CHAPTER 2740
DEPARTMENT OF COMMERCE
COMPREHENSIVE HEALTH INSURANCE

2740.0100 DEFINITIONS.

Subpart 1. **Scope.** All terms used herein that are defined in Minnesota Statutes, chapter 62E shall have the meanings attributed to them therein. For the purpose of Minnesota Statutes, chapter 62E and these rules, the terms defined herein shall have the meanings given to them.

Subp. 2. **Accident only coverage.** "Accident only coverage" means a policy designed to provide coverage solely upon the occurrence of an accidental injury or death.

Subp. 3. **Act.** "Act" means Minnesota Statutes, sections 62E.01 to 62E.17, as amended, which shall be cited as the Minnesota Comprehensive Health Insurance Act of 1976.

Subp. 4. **Actuarial equivalent.** "Actuarial equivalent" or "an actuarially equivalent benefit" means a benefit, the expected value of which when substituted for another benefit or benefits in a plan of health coverage will be the same as the benefit or benefits for which it was substituted, and which will result in the plan of health coverage after substitution of the actuarially equivalent benefit, being the actuarial equivalence of the original plan of health coverage.

"Actuarial equivalence" shall be recognized for two plans where, employing the same set of assumptions for the same population, the expected value of benefits provided by the plans is equal. Expected value of benefits shall be measured by the probability of the claim for each benefit multiplied by the average expected amount of each of those benefits.

Subp. 5. **Administrative expenses of the pool.** "Administrative expenses of the pool" means the actual operating and administrative expenses of the association incurred directly in the operation of the reinsurance plan including fees to a reinsurance administrator.

Subp. 6. **Association.** "Association" means the Minnesota Comprehensive Health Association.

Subp. 7. **Board.** "Board" means the board of directors of the association.

Subp. 8. **Calendar year.** "Calendar year" means a 12-month period from January 1 to and including December 31.

Subp. 9. **Certificate of eligibility and enrollment form.** "Certificate of eligibility" or "certificate of eligibility and enrollment form" means the document entitled "certificate of eligibility and enrollment form" or any other document which is used to apply for coverage under the state plan.

Subp. 10. **Claims expenses; payment of benefits.** "Claims expenses" or "payment of benefits" means all payments to covered persons or providers including payments for hospital, surgical and medical care, and reasonable estimates, as determined by the association and approved by the commissioner, of the incurred but not reported claims of the state plan.

Subp. 11. **Close relative.** "Close relative" means the insured person's spouse, brother, sister, parent or child.

Subp. 12. **Commercial reinsurance; excess of loss reinsurance.** "Commercial reinsurance" or "excess of loss reinsurance" means reinsurance arranged by the association under which the pool pays premiums to a reinsurer which assumes part of the risk of the reinsurance plan.

Subp. 13. **Covered expenses.** "Covered expenses" means the usual and customary charges for the services and articles listed in Minnesota Statutes, section 62E.06, or the actuarial equivalence thereof, when prescribed for a covered person by a physician and when such expenses are incurred during a period in which the state plan policy or contract is in effect.

Subp. 14. **Covered person.** "Covered person" means the insured person or an insured dependent.

Subp. 15. **Dental care.** "Dental care" means those services which a person licensed to practice dentistry may provide as defined in Minnesota Statutes, section 150A.05, subdivision 1.

Subp. 16. **Disabled child; dependent child of any age who is disabled.** "Disabled child" or a "dependent child of any age who is disabled" means a child, married or unmarried, who is and has been continuously incapable of self-sustaining employment by reason of mental retardation or physical handicap and is financially dependent upon the insured, provided proof of such incapacity and dependency is furnished to the insurer or to the association within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer or the association, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Subp. 17. **Employee welfare benefit plan.** "Employee welfare benefit plan" means any plan, fund, or program through which an employer provides, directly or indirectly, accident and health benefits to its employees through a trust, through the purchase of insurance, or through the provision of benefits for medical, surgical, or hospital care.

Subp. 18. **Financially dependent.** A person shall be considered "financially dependent" if that person is chiefly dependent upon the insured person for support and maintenance.

Subp. 19. **Free standing ambulatory surgical or medical center.** "Free standing ambulatory surgical center" or "free standing ambulatory medical center" means a surgical or medical center approved as such by the state of Minnesota.

Subp. 20. **Home health agency.** "Home health agency" means a public or private agency that specializes in giving nursing service and other therapeutic services in the insured person's home and is approved as such by the state of Minnesota.

Subp. 21. **Hospital.** "Hospital" means:

A. an institution which is operated pursuant to law and which is primarily engaged in providing on an inpatient basis for the medical care and treatment of sick and injured persons through medical, diagnostic, and surgical facilities, under the supervision of a staff of physicians and with 24-hour a day nursing service; or

B. an institution not meeting all the requirements of item A, but which is accredited as a hospital by the Joint Commission on Accreditation of Hospitals; but

C. in no event shall the term "hospital" include a nursing home or any institution or part thereof which is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged.

Subp. 22. **Hospital indemnity coverage.** "Hospital indemnity coverage" means coverage which provides a fixed dollar benefit on the occurrence of the condition precedent that the covered person was confined in a hospital.

Subp. 23. **Illness.** "Illness" means disease, injury, or a condition involving bodily or mental disorder of any kind, and including pregnancy.

Subp. 24. **Independent contractor.** "Independent contractor" means a person who exercises an independent employment and contracts to do certain work without being subject to the control of his employer except as to the results of the work.

Subp. 25. **Individual insured.** "Individual insured" means the covered employee or surviving spouse or surviving dependent of a covered employee as those terms are used in Minnesota Statutes, section 62A.17, subdivision 6.

Subp. 26. **Insured dependent.** "Insured dependent" means an eligible dependent originally named in the policy or contract schedule or otherwise insured subsequent to the effective date of the policy or contract.

Subp. 27. **Insured person.** "Insured person" means the person named in the policy or contract schedule.

Subp. 28. **Interim reinsurance assessment.** "Interim reinsurance assessment" means an assessment at any time other than at the end of a calendar year (or other fiscal year end as determined by the association) of participating members when pooling payments and payments by reinsurers for the year are not sufficient to fund paid and estimated obligations of the pool and administrative expenses of the pool.

Subp. 29. **Licensed and tested insurance agent or solicitor.** "Licensed and tested insurance agent or solicitor" means an agent or solicitor as defined in Minnesota Statutes, section 60A.02, subdivision 7 or 8, and licensed by the commissioner under Minnesota Statutes, section 60A.17 to act as an agent or solicitor for accident and health insurance as defined in Minnesota Statutes, section 60A.06, subdivision 1, clause (5)(a).

Subp. 30. **Losses.** "Losses" means all claims expenses.

Subp. 31. **Major medical expenses.** "Major medical expenses" as used in Minnesota Statutes, section 62E.04 means the covered expenses for services and articles listed in Minnesota Statutes, section 62E.06, subdivision 1, or the actuarial equivalence thereof, provided that the maximum lifetime benefit limit shall not be less than $250,000.

Subp. 32. **Net gains.** "Net gains" means the excess of premiums or contract charges over claims expenses, after the writing carrier's expenses and agent referral fees (not to exceed 12-1/2 percent of premiums or contract charges) have been paid as provided in part 2740.4400, subpart 4.

Subp. 33. **Nonqualified policy; unqualified policy or plan.** A "nonqualified policy" or "unqualified policy" or "unqualified plan" means a policy, contract, or plan which has not been certified by the commissioner as qualified pursuant to the terms of the act.

Subp. 34. **Nursing home.** "Nursing home" means an institution meeting the following requirements:

A. It is operated pursuant to law and is primarily engaged in providing the following services for persons convalescing from illness: room, board, and 24-hour a day nursing service by one or more professional nurses and such other nursing personnel as are needed to provide adequate medical care.

B. It provides such services under the full-time supervision of a proprietor or employee who is a physician or a registered nurse.

C. It maintains adequate medical records and has available the services of a physician under an established agreement if not supervised by a physician.

Subp. 35. **Operating and administrative expenses of association.** "Operating and administrative expenses of association" means expenditures reasonably necessary to the operation and administration of the association including but not limited to rents, stationery, telegraph and telephone charges, salaries and expenses of office employees, investigators or adjusters, and legal expenses, as well as expenses of directors of the board of the association relating to the conduct of or attendance at meetings. The operating and administrative expenses of the association do not include the operating and administrative expenses of the writing carrier.

Subp. 36. **Out-of-pocket expenses.** "Out-of-pocket expenses" means any cost or charge in a calendar year for a health service or article that is included in the list of covered services and articles under the qualified plan, qualified medicare supplement plan, policy or contract of major medical coverage, or state plan policy or contract under which the person is a covered person, and which is not paid or payable if claim were made under any plan of health coverage, medicare, or other governmental program.

Subp. 37. **Participating members.** "Participating members" means insurer and fraternal members of the association that elect to reinsure risks of issuing certain coverages required under the act through the association under its reinsurance plan.

Subp. 38. **Per diem policies.** "Designed solely to provide payments on a per diem, fixed indemnity or nonexpense incurred basis" means policies that provide benefits upon the occurrence or existence of a condition precedent, without reference to expenses incurred or services provided, for hospital, surgical, or medical care.

Subp. 39. **Policies or contracts of accident and health insurance.** "Policies or contracts of accident and health insurance" means accident and health insurance policies as defined by Minnesota Statutes, section 62E.02, subdivision 11.

Subp. 40. **Pooling payment.** "Pooling payment" means the amount each participating member pays the association or its reinsurance administrator during a given period of time as determined by the association or its reinsurance

administrator based on pooling rates and volume of policies and contracts reinsured by the participating member in each category.

Subp. 41. **Pooling rates.** "Pooling rates" means unit rates approved by the association and used as the basis for pooling payments.

Subp. 42. **Preexisting condition.** "Preexisting condition" means an injury, illness, or other physical or mental condition of a covered person that existed prior to the issuance of the covered person's policy or contract.

Subp. 43. **Preexisting conditions limitation.** "Preexisting conditions limitation" means a limitation excluding coverage for an injury, illness, or other physical or mental condition of an applicant that existed prior to the issuance of the applicant's policy or contract.

Subp. 44. **Professional services.** "Professional services" means only services rendered by a physician or at the physician's direction by a private duty, licensed, registered nurse or an allied health professional. Professional services shall not include a service rendered by a close relative.

Subp. 45. **Reasonable benefits in relation to cost of covered services.** "Reasonable benefits in relation to cost of covered services" means reasonable benefits in relation to premium charged for coverage under a policy as determined by the minimum anticipated loss ratio requirement of Minnesota Statutes, section 62A.02, subdivision 3.

Subp. 46. **Reimbursable services.** "Reimbursable services" means eligible services under medicare.

Subp. 47. **Reinsurance administrator.** "Reinsurance administrator" means an entity with which the association contracts for administration of its reinsurance plan.

Subp. 48. **Reinsurance assessment.** "Reinsurance assessment" means a calendar year end (or other fiscal year end as determined by the association) assessment of participating members when pooling payments and payments by reinsurers for the year are not sufficient to fund paid and estimated obligations of the pool and administrative expenses of the pool.

Subp. 49. **Reinsurance plan.** "Reinsurance plan" means any mechanism by which the association undertakes to reinsure the risks which Minnesota Statutes, section 62E.10, subdivision 7 authorizes the association to reinsure.

Subp. 50. **Reinsurance pool; pool.** "Reinsurance pool" or "pool" means the pool or fund into which the association or the reinsurance administrator deposits pooling payments, interim reinsurance assessments and reinsurance assessments paid to the association or its reinsurance administrator by insurer or fraternal members wishing to reinsure certain risks, as well as claims paid by reinsurers under contract for commercial reinsurance with the association, and other receipts, and from which the association or its reinsurance administrator pays premiums for commercial reinsurance, administrative expenses of the pool, and reimbursement for claims paid by insurer or fraternal members that have reinsured all or any portion of risks covered under policies or contracts which have been reinsured pursuant to a reinsurance pooling agreement with the association.

Subp. 51. **Reinsurance pooling agreement.** "Reinsurance pooling agreement" means the agreement between the association and participating members which establishes a reinsurance plan.

Subp. 52. **Reinsurer.** "Reinsurer" means the commercial reinsurance company that contracts with the association to provide excess of loss coverage for the risks which participating members reinsure through the association.

Subp. 53. **Rejection.** "Rejection" means refusal by any association member to issue a qualified plan to a person who completes an application for coverage under such qualified plan, as determined by the board.

Subp. 54. **Renewal date.** "Renewal date" means the date specified in a policy or contract on which renewal occurs. In the absence of a specified renewal date in a policy or contract, renewal date shall be determined in reference to the anniversary date specified in the policy or contract and shall occur in intervals of no greater than 12 months duration as determined in reference to the date on which the policy or contract became effective. Renewal of a policy or contract shall be deemed to occur upon the expiration of a renewal date if coverage under the policy or contract is continued.

Subp. 55. **Resident of Minnesota.** "Resident of Minnesota" means a person who is an actual resident of Minnesota, having there his or her principal and permanent abode.

Subp. 56. **Restrictive rider.** "Restrictive rider" means a document or contractual provision adding certain conditions to the policy's or contract's coverage, the effect of which is to substantially reduce coverage from that received by a person who is considered a standard risk.

Subp. 57. **Student.** "Student" means any unmarried child under the age of 25 who during the calendar year is enrolled in and attends an educational institution as a full-time student and who is financially dependent upon an insured person.

Subp. 58. **Total cost of self-insurance.** "Total cost of self-insurance" includes any direct and indirect administrative expenses incurred that are related to the operation of a plan or self-insurance, plus the sum of any payment made to or on behalf of Minnesota residents for costs or charges for health benefits by a self-insurer under a plan of health coverage, regardless of the amount incurred or relationship of the cost to an insured or partially insured plan of health coverage, which is not counted as premium by an insurer, except to the extent of such payments made for coverage of the types described in Minnesota Statutes, section 62E.02, subdivision 11, clauses (1) to (8).

Subp. 59. **Usual and customary charge.** "Usual and customary charge" for the purpose of the state plan means the normal charge, in absence of insurance, of the provider for a service or article, but not more than the prevailing charge in the area for a like service or article. A "like service" is of the same nature and duration, requires the same skill and is performed by a provider of similar training and experience. A "like article" is one that is identical or substantially equivalent. "Area" means the municipality or, in the case of a large city, a subdivision thereof, in which the service or article is actually provided or such greater area as is necessary to obtain a representative cross-section of charges for a like service or article.

Statutory Authority: *MS s 62E.09*

2740.0200 AUTHORITY, SCOPE, AND PURPOSE.

These rules are promulgated pursuant to Minnesota Statutes, section 62E.09, clause (i) relating to qualified comprehensive health insurance plans and the operations of the Minnesota Comprehensive Health Association. These rules and all future changes herein apply to all insurers (including nonprofit health service plan corporations), self-insurers, fraternals, health maintenance organizations and other organizations that are at the time of adoption of these rules, or at any time in the future, licensed or authorized to do business in or otherwise doing business in this state and thereby subject to the provisions of the Minnesota Comprehensive Health Insurance Act of 1976, as amended. These rules are promulgated to carry out the act, as amended, and to facilitate its full and uniform implementation, enforcement and application to all persons affected thereby.

Statutory Authority: *MS s 62E.09*

QUALIFIED PLAN

2740.1100 DUTIES OF EMPLOYERS.

Subpart 1. **Duty to make available a qualified plan.** An employer shall be deemed to have made available a qualified plan to its employees as required in Minnesota Statutes, section 62E.03, subdivision 1 when participation under a number 2 or number 3 qualified plan or a health maintenance plan is offered to the employee directly or through an insurer or health maintenance organization and without regard to whether the cost of such participation is paid directly or indirectly by the employer or by the employee or by their joint payment.

Subp. 2. **Effect of collective bargaining on duty to make available a qualified plan.** An employer whose employees are represented by one or more exclusive bargaining representatives shall be deemed to have complied with the provisions of Minnesota Statutes, section 62E.03, subdivision 1 with respect to all employees within each unit for collective bargaining if the employer makes available qualified plans of health coverage to the exclusive bargaining representatives.

A. Such employers shall be deemed to have complied with requirements of Minnesota Statutes, section 62E.03, subdivision 1 for each accounting period utilized by the employer for Minnesota income tax purposes during the entire term of any collective bargaining agreement executed after an offer of qualified health coverage has been made.

B. Nothing in this part shall require the employer to renegotiate any collectively bargained agreement solely for the purposes of compliance with this act.

Subp. 3. **Frequency of required offer.** Except as provided in subpart 2, an employer shall be deemed to have complied with the requirements of Minnesota Statutes, section 62E.03, subdivision 1 if he makes available to his employees a plan of health coverage which is certified as a number 2 or number 3 qualified plan or a health maintenance plan at least once during each accounting period utilized by the employer for Minnesota income tax purposes.

Statutory Authority: *MS s 62E.09*

2740.1200 DUTIES OF INSURERS AND FRATERNALS.

Subpart 1. **Exception to definition of accident and health insurance policy.** The exception provided by Minnesota Statutes, section 62E.02, subdivision 11, clause (4) shall apply with respect to hospital indemnity coverage sold by an insurer to an applicant who is, at the time of application for hospital indemnity coverage, covered by a qualified plan, notwithstanding the possibility that the applicant may subsequently terminate coverage under a qualified plan.

A. The exclusion of Minnesota Statutes, section 62E.02, subdivision 11, clause (4) shall also apply to a hospital indemnity coverage which is sold by an insurer to an applicant who is then currently covered by a health maintenance plan.

B. Insurers shall be entitled to conclusively rely upon the written statement of an applicant for hospital indemnity coverage that such applicant is, at the time of the application, covered by a qualified plan or a health maintenance plan.

Subp. 2. **Timing of required offer of a qualified plan or qualified medicare supplement plan.** Timing of required offer of a qualified plan or qualified medicare supplement plan is as follows:

A. The offer of each type of qualified plan (that is, a number 1, number 2, and number 3 qualified plan) that is required when an insurer or fraternal is offering an individual policy of accident health insurance shall occur no later than the date of delivery of such policy to the applicant.

B. The offer of a qualified medicare supplement plan that is required when an insurer or fraternal is offering a medicare supplement policy shall occur no later than the date of delivery of such policy to the applicant.

C. The offer of each type of qualified plan (that is, a number 1, number 2, or number 3 qualified plan) required when an insurer or fraternal is offering a group policy of accident and health insurance shall occur no later than the date of delivery of such policy to the applicant.

D. "Each person who applies" and "applicant" for the purposes of Minnesota Statutes, section 62E.04 and this part shall be deemed to be only the individual making an initial application for an individual policy or in the case of a group policy, the corporation, partnership, proprietorship, association or other qualified entity making application for a group policy.

E. Minnesota Statutes, section 62E.04, subdivisions 1, 2, and 3 shall not be deemed to require an insurer or fraternal to offer a qualified plan or qualified medicare supplement plan at the time a policy is subject to renewal.

Subp. 3. **No duty to offer particular category of insurance.** For the purposes of the act, individual accident and health insurance, group accident and health insurance, individual medicare supplement plans, and group medicare supplement plans are recognized as separate and distinct categories of insurance. Nothing in Minnesota Statutes, section 62E.04, subdivisions 1, 2, and 3 shall be construed as requiring an insurer or fraternal to engage in the business of offering or issuing a particular category of accident and health insurance policy or medicare supplement plan that it does not otherwise offer or issue in this state.

Subp. 4. **Duty to offer major medical coverage.** Each insurer and fraternal shall affirmatively offer, subject to its underwriting standards, coverage of major medical expenses to every applicant for a new unqualified policy at the time of application and annually thereafter to every holder of an unqualified policy of accident and health insurance as required by Minnesota Statutes, section 62E.04, subdivision 4. "Affirmatively offer" shall mean written advice to the applicant for, or the holder of, an unqualified policy of accident and health insurance, of the availability of coverage for major medical expenses. Such written advice of the availability of the coverage for major medical expenses may be satisfied by a contractual provision in the unqualified policy that gives the insured the contractual right to apply to the insurer or fraternal for a policy or rider that provides coverage for 80 percent of the covered expenses for services listed in Minnesota Statutes, section 62E.06, subdivision 1 or the actuarial equivalence thereof subject to a $5,000 deductible for out-of-pocket expenses, subject to the insurer's or fraternal's underwriting requirements.

Subp. 5. **Effect on foreign contracts.** No provision of the act shall be construed to require any insurer or fraternal to alter or amend any policy or contract issued outside the state of Minnesota.

Subp. 6. **Exclusion of certain foreign conversion policies.** The issuance of individual group conversion policies or contracts in Minnesota pursuant to Minnesota Statutes, section 62A.17 or 62E.16 shall not, in and of itself, constitute the transaction of accident and health insurance business by an insurer or fraternal that has relinquished prior authority to transact such business in Minnesota and that is not otherwise currently issuing policies or contracts in Minnesota.

Subp. 7. **Exceptions to duties for certain policies and contracts.** Exceptions to duties for certain policies and contracts are as follows:

A. The continuation in force of a policy or contract under which there is no unilateral right of the insurer or fraternal to cancel, nonrenew, amend or change the terms, conditions or premium rate of the policy or contract in any way, shall not be considered a renewal for the purposes of Minnesota Statutes, section 62E.04 and part 2740.2100 if the policy or contract:

(1) was issued prior to July 1, 1976; or

(2) was designed solely to provide payments on a per diem, fixed indemnity or nonexpense incurred basis and was issued prior to June 3, 1977.

B. The issuance or renewal by an insurer or fraternal on or after June 3, 1977 of the policy or contract that is designed solely to provide payments on a per diem, fixed indemnity or nonexpense incurred basis, shall not be subject to Minnesota Statutes, section 62E.04, except for policies and contracts sold by an insurer to provide payments on a hospital indemnity basis if such coverage is issued to an applicant who is not covered by a qualified plan or a health maintenance plan at the time of issue.

Subp. 8. **Sanction for failure to comply with duties of insurers and fraternals.** Any insurer or fraternal not in compliance with Minnesota Statutes, section 62E.04 shall cease and desist from transacting accident and health insurance business in the state of Minnesota. Nothing in this part shall prohibit such an insurer or fraternal no longer meeting the definition of insurer in Minnesota Statutes, section 62E.02, subdivision 10 or fraternal in Minnesota Statutes, section 62E.02, subdivision 19 from continuing to maintain in force any policies or contracts described in subpart 7, item A.

Statutory Authority: *MS s 62E.09*

2740.1300 QUALIFIED PLAN PREEXISTING CONDITIONS.

A qualified plan may include provisions consistent with generally accepted underwriting practices that provide that any preexisting condition for any person covered under the policy which was diagnosed prior to the effective date of the policy, and for which medical care or treatment was rendered or prescribed during the 90 days immediately prior to the application for such policy, shall not be covered or eligible for the payment of any benefits for care or treatment rendered during a period of time beginning on the effective date of the policy and ending 24 months after the policy has been continuously in force.

Statutory Authority: *MS s 62E.09*

2740.1400 MINIMUM BENEFITS OF QUALIFIED MEDICARE SUPPLEMENT PLANS.

The minimum benefits of qualified medicare supplement plans shall be as provided in Minnesota Statutes, section 62E.07 and as described for the purposes of the state plan in part 2740.3100.

Statutory Authority: *MS s 62E.09*

2740.1500 CERTIFICATION OF QUALIFIED PLANS.

Subpart 1. **Application for certification.** The application of an insurer, fraternal, or employer for certification by the commissioner of a plan of health coverage as a qualified plan or a qualified medicare supplement plan under Minnesota Statutes, section 62E.05 shall include the qualification number of the plan for which certification is sought pursuant to the procedures specified in the actuarial equivalence tables set forth in parts 2740.9905 to 2740.9986.

Subp. 2. **Certification by commissioner.** An accident and health insurance policy or plan is deemed certified as a qualified plan or qualified medicare supplement plan for the purpose of Minnesota Statutes, section 62E.05 if it meets the requirements of these rules and other relevant laws of the state upon the expiration of 90 days after receipt of the request for certification by the commissioner, unless earlier rejected or certified by the commissioner. In the event the commissioner rejects such request, he shall give written notice of the grounds for rejection to the person submitting the plan, and the insurer, fraternal, or employer has the same rights in the event of such rejection as provided in Minnesota Statutes, section 62A.02.

Subp. 3. **Required benefits under the act.** On or after June 3, 1977 each plan of health coverage, in order to be certified as a number 1, number 2, or number 3 qualified plan, shall provide a limitation of $3,000 per person on total annual out-of-pocket expenses and a maximum lifetime benefit of not less than

$250,000, and shall provide all other benefits required under the act that are not subject to substitution of actuarially equivalent benefits under Minnesota Statutes, section 62E.06.

Subp. 4. **Certification of an employer's plan of health coverage.** For purposes of certification of an employer's plan of health coverage pursuant to Minnesota Statutes, section 62E.03, any plan of health coverage that constitutes a qualified plan at the time of issue shall continue to be a qualified plan until the later of the next renewal date of the plan of health coverage or the expiration of an applicable collective bargaining agreement, if any.

Statutory Authority: *MS s 62E.09*

2740.1600 TERMINATION OF COVERAGE; CONVERSION PRIVILEGES.

Subpart 1. **Eligibility for conversion upon termination.** A person whose employment has terminated may elect to exercise the right provided by Minnesota Statutes, section 62A.17 for continued coverage under the group insurance policy, group subscriber contract, health maintenance contract, or plan of health coverage that is self-insured or, at the employee's option, may exercise the right provided by Minnesota Statutes, section 62E.16 to convert to an individual coverage qualified plan. If the employee elects to continue coverage under Minnesota Statutes, section 62A.17, such employee may not exercise the right of conversion under Minnesota Statutes, section 62E.16 until the continuation coverage obtained pursuant to Minnesota Statutes, section 62A.17 is terminated, and if the employee elects to convert to an individual qualified plan, the employee may not elect to continue group coverage pursuant to Minnesota Statutes, section 62A.17.

Subp. 2. **Duty to offer conversion policy or contract.** Duty to offer conversion policy or contracts:

A. For the purposes of Minnesota Statutes, sections 62E.16 and 62A.17, an insurer, health maintenance organization, or self-insurer shall not be required to offer a conversion policy or contract to a person who is then covered by a qualified plan or eligible for medicare.

B. An insurer, health maintenance organization, or self-insurer shall not be required to renew a conversion policy or contract issued to a person who, during the prior policy or contract year, became covered by a qualified plan, or became eligible for medicare.

C. An insurer, health maintenance organization, or self-insurer that is required to offer conversion coverage to a terminated employee must offer, at the employee's option, a number 1, number 2, or number 3 qualified plan. A policy providing reduced benefits at a reduced premium rate may be accepted by the employee, spouse or a dependent in lieu of the optional coverage otherwise required by Minnesota Statutes, sections 62A.17, subdivision 6 and 62E.16.

Subp. 3. **Due notice of cancellation or termination.** An insurer, health maintenance organization, or self-insurer shall be deemed to have provided "due notice of cancellation or termination" as required in Minnesota Statutes, section 62E.16 if the insurer, health maintenance organization, or self-insurer notifies in writing those employees at their respective addresses as provided the insurer, health maintenance organization, or self-insurer by the employer pursuant to the terms of Minnesota Statutes, section 62E.16.

Statutory Authority: *MS s 62E.09*

2740.1700 REVISION OF ACTUARIAL EQUIVALENCE TABLES.

The commissioner shall periodically, no less frequently than biennially, review the actuarial equivalence tables set forth in parts 2740.9905 to 2740.9986, and shall require that the relative point values set forth therein be actuarially updated when required to more accurately reflect changes in the relative values of benefits, including copayments. Any revision of relative point values which

the commissioner shall make shall be promulgated pursuant to the rulemaking requirements of the Administrative Procedure Act, Minnesota Statutes, chapter 14. Following revision of the actuarial equivalence tables pursuant to this part, recertification of existing plans of health coverage may be required subject to the provisions set forth in parts 2740.1100, 2740.1200, and 2740.1500.

Statutory Authority: *MS s 62E.09*

MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION

2740.2100 DEFINITIONS.

Subpart 1. **Accident and health insurance business.** "Accident and health insurance business" means the issuance or renewal of any accident and health insurance policy as defined in Minnesota Statutes, section 62E.02, subdivision 11.

A. An insurer is engaged in accident and health insurance business during the period in which any policy or contract which has been issued or renewed remains in effect.

B. Such business shall not include the issuance or renewal of policies or contracts providing coverage that is:

(1) limited to disability or income protection coverage for a specified period of time;

(2) limited to automobile insurance that provides coverage for medical payments as defined and authorized under Minnesota Statutes, section 60A.06, subdivision 1, clause (12);

(3) supplemental to liability insurance, as defined and authorized in Minnesota Statutes, section 60A.06, subdivision 1, clause (13);

(4) limited to policies or contracts issued prior to July 1, 1976 under which there is no unilateral right of the insurer or fraternal to cancel, nonrenew, amend, or change the terms, conditions, or premium rate of the policy or contract in any way; provided that all policies and contracts designed solely to provide payments on a per diem, fixed indemity or nonexpense incurred basis issued prior to June 3, 1977 under which there is no unilateral right of the insurer or fraternal to cancel, nonrenew, amend, or change the terms, conditions, or premium rate of the policy or contract in any way, are also excluded;

(5) designed solely to provide payment on a per diem, fixed indemnity, or nonexpense incurred basis, except that all policies and contracts designed solely to provide payments on a hospital indemnity basis issued or renewed by an insurer on or after June 3, 1977 are included to the extent that such coverage is issued to an applicant who is not covered by a qualified plan or a health maintenance plan at the time of issue;

(6) limited to credit accident and health insurance, meaning insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy, as authorized by Minnesota Statutes, chapter 62B;

(7) designed solely to provide dental or vision care;

(8) limited to blanket accident and sickness insurance as defined in Minnesota Statutes, section 62A.11; or

(9) limited to accident-only coverage issued by a licensed and tested insurance agent or solicitor and that provides reasonable benefits in relation to the cost of covered services.

Subp. 2. **Health maintenance organization business.** "Health maintenance organization business" means the operation of a nonprofit corporation licensed and operated as provided in Minnesota Statutes, chapter 62D.

Subp. 3. **Licensed or authorized to do business.** "Licensed or authorized to do business" means:

A. licensed by the commissioner to conduct business under Minnesota Statutes, chapter 62A, 62C, or 64A, or by the commissioner of health under Minnesota Statutes, chapter 62D; or

B. authorized by the secretary of state to carry on any business in the state of Minnesota or otherwise doing business in this state and acting as an insurer, self-insurer, fraternal, or health maintenance organization.

Subp. 4. **Self-insurance business.** "Self-insurance business" means the provision, directly or indirectly, of a plan of health coverage by a self-insurer. "Self-insurance business" does not include the direct provision of health care services to employees at no charge to them by an employer engaged in the business of providing health care services to the public, nor does it include provision of benefits that, if provided by an insurer doing accident and health insurance business, would be excluded under subpart 1, item B. "Directly or indirectly" for the purposes of parts 2740.2100 to 2740.2600 means that the employer or employee welfare benefit plan funds the plan of health coverage in any amount or collects any employee contributions which are used to pay for the plan of health coverage.

Statutory Authority: *MS s 62E.09*

2740.2200 MANDATORY MEMBERSHIP.

As a condition of doing accident and health insurance business, self-insurance business, or health maintenance organization business in Minnesota, all insurers, self-insurers, fraternals, and health maintenance organizations licensed or authorized to do business in this state shall become members of the association and maintain their membership therein.

Statutory Authority: *MS s 62E.09*

2740.2300 ASSESSMENT AGREEMENT.

Each member shall enter into an assessment agreement with the association for a one year term, renewable annually thereafter as required by the act. Signing this assessment agreement shall fulfill the requirement that members enter into a reinsurance contract with the association under Minnesota Statutes, section 62E.10, subdivision 5. The agreement shall be signed by an officer of the member who is authorized to enter into contracts on behalf of the member, shall be in a form adopted by the board of directors of the association and approved by the commissioner, and shall include, but not be limited to, provisions regarding the members' obligation to:

A. share proportionately in funding the operating and administrative expenses of the association in accordance with parts 2740.2400 and 2740.2500;

B. share proportionately in the losses of the association in accordance with parts 2740.2400 and 2740.2500; and

C. pay all fiscal year-end assessments that shall be due within 30 days after the end of the association's fiscal year (December 31 unless the association establishes a different fiscal year end) and shall be payable 30 days after receipt of a written assessment notice.

Statutory Authority: *MS s 62E.09*

2740.2400 ASSESSMENTS.

Members, according to the assessment agreement, will be assessed for their proportionate share of the operating and administrative expenses of the association, incurred or estimated to be incurred, together with losses, if any, incurred by the association as a result of operation of the state plan. The total amount of operating and administrative expenses and losses:

A. shall be determined annually by the board at each fiscal year end;

B. may, at the recommendation of the board, subject to the approval of the commissioner, consist of a reasonable estimate of the operating and

administrative expenses of the association for the succeeding fiscal year, which amount shall be adjusted at the end of the succeeding fiscal year to the amount of actual operating and administrative expenses, and members shall be entitled to credit for any excess or shall be assessed for any deficit in these expenses in the next annual fiscal year end assessment.

Statutory Authority: *MS s 62E.09*

2740.2500 LEVY OF ASSESSMENTS.

Subpart 1. **Annual.** The association may levy assessments following each fiscal year end.

Subp. 2. **Interim.** The association may also, upon approval of the commissioner, levy interim assessments when deemed necessary to assure the financial capability of the association to meet the incurred or estimated operating and administrative expenses of the association and losses resulting from the state plan. Interim assessments shall be due and payable within 30 days of receipt by a member of a written interim assessment notice.

Subp. 3. **Member share.** The association shall levy each member's share of the total assessment based on the ratio of: the member's total accident and health insurance premium, subscriber contract charges, or health maintenance organization contract charges (the preceding defined as charges for business defined in part 2740.2100, subparts 1 and 2) received from or on behalf of residents of Minnesota, or total cost of self-insurance, as determined by the commissioner; to the total for all members of premiums, contract charges, and benefit plan costs reported.

Subp. 4. **Costs and charges.** The costs and charges referred to in the ratio in subpart 3 shall, to the extent possible, be determined by reference to a form issued by the association or the commissioner which all members shall submit to the commissioner annually for the preceding calendar year.

A. If the required information is not available to the commissioner when necessary to levy an assessment, the commissioner may estimate the member's share based on other available information relative to its experience, including but not limited to, the annual statement that all insurers are required to transmit to the commissioner under Minnesota Statutes, section 60A.13.

B. The commissioner shall have the authority to audit the accounts and records of any member and any agent, trust, third party administrator, or other entity administering all or any portion of a plan of health coverage with or on behalf of a self-insurer for the purpose of obtaining information necessary to levy an assessment.

Subp. 5. **Discretionary waiver.** The board may, in its discretion, decline to levy assessments against members that owe up to $5 or less in a given year.

Statutory Authority: *MS s 62E.09*

2740.2600 FAILURE TO EXECUTE ASSESSMENT AGREEMENT OR TO PAY ASSESSMENTS.

The names of all insurers, self-insurers, fraternals, and health maintenance organizations that are required under the act to be members of the association, but which fail to execute an assessment agreement, will be forwarded by the association to the commissioner for appropriate action within the discretion of the commissioner. Any members that fail to pay annual or interim assessments when such assessments become payable will be reported by the association to the commissioner for appropriate action within the discretion of the commissioner.

Statutory Authority: *MS s 62E.09*

2740.2700 ORGANIZATION AND APPROVAL.

Subpart 1. **Powers.** The association shall operate pursuant to the provisions of Minnesota Statutes, chapter 62E, with all the powers of a corporation formed under Minnesota Statutes, chapter 317, except that if the provisions of the two chapters conflict, Minnesota Statutes, chapter 62E shall govern.

Subp. 2. **Amendments to articles of incorporation.** Amendments to the articles of incorporation shall be submitted to and approved by the commissioner before filing with the secretary of state.

Subp. 3. **Amendments to bylaws.** All amendments to the bylaws of the association shall be submitted to and approved by the commissioner before they become effective.

Subp. 4. **Operating rules.** The board is authorized to adopt and to amend from time to time reasonable operating rules that are not inconsistent with the act and these rules for the management and operation of the association. Upon submission to and approval by the commissioner, these operating rules shall become effective.

Statutory Authority: *MS s 62E.09*

2740.2800 BOARD OF DIRECTORS.

Subpart 1. **Composition.** The management of the association shall be vested in a board of seven directors who shall be representative of the membership of the association, and be officers, employees, or agents of members of the association during their terms of office, and shall automatically be removed for failure to meet this qualification.

Subp. 2. **Election.** The board shall be elected by members at the annual meeting of the association in accordance with the bylaws of the association, to the extent that such bylaws are consistent with the provisions of Minnesota Statutes, chapters 62E and 317, and in accordance with the provisions relating to voting rights as outlined in part 2740.2900.

Prior to the election, the association may submit the names of proposed board members to the commissioner for approval. After the annual meeting, the results of the election shall be certified and submitted to the commissioner for approval pursuant to criteria set forth in Minnesota Statutes, section 62E.10, subdivision 2.

Subp. 3. **Duties and compensation.** The duties of the board shall include management of the association in furtherance of its purposes as provided in the act, and as authorized in the articles of incorporation and bylaws of the association.

Members of the board may be reimbursed by the association for expenses incurred by them in attending board or board committee meetings and for other reasonable expenses incurred within the scope of their activities as directors and within guidelines established by the board and approved by the commissioner, but shall not otherwise be compensated for their services.

Subp. 4. **Officers and committees.** The board may elect officers and establish committees as provided in the bylaws of the association. These officers and committees shall be charged with such duties as authorized by the board in accordance with the bylaws of the association.

Statutory Authority: *MS s 62E.09*

2740.2900 DETERMINATION OF MEMBER'S VOTING RIGHTS.

Subpart 1. **Meetings.** Every member is entitled to vote at the annual meeting and at any special meeting of the members.

Subp. 2. **Weighted vote.** A member's vote shall be a weighted vote based on the member's cost of self-insurance, accident and health insurance premiums, subscriber contract charges, or health maintenance contract charges derived from or on behalf of residents of Minnesota in the previous calendar year, as determined by the commissioner. To the extent possible, this figure shall be determined by reference to the annual reporting form submitted to the commissioner in accordance with part 2740.2500, subpart 4.

If the necessary information is not available to the commissioner on the form described in this subpart at the time that voting rights must be determined, the commissioner may estimate the member's weighted vote based on other information available to the commissioner.

Subp. 3. **Voting procedures.** Members are entitled to vote in person, by proxy, or by mail as determined by the board.

When a member elects to vote in person at a members' meeting, the representative casting the vote shall present credentials as required pursuant to the bylaws or operating rules of the association.

When a member elects to vote by proxy, the proxy statement as approved by the board and by the commissioner shall be returned on or before the date indicated in the meeting notice sent to the members.

Voting by mail may be permitted as authorized by the bylaws or operating rules of the association, and the meeting notice to members shall so indicate.

Statutory Authority: *MS s 62E.09*

2740.3000 MEETINGS OF ASSOCIATION.

Subpart 1. **Annual meeting.** An annual meeting of the members shall be held for the purpose of electing directors as provided in part 2740.2800, subpart 2 and for the purpose of transacting any other appropriate business of the membership of the association.

The meeting shall be held in the second calendar quarter of each year unless otherwise determined by the board, and shall occur at such date, time, and place as the board determines.

"Appropriate business" includes any activities related to the powers and duties of the association under Minnesota Statutes, chapter 62E or 317.

Notice and quorum requirements shall be as provided in the articles of incorporation or bylaws of the association or as otherwise authorized by the board.

Subp. 2. **Special meetings.** Special meetings of the members shall be held at the request of the commissioner and may otherwise be held as provided by the articles of incorporation or bylaws of the association for the purpose of conducting any appropriate business of the association.

A special meeting may be held at such date, time, and place designated in the notice of the meeting.

Notice and quorum requirements shall be as provided in the articles of incorporation or bylaws of the association or as otherwise authorized by the board.

Subp. 3. **Open meetings.** All meetings of the association membership, board, and any committees established in accordance with part 2740.2800, subpart 4 shall be held in compliance with the provisions of the open meeting law (Minnesota Statutes, section 471.705).

Statutory Authority: *MS s 62E.09*

2740.3100 MINIMUM BENEFITS OF COMPREHENSIVE HEALTH INSURANCE PLANS.

Subpart 1. **Duty to offer.** The association shall offer a number 1 and number 2 qualified plan and a qualified medicare supplement plan to eligible persons. The association shall offer health maintenance plans in areas of the state where a health maintenance organization has agreed to make the coverage available and has been selected as a writing carrier in accordance with part 2740.4300. The association may provide for coverage for eligible dependents.

Subp. 2. **Benefits of number 1 and number 2 qualified plan.** Benefits shall meet or exceed the requirements of Minnesota Statutes, section 62E.06 or the actuarial equivalence thereof as determined pursuant to the actuarial equivalence tables set forth in parts 2740.9905 to 2740.9986, except where substitution of an actuarially equivalent benefit is not permissible under the act.

A. The minimum benefits shall be equal to at least 80 percent of the charges for covered expenses in excess of the annual deductible, which shall not exceed $500 for a number 2 qualified plan, or $1,000 for a number 1 qualified plan.

B. Coverage shall include an annual (calendar year) limitation of not more than $3,000 per covered person on total out-of-pocket expenses, which out-of-pocket expenses shall include the deductible under the state plan policy or contract, and which benefit (copayment) is not subject to substitution of an actuarially equivalent benefit (copayment).

C. Coverage shall be subject to a maximum lifetime benefit of not less than $250,000 per covered person, less any amount paid to or on behalf of the covered person under any other state plan policy or contract. This benefit is not subject to substitution of an actuarially equivalent benefit.

Subp. 3. **Benefits of qualified medicare supplement plan.** Benefits of a qualified medicare supplement plan shall meet or exceed the following minimum standards or the actuarial equivalence thereof as determined pursuant to the actuarial equivalence tables set forth in parts 2740.9905 to 2740.9986.

A. The plan shall provide benefits to covered persons who are 65 years of age or older by supplementing medicare through provision of 50 percent of the deductible and copayment required under medicare.

B. The plan shall provide 80 percent of the covered charges for expenses as provided in Minnesota Statutes, section 62E.06 or the actuarial equivalence thereof, which charges are not paid or payable under medicare or would not have been paid or payable had the covered person who is or was entitled or eligible to enroll in medicare been so enrolled.

C. Coverage shall include an annual limitation of $1,000 total out-of-pocket expenses per covered person for covered expenses.

D. Coverage may not be subject to a maximum lifetime benefit of less than $100,000, or the unused portion of the maximum lifetime benefit under any policy or contract of the state plan under which the person was previously covered, whichever is less.

Subp. 4. **Benefits of health maintenance plan.** Benefits of a health maintenance plan shall include those comprehensive health maintenance services required by Minnesota Statutes, chapter 62D and rules promulgated thereunder.

Subp. 5. **Preexisting conditions.** No person who obtains coverage under a policy or contract of the state plan shall be covered for any preexisting condition during the first six months of coverage under the state plan if such covered person was diagnosed or treated for that condition during the 90 days immediately preceding the filing of a completed certificate of eligibility.

Statutory Authority: *MS s 62E.09*

2740.3200 APPROVAL OF STATE PLAN.

Subpart 1. **Submission of proposed state plan.** Members of the association may submit to the association policies or contracts that have been approved by the commissioner for selection by the association as the state plan.

Subp. 2. **Approval of policies or contracts by association.** The association shall select policies or contracts to constitute the state plan from among the proposals submitted by the members or from proposals developed by the association or others. These policies and contracts, or parts thereof, may be used to develop specifications for bids from members that wish to be selected as a writing carrier to administer the state plan.

Subp. 3. **Approval of state plan.** The policies or contracts approved by the association as the state plan shall be approved by the commissioner prior to issuance.

Statutory Authority: *MS s 62E.09*

SOLICITATION, APPLICATION, AND ENROLLMENT

2740.3600 ENROLLMENT.

Subpart 1. **Open enrollment.** The state plan shall be open for enrollment by eligible persons at all times.

Subp. 2. **Eligible person.** "Eligible person," as used in subpart 1, means a resident of Minnesota who submits or on whose behalf is submitted a complete certificate of eligibility and enrollment form to the association or its writing carrier and who is not already covered by another state plan policy or contract.

A. A complete certificate of eligibility and enrollment form may provide:

(1) name, address, age, sex, and length of time as a resident of Minnesota;

(2) name, address, and age of eligible dependents, if any, if they are to be insured. "Eligible dependent" means the insured person's spouse who has not reached age 65 or unmarried child, excluding:

(a) a legally separated spouse;

(b) a child who is 19 years old or older unless that child is a student or disabled child;

(c) a spouse or child who has applied for an individual state plan policy or contract pursuant to any conversion privilege granted to such eligible dependent under the insured person's state plan policy or contract; and

(d) a spouse or child on active duty in any military, naval or air force of any country;

(3) evidence of rejection, or a requirement of a restrictive rider or preexisting conditions limitation on a qualified plan, the effect of which is to substantially reduce coverage from that received by a person who is considered a standard risk, by at least two association members within six months of the date of application. "Substantially reduce coverage from that received by a person who is considered a standard risk" includes any restriction on coverage as a result of an illness, condition, or risk which the association deems substantial, any increase in rates for an applicant based on an illness, condition or risk, which the association deems substantial, and any preexisting conditions limitation which the association deems substantial.

B. Before a person is determined to be an eligible person, the board may require that any items listed in item A or, if acting pursuant to provisions of the association's operating rules, other necessary information be submitted to the association or its writing carrier and may also investigate the authenticity of information submitted as a part of the certificate of eligiblity.

C. If a covered person, upon reaching age 65, wishes to purchase a state plan qualified medicare supplement plan, the requirement that the person

obtain two rejections from members of the association within the preceding six months may be waived by the board if acting pursuant to provisions of the association's operating rules.

D. A person who is age 65 or older shall be eligible for coverage only under the state plan's qualified medicare supplement plan and when an insured person under a qualified plan reaches age 65, the board may, if acting pursuant to provisions of the association's operating rules, terminate or refuse to renew coverage under the qualified plan.

E. An applicant or any person proposed to be covered under the state plan who has previously been covered by a state plan policy or contract and who has exhausted the maximum lifetime benefit under the state plan shall not be an eligible person for coverage under the state plan, provided that an applicant for a qualified medicare supplement policy or contract of the state plan who has previously been covered under the state plan shall be eligible for a maximum benefit under the qualified medicare supplement policy or contract of $100,000, or the unused portion of the maximum lifetime benefit under any policy or contract of the state plan under which the person was previously covered, whichever is less.

F. When a covered person under the state plan no longer meets one or more of the requirements for eligibility for coverage under the state plan, the board may, if acting pursuant to the association's operating rules, terminate or refuse to renew coverage under the state plan.

Statutory Authority: *MS s 62E.09*

2740.3700 ASSOCIATION'S RESPONSE.

Subpart 1. **Time limitation.** Within 30 days of receipt of a complete certificate of eligibility and enrollment form pursuant to part 2740.3600, subpart 2, items A and B, the association or the writing carrier shall accept the certificate of eligibility or shall reject the certificate of eligibility for failure to meet the eligibility requirements.

Subp. 2. **Acceptance.** If the association or its writing carrier accepts the certificate of eligibility, it shall forward a notice of acceptance, billing information, and a policy or contract or certificate that shall evidence coverage under the state plan.

A. Such policy or contract or certificate of coverage shall include but not be limited to:

(1) a statement that the person is covered under the state plan from the effective date contained therein;

(2) specification of the type of state plan under which the person is covered;

(3) a statement that the plan is provided by the association;

(4) a description of the benefits provided by the plan, conditions for eligibility, and exclusions and limitations of coverage; and

(5) provision for an identification card for each insured person indicating the type of state plan and also that coverage is being provided by the association.

B. When the state plan premium is received by the association or its writing carrier for the first billing period and accepted in accordance with this part, the coverage shall be effective retroactive to the date of receipt by the association or its writing carrier of the completed certificate of eligibility pursuant to part 2740.3600, subpart 2, items A and B unless otherwise requested by the insured person and approved by the board.

Subp. 3. **Nonacceptance.** If the association does not accept the certificate of eligibility, the applicant shall be informed of the reason for the rejection and shall have the opportunity to submit additional information to substantiate

eligibility for coverage under the state plan and to request reconsideration of the decision. The board shall establish a review mechanism for reviewing requests for reconsideration of rejected certificates of eligibility. The association shall give notice of a final determination of ineligibility to the applicant stating the reasons therefor and advising the applicant of the right to appeal to the commissioner within a reasonable period of time.

Statutory Authority: *MS s 62E.09*

2740.3800 APPEAL TO COMMISSIONER.

Any applicant or covered person who is determined by the association to be ineligible for coverage under the state plan may appeal such determination to the commissioner within a reasonable period of time. Upon receipt of an appeal from a determination of ineligibility, the commissioner may, in his discretion, affirm, reverse, or modify the determination of the association.

Statutory Authority: *MS s 62E.09*

2740.3900 SOLICITATION OF ELIGIBLE PERSONS.

Subpart 1. **Plan.** The association shall develop a plan for use by the association, upon approval by the commissioner, to publicize the existence of the state plan, the eligibility requirements, and procedures for enrollment, and to maintain public awareness of and participation in the state plan.

Subp. 2. **Forms and instructions.** The association shall prepare and make available certificate of eligibility forms and enrollment instruction forms to insurance solicitors, agents and brokers, and to the general public in Minnesota.

Subp. 3. **Referral fee.** The association shall require the writing carrier to pay a referral fee of $25 for any certificate of eligibility accepted by the association or its writing carrier. The referral fee shall be paid to the licensed agent whose signature appears as the agent on the accepted certificate of eligibility. The referral fee shall be paid from the premium received for the state plan.

Statutory Authority: *MS s 62E.09*

WRITING CARRIERS

2740.4300 SELECTION AND APPROVAL OF WRITING CARRIERS.

Subpart 1. **Selection.** The association may select a writing carrier or writing carriers on the basis of criteria for selection which shall include but not be limited to:

A. the member's proven ability to handle large group accident and health insurance cases;

B. the efficiency of the member's claim paying capacity;

C. an estimate of total charges for administering the plan; and

D. other criteria developed by the association and set forth in its operating rules.

Subp. 2. **Approval.** The writing carrier selected by the association shall be approved by the commissioner prior to the establishment of a contract with the association and prior to the commencement of its duties pursuant to Minnesota Statutes, section 62E.13 and part 2740.4400.

Subp. 3. **Term.** The writing carrier shall serve for a period of three years, unless the commissioner approves an earlier termination at the request of the writing carrier or the association in accordance with the terms of its contract with the writing carrier.

The commissioner shall approve or deny a request for termination within 90 days of receipt of such request. Failure to make a determination within 90 days of receipt of such request shall be deemed to be an approval.

Subp. 4. **Termination.** If termination is approved by the commissioner, the writing carrier shall serve for up to six months from the date of the writing carrier's request for termination, at the discretion of the association, to allow the association to select another writing carrier.

Subp. 5. **Bids for renewal.** Six months prior to the expiration of each three year period of service by a writing carrier, the association shall invite insurer and health maintenance organization members, including the current writing carriers, to submit bids to serve as writing carrier for the succeeding three year period.

Statutory Authority: *MS s 62E.09*

2740.4400 OPERATIONS OF THE WRITING CARRIER.

Subpart 1. **Administrative and claims payment functions.** The writing carrier shall perform all administrative and claims payment functions relating to the state plan.

A. The writing carrier shall establish a premium billing procedure for collection of premiums from insured persons.

(1) Billings shall be made on a periodic basis as determined by the board.

(2) The amount of the premium shall be as determined from time to time by the board pursuant to Minnesota Statutes, section 62E.08.

B. The writing carrier shall perform all necessary functions to assure timely payment of benefits to covered persons under the state plan.

(1) The writing carrier shall make available information relating to the proper manner of submitting a claim for benefits under the state plan and shall distribute forms upon which submissions shall be made.

(2) The writing carrier shall evaluate the eligibility of the claim for payment under the state plan.

(3) The writing carrier shall determine the usual and customary charges for professional services, supplies, or institutional care for which a claim is made under the state plan policy or contract.

(4) The writing carrier shall exercise reasonable efforts to advise covered persons, within 15 working days of receipt of a properly completed and executed proof of loss, whether the submitted claim was accepted or rejected by the writing carrier, unless sooner settled.

(5) The writing carrier shall establish an appeals procedure approved by the board to review claims that are denied in whole or in part. When a claim or any portion thereof is denied, the writing carrier shall inform the covered person of the existence of the procedure, including the right to appeal to the commissioner within a reasonable period of time.

Subp. 2. **Monthly reports.** The writing carrier shall submit monthly reports to the commissioner and the board on the operation of the state plan. The content and form of the report shall be as determined by the board and approved by the commissioner.

Subp. 3. **Claims expenses.** The writing carrier shall pay claims expenses from the premium payments received from or on behalf of covered persons under the state plan. If the writing carrier's payments for claims expenses exceed the portion of the state plan premiums allocated by the board for payment of claims expenses, the association shall provide to the writing carrier additional funds for payment of claims expenses. Not less than 87-1/2 percent of the state plan premium, as determined by the board, shall be used to pay claims expenses, and not more than 12-1/2 percent of the state plan premium shall be used to pay agent referral fees (authorized by Minnesota Statutes, section 62E.15, subdivision 3) and to pay the writing carrier's direct and indirect expenses, as defined and authorized in Minnesota Statutes, section 62E.13, subdivision 7 and described in parts 2740.4300 to 2740.4500.

Subp. 4. **Direct and indirect expense reimbursement.** The writing carrier shall be paid from time to time as provided in the association's contract with the writing carrier for its direct and indirect expenses incurred in the performance of its services from the state plan premiums received in an amount not to exceed the lesser of:

A. 12-1/2 percent of the state plan premium, less agent referral fees payable under part 2740.3900, subpart 3;

B. direct and indirect operating and administrative expenses incurred in the performance of its services; or

C. an amount agreed upon by the board and the writing carrier.

Subp. 5. **Direct and indirect expenses.** Direct and indirect expenses shall include that portion of the carrier's actual administrative, printing, claims administration, management, building overhead expenses, and other actual operating and administrative expenses approved by the board as allocable to the administration of the state plan.

Subp. 6. **Cost accounting method.** The board shall approve cost accounting methods of the writing carrier, which shall be consistent with generally accepted accounting principles.

Subp. 7. **Audits.** The board shall have the authority to conduct periodic audits to verify the accuracy of financial data and reports submitted by the writing carrier.

Statutory Authority: *MS s 62E.09*

2740.4500 APPEAL TO COMMISSIONER.

Any covered person whose claim for benefits under the state plan is denied, in whole or in part, may appeal such determination to the commissioner within a reasonable period of time. Upon receipt of an appeal from a claim denial, the commissioner may, in his discretion, affirm, reverse or modify the determination of the association.

Statutory Authority: *MS s 62E.09*

REINSURANCE

2740.5100 AUTHORITY TO MAKE AVAILABLE REINSURANCE.

The association may provide for reinsurance of risks incurred by insurer or fraternal members resulting from such members' issuance of all or any of the following categories of coverage as provided in the act. A member may make a separate election to reinsure each of these categories:

A. individual qualified plans, but not including group conversions;

B. individual qualified medicare supplement plans but not including group conversions;

C. group conversions on qualified plans; "group conversions" means the conversion policies or contracts required to be issued under Minnesota Statutes, sections 62A.16 and 62A.17 or 62E.16;

D. group qualified plans which cover fewer than 50 employees or insured persons;

E. group qualified medicare supplement plans with fewer than 50 employees or insured persons;

F. individual major medical coverage; and

G. group major medical coverage.

Statutory Authority: *MS s 62E.09*

2740.5200 REINSURANCE PLAN.

Subpart 1. **Pool agreement.** The association may enter into reinsurance pooling agreements with insurer and fraternal members to establish a reinsurance plan for risks of categories of coverage described in part 2740.5100. The reinsurance plan may provide for a reinsurance pool.

Subp. 2. **Application and acceptance.** Insurer or fraternal members wishing to participate in the pool shall apply to the association for participation in the pool, specifying the categories of coverage that the member desires to reinsure.

Members entering into a reinsurance pooling agreement for a particular category or categories of coverage shall offer to place in the pool all policies and contracts that it issues in the category or categories listed in part 2740.5100 that it wishes to reinsure.

Only policies and contracts acceptable to the association or its reinsurance administrator may be accepted for reinsurance. The association is under no obligation to accept any but standard risks in the reinsurance plan.

Subp. 3. **Commercial reinsurance.** The association may obtain commercial reinsurance to reduce the risk of loss through the pool to insurer or fraternal members entering into reinsurance pooling agreements. Any contract for commercial reinsurance entered into between the association and a commercial reinsurer shall be binding on any insurer or fraternal member entering into a reinsurance pooling agreement.

Subp. 4. **Pool administration.** The association may administer the pool directly or through a reinsurance administrator.

The association or its reinsurance administrator may establish underwriting standards with which participating members shall comply and may perform reinsurance underwriting on all policies or contracts submitted for reinsurance.

The association or its reinsurance administrator may perform benefit calculation (claims processing) for all claims eligible for reimbursement to participating members. Only claims paid by participating members and approved by the association or its reinsurance administrator shall be eligible for reimbursement by the association or its reinsurance administrator in accordance with the reinsurance pooling agreement.

Except for underwriting and claims processing functions, the association or the reinsurance administrator shall have no responsibility for other administration functions for any member's reinsured policies or contracts unless otherwise agreed to by the association.

Subp. 5. **Duties of members.** Participating members shall have the duties established in the reinsurance pooling agreement, including but not limited to:

A. submitting reports that provide all information deemed necessary by the association or its reinsurance administrator for performance of reinsurance, underwriting, and claims processing functions;

B. paying all pooling payments; and

C. paying all reinsurance assessments and interim reinsurance assessments as required by the board.

Statutory Authority: *MS s 62E.09*

2740.5300 POOLING PAYMENTS.

The association may require pooling payments from all participating members, to provide for reimbursement to participating members for claims paid under reinsured policies and contracts and for payment of administrative expenses of the pool incurred or estimated to be incurred during the period for which the pooling payment is made. Pooling payments shall be established by the association to provide at least 110 percent of total anticipated expenses for

reinsurance and for administration of the policies or contracts which are reinsured.

Statutory Authority: *MS s 62E.09*

2740.5400 ASSESSMENT OF PARTICIPATING MEMBERS.

Subpart 1. **Annual.** At the end of each calendar year (or other fiscal year end established by the association) the board may assess participating members on the basis of the formula established in or as a part of the reinsurance pooling agreement.

Subp. 2. **Interim.** The board may also levy interim reinsurance assessments to assure the financial ability of the association to reimburse participating members for claims paid under reinsured policies and contracts and operating and administrative expenses incurred or estimated to be incurred in the operation of the reinsurance plan until the calendar year end (or other fiscal year end established by the association) reinsurance assessment.

Interim reinsurance assessments shall be due and payable within 30 days of receipt by a participating member of an interim reinsurance assessment notice.

Interim reinsurance assessments shall be credited to each participating member in the year end reinsurance assessment calculation.

Subp. 3. **Time for payment.** Each participating member's reinsurance assessment (net after credit for any interim reinsurance assessment) shall be billed to the member by the association following each calendar year end (or other fiscal year end established by the association) and shall be due and payable within 30 days of receipt by the member of the reinsurance assessment notice.

Statutory Authority: *MS s 62E.09*

2740.5500 EXCESS RECEIPTS.

If pooling payments, reinsurance assessments and other receipts by the association or its reinsurance administrator as a result of the reinsurance plan exceed actual reinsurance losses and administrative expenses of the pool, such excess shall be held at interest and used by the association to offset losses (including but not limited to reserves for incurred but not reported claims) due to claims expenses of the state plan or allocated to reduce state plan premiums.

Statutory Authority: *MS s 62E.09*

ACTUARIAL EQUIVALENCE OF QUALIFIED PLANS AND QUALIFIED MEDICARE SUPPLEMENT PLANS

2740.9905 HOW TO USE TESTS.

Subpart 1. **Basic and comprehensive major medical plans.** Tests for basic and comprehensive major medical plans are as follows:

A. List the plan benefits, ignoring deductibles and coinsurance.

B. For each benefit, find the appropriate table of equivalent points for basic and major medical plans.

C. Extract the appropriate point value for the benefit from the table, interpolating as necessary or indicated, and place it opposite the listed benefit.

D. Ignore benefits for which no table exists.

E. List deductible, coinsurance and plan maximum if the plan is a comprehensive major medical plan.

F. Find tables of points for deductible, coinsurance, and plan maximum.

G. Extract the appropriate point values for deductible, coinsurance, and plan maximum, usually negative, interpolating as necessary, and place the values in the list of points.

H. Add algebraically the list of points.

I. Refer the result to the test for actuarial equivalence to determine qualification.

Subp. 2. **Superimposed major medical plans.** Tests for superimposed major medical plans are as follows:

A. Follow steps in Subpart 1, items A to D for basic health plan benefits.

B. Total the points for the basic plan.

C. Enter tables 21, 22, and 23 of the tables of equivalent points to determine the point value of a qualified plan superimposed over the basic plan with the deductible and benefit period of the plan at hand, interpolating as necessary. Put the points in the point column.

D. Compare the benefits in the superimposed major medical plan with the benefit structure of a qualified plan:

(1) $250,000 lifetime maximum;

(2) 80/20 coinsurance;

(3) $3,000 annual per person out-of-pocket maximum;

(4) eligible expenses are usual and customary expenses for:

(a) hospital services;

(b) physician care;

(c) prescription drugs;

(d) nursing-home care of up to 120 days in one year commencing within 14 days of hospitalization of at least three days;

(e) home health care;

(f) radium and radioactive therapy;

(g) oxygen;

(h) anesthetics;

(i) prostheses;

(j) rental or purchase of durable medical equipment;

(k) diagnostic x-rays and laboratory tests;

(l) oral surgery on impacted teeth, teeth roots and gums, and tissues, not in connection with tooth extraction;

(m) physical therapy;

(n) maternity same as any illness;

(o) Minnesota statutorily mandated benefits;

(p) coordination of benefits.

E. Consult the tables for point adjustments (usually negative) for qualified plan benefits not in the superimposed major medical plan being tested. Put the adjustments in the point column.

F. Add algebraically the points for the basic plan, item B, the superimposed major medical plan, item C, and the adjustments, item E.

G. Refer the result to the test for actuarial equivalence to determine qualification.

Subp. 3. **Medicare supplement plans.** Follow the rules for basic and comprehensive major medical plans but use the tables of equivalent points for medicare supplement plans and the medicare supplement table of actuarial equivalence.

Statutory Authority: *MS s 62E.09*

2740.9910 BENEFIT VARIATIONS NOT COVERED BY TABLES.

Only those plan variations that are most common are recognized. For instance, comprehensive plan coinsurance was assumed to normally not exceed 20 percent. Therefore, no points are shown for 25 percent. However, points

for such missing benefit variations can be extrapolated or estimated.

Statutory Authority: *MS s 62E.09*

2740.9915 USE OF TABLES.

Any insurer, self insurer, or policyholder may use the test for actuarial equivalence as a guide. However, to obtain certification of any plan of health benefits as "qualified," it must be submitted to the commissioner. If an uninsured plan description or a policy form number or policy identification number is sent to the commissioner, together with a statement of its total equivalent point value from the tables, and with a certification by a principal or officer of an insurer, or by a member of the academy of actuaries for plans submitted by employers, that the plan is qualified by virtue of the test of actuarial equivalence as either a plan 1, 2, or 3, or a medicare supplement plan, the plan will be deemed certified as filed. If the test does not qualify a plan or does not result in qualification for the plan (i.e., 1, 2, or 3) desired by the insurer or self insurer, the filing must include the plan document or policy, the equivalent point calculation, and a statement of specific reasons for the desired qualification. Such plan will not be qualified until and unless so certified by the commissioner.

Statutory Authority: *MS s 62E.09*

2740.9920 UPDATE OF TABLES.

Periodically, the tables may be revised as health care costs change. The commissioner may reevaluate actuarial equivalence of any plan or policy at any time as he believes appropriate. Annual reevaluation of plans is therefore suggested. When a plan is reevaluated and its qualification status changes, the filing procedures in part 2740.9915 will be followed.

Statutory Authority: *MS s 62E.09*

2740.9925 MISUSE OF TABLES.

The tables of equivalent points are not intended for any other use, especially not for premium calculations. They represent a composite of data, adjusted to be useable for testing actuarial equivalence. No other use is contemplated.

Statutory Authority: *MS s 62E.09*

2740.9930 WHY TEST WAS DEVELOPED.

Minnesota Statutes, section 62E.02, defines "qualified plans" and "qualified medicare supplement plans" as health benefit plans that provide the benefits required in Minnesota Statutes, sections 62E.06 or 62E.07, "or the actuarial equivalent to those benefits;" Minnesota Statutes, section 62E.06 describes three qualified plans and Minnesota Statutes, section 62E.07 describes a qualified medicare supplement plan. These statutes require all plans of health coverage to be labelled as qualified or nonqualified. The commissioner may be requested to determine whether a plan is qualified and he may take up to 90 days to make that determination.

Statutory Authority: *MS s 62E.09*

2740.9935 COMPOSITE POINT VALUES FOR QUALIFIED PLAN NUMBER THREE.

The composite point values for a qualified plan number three and the point values for the qualified medicare supplement plan are as shown herein.

Composite Point Values For Minnesota Qualified Plan No. 3 Arbitrary Radix = 1,000 Points

Points	Benefit
395	Hospital room and board--unlimited days, semi-private.
485	Hospital extras (i.e., hospital services, hospital miscellaneous, hospital special services, or ancillary services) including anesthesia.
210	Surgery, including oral surgery but not tooth repair or extraction.
220	Home and office physician care--unlimited.
55	Physician care in hospital--unlimited.
75	Obstetrics--unlimited.
125	Hospital maternity--unlimited.
90	X-rays and laboratory tests--outpatient and out-of-hospital.
90	Prescription drugs and medicine--outpatient and out of hospital.
20	Emergency accident care.
15	Radioactive therapy--outpatient and out-of-hospital.
20	Nursing or convalescent facility.
10	Home health agency care.
10	Physical therapy.
20	$3,000 annual "out-of-pocket" expense limit.
-75	Coordination of benefits.
-45	Nonduplication with no-fault.
-430	$150 Deductible.
-290	20 percent coinsurance.
1,000	Total

Note: When setting up the above table, some minor benefits (e.g., student dependents to age 25, oxygen, etc.) specified in the statute were overlooked. All have extremely nominal point value so no recalculation has been made for them at this time.

Plan Name_____

Statutory Authority: *MS s 62E.09*

2740.9940 COMPOSITE POINT VALUES FOR QUALIFIED MEDICARE SUPPLEMENT PLAN.

Arbitrary Radix = 100 Points

Points	Benefit
26.13	Hospital room and board--unlimited days, semi-private, reasonable and customary--net of medicare payments.
3.90	Skilled nursing home--net of medicare payments.
.15	Blood and blood plasma (in-hospital)--not provided by medicare.
45.78	*Surgery, including oral surgery but no tooth repair or extraction.
104.66	*Home and office physician care--unlimited.
22.70	*Physician care in hospital--unlimited.
57.58	*X-rays and laboratory tests--outpatient and out-of-hospital.
5.00	*Radioactive therapy--outpatient and out-of-hospital.
3.75	*Home health agency care.
1.48	*Miscellaneous.
48.67	Drugs and medicine--outpatient and out-of-hospital.
5.00	Private duty nursing.
-158.89	Part B medicare payments credit.
-54.64	50 percent of medicare coinsurance and deductibles.
-11.27	20 percent of expenses not covered by medicare.
100.00	Total

* Gross expense--before medicare payment under part B.

Plan No._____

Statutory Authority: *MS s 62E.09*

2740.9945 WORKSHEET FOR OTHER THAN MEDICARE SUPPLEMENT PLANS.

Test for Actuarial Equivalence

Other Than Medicare Supplement Plans

Table	Benefit	Basic	Major Medical Super-imposed	Major Medical Compre-hensive
21-23	Superimposed major	XXX		XXX

	medical			
1.	Hospital room and board			
2.	Hospital extras			
3.	Surgery			
4.	Physician care --home, office			
5.	Physician care --hospital			
15-18	Benefits in full			
6.	Maternity			
7.	Diagnostic x-ray and lab			
8.	Drugs and medicine			
9.	Emergency/supplemental accident			
10.	Radioactive therapy			
12.	Nursing/convalescent facility			
13.	Home health care			
14.	Physical therapy			
14.	Oxygen			
14.	Prostheses			
14.	Durable medical equipment			
11.	Student dependents			
24.	Limit on out-of-pocket			
25.	Maximum benefit	XXX		
XX.	Subtotal			
26.	COB/no-fault			
19-20	Coinsurance/ deductible	XXX		
XX.	Total			
XX.	Combined basic and superimposed		XXX	XXX

Equivalent to Minnesota qualified plan number ___

Non-qualified ____

Date_____ By_____

Plan name_____ Plan no._____

Statutory Authority: *MS s 62E.09*

2740.9950 WORKSHEET FOR MEDICARE SUPPLEMENT PLANS.

Test for Actuarial Equivalence

Medicare Supplement Plan.

Table	Benefit
27.	Hospital--defined daily benefit

	Days	Daily Benefit	Factor	Product
	1		9.59	
	2-60		83.56	
	61-90		1.50	
	91-150		.61	
	151 & Over		1.02	
	Total	XXX		
	Divisor			
	Quotient			
	Multiplier			
	Product			
27.	Hospital--usual and customary charges not paid by medicare			
	A. Medicare deductible and coinsurance			
	B. Benefits not covered by medicare			
28.	Skilled nursing facility			
29.	Blood			
30.	Surgery			
31.	Physician care--home and office			
32.	Physician care--hospital			
33.	Home health care			
34.	Diagnostic x-ray and laboratory			
35.	Radioactive therapy			
36.	Drugs and medicine			
37.	Private duty nursing			
38.	Miscellaneous			
41.	Comprehensive major medical			
XX.	Subtotal			
39.	Medicare part B payments			
40.	Medicare part B deductible not eligible			
XX.	Total			

Equivalent to Minnesota qualified medicare supplement plan? Yes ___ No ___

Date_____By_____

Statutory Authority: *MS s 62E.09*

2740.9955 TEST FOR ACTUARIAL EQUIVALENCE.

Subpart 1. **For plans other than medicare supplement plans.**

If the Point Value of any Plan is:	Then that Plan is the Actuarial Equivalent of Minnesota Qualified Plan No.:
1,000 + points	3
700 + points	2
550 + points	1
Less than 550 points	Non-Qualified

Subp. 2. **For medicare supplement plans.**

If the Point Value of any Plan is:	Then that Plan is the Actuarial Equivalent of Minnesota Qualfied Plan No.:

100 + points	Minnesota Medicare Supplemental Plan

Statutory Authority: *MS s 62E.09*

2740.9960 LOCATION OF TABLES OF EQUIVALENT POINTS.

Subpart 1. **Basic and major medical health plans.**

Table	Name
1.	Hospital room and board
2.	Hospital extras
3.	Surgery
4.	Home and office physician care
5.	In-hospital physician care
6.	Maternity
7.	Diagnostic x-ray and laboratory
8.	Drugs and medicine
9.	Emergency and supplemental accident
10.	Radioactive therapy
11.	Student dependents
12.	Nursing or convalescent -- home care
13.	Home health care agency service
14.	Physical therapy
14.	Oxygen
14.	Prostheses
14.	Durable medical equipment
15.	Hospital room and board in full
16.	All hospital charges in full
17.	All hospital and surgical charges in full
18.	All hospital, surgical, and in-hospital physicians care in full
19.	Coinsurance and deductibles
20.	Combined dental and health insurance deductible
21.	Superimposed major medical
22.	Superimposed major medical
23.	Superimposed major medical
24.	Limit on "out of pocket" expenses
25.	Major medical maximums
26.	Coordination and nonduplication of benefits

Subp. 2. **Medicare supplement plans.**

27.	Hospital room and board and extras
28.	Skilled nursing facility
29.	Blood
30.	Surgery
31.	Home and office physician care
32.	In-hospital physician care
33.	Home health care
34.	Diagnostic x-ray and laboratory
35.	Radioactive therapy
36.	Drugs and medicines
37.	Private duty nursing
38.	Physical therapy
38.	Oxygen
38.	Prostheses
38.	Durable medical equipment

39. Medicare part B payments
40. Medicare part B deductible
41. Comprehensive major medical

Statutory Authority: *MS s 62E.09*

2740.9965 TABLES 1 TO 26: EQUIVALENT POINTS FOR BASIC AND MAJOR MEDICAL HEALTH PLANS; NOT TO BE USED FOR MEDICARE SUPPLEMENT PLANS.

Subpart 1. **Table 1: hospital room and board.**

Maximum Days	Semi-Private Room at $81 Per day	Deduct for Each $10/Day Less than Semi-Private
31	330	40
70	370	46
120	380	48
365	390	49
Unlimited	395	50
Additional Points Per $1 Excess of Private over Semi-Private	2	

Subp. 2. **Table 2: hospital extras such as hospital services, special hospital services, ancillary services, and hospital therapeutics.**

Maximum Amount	Anesthesia Included	Anesthesia Not Included
$ 250	250	245
500	335	305
1,000	410	265
2,000	450	400
5,000	475	415
Unlimited	485	425

Subp. 3. **Table 3: surgery.**

Limit	Assistant Surgeon Included	Anesthesia Included	Anesthesia Not Included
1957 Intercompany			
$420 Maximum	No	100	85
$900 Maximum	No	195	170
Prevailing Fee*	No	230	200
Deduct for each "$1 per 1964 CRVS Unit" less than Prevailing Fee		25	22
Prevailing Fee*	Yes	240	210
Deduct for each "$1 per 1964 CRVS Unit" less than Prevailing Fee		25	22

* Equivalent to $9 per 1964 CRVS Unit

Subp. 4. **Table 4: home and office physician care.**

Annual Maximum	First Visit Accident First Visit Sickness	Third Visit Sickness
$ 100	115	65
200	140	75
500	170	95
Unlimited	220	120

Subp. 5. **Table 5: in-hospital physician care.**

Maximum Number of Visits	Prevailing Fee at Average $15.50/Day/Visit	Deduct for Each $1 Per Day Per Visit Less Than Prevailing Fee
31	40	3
70	46	3
120	49	3
365	52	4
Unlimited	55	4

Subp. 6. **Table 6: maternity.**

A. Complications only:

Limited to some specified list	20
Any complications	25

B. Full maternity (including complications):

Limit	Deductible	Flat Maternity	Obstetrics	Hospital Maternity
$ 150	None	--	25	30
300	None	55	50	60
500	None	90	70	90
1,000	None	170	--	--
Unlimited	None	200	75	125
Unlimited	$500	100	--	--
Unlimited	$1,000	30	--	--

Subp. 7. **Table 7: x-rays and laboratory tests, out-of- hospital.**

Maximum	Scheduled (Any Schedule)	Unscheduled
$ 50	40	50
100	55	70
200	60	80
Unlimited	65	90

Subp. 8. **Table 8: prescription drugs and medicine, out-of- hospital.**

Deductible Per Prescription	
$2	60
1	75
None	90

Subp. 9. **Table 9: emergency and supplemental accident, basic plans only.**

Maximum	Emergency	Supplemental
$ 25	10	--
50	15	20
150	--	30
300	--	35
500	--	40

Unlimited	20	--

Subp. 10. **Table 10: radioactive therapy, out-of-hospital.**

Scheduled (Any Schedule)	10
Unscheduled	15

Subp. 11. **Table 11: student dependents.**

Student Extension Beyond Age 19	
None	0
To Age 21	2
To Age 23	4
To Age 25	5

Subp. 12. **Table 12: nursing or convalescent home care, within 14 days of hospital confinement of at least three days.**

Maximum days	
120 or More	20
Less than 120	0

Subp. 13. **Table 13: home health care agency services.**

Maximum Visits/Year	
180 or More	10
Less than 180	0

Subp. 14. **Table 14: miscellaneous, out-of-hospital.**

A.	Physical therapy	10
B.	Oxygen	5
C.	Prostheses	5
D.	Durable medical equipment Rental or purchase	5

Subp. 15. **Table 15: hospital room and board in lieu of subpart 1. Hospital room and board in full to indicated limit (basic and comprehensive major medical plans) -- use in leiu of room and board points in subpart 1.**

Plan	Plan Deductible On All Benefits	Insured Pays % of Excess Over Limit	Limit $1,000	$2,000	$5,000	Unlimited
Basic	0	100%	300	325	365	395
Comprehensive	0	20%	455	460	470	475
Comprehensive	$ 50	20%	480	485	500	505
Comprehensive	100	20%	495	505	520	530
Comprehensive	150	20%	510	520	535	550

Subp. 16. **Table 16: hospital changes in lieu of subparts 1 and 2. All hospital charges in full to indicated limit (basic a comprehensive major medical plans) -- use in lieu of room and board and hospital extras in subparts 1 and 2.**

Plan	Plan Deductible On All Benefits	Insured Pays % of Excess Over Limit	Limit $1,000	$2,000	$5,000	Unlimited
Basic	0	100%	615	710	805	880
Comprehensive	0	20%	1,005	1,025	1,045	1,060

Comprehensive	$ 50	20%	1,050	1,080	1,100	1,130
Comprehensive	100	20%	1,090	1,125	1,150	1,180
Comprehensive	150	20%	1,120	1,160	1,195	1,225

Subp. 17. **Table 17: hospital and surgical charges in lieu of subparts 1, 2, and 3.** All hospital and surgical charges in full to indicated limit (basic and comprehensive major medical plans) -- use in lieu of room and board, hospital extras, and surgery points in subparts 1, 2, and 3.

Plan	Plan Deductible On All Benefits	Insured Pays % of Excess Over Limit	Hospital Surgery	$1,000 $5 CRVS	$2,000 $6 CRVS	$5,000 $8 CRVS	Unlimited Unlimited
Basic	0	100%		740	855	955	1090
Comprehensive	0	20%		1240	1265	1295	1310
Comprehensive	$ 50	20%		1295	1330	1370	1400
Comprehensive	100	20%		1340	1385	1440	1465
Comprehensive	150	20%		1375	1425	1480	1515

Subp. 18. **Table 18: charges in lieu of subparts 1, 2, 3, and 5.** All hospital, surgical, and in-hospital physicians care in full to indicated limit (basic and comprehensive major medical plans) -- use in lieu of room and board, hospital extras, surgical, and in-hospital physician care points in subparts 1, 2, 3, and 5.

Plans	Plan Deductible On All Benefits	Insured Pays % of Excess Over Limit	Hospital Surgical Physician	$1,000 $5 CRVS $5/Day	$2,000 $6 CRVS $6/Day	$5,000 $8 CRVS $8/Day	Unlimited Unlimited Unlimited
Basic	0	100%		750	865	1015	1145
Comprehensive	0	20%		1290	1320	1350	1375
Comprehensive	$ 50	20%		1355	1390	1430	1465
Comprehensive	100	20%		1400	1440	1490	1530
Comprehensive	150	20%		1440	1485	1540	1585

Subp. 19. **Table 19: coinsurance and deductibles, comprehensive major medical plans.**

Deductible	Coinsurance: Insured Pays Designated Percent of Expense in Excess of Deductible 0%	10%	20%
$ 0	0	-170	-375
50	-170	-325	-520
100	-310	-455	-630
150	-410	-520	-720
200	-520	-640	-790
500	-820	-910	-1,020
1,000	-1,010	-1,080	-1,170

Subp. 20. **Table 20: combined dental and health insurance deductible, comprehensive major medical plans.**

Deductible	Added Points
$ 50	90
100	75
150	65
200	40

500	35
1,000	15

Subp. 21. **Table 21: superimposed major medical plans; over basic health plans with less than 500 points.**

A. Calculate point value of a comprehensive major medical plan using deductible $100 greater than actual.

B. Add basic health plans points.

Subp. 22. **Table 22: superimposed major medical plans; 80/20 coinsurance; over basic health plans with 500 to 799 points.**

	Add to Basic Plan Points			
	Calendar Year Plan		2 Year Benefit Period Plan	
Deductible:	Individual	2 x Family	Individual	2 x Family
A. Corridor				
$ 50	740	780	745	765
100	665	705	680	700
150	615	655	630	650
200	575	615	590	610
500	365	405	380	400
B. Integrated				
$ 500	615	635	650	670
1,000	515	525	535	545

NOTE: Points assume major medical contains Minnesota qualified plan number 3 benefits. Adjust for benefits not included and for variation in coinsurance.

Subp. 23. **Table 23: superimposed major medical plans; 80/20 coinsurance; over basic health plans with 800 or more points.**

	Add to Basic Plan Points			
	Calendar Year Plan		2 Year Benefit Period Plan	
Deductible:	Individual	2 x Family	Individual	2 x Family
A. Corridor				
$ 50	505	535	515	525
100	445	475	455	465
150	405	435	415	425
200	365	395	375	385
500	205	235	215	225
B. Integrated				
$ 500	505	525	530	550
1,000	405	415	420	430

NOTE: Points assume major medical contains Minnesota Qualified Plan Number 3 benefits. Adjust for benefits not included and for variation in coinsurance.

Subp. 24. **Table 24: limit on "out of pocket" expenses (i.e., maximum co-payment and deductible per benefit year -- comprehensive and superimposed major medical plans.**

Out of Pocket Limit	Deductible: Coinsurance:	$50 20%	$150 20%	$500* 20%	$1,000 20%
$ 500		80	100	200	--

1,000	36	40	55	60
3,000	20	20	22	25
5,000	10	10	11	13
10,000	5	5	5	6

* Use this column for superimposed major medical plans

Subp. 25. **Table 25: major medical maximum, comprehensive and superimposed plans.**

Maximum	Add (+) or Subtract (-)
$ 10,000	-50
20,000	-40
50,000	-20
100,000	-7
250,000	0
Unlimited	+5

Subp. 26. **Table 26: coordination and nonduplication of benefits (all plans).**

Coordination and Non-Duplication of Benefits (All Plans)	Deduct the Following Percentage of Total Points Before Crediting Points For Deductible and Coinsurance
A. With other health plans	4.0%
B. With No Fault	2.5%
C. With both items A and B	6.5%
D. With neither	0

Statutory Authority: *MS s 62E.09*

2740.9970 TABLES 27 TO 41: EQUIVALENT POINTS FOR MEDICARE SUPPLEMENT.

Subpart 1. **Table 27: hospital room and board and extras.** During a spell of illness, medicare part A pays all expenses except for the deductible and coinsurance amounts for hospital services during the first 90 days of hospitalization. If hospitalization continues, medicare will pay the expenses greater than the coinsurance amount until the lifetime reserve of 60 days is reached.

Use the following procedure to obtain the equivalent point value for a benefit that pays a certain amount if the individual is hospitalized a specified number of days:

A. Multiply the benefits provided by the policy by the appropriate adjustment factors given below and sum.

B. Calculate value of medicare deductible and coinsurance. Multiply the current medicare deductible and coinsurance amounts by the appropriate adjustment factors and sum. (Calculated below for July 1, 1976 deductible and coinsurance; recalculate each time medicare changes deductible and coinsurance.)

C. Divide the value from item A by item B.

D. Multiply result from item C by 23.78.

Value of July 1, 1976 Medicare Deductible and Coinsurance

Days in Hospital	Adjustment Factor	Medicare Deductible and Coinsurance	Value
1	09.59	$104	997.36

2-60	83.56	0	0.00
61-90	1.50	26	39.00
91-105	.61	52	31.72
151	1.02	0	0.00
Total			1068.08

Since the medicare deductible and coinsurance provisions change annually, policies using the defined benefit approach should be reevaluated annually.

If the policy does not pay a defined benefit during hospitalization but pays all usual and customary charges for hospital inpatient services not paid by medicare, then use 23.78 and 2.35 as the equivalent point value for the benefits providing for the medicare deductible and coinsurance amounts and for the benefits not covered by medicare respectively.

Subp. 2. **Table 28: skilled nursing facility.** Medicare part A pays the usual and customary expenses of a qualified skilled nursing facility exclusive of a coinsurance amount after 20 days of confinement up to a maximum of 100 days per spell of illness.

Payment of the coinsurance amount. (currently $13) up to 100 days	3.50
Payment of reasonable and customary expenses 100 to 120 days	.30
Payment of reasonable and customary expenses after the 120th day	.10

Subp. 3. **Table 29: blood.** Medicare does not pay for the first three pints of blood while in the hospital. If the policy covers this, then the equivalent point value is .15.

Subp. 4. **Table 30: surgery.**

Surgery	Assistant Surgeon Included	Anesthesia Included	Anesthesia Not Included
Prevailing Fee*	no	48.70	43.60
Deduct for each "$1 per 1964 CRVS Unit" less than prevailing fee		5.05	4.60
Prevailing Fee*	yes	50.45	45.78
Deduct for each "$1 per 1964 CRVS Unit" less than prevailing fee		5.05	4.60

* Equivalent to $9 factor on the 1964 CRVS

Subp. 5. **Table 31: physician care, home and office.**

	First Visit Sickness	First Visit Accident	Third Visit Sickness
unlimited	104.46		74.50

Subp. 6. **Table 32: physician care, hospital.**

Maximum Number of Visits	Prevailing Fee at Average 14.50/Day/Visit	Deduct for each $1 Per Day Per Visit Less than Prevailing Fee
31	17.51	1.21
70	19.10	1.32

120	20.30	1.40
365	21.46	1.48
unlimited	22.70	1.57

Subp. 7. **Table 33: home health care.***

Maximum Visits/Year	
180 or More	3.75
Less than 180	0

*Excludes home health care after individual is discharged from a hospital after a stay of at least three days.

Subp. 8. **Table 34: diagnostic x-ray and laboratory, outpatient or out-of-hospital.**

	Scheduled	Unscheduled
Unlimited	40.60	57.58

Subp. 9. **Table 35: radioactive therapy, outpatient or out-of-hospital.**

Scheduled	3.00
Unscheduled	5.00

Subp. 10. **Table 36: drugs and medicines, outpatient or out-of-hospital.**

Deductible Per Prescription	
2.00	30.00
1.00	38.75
None	48.67

Subp. 11. **Table 37: private duty nurse.**

Private duty nursing (either RN or LPN)	5.00

Subp. 12. **Table 38: miscellaneous.**

Miscellaneous (in clinic or as outpatient)	1.48

A. Physical therapy

B. Oxygen

C. Prostheses

D. Durable medical equipment -- (rental or purchase)

Subp. 13. **Table 39: medicare part B payments.**

Deduct	158.89

Subp. 14. **Table 40: medicare part B deductible, $60.**

Deduct if not eligible	28.50

Subp. 15. **Table 41: comprehensive major medical plans.**

Type	Equivalent Points
With C.O.B. against medicare A and B maximum of $50 or more. Deductible of $100 or less, and coinsurance of 20 percent or less.	100
Other, including "medicare carve out" plans file with commissioner.	*

*File with commissioner.

Statutory Authority: *MS s 62E.09*

2740.9981 EXAMPLE I.

Subpart 1. **Use of actuarial equivalence test.**

A. Question: is the following plan actuarially equivalent to any Minnesota qualified plan?

Deductible	$100
Coinsurance	80/20
Maximum	$10,000
Maternity	Any complications
Student dependents	To 23
Limits on specified benefits	Outpatient mental limited to Minnesota required benefits
Excluded care	Home health care
Out-of-pocket limit	$5,000 per year
Coordination of benefits	Yes, but no COB with no-fault

B. Answer (calculated January 1, 1977): test result is 919 points. This plan is a Minnesota qualified plan number 2.

Plan name--Comprehensive plan.

Plan no.--Example I.

Subp. 2. **Worksheet.** Test for actuarial equivalence other than medicare supplement plans.

			Major Medical	
Table	Benefit	Basic	Super-imposed	Compre-hensive
21-23	Superimposed major medical	XXX		XXX
1.	Hospital room and board			395
2.	Hospital extras			485
3.	Surgery			240
4.	Physician care--home, office			210
5.	Physician care--hospital			55
15-18	Benefits in full			--
6.	Maternity			25
7.	Diagnostic x-ray and lab			90
8.	Drugs and medicine			90
9.	Emergency/supplemental accident			0
10.	Radioactive therapy			15
12.	Nursing/convalescent facility			20
13.	Home health care			0
14.	Physical therapy			10
14.	Oxygen			5
14.	Prostheses			5
14.	Durable medical equipment			5
11.	Student dependents			4
24.	Limit on out-of-pocket			10
25.	Maximum benefit	XXX		-50
XX.	Subtotal			1614
26.	COB/no-fault			-65

19-20	Coinsurance/ deductible	XXX		-630
XX.	Total			919
XX.	Combined basic and superimposed		XXX	XXX

Equivalent to Minnesota Qualified Plan Number 2 Non-Qualified __

Date_____By_____

Statutory Authority: *MS s 62E.09*

2740.9982 EXAMPLE II.

Subpart 1. **Use of actuarial equivalence test.**

A. Question: is the following plan actuarially equivalent to any Minnesota qualified plan?

Hospital	$70 per day, 365 days, $2,000 extras
Surgery	$7 CRVS, an assistant surgeon
In-hospital physicians calls	$10 per day, 365 days
Maternity	Specified complications only
Coordination of benefits	No

B. Answer (calculated January 1, 1977): test result is 1016 points.

This plan is a Minnesota qualified plan number 3.

Plan name--Basic plan

Plan No.--Example II

Subp. 2. **Worksheet.** Test for actuarial equivalence other than medicare supplement plans.

			Major Medical	
Table	Benefit	Basic	Super-imposed	Compre-hensive
21-23	Superimposed major medical	XXX		XXX
1.	Hospital room and board	336		
2.	Hospital extras	450		
3.	Surgery	180		
4.	Physician care --home, office	30		
5.	Physician care --hospital	20		
15-18	Benefits in full			
6.	Maternity			
7.	Diagnostic x-ray and lab			
8.	Drugs and medicine			
9.	Emergency/supple-mental accident			
10.	Radioactive therapy			
12.	Nursing/convalescent			

	facility			
13.	Home health care			
14.	Physical therapy			
14.	Oxygen			
14.	Prostheses			
14.	Durable medical equipment			
11.	Student dependents			
24.	Limit on out-of-pocket			
25.	Maximum benefit	XXX		
XX.	Subtotal			
26.	COB/no-fault			
19-20	Coinsurance/ deductible	XXX		
XX.	Total	1016		
XX.	Combined basic and superimposed		XXX	XXX

Equivalent to Minnesota qualified plan number 3

Non-qualified ____

Date_____By_____

Statutory Authority: *MS s 62E.09*

2740.9983 EXAMPLE III.

Subpart 1. **Use of actuarial equivalence test.**

A. Question: is the following plan actuarially equivalent to any Minnesota qualified plan?

Hospital	$30 per day, 70 days, $500 extras
Surgery	$420 intercompany
Superimposed major medical	
Deductible	$100 corridor
Coinsurance	80/20
Maximum	$10,000
Maternity	Any complications
Student dependents	No
Out-of-pocket limit	None
Excluded care	Home health care Nursing home care
Limits on specified benefits	Maximum eligible charges as follows
Room & board	$50 less basic benefit
Hospital extras	$2,000 less basic benefit
Surgery	$7.00 per CRVS unit
Coordination of benefits	Yes, including no-fault

B. Answer (calculated January 1, 1977): test result is 611 points.

This plan is a Minnesota qualified plan number 1.

Plan name--Basic and Superimposed

Plan no.--Example III

Subp. 2. **Worksheet.** Test for actuarial equivalence other than medicare supplement plans.

Table	Benefit	Basic	Major Medical Superimposed	Major Medical Comprehensive
21-23	Superimposed major medical	XXX	665	XXX
1.	Hospital room and board	135	-143	(3.1 times 46)
2.	Hospital extras	335	-95	(402 less 305)
3.	Surgery	85	-50	(2 times 25)
4.	Physician care --home, office			
5.	Physician care --hospital			
15-18	Benefits in full			
6.	Maternity		-175	(200 less 25)
7.	Diagnostic x-ray and lab			
8.	Drugs and medicine			
9.	Emergency/supplemental accident			
10.	Radioactive therapy			
12.	Nursing/convalescent facility		-20	
13.	Home health care		-10	
14.	Physical therapy			
14.	Oxygen			
14.	Prostheses			
14.	Durable medical equipment			
11.	Student dependents		-4	
24.	Limit on out-of-pocket		-20	
25.	Maximum benefit	XXX	-50	
XX.	Subtotal	555	98	
26.	COB/no-fault	-36	-6	
19-20	Coinsurance/ deductible	XXX		
XX.	Total	519	92	
XX.	Combined basic and superimposed	611	XXX	XXX

Equivalent to Minnesota qualified plan number 1

Non-qualified ____

Date_____By_____

Statutory Authority: *MS s 62E.09*

2740.9984 EXAMPLE IV.

Subpart 1. **Use of actuarial equivalence test**

A. Question: is the following plan actuarially equivalent to any Minnesota qualified plan?

Hospital	First $3,000 of all hospital charges in full
Surgery	$420 intercompany
Emergency accident	$25
Superimposed major medical	

Deductible	$500 integrated
Coinsurance	80/20
Maximum	$25,000
Maternity	Full
Student dependents	No
Out-of-pocket limits	None
Excluded care	Home health care
Coordination of benefits	Yes, other health and no-fault plans

B. Answer (calculated January 1, 1977): test result is 1290 points.

This plan is a Minnesota qualified plan number 3.

Plan name--Basic With Benefits In Full and Comprehensive

Plan No.--Example IV

Subp. 2. **Worksheet.** Test for actuarial equivalence other than medicare supplement plans.

			Major Medical	
Table	Benefit	Basic	Super-imposed	Compre-hensive
21-23	Superimposed major medical	XXX	615	XXX
1.	Hospital room and board			
2.	Hospital extras			
3.	Surgery	85		
4.	Physician care --home, office			
5.	Physician care --hospital			
15-18	Benefits in full	741 (710 plus 33% of 95)		
6.	Maternity			
7.	Diagnostic x-ray and lab			
8.	Drugs and medicine			
9.	Emergency/supple-mental accident	10		
10.	Radioactive therapy			
12.	Nursing/convalescent facility			
13.	Home health care		-10	
14.	Physical therapy			
14.	Oxygen			
14.	Prostheses			
14.	Durable medical equipment			
11.	Student dependents		-5	
24.	Limit on out-of-pocket		-22	
25.	Maximum benefit	XXX	-35	
XX.	Subtotal	836	543	
26.	COB/no-fault	-54	-35	

19-20	Coinsurance/ deductible	XXX		
XX.		782	508	508
XX.	Combined basic and superimposed	1290	XXX	XXX

Equivalent to Minnesota qualified plan number 3

Non-qualified ____

Date_____By_____

Statutory Authority: *MS s 62E.09*

2740.9985 EXAMPLE V.

Subpart 1. **Use of actuarial equivalence test.**

A. Question: is the following plan actuarially equivalent to a Minnesota qualified medicare supplement plan?

Hospital benefit	$100 first day $21 (61 to 90 days)
Skilled nursing home	$13 100 days
Blood	3 pints in hospital
Surgery	$1.50 CRVS with anesthesia, no assistant surgeon
Physician care--In-hospital	$4 per day, 90 days
Drugs and medicines	$2 deductible per prescription

B. Answer (calculated January 1, 1977): test result is 72.1 points.

This plan is not a Minnesota qualified medicare supplement plan.

Plan name--Medicare Supplement

Plan no.--Example V

Subp. 2. **Worksheet.** Test for actuarial equivalence medicare supplement plan.

Table Benefit

27. Hospital--Defined daily benefit

Days	Daily Benefit	Factor	Product	
1	100	9.59	959.00	
2-60	0	83.56		
61-90	26	1.50	39.00	
91-150		.61		
151 & Over		1.02		
Total	XXX		998.00	
Divisor			1068.08	
Quotient			.9344	
Multiplier			23.78	
Product				22.22

27. Hospital--usual and customary charges not paid by medicare
    A. medicare deductible and co-insurance
    B. benefits not covered by medicare

28. Skilled nursing facility 3.50

29.	Blood	.15
30.	Surgery	10.82
31.	Physician care--home and office	
32.	Physician care--hospital	5.41
33.	Home health care	
34.	Diagnostic x-ray and laboratory	
35.	Radioactive therapy	
36.	Drugs and medicine	30.00
37.	Private duty nursing	
38.	Miscellaneous	
41.	Comprehensive major medical	
XX.	Subtotal	72.10
39.	Medicare part B payments	
40.	Medicare part B deductible not eligible	
XX.	Total	72.10

Equivalent to Minnesota qualified medicare supplement plan? Yes___ No___

Date_____By_____

Statutory Authority: *MS s 62E.09*

2740.9986 EXAMPLE VI.

Subpart 1. **Use of actuarial test.**

A. Question: is the following plan actuarially equivalent to a Minnesota qualified medicare supplement plan?

Benefit:

(1) 100 percent of reasonable and customary hospital and nursing home expenses in excess of medicare part A.

(2) 20 percent of reasonable and customary charges for medical services after $60 deductible applied to expenses eligible under part B of medicare.

B. Answer (calculated January 1, 1977): test result is 84.3 points.

The plan is not qualified.

Plan name--Medicare Supplement

Plan no.--Example VI

Subp. 2. **Worksheet.** Test for actuarial equivalence medicare supplement plan.

Table Benefit

27. Hospital--Defined daily benefit

Days	Daily Benefit	Factor	Product
1		9.59	
2-60		83.56	
61-90		1.50	
91-150		.61	
151 & Over		1.02	
Total	XXX		
Divisor			
Quotient			23.78
Multiplier			
Product			

27. Hospital--Usual and customary charges not

paid by medicare		
A. Medicare Deductible and Coinsurance	23.78	
B. Benefits not covered by medicare	2.35	
28. Skilled nursing facility	3.90	
29. Blood	.15	
30. Surgery	10.09	(=20%)
31. Physician care--home and office	20.89	(=20%)
32. Physician care--hospital	4.54	(=20%)
33. Home health care	.75	(=20%)
34. Diagnostic x-ray and laboratory	11.52	(=20%)
35. Radioactive therapy	1.00	(=20%)
36. Drugs and medicine	9.73	(=20%)
37. Private duty nursing	1.00	(=20%)
38. Miscellaneous	.30	(=20%)
41. Comprehensive major medical		
XX. Subtotal	90.00	
39. Medicare part B payments		
40. Medicare part B deductible not eligible	-5.70	(=20%)
XX. Total	84.30	

Equivalent to Minnesota qualified medicare supplement plan? Yes___No___

Date_____By_____

Statutory Authority: *MS s 62E.09*