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

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

(3) Such conversion benefit plans:

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

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

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

(d) May be rated based upon attained age.

(e) Which provide coverage for dependent children, may require evidence of insurability for newly acquired dependents except that newborn infants shall be covered from the moment of birth without evidence of insurability provided application therefor and payment of applicable rates, if any, are made within sixty days of birth.

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

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

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

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