1977, unless approval is specifically withdrawn pursuant to RCW 48.18.110.

[Order R-76-4, § 284-50-310, filed 10/29/76, effective 3/1/77.]

WAC 284-50-315 Policy definitions. Except as provided hereinafter, no individual disability insurance policy delivered or issued for delivery to any person in this state shall contain definitions respecting the matters set forth in this section unless such definitions comply with the requirements of this section.

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

(2) "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals.

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

(i) Be an institution operated pursuant to law; and
(ii) Be primarily and continuously engaged in providing 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

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

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

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

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

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

(iv) 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 emergency basis where a legal liability exists for charges made to the individual for such services.

(3) "Convalescent nursing homes," "extended care facility," or "skilled nursing facility" shall be defined in relation to its status, facilities and available services.

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

(i) Be operated pursuant to law;

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

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

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

(v) Maintains 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:

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

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

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

(4) "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 injuries, sustained by the insured person which are the direct result of an accident, independent of disease or bodily infirmity or any other cause, and which occur while the insurance is in force.

(b) Such definition may provide that injuries shall not include injuries for which benefits are provided under any worker'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.

(5) "Sickness" shall not be defined to be more restrictive than the following: Sickness means sickness or disease of any insured person which first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period which will not exceed 30 days (or 90 days in a cancer only policy) from the effective date of the coverage of the insured person. The definition may be further modified to exclude sickness or disease for which benefits are provided under any worker's compensation, occupational disease, employer's liability or similar law.

(6) "Preexisting condition" shall not be defined to be more restrictive than the following: Preexisting condition means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a five year 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 five year period preceding the effective date of the coverage of the insured person.

(7) "Physician" may be defined by including words such as "duly qualified physician" or "duly 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.

(8) "Nurses" may be defined so that the description of nurse is restricted to a type of nurse, such as registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the words "nurse," "trained nurse" or "registered nurse" are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualifies under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

(9) "Total disability" is subject to the following:

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

(b) Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual's inability to:

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

(ii) Engage in any training or rehabilitation program.

(c) An insurer may specify the requirement of the complete inability of the person to perform all of the substantial and material duties of his regular occupation or words of similar import. An insurer may require care by a physician (other than the insured or a member of the insured's immediate family).

(10) "Partial disability" shall be defined in relation to the individual's inability to perform one or more but not all of the "major," "important," or "essential" duties of employment or occupation or may be related to a "percentage" of time worked or to a "specified number of hours" or to "compensation." Where a policy provides total disability benefits and partial disability benefits, only one elimination period may be required.

(11) "Residual disability" shall be defined in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major," "important," or "essential duties" of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. A policy which provides for residual disability benefits may require a qualification period, during which the insured must be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term "residual disability," the insurer may use "proportionate disability" or other term of similar import which in the opinion of the commissioner adequately and fairly describes the benefit.

(12) "Medicare" shall be defined in any hospital, surgical or medical expense policy which relates its coverage to eligibility for medicare or medicare benefits. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or Title I, Part I of Public Laws 89-97, as enacted by the 89th Congress of the United States of America and popularly known as the ["Health Insurance for the Aged Act, as then constituted and

any later amendments or substitutes thereof" or words of similar import.

(13) "Mental or nervous 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.

[Order R-76-4, § 284-50-315, filed 10/29/76, effective 3/1/77.]

WAC 284-50-320 Prohibited policy provisions. (1)

Except as provided in WAC 284-50-315(5), no policy shall contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy subject to the further exception that a policy may specify a probationary or waiting period not to exceed six months for specified diseases or conditions and losses resulting therefrom for hernia, disorder of reproduction organs, varicose veins, adenoids, appendix and tonsils. However, the permissible six months exception shall not be applicable where such specified diseases or conditions are treated on an emergency basis. Accident policies shall not contain probationary or waiting periods.

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

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

(4) No policy shall provide a return of premium benefit except as permitted by this rule. For purposes of this rule, a return of premium benefit refers only to that benefit which is equal to a stated portion of the premiums paid for the benefit and the basic coverage decreased by claims paid to the insured under the basic coverage. A disability income policy may contain a return of premium benefit if it meets the following conditions:

(a) Such return of premium benefit shall not be reduced by an amount greater than the aggregate of any claims paid under the policy; and

(b) Such benefit shall be provided by rider or the insurer shall provide a similar policy without such benefit to which the insured may convert; and

(c) The premiums for the disability income and return of premium benefits shall be shown separately on the schedule page of the policy; and

(d) The policy shall guarantee that it is renewable; and

(e) Submission of the benefit form for approval shall be accompanied by a demonstration that the premium and

reserve structure is such that adverse deviations from the assumptions thereunder are minimized; and

(f) The insurer provides the commissioner with its assurance that it will promptly notify the insured at such time as the return of premium benefit is not payable to the insured because of the aggregate of claims paid under the policy, together with instructions as to the insured's right and manner of converting to the similar policy or to cancel the rider.

(5) Policies providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

(6) No policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition, except with respect to the following:

(a) Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;

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

(c) Pregnancy, except for complications of pregnancy, other than for policies defined in WAC 284-50-355;

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

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

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

(iii) Aviation;

(iv) With respect to short-term nonrenewable policies, interscholastic sports;

(e) 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;

(f) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, or chronic foot strain;

(g) Treatment (except emergency treatment for which legal liability exists to the insured 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, or any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

(h) Dental care or treatment;

(i) Eye glasses, hearing aids and examination for the prescription or fitting thereof;

(j) Rest cures, custodial care, transportation and routine physical examinations;

(k) Territorial limitations;

(l) Specified disease and specified accident policies issued in accord with WAC 284-50-365.

(7) Other provisions of this regulation shall not impair or limit the use of waivers to exclude, limit or reduce coverage

or benefits for specifically named or described preexisting diseases, physical condition or extra-hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required, and use of endorsements is governed by RCW 48.20.015.

(8) Except as otherwise provided in WAC 284-50-330(2) and 284-50-380(5), the terms "medicare supplement," "Medigap" and words of similar import shall not be used unless the policy is issued in compliance with The Medicare Supplemental Health Insurance Act, chapter 153, Laws of 1981, and chapter 284-55 WAC.

(9) Policy provisions precluded in this section shall not be construed as a limitation on the authority of the commissioner to disapprove other policy provisions in accordance with RCW 48.18.110.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. WSR 82-01-017 (Order R 81-7), § 284-50-320, filed 12/9/81; Order R-76-4, § 284-50-320, filed 10/29/76, effective 3/1/77.]

WAC 284-50-321 Discretionary clauses prohibited.

(1) No disability insurance policy may contain a discretionary clause. "Discretionary clause" means a provision that purports to reserve discretion to an insurer, its agents, officers, employees, or designees in interpreting the terms of a policy or deciding eligibility for benefits, or requires deference to such interpretations or decisions, including a provision that provides for any of the following results:

(a) That the insurer's interpretation of the terms of the policy is binding;

(b) That the insurer's decision regarding eligibility or continued receipt of benefits is binding;

(c) That the insurer's decision to deny, modify, reduce or terminate payment, coverage, authorization, or provision of health care service or benefits, is binding;

(d) That there is no appeal or judicial remedy from a denial of a claim;

(e) That deference must be given to the insurer's interpretation of the contract or claim decision; and

(f) That the standard of review of an insurer's interpretation of the policy or claim decision is other than a de novo review.

(2) Nothing in this section prohibits an insurer from including a provision in a policy that informs an insured that as part of its routine operations the insurer applies the terms of its policies for making decisions, including making determination regarding eligibility, receipt of benefits and claims, or explaining its policies, procedures, and processes.

[Statutory Authority: RCW 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.200, 48.02.060, 48.18.110, 48.44.020, and 48.46.060. WSR 09-16-128 (Matter No. R 2008-25), § 284-50-321, filed 8/5/09, effective 9/5/09.]

WAC 284-50-325 Minimum standards for benefits.

Minimum standards for benefits are prescribed for the categories of coverage noted in WAC 284-50-330 through 284-50-370. No individual disability insurance policy shall be delivered or issued for delivery in this state which does not meet the required minimum standards for its specified category. Nothing in this section shall preclude the issuance of any policy combining two or more categories of coverage.

[Order R-76-4, § 284-50-325, filed 10/29/76, effective 3/1/77.]

WAC 284-50-330 General rules as to minimum standards. (1) A "noncancellable," "guaranteed renewable" or "noncancellable and guaranteed renewable" policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. The policy shall provide that in the event of the insured's death the spouse of the insured, if covered under the policy, shall become the insured.

(2) The terms "noncancellable," "guaranteed renewable" or "noncancellable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of WAC 284-50-375(1). The terms "noncancellable" or "noncancellable and guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of 65 or to eligibility for medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force: Provided, however, any accident and health or accident only policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age 60 if, at age 60, the insured has the right to continue the policy in force at least to age 65 while actively or regularly employed. Except as provided above, the term "guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums until the age of 65 or to eligibility for medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes: Provided, however, any accident and health or accident only policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age 60, if at age 60, the insured has the right to continue the policy in force at least to age 65 while actively and regularly employed.

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

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

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

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

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

(8) In accord with RCW 48.20.420, coverage shall continue for any dependent child who is incapable of self-sustaining employment due to developmental disability or physical handicap, on the date that such child's coverage would otherwise terminate under the policy due to the attainment of a specified age limit for children, and who is chiefly dependent on the insured for support and maintenance. The policy may require that within 31 days of such date the company receive due proof of such incapacity and dependency in order for the insured to elect to continue the policy in force with respect to such child, or that a separate converted policy be issued at the option of the insured or policyholder.

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

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

(11) Accidental death and dismemberment benefits shall be payable if the loss occurs within no less than ninety days from the date of the accident, irrespective of total disability. Disability income benefits, if provided, shall not require the loss to commence less than thirty days after the date of accident, nor shall any policy which the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the policy was in force.

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

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

(14) All medicare supplement policies providing in-hospital benefits only shall include in their 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.

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

(16) As an alternative to hospitalization or institutionalization of an insured and with the intent to cover placement of the insured patient in the most appropriate and cost-effective setting, every individual disability insurance policy or contract issued, amended, or renewed on or after January 1, 1995, which provides coverage for hospitalization or other institutional expenses to a resident of this state shall include substitution of home health care, provided in lieu of hospitalization or other institutional care, furnished by home health, hospice, or home care agencies licensed under chapter 70.127 RCW, at equal or lesser cost.

(a) In addition, such expenses may include coverage for durable medical equipment which permits the insured to stay at home, care provided in Alzheimer's centers, adult family homes, assisted living facilities, congregate care facilities, adult day health care, home health, hospice, and home care, or similar alternative care arrangements which provide necessary care in less restrictive or less expensive environments.

(b) Substitution of less expensive or less intensive services shall be made only with the consent of the insured and upon the recommendation of the insured's attending physician or licensed health care provider that such services will adequately meet the insured patient's needs. The decision to substitute less expensive or less intensive services shall be determined based on the medical needs of the individual insured patient.

(c) An insurer may require that home health agencies or similar alternative care providers have written treatment plans which are approved by the insured patient's attending physician or other licensed health care provider.

(d) Coverage may be limited to no less than the maximum benefits which would be payable for hospital or other institutional expenses under the policy or contract, and may include all deductibles and coinsurances which would be payable by the insured under the hospital or other institutional expense coverage of the insured's policy or contract.

(e) This subsection shall not apply to long-term care, medicare supplement, or disability income protection insurance policies or contracts. This subsection shall not apply to guaranteed renewable disability insurance policies or contracts issued prior to January 1, 1995.

[Statutory Authority: RCW 48.02.060, WSR 17-18-102 (Matter No. R 2017-08), § 284-50-330, filed 9/6/17, effective 10/7/17. Statutory Authority: RCW 48.01.030, 48.02.060, 48.44.050, 48.44.020, 48.46.200 and 48.46.060. WSR 94-19-015 (Order R 94-16), § 284-50-330, filed 9/9/94, effective 10/10/94; Order R-76-4, § 284-50-330, filed 10/29/76, effective 3/1/77.]

WAC 284-50-335 Basic hospital expense coverage.

"Basic hospital expense coverage" is a policy of disability insurance which provides coverage for a period of not less than 31 days during any continuous hospital confinement for each person insured under the policy for expense incurred for necessary treatment and services rendered as a result of accident or sickness for at least the following:

(1) Daily hospital room and board in an amount not less than the lesser of 80% of the charges for semi-private room accommodations or \$50 per day;

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

amount not less than either 80% of the charges incurred up to at least \$1,000 or ten times the daily hospital room and board benefits; and

(3) Hospital outpatient services consisting of:

(a) Hospital services on the day surgery is performed, and accidental injury, in an amount not less than \$50; and

(b) Hospital services rendered within 72 hours after accidental injury, in an amount not less than \$50; and

(c) X-ray and laboratory tests to the extent that benefits for such services would have been provided to an extent not less than \$100 if rendered to an in-patient of the hospital.

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

[Order R-76-4, § 284-50-335, filed 10/29/76, effective 3/1/77.]

WAC 284-50-340 Basic medical-surgical expense coverage. "Basic medical-surgical expense coverage" is a policy of disability insurance which provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for at least the following:

(1) Surgical services:

(a) In amounts not less than those provided on a fee schedule based on the relative values contained in the state of New York certified surgical fee schedule, or the 1974 California relative value schedule or other acceptable relative value scale of surgical procedures, up to a maximum of at least \$500 for any one procedure; or

(b) Not less than 80% of the reasonable charges.

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

(a) In an amount not less than 80% of the reasonable charges; or

(b) 15% of the surgical service benefit.

(3) In-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than 80% of the reasonable charges; or \$5 per day for not less than 21 days during one period of confinement.

[Order R-76-4, § 284-50-340, filed 10/29/76, effective 3/1/77.]

WAC 284-50-345 Hospital confinement indemnity coverage. "Hospital confinement indemnity coverage" is a policy of disability insurance which principally provides daily benefits for hospital confinement on an indemnity basis in an amount not less than \$10 per day and not less than 31 days during any one period of confinement for each person insured under the policy. Additional benefits may be provided in such policy.

[Order R-76-4, § 284-50-345, filed 10/29/76, effective 3/1/77.]

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 physiotherapist;

(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.]

WAC 284-50-355 Disability income protection coverage. (1) "Disability income protection coverage" is a policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination thereof which:

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

(b) Contains an elimination period no greater than:

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

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

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

(c) Has a maximum period of time for which it is payable during disability of at least six months except in the case of a policy covering disability arising out of pregnancy, childbirth, or miscarriage in which case the period for such disability may be one month.

(2) No disability income protection policy shall contain any provision permitting a reduction in benefits because of an increase in Social Security benefits.

(3) This section does not apply to those policies providing business buyout coverage.

[Order R-76-4, § 284-50-355, filed 10/29/76, effective 3/1/77.]

WAC 284-50-360 Accident only coverage. "Accident only coverage" is a policy of accident insurance which provides coverage, singly or combination, for death, dismemberment, disability or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under such a policy shall be at least \$1,000 and a single dismemberment amount shall be at least \$500.

[Order R-76-4, § 284-50-360, filed 10/29/76, effective 3/1/77.]

WAC 284-50-365 Specified disease and specified accident coverage. (1) "Specified disease coverage" is a policy which meets one of the following definitions:

(a) A policy which provides coverage for each person insured under the policy for a specifically named disease (or diseases) with a deductible amount not in excess of \$250 and an overall aggregate benefit limit of no less than \$5,000 and a benefit period of not less than two years for at least the following incurred expenses:

- (i) Hospital room and board and any other hospital furnished medical services or supplies;
- (ii) Treatment by a legally qualified physician or surgeon;
- (iii) Private duty services of a registered nurse (R.N.);
- (iv) X-ray, radium and other therapy procedures used in diagnosis and treatment;
- (v) Professional ambulance for local service to or from a local hospital;
- (vi) Blood transfusions, including expense incurred for blood donors;
- (vii) Drugs and medicines prescribed by a physician;
- (viii) The rental of an iron lung or similar mechanical apparatus;
- (ix) Braces, crutches and wheel chairs as are deemed necessary by the attending physician for the treatment of the disease;
- (x) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and
- (xi) May include coverage of any other expenses necessarily incurred in the treatment of the disease.

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

(2) "Specified accident coverage" is an accident insurance policy which provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment combined, with a benefit amount not less than \$1,000 for accidental death; \$1,000 for double dismemberment and \$500 for single dismemberment.

[Order R-76-4, § 284-50-365, filed 10/29/76, effective 3/1/77.]

WAC 284-50-370 Limited benefit health insurance coverage. "Limited benefit health insurance coverage" is any policy which provides benefits that are less than the mini-

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imum standards for benefits required under WAC 284-50-335 through 284-50-365, and which the commissioner approves as being in the public interest. Such policies may be delivered or issued for delivery in this state only if the outline of coverage required by WAC 284-50-425 is completed and delivered as required by WAC 284-50-380.

[Order R-76-4, § 284-50-370, filed 10/29/76, effective 3/1/77.]

WAC 284-50-375 Required disclosure provisions, general rules. (1) Each individual disability insurance policy 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, shall appear or bear a prominent reference thereto on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

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

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

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

(5) If a policy contains any limitations with respect to preexisting conditions such limitations must appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

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

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

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

(9) If a policy contains a conversion privilege, it shall comply, in substance, with the following: The caption of the

provision shall be "Conversion Privilege," or words of similar import. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion (including those with respect to the reimposition of a time limit on certain defenses provision), and the person by whom the conversion privilege may be exercised. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

[Order R-76-4, § 284-50-375, filed 10/29/76, effective 3/1/77.]

WAC 284-50-377 Experimental and investigational prescriptions, treatments, procedures, or service—Definition required—Standard for definition—Written notice of denial required—Appeal process required. (1) Every individual disability insurance policy which excludes or limits, or reserves the right to exclude or limit, benefits for any treatment, procedure, facility, equipment, drug, drug usage, medical device, or supply (hereinafter individually and collectively referred to as services) for one or more medical condition or illness because such services are deemed to be experimental or investigational must include within the policy a definition of experimental or investigational.

(2) The definition of experimental or investigational services must include an identification of the authority or authorities which will make a determination of which services will be considered to be experimental or investigational. If the individual disability insurer specifies that it, or an affiliated entity, is the authority making the determination, the criteria it will utilize to determine whether a service is experimental or investigational must be set forth in the policy. As an example, and not by way of limitation, the requirement to set forth criteria in the policy may be satisfied by using one or more of the following statements, or other similar statements:

(a) "In determining whether services are experimental or investigational, we will consider whether the services are in general use in the medical community in the state of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious."

(b) "In determining whether services are experimental or investigational, we will consider whether the services result in greater benefits for a particular illness or disease than other generally available services, and do not pose a significant risk to health or safety of the patient."

The supporting documentation upon which the criteria are established must be made available for inspection upon written request in all instances and may not be withheld as proprietary.

(3) Every individual disability insurer that denies a request for benefits or that refuses to approve a request to preauthorize services, whether made in writing or through other claim presentation or preauthorization procedures set out in the policy, because of an experimental or investigational exclusion or limitation, must do so in writing within twenty working days of receipt of a fully documented request. The individual disability insurer may extend the review period

beyond twenty days only with the informed written consent of the covered individual. The denial letter must identify by name and job title the individual making the decision and fully disclose:

(a) The basis for the denial of benefits or refusal to preauthorize services;

(b) The procedure through which the decision to deny benefits or to refuse to preauthorize services may be appealed;

(c) What information the appellant is required to submit with the appeal; and

(d) The specific time period within which the company will reconsider its decision.

(4)(a) Every individual disability insurer must establish a reasonable procedure under which denials of benefits or refusals to preauthorize services because of an experimental or investigational exclusion or limitation may be appealed. The appeals procedure may be considered reasonable if it provides that:

(i) A final determination must be made and provided to the appellant in writing within twenty working days of receipt of the fully documented appeal. The individual disability insurer may extend the review period beyond twenty days only with the informed written consent of the covered individual;

(ii) The appeal must be reviewed by a person or persons qualified by reasons of training, experience and medical expertise to evaluate it; and

(iii) The appeal must be reviewed by a person or persons other than the person or persons making the initial decision to deny benefits or to refuse to preauthorize services.

(b) When the initial decision to deny benefits or to refuse to preauthorize services is upheld upon appeal, the written notice shall set forth:

(i) The basis for the denial of benefits or refusal to preauthorize services; and

(ii) The name and professional qualifications of the person or persons reviewing the appeal.

(c) Disclosure of the existence of an appeal procedure shall be made by the individual disability insurer in each policy which contains an experimental or investigational exclusion or limitation.

(5) Whenever a covered person appeals the insurer's decision and delay would jeopardize the covered person's life or health, the insurer must follow the appeal procedures and time frames in WAC 284-43-4040(2).

[Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-50-377, filed 7/6/16, effective 8/6/16. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.43.055, 48.44.050, 48.46.100 and 48.46.200. WSR 99-24-075 (Matter No. R 98-17), § 284-50-377, filed 11/29/99, effective 12/30/99. Statutory Authority: RCW 48.02.060 (3)(a) and 48.18.120. WSR 92-21-101 (Order R 92-17), § 284-50-377, filed 10/21/92, effective 11/21/92.]

WAC 284-50-380 Outline of coverage requirements for individual coverages. (1) No individual disability insurance policy subject to this regulation shall be delivered or issued for delivery in this state unless an appropriate outline of coverage, as prescribed in WAC 284-50-385 through 284-50-425 is completed as to such policy and:

(a) Is either delivered with the policy; or

(b) Delivered to the applicant at the time application is made and acknowledgment 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 policy is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy must accompany the policy when it is delivered and contain the following statement, in no less than twelve 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." In addition, the insurer shall comply with the provisions set forth in RCW 48.20.015.

(3) The appropriate outline of coverage for policies providing hospital coverage which only meets the standards of WAC 284-50-335 shall be that statement contained in WAC 284-50-385. The appropriate outline of coverage for policies providing coverage which meets the standards of both WAC 284-50-335 and 284-50-340 shall be the statement contained in WAC 284-50-395. The appropriate outline of coverage for policies providing coverage which meets the standards of both WAC 284-50-335 and 284-50-350 or 284-50-340 and 284-50-350 or 284-50-335, 284-50-340, and 284-50-350 shall be the statement contained in WAC 284-50-405.

(4) In any case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy, an alternate outline of coverage shall be submitted to the commissioner for prior approval.

(5) Outlines of coverage delivered in connection with policies defined in this regulation as hospital confinement indemnity (WAC 284-50-345), Specified disease (WAC 284-50-365), or Limited benefit health insurance coverages (WAC 284-50-370) to persons eligible for medicare by reason of age shall contain, in addition to the requirements of WAC 284-50-400, 284-50-420 and 284-50-425, the following language which shall be printed or stamped on or attached to the first page of the outline of coverage: "**This policy is not a medicare supplement policy.** If you are eligible for medicare, review the *Medicare Supplement Buyer's Guide* available from the company." Such notice shall be in no less than twelve point type.

[Statutory Authority: RCW 48.66.100, 48.20.470 and 1982 c 200 § 1. WSR 82-12-032 (Order R 82-3), § 284-50-380, filed 5/26/82. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. WSR 82-01-017 (Order R 81-7), § 284-50-380, filed 12/9/81; Order R-76-4, § 284-50-380, filed 10/29/76, effective 3/1/77.]

WAC 284-50-385 Basic hospital expense coverage, outline of coverage. An outline of coverage, in substantially the following form, shall be issued in connection with policies meeting the standards of WAC 284-50-335.

(COMPANY NAME)
BASIC HOSPITAL EXPENSE COVERAGE -
OUTLINE OF COVERAGE

(1) **Read your policy carefully** - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets

forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) **Basic hospital expense coverage** - Policies 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 outpatient services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for physicians or surgeons fees or *unlimited* hospital expenses.

(3) (A brief *specific* description of the benefits, including dollar amounts and number of days duration where applicable, contained in *this policy*, in the following order:

- (a) Daily hospital room and board;
- (b) Miscellaneous hospital services;
- (c) Hospital outpatient services; and
- (d) Other benefits, if any.)

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

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

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

[Order R-76-4, § 284-50-385, filed 10/29/76, effective 3/1/77.]

WAC 284-50-390 Basic medical-surgical expense coverage, outline of coverage. An outline of coverage, in substantially the following form, shall be issued in connection with policies meeting the standards of WAC 284-50-340.

(COMPANY NAME)
BASIC MEDICAL-SURGICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

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

(2) **Basic medical-surgical expense coverage** - Policies of this category are designed to provide to persons insured coverage for medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for hospital expenses or unlimited medical-surgical expenses.

(3) (A brief *specific* description of the benefits, including dollar amounts and number of days duration where applicable, contained in *this policy*, in the following order:

- (a) Surgical services;

- (b) Anesthesia services;
- (c) In-hospital medical services; and
- (d) Other benefits, if any.

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

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

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

[Order R-76-4, § 284-50-390, filed 10/29/76, effective 3/1/77.]

WAC 284-50-395 Basic hospital and medical surgical expense coverage, outline of coverage. An outline of coverage, in substantially the following form, shall be issued in connection with policies meeting the standards of WAC 284-50-335 and 284-50-340.

(COMPANY NAME)

BASIC HOSPITAL AND MEDICAL SURGICAL EXPENSE COVERAGE
 OUTLINE OF COVERAGE

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

(2) **Basic hospital and medical surgical expense coverage** - Policies of this category are designed to provide, to persons insured, coverage for hospital and medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital outpatient services, surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for *unlimited* hospital or medical-surgical expenses.

(3) (A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in *this policy*, in the following order:

- (a) Daily hospital room and board;
- (b) Miscellaneous hospital services;
- (c) Hospital outpatient services;
- (d) Surgical services;
- (e) Anesthesia services;
- (f) In-hospital medical services; and
- (g) Other benefits, if any.

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

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

(9/6/17)

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

[Order R-76-4, § 284-50-395, filed 10/29/76, effective 3/1/77.]

WAC 284-50-400 Hospital confinement indemnity coverage, outline of coverage. An outline of coverage, in substantially the following form, shall be issued in connection with policies meeting the standards of WAC 284-50-345.

(COMPANY NAME)

HOSPITAL CONFINEMENT INDEMNITY COVERAGE
 OUTLINE OF COVERAGE

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

(2) **Hospital confinement indemnity coverage** - Policies of this category are designed to provide, to persons insured, coverage in the form of a fixed daily benefit during period of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Such policies do not provide any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.

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

- (a) Daily benefit payable during hospital confinement; and
- (b) Duration of benefit described in (a).
- (c) Any benefits provided in addition to the daily hospital benefit.

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

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

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

[Order R-76-4, § 284-50-400, filed 10/29/76, effective 3/1/77.]

WAC 284-50-405 Major medical expense coverage, outline of coverage. An outline of coverage, in substantially the following form, shall be issued in connection with policies meeting the standards of WAC 284-50-350.

(COMPANY NAME)

MAJOR MEDICAL EXPENSE COVERAGE
 OUTLINE OF COVERAGE

(1) **Read your policy carefully** - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the

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actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **read your policy carefully!**

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

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

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

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

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

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

[Order R-76-4, § 284-50-405, filed 10/29/76, effective 3/1/77.]

WAC 284-50-410 Disability income protection coverage, outline of coverage. An outline of coverage, in substantially the following form, shall be issued in connection with policies meeting the standards of WAC 284-50-355.

(COMPANY NAME)
DISABILITY INCOME PROTECTION COVERAGE
OUTLINE OF COVERAGE

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

(2) **Disability income protection coverage** - Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major-medical expenses.

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

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

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

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

[Order R-76-4, § 284-50-410, filed 10/29/76, effective 3/1/77.]

WAC 284-50-415 Accident only coverage, outline of coverage. An outline of coverage, in substantially the following form, shall be issued in connection with policies meeting the standards of WAC 284-50-360.

(COMPANY NAME)
ACCIDENT ONLY COVERAGE
OUTLINE OF COVERAGE

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

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

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

Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with WAC 284-50-325(13) of this regulation.)

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

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

[Order R-76-4, § 284-50-415, filed 10/29/76, effective 3/1/77.]

WAC 284-50-420 Specified disease or specified accident coverage, outline of coverage. An outline of coverage in substantially the following form, shall be issued in connection with policies meeting the standards of WAC 284-50-365.

(COMPANY NAME)
(SPECIFIED DISEASE) (SPECIFIED ACCIDENT) COVERAGE
OUTLINE OF COVERAGE

(1) **Read your policy carefully** - This outline of coverage provides a very brief description of the important features

of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **read your policy carefully!**

(2) **(Specified disease) (specified accident) coverage -** Policies of this category are designed to provide, to persons insured, restricted coverage paying benefits *only* when certain losses occur as a result of (specified diseases) or (specified accidents). Coverage is not provided for basic hospital, basic medical-surgical, or major-medical expenses.

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

Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with WAC 284-50-325(13).

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

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

[Order R-76-4, § 284-50-420, filed 10/29/76, effective 3/1/77.]

WAC 284-50-425 Limited benefit health coverage, outline of coverage. An outline of coverage, in substantially the following form, shall be issued in connection with policies which do not meet the minimum standards of WAC 284-50-335 through 284-50-365.

(COMPANY NAME)
LIMITED BENEFIT HEALTH COVERAGE
OUTLINE OF COVERAGE

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

(2) **Limited benefit health coverage -** Policies of this category are designed to provide, to persons insured, limited or supplemental coverage.

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

Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with subsection (13) of WAC 284-50-330.

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

(9/6/17)

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

[Order R-76-4, § 284-50-425, filed 10/29/76, effective 3/1/77.]

WAC 284-50-430 Requirements for replacement. (1) Application forms shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other disability insurance presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

(2) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in subsection (3) of this section. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in subsection (4) of this section. In no event, however, will such a notice be required in the solicitation of the following types of policies: accident only and single premium nonrenewable policies.

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

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS INSURANCE

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

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

[Ch. 284-50 WAC p. 19]

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

.....
(Date)

.....
(Applicants' Signature)

(4) The notice required by subsection (2) of this section, for a direct response insurer, shall be as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

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

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

.....
(Company Name)

(5) The required notice may be modified if preexisting conditions are covered under the new policy.

[Order R-76-4, § 284-50-430, filed 10/29/76, effective 3/1/77.]

WAC 284-50-440 Standard disclosure form for individual policies—Illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance. (1) All disability insurers offering individual policies that provide benefits in the form of illness-triggered fixed payments, hospital confinement fixed payments or other fixed payment insurance, must issue a disclosure form in substantially the format and content outlined below. The disclosure form must be provided to all

applicants at the time of solicitation and completion of the application form for coverage. Every insurer must have a mechanism in place to verify delivery of the disclosure to the applicant.

(2) The type size and font of the disclosure form must be easily read and be no smaller than 10 point.

(3) The insurer's disclosure form must be filed for approval with the commissioner prior to use.

(4) The standard disclosure form replaces any outline of coverage that would otherwise be required for fixed payment policies and must include, at a minimum, the following information:

(Insurer's name and address)

IMPORTANT INFORMATION ABOUT THE COVERAGE YOU ARE BEING OFFERED

Save this statement! It may be important to you in the future. The Washington State Insurance Commissioner requires that we give you the following information about fixed payment benefits.

This coverage is not comprehensive health care insurance and will not cover the cost of most hospital and other medical services.

This disclosure document provides a very brief description of the important features of the coverage you are considering. It is not an insurance contract and only the actual policy provisions will control. The policy itself will include in detail the rights and obligations of both you and (insurer's name).

This coverage is designed to pay you a fixed dollar amount regardless of the amount that the provider charges. Payments are not based on a percentage of the provider's charge and are paid in addition to any other health plan coverage you may have.

CAUTION: If you are also covered under a High Deductible Health Plan (HDHP) and are contributing to a Health Savings Account (HSA), before you purchase this policy you should check with your tax advisor to be sure that you will continue to be eligible to contribute to the HSA if you purchase this coverage.

The benefits under this policy are summarized below.

- Type of coverage:
- Benefit amount:
- Benefit trigger (identify any periods of no coverage such as eligibility or waiting periods):
- Duration of coverage:
- Renewability of coverage:

Policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described above include the following:

(List all exclusions including those that relate to limitations for preexisting conditions.)

[Statutory Authority: RCW 48.02.060, 48.20.550, and 48.21.370. WSR 07-21-073 (Matter No. R 2007-05), § 284-50-440, filed 10/15/07, effective 11/15/07.]