CHAPTER 62A

ACCIDENT AND HEALTH INSURANCE

62A.01 POLICY OF ACCIDENT AND SICKNESS INSURANCE.

Subdivision 1. **Definition.** The term "policy of accident and sickness insurance" as used herein includes any policy covering the kind of insurance described in section 60A.06, subdivision 1, clause (5)(a).

Subd. 2. **Equal protection.** A certificate of insurance or similar evidence of coverage issued to a Minnesota resident shall provide coverage for all benefits required to be covered in group policies in Minnesota by this chapter and chapter 62E.

This subdivision supersedes any inconsistent provision of this chapter and chapter 62E.

A policy of accident and sickness insurance that is issued or delivered in this state and that covers a person residing in another state may provide coverage or contain provisions that are less favorable to that person than required by this chapter and chapter 62E. Less favorable coverages or provisions must meet the requirements that the state

in which the person resides would have required had the policy been issued or delivered in that state.

Subd. 3. **Exclusions.** Subdivision 2 does not apply to certificates issued in regard to a master policy issued outside the state of Minnesota if all of the following are true:

(1) the policyholder or certificate holder exists primarily for purposes other than to obtain insurance;

(2) the policyholder or certificate holder is not a Minnesota corporation and does not have its principal office in Minnesota;

(3) the policy or certificate covers fewer than 25 employees who are residents of Minnesota and the Minnesota employees represent less than 25 percent of all covered employees; and

(4) on request of the commissioner, the issuer files with the commissioner a copy of the policy and a copy of each form of certificate.

This subdivision applies to employers who are not corporations if they are policyholders or certificate holders providing coverage to employees through the certificate or policy.

Subd. 4. **Application of other laws.** Section 60A.08, subdivision 4, shall not be construed as requiring a certificate of insurance or similar evidence of insurance that meets the conditions of subdivision 3 to comply with this chapter or chapter 62E.

History: *1967 c 395 art 3 s 1; 1989 c 330 s 8*

62A.02 POLICY FORMS.

Subdivision 1. **Filing.** No policy of accident and sickness insurance shall be issued or delivered to any person in this state, nor shall any application, rider, or endorsement be used in connection therewith, until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto have been filed with the commissioner. The filing for nongroup policies shall include a statement of actuarial reasons and data to support the need for any premium rate increase.

Subd. 2. **Approval.** No such policy shall be issued, nor shall any application, rider, or endorsement be used in connection therewith, until the expiration of 60 days after it has been so filed unless the commissioner shall sooner give written approval thereto.

Subd. 3. **Disapproval.** The commissioner shall, within 60 days after the filing of any form, disapprove the form:

(1) if the benefits provided therein are unreasonable in relation to the premium charged;

(2) if it contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of the policy; or

(3) if the proposed premium rate is excessive because the insurer has failed to exercise reasonable cost control.

For the purposes of clause (1), the commissioner shall establish by rule a schedule of minimum anticipated loss ratios which shall be based on (i) the type or types of coverage provided, (ii) whether the policy is for group or individual coverage, and (iii) the size of the group for group policies. Except for individual policies of disability or income protection insurance, the minimum anticipated loss ratio shall not be less than 50 percent after the first year that a policy is in force. All applicants for a policy shall be informed in writing at the time of application of the anticipated loss ratio of the policy. For the purposes of this subdivision, "anticipated loss ratio" means the ratio at the time of form filing or at the time of subsequent rate revision of the present value of all expected future benefits, excluding dividends, to the present value of all expected future premiums. Nothing in this paragraph shall prohibit the commissioner from disapproving a form which meets the requirements of this paragraph but which the commissioner determines still provides benefits which are unreasonable in relation to the premium charged.

If the commissioner notifies an insurer which has filed any form that the form does

not comply with the provisions of this section or sections 62A.03 to 62A.05 and 72A.20, it shall be unlawful thereafter for the insurer to issue the form or use it in connection with any policy. In the notice the commissioner shall specify the reasons for disapproval and state that a hearing will be granted within 20 days after request in writing by the insurer.

Subd. 4. **Hearing.** The commissioner shall hear the party or parties within 20 days after receipt of the request and shall give not less than ten days written notice of the time and place of the hearing. Within 15 days after the hearing the commissioner shall affirm, reverse or modify any previous action, specifying the reasons therefor. Pending the hearing and decision thereon, the commissioner may suspend or postpone the effective date of the previous action.

Subd. 5. **Withdrawal of approval.** The commissioner may at any time, after a hearing of which not less than 20 days written notice shall have been given to the insurer, withdraw approval of any such form on any of the grounds stated in this section. It shall be unlawful for the insurer to issue such form or use it in connection with any policy after the effective date of such withdrawal of approval. The notice of any hearing called under this subdivision shall specify the matters to be considered at such hearing and any decision affirming disapproval or directing withdrawal of approval under this subdivision shall be in writing and shall specify the reasons therefor.

Subd. 6. **Appeal.** Any order or decision of the commissioner under this section shall be subject to appeal in accordance with chapter 14.

History: *1967 c 395 art 3 s 2; 1976 c 296 art 2 s 10,11; 1977 c 409 s 1; 1979 c 207 s 1; 1980 c 509 s 18; 1982 c 424 s 130; 1983 c 247 s 31; 1986 c 444; 1986 c 455 s 9,10*

62A.025 [Repealed, 1Sp1985 c 10 s 123]

62A.03 GENERAL PROVISIONS OF POLICY.

Subdivision 1. **Conditions.** No policy of individual accident and sickness insurance may be delivered or issued for delivery to a person in this state unless:

(1) **Premium.** The entire money and other considerations therefor are expressed therein.

(2) **Time effective.** The time at which the insurance takes effect and terminates is expressed therein.

(3) **One person.** It purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family deemed the policyholder, any two or more eligible members of that family, including:

(a) husband,

(b) wife,

(c) dependent children,

(d) any children under a specified age of 19 years or less, or

(e) any other person dependent upon the policyholder.

(4) **Appearance.** The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text and every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light-face type of a style in general use. The type size must be uniform and not less than ten point with a lower case unspaced alphabet length not less than 120 point. The "text" includes all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, the reference to renewal or cancellation by a separate statement, if any, and the captions and subcaptions.

(5) **Description of policy.** The policy, on the first page, indicates or refers to its provisions for renewal or cancellation either in the brief description, if any, or by a separate statement printed in type not smaller than the type used for captions or a separate provision bearing a caption which accurately describes the renewability or cancelability of the policy.

(6) **Exceptions in policy.** The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in section 62A.04, printed, at the insurer's option, either with the benefit provision to which they apply, or under an appropriate caption such as "EXCEPTIONS" or "EXCEPTIONS AND REDUCTIONS." However, if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction must be included with the benefit provision to which it applies.

(7) **Form number.** Each form, including riders and endorsements, is identified by a form number in the lower left hand corner of the first page thereof.

(8) **No incorporation by reference.** It contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless the portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates, classification of risks, or short rate table filed with the commissioner.

(9) **Medical benefits.** If the policy contains a provision for medical expense benefits, the term "medical benefits" or similar terms as used therein includes treatments by all licensed practitioners of the healing arts unless, subject to the qualifications contained in clause (10), the policy specifically states the practitioners whose services are covered.

(10) **Osteopath, optometrist, chiropractor, or registered nurse services.** With respect to any policy of individual accident and sickness insurance issued or entered into subsequent to August 1, 1974, notwithstanding the provisions of the policy, if it contains a provision providing for reimbursement for any service which is in the lawful scope of practice of a duly licensed osteopath, optometrist, chiropractor, or registered nurse meeting the requirements of section 62A.15, subdivision 3a, the person entitled to benefits or person performing services under the policy is entitled to reimbursement on an equal basis for the service, whether the service is performed by a physician, osteopath, optometrist, chiropractor, or registered nurse meeting the requirements of section 62A.15, subdivision 3a, licensed under the laws of this state.

Subd. 2. **Delivery of policy to nonresident.** If any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state shall have advised the commissioner that any such policy is not subject to approval or disapproval by such official, the commissioner may by ruling require that such policy meet the standards set forth in subdivision 1 and in section 62A.04.

History: *1967 c 395 art 3 s 3; 1969 c 985 s 1; 1974 c 30 s 1; 1983 c 221 s 1*

62A.04 STANDARD PROVISIONS.

Subdivision 1. **Reference.** Any reference to "standard provisions" which may appear in other sections and which refer to accident and sickness or accident and health insurance shall hereinafter be construed as referring to accident and sickness policy provisions.

Subd. 2. **Required provisions.** Except as provided in subdivision 4 each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this subdivision in the words in which the same appear in this section. The insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this subdivision or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

(1) A provision as follows:

ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless

such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

(2) A provision as follows:

TIME LIMIT ON CERTAIN DEFENSES: (a) After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two year period.

The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two year period, nor to limit the application of clauses (1), (2), (3), (4) and (5), in the event of misstatement with respect to age or occupation or other insurance. A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age 50 or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the foregoing the following provisions (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONTESTABLE":

After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

(b) No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

(3) A provision as follows:

GRACE PERIOD: A grace period of ..... (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

A policy which contains a cancellation provision may add, at the end of the above provision,

subject to the right of the insurer to cancel in accordance with the cancellation provision hereof.

A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision,

Unless not less than five days prior to the premium due date the insurer has delivered to the insured or has mailed to the insured's last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.

(4) A provision as follows:

REINSTATEMENT: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. If the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection

with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement. The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age 50, or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue.

(5) A provision as follows:

NOTICE OF CLAIM: Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at ..... (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences of the above provision:

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, the insured shall, at least once in every six months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial or liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given.

(6) A provision as follows:

CLAIM FORMS: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

(7) A provision as follows:

PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

(8) A provision as follows:

TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss other than loss for which this policy provides periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid ..... (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

(9) A provision as follows:

PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may

be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $..... (insert an amount which shall not exceed $1,000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.

(10) A provision as follows:

PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

(11) A provision as follows:

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

(12) A provision as follows:

CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy. The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.

Subd. 3. **Optional provisions.** Except as provided in subdivision 4, no such policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section. The insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the commissioner which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this subdivision or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

(1) A provision as follows:

CHANGE OF OCCUPATION: If the insured be injured or contract sickness after having changed occupations to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premiums paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes occupations to one classified by the insurer as less hazardous than that stated

in this policy, the insurer, upon receipt of proof of such change of occupation will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change of occupation.

(2) A provision as follows:

MISSTATEMENT OF AGE: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

(3) A provision as follows:

OTHER INSURANCE IN THIS INSURER: If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for ..... (insert type of coverage or coverages) in excess of $..... (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to the insured's estate, or, in lieu thereof:

Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, or the insured's beneficiary or estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

(4) A provision as follows:

INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

If the foregoing policy provision is included in a policy which also contains the next following policy provision there shall be added to the caption of the foregoing provision the phrase "EXPENSE INCURRED BENEFITS." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute) whether provided by a governmental

agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage."

(5) A provision as follows:

INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined.

If the foregoing policy provision is included in a policy which also contains the next preceding policy provision there shall be added to the caption of the foregoing provision the phrase — "OTHER BENEFITS." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage."

(6) A provision as follows:

RELATION OF EARNINGS TO INSURANCE: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or the insured's average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of $200 or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.

The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age 50, or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the commissioner or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compul-

sory benefit statute (including any workers' compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations.

(7) A provision as follows:

UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

(8) A provision as follows:

CANCELLATION: The insurer may cancel this policy at any time by written notice delivered to the insured or mailed to the insured's last address as shown by the records of the insurer, stating when, not less than five days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

(9) A provision as follows:

CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

(10) A provision as follows:

ILLEGAL OCCUPATION: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

(11) A provision as follows:

NARCOTICS: The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being under the influence of any narcotic unless administered on the advice of a physician.

Subd. 4. **Coverage inconsistent.** If any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy the insurer, with the approval of the commissioner, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

Subd. 5. **Order of provisions.** The provisions which are the subject of subdivisions 2 and 3, or any corresponding provisions which are used in lieu thereof in accordance with subdivisions 2 and 3, shall be printed in the consecutive order of the provisions in subdivisions 2 and 3 or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

Subd. 6. **Applicant other than insured.** The word "insured," as used in sections 62A.01 to 62A.09, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits and rights provided therein.

Subd. 7. **Reciprocal provisions; foreign insurer.** Any policy of a foreign or alien

insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of sections 62A.01 to 62A.09 hereof, and which is prescribed or required by the law of the state under which the insurer is organized.

Subd. 8. **Reciprocal provisions; domestic insurer.** Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

Subd. 9. **Rules.** The commissioner may make such reasonable rules concerning the procedure for the filing or submission of policies subject to sections 62A.01 to 62A.09, as are necessary, proper or advisable to the administration of sections 62A.01 to 62A.09. This provision shall not abridge any other authority granted the commissioner by law.

Subd. 10. **Return of premium.** A policy of accident and sickness insurance as defined in section 62A.01 may contain or may be amended by rider to provide for a return of premium benefit so long as:

(1) the return of premium benefit is not applicable until the policy has been in force for five years;

(2) the return of premium benefit is not reduced by an amount greater than the aggregate of any claims paid under the policy;

(3) the return of premium benefit is not included in or used with a policy with benefits that are reduced based on an insured's age;

(4) the return of premium benefit is not payable in lieu of benefits at the option of the insurer;

(5) the insurer demonstrates that the reserve basis for such benefit is adequate; and

(6) the cost of the benefit is disclosed to the insured and the insured is given the option of the coverage.

History: *1967 c 395 art 3 s 4; 1975 c 359 s 23; 1985 c 248 s 70; 1986 c 444; 1988 c 642 s 1*

62A.041 MATERNITY BENEFITS.

Subdivision 1. **Discrimination prohibited against unmarried women.** Each group policy of accident and health insurance and each group health maintenance contract shall provide the same coverage for maternity benefits to unmarried women and minor female dependents that it provides to married women including the wives of employees choosing dependent family coverage. If an unmarried insured or an unmarried enrollee is a parent of a dependent child, each group policy and each group contract shall provide the same coverage for that child as that provided for the child of a married employee choosing dependent family coverage if the insured or the enrollee elects dependent family coverage.

Each individual policy of accident and health insurance and each individual health maintenance contract shall provide the same coverage for maternity benefits to unmarried women and minor female dependents as that provided for married women. If an unmarried insured or an unmarried enrollee is a parent of a dependent child, each individual policy and each individual contract shall also provide the same coverage for that child as that provided for the child of a married insured or a married enrollee choosing dependent family coverage if the insured or the enrollee elects dependent family coverage.

Subd. 2. **Limitation on coverage prohibited.** Each group policy of accident and health insurance, except for policies which only provide coverage for specified diseases, or each group subscriber contract of accident and health insurance or health maintenance contract, issued or renewed after August 1, 1987, shall include maternity benefits in the same manner as any other illness covered under the policy or contract.

Subd. 3. **Abortion.** For the purposes of this section, the term "maternity benefits" shall not include elective, induced abortion whether performed in a hospital, other abortion facility, or the office of a physician.

This section applies to policies and contracts issued, delivered, or renewed after August 1, 1985, that cover Minnesota residents.

History: *1971 c 680 s 1; 1973 c 651 s 1; 1976 c 121 s 3; 1980 c 589 s 25; 1984 c 464 s 2; 1986 c 397 s 1; 1987 c 337 s 45; 1989 c 330 s 9*

62A.042 FAMILY COVERAGE; COVERAGE OF NEWBORN INFANTS.

Subdivision 1. **Individual family policies; renewals.** (a) No policy of individual accident and sickness insurance which provides for insurance for more than one person under section 62A.03, subdivision 1, clause (3), and no individual health maintenance contract which provides for coverage for more than one person under chapter 62D, shall be renewed to insure or cover any person in this state or be delivered or issued for delivery to any person in this state unless the policy or contract includes as insured or covered members of the family any newborn infants immediately from the moment of birth and thereafter which insurance or contract shall provide coverage for illness, injury, congenital malformation, or premature birth.

(b) The coverage under paragraph (a) includes benefits for inpatient or outpatient expenses arising from medical and dental treatment up to age 18, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate. If orthodontic services are eligible for coverage under a dental insurance plan and another policy or contract, the dental plan shall be primary and the other policy or contract shall be secondary in regard to the coverage required under paragraph (a). Payment for dental or orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate shall not be covered under this provision.

Subd. 2. **Group policies; renewals.** (a) No group accident and sickness insurance policy and no group health maintenance contract which provide for coverage of family members or other dependents of an employee or other member of the covered group shall be renewed to cover members of a group located in this state or delivered or issued for delivery to any person in this state unless the policy or contract includes as insured or covered family members or dependents any newborn infants immediately from the moment of birth and thereafter which insurance or contract shall provide coverage for illness, injury, congenital malformation, or premature birth.

(b) The coverage under paragraph (a) includes benefits for inpatient or outpatient expenses arising from medical and dental treatment up to age 18, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate. If orthodontic services are eligible for coverage under a dental insurance plan and another policy or contract, the dental plan shall be primary and the other policy or contract shall be secondary in regard to the coverage required under paragraph (a). Payment for dental or orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate shall not be covered under this provision.

History: *1973 c 303 s 1; 1984 c 464 s 3; 1988 c 656 s 1*

62A.043 DENTAL PROCEDURES.

Subdivision 1. The provisions of this section shall apply to all individual or group policies or subscriber contracts providing payment for care in this state, which policies or contracts are issued or renewed after August 1, 1976 by an accident and health insurance company regulated under this chapter, or a nonprofit health service plan corporation regulated under chapter 62C.

Subd. 2. Any policy or contract referred to in subdivision 1 which provides coverage for services which can be lawfully performed within the scope of the license of a duly licensed dentist or podiatrist, shall provide benefits for such services whether performed by a duly licensed physician, dentist or podiatrist.

Subd. 3. Except for policies which only provide coverage for specified diseases, no policy or certificate of health, medical, hospitalization, or accident and sickness insur-

ance regulated under this chapter, or subscriber contract provided by a nonprofit health service plan corporation regulated under chapter 62C, or health maintenance organization regulated under chapter 62D, shall be issued, renewed, continued, delivered, issued for delivery, or executed in this state after August 1, 1987, unless the policy, plan, or contract specifically provides coverage for surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder. Coverage shall be the same as that for treatment to any other joint in the body, and shall apply if the treatment is administered or prescribed by a physician or dentist.

History: *1973 c 430 s 1; 1976 c 207 s 1; 1987 c 337 s 46*

62A.044 PAYMENTS TO GOVERNMENTAL INSTITUTIONS.

No group or individual policy of accident and sickness insurance issued or renewed after May 22, 1973, pursuant to this chapter, no group or individual service plan or subscriber contract issued or renewed after May 22, 1973, pursuant to chapter 62C, and no group or individual health maintenance contract issued or renewed after August 1, 1984, pursuant to chapter 62D, shall contain any provision excluding, denying, or prohibiting payments for covered and authorized services rendered or paid by a hospital or medical institution owned or operated by the federal, state, or local government, including correctional facilities, or practitioners therein in any instance wherein charges for such services are imposed against the policy holder, subscriber, or enrollee. The unit of government operating the institution may maintain an action for recovery of such charges.

History: *1973 c 471 s 1; 1984 c 464 s 4; 1988 c 656 s 2*

62A.045 PAYMENTS ON BEHALF OF WELFARE RECIPIENTS.

No policy of accident and sickness insurance regulated under this chapter; vendor of risk management services regulated under section 60A.23; nonprofit health service plan corporation regulated under chapter 62C; health maintenance organization regulated under chapter 62D; or self-insured plan regulated under chapter 62E shall contain any provision denying or reducing benefits because services are rendered to a person who is eligible for or receiving medical benefits pursuant to chapter 256B or 256D or services pursuant to section 252.27; 256.936; 260.251, subdivision 1a; or 393.07, subdivision 1 or 2.

Notwithstanding any law to the contrary, when a person covered under a policy of accident and sickness insurance, risk management plan, nonprofit health service plan, health maintenance organization, or self-insured plan receives medical benefits according to any statute listed in this section, payment for covered services or notice of denial for services billed by the provider must be issued directly to the provider. If a person was receiving medical benefits through the department of human services at the time a service was provided, the provider must indicate this benefit coverage on any claim forms submitted by the provider to the insurer for those services. If the commissioner of human services notifies the insurer that the commissioner has made payments to the provider, payment for benefits or notices of denials issued by the insurer must be issued directly to the commissioner. Submission by the department to the insurer of the claim on a department of human services claim form is proper notice and shall be considered proof of payment of the claim to the provider and supersedes any contract requirements of the insurer relating to the form of submission. Liability to the insured for coverage is satisfied to the extent that payments for those benefits are made by the insurer to the provider or the commissioner.

History: *1975 c 247 s 1; 1979 c 174 s 1; 1989 c 282 art 3 s 1; 1990 c 426 art 2 s 2*

62A.046 COORDINATION OF BENEFITS.

(1) No group contract providing coverage for hospital and medical treatment or expenses issued or renewed after August 1, 1984, which is responsible for secondary coverage for services provided, may deny coverage or payment of the amount it owes

as a secondary payor solely on the basis of the failure of another group contract, which is responsible for primary coverage, to pay for those services.

(2) A group contract which provides coverage of a claimant as a dependent of a parent who has legal responsibility for the dependent's medical care pursuant to a court order under section 518.171 must make payments directly to the provider of care. In such cases, liability to the insured is satisfied to the extent of benefit payments made to the provider.

(3) This section applies to an insurer, a vendor of risk management services regulated under section 60A.23, a nonprofit health service plan corporation regulated under chapter 62C and a health maintenance organization regulated under chapter 62D. Nothing in this section shall require a secondary payor to pay the obligations of the primary payor nor shall it prevent the secondary payor from recovering from the primary payor the amount of any obligation of the primary payor that the secondary payor elects to pay.

(4) Payments made by an enrollee or by the commissioner on behalf of an enrollee in the children's health plan under section 256.936, or a person receiving benefits under chapter 256B or 256D, for services that are covered by the policy or plan of health insurance shall, for purposes of the deductible, be treated as if made by the insured.

(5) The commissioner of human services shall recover payments made by the children's health plan from the responsible insurer, for services provided by the children's health plan and covered by the policy or plan of health insurance.

(6) Insurers, vendors of risk management services, nonprofit health service plan corporations, fraternals, and health maintenance organizations may coordinate benefits to prohibit greater than 100 percent coverage when an insured, subscriber, or enrollee is covered by both an individual and a group contract providing coverage for hospital and medical treatment or expenses. Benefits coordinated under this paragraph must provide for 100 percent coverage of an insured, subscriber, or enrollee. To the extent appropriate, all coordination of benefits provisions currently applicable by law or rule to insurers, vendors of risk management services, nonprofit health service plan corporations, fraternals, and health maintenance organizations, shall apply to coordination of benefits between individual and group contracts, except that the group contract shall always be the primary plan. This paragraph does not apply to specified accident, hospital indemnity, specified disease, or other limited benefit insurance policies.

History: *1984 c 538 s 2; 1984 c 655 art 2 s 6 subd 1; 1987 c 370 art 2 s 1; 1989 c 282 art 3 s 2; 1990 c 404 s 1*

62A.047 CHILDREN'S HEALTH SUPERVISION SERVICES AND PRENATAL CARE SERVICES.

A policy of individual or group health and accident insurance regulated under this chapter, or individual or group subscriber contract regulated under chapter 62C, health maintenance contract regulated under chapter 62D, or health benefit certificate regulated under chapter 64B, issued, renewed, or continued to provide coverage to a Minnesota resident, must provide coverage for child health supervision services and prenatal care services. The policy, contract, or certificate must specifically exempt reasonable and customary charges for child health supervision services and prenatal care services from a deductible, copayment, or other coinsurance or dollar limitation requirement. For individual policies, this section does not prohibit the use of waiting periods or preexisting condition limitations for these services. Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this section subject to the schedule set forth in this section. Nothing in this section applies to a commercial health insurance policy issued as a companion to a health maintenance organization contract, a policy designed primarily to provide coverage payable on a per diem, fixed indemnity, or nonexpense incurred basis, or a policy that provides only accident coverage.

"Child health supervision services" means pediatric preventive services, appropriate immunizations, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six as defined by Standards of Child Health Care issued by the American Academy of Pediatrics. Reimbursement must be made for at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, once a year from 24 months to 72 months.

"Prenatal care services" means the comprehensive package of medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists.

History: *1988 c 571 s 1; 1989 c 69 s 1*

62A.048 DEPENDENT COVERAGE.

A policy of accident and sickness insurance that covers an employee who is a Minnesota resident must, if it provides dependent coverage, allow dependent children who do not reside with the covered employee to be covered on the same basis as if they reside with the covered employee. Neither the amount of support provided by the employee to the dependent child nor the residency of the child may be used as an excluding or limiting factor for coverage or payment for health care.

History: *1988 c 689 art 2 s 6*

62A.049 LIMITATION ON PREAUTHORIZATIONS.

No policy of accident and sickness insurance or group subscriber contract regulated under chapter 62C issued or renewed in this state may contain a provision that makes an insured person ineligible to receive full benefits because of the insured's failure to obtain preauthorization, if that failure occurs because of the need for emergency confinement or emergency treatment. The insured or an authorized representative of the insured shall notify the insurer as soon after the beginning of emergency confinement or emergency treatment as reasonably possible. However, to the extent that the insurer suffers actual prejudice caused by the failure to obtain preauthorization, the insured may be denied all or part of the insured's benefits. This provision does not apply to admissions for treatment of chemical dependency and nervous and mental disorders.

History: *1989 c 330 s 10*

62A.05 CONSTRUCTION OF PROVISIONS.

Subdivision 1. No policy provision which is not subject to section 62A.04 shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to sections 62A.01 to 62A.09 hereof.

Subd. 2. A policy delivered or issued for delivery to any person in this state in violation of sections 62A.01 to 62A.09 hereof, shall be held valid but shall be construed as provided in sections 62A.01 to 62A.09 hereof. When any provision in a policy subject to sections 62A.01 to 62A.09 hereof, is in conflict with any provision of sections 62A.01 to 62A.09 hereof, the rights, duties and obligations of the insurer, the insured and the beneficiary shall be governed by the provisions of sections 62A.01 to 62A.09 hereof.

History: *1967 c 395 art 3 s 5*

62A.06 STATEMENTS IN APPLICATION.

Subdivision 1. **Inclusion in policy.** The insured shall not be bound by any statement made in an application for a policy unless a copy of such application is attached to or endorsed on the policy when issued as a part thereof. If any such policy delivered or

issued for delivery to any person in this state shall be reinstated or renewed, and the insured or the beneficiary or assignee of such policy shall make written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall within 15 days after the receipt of such request at its home office or any branch office of the insurer, deliver or mail to the person making such request, a copy of such application. If such copy shall not be so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action or proceeding based upon or involving such policy or its reinstatement or renewal.

Subd. 2. **Alterations.** No alteration of any written application for any such policy shall be made by any person other than the applicant without written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

Subd. 3. **Effect of applicant's statement.** The falsity of any statement in the application for any policy covered by sections 62A.01 to 62A.09 hereof, may not bar the right to recovery thereunder unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.

History: *1967 c 395 art 3 s 6; 1986 c 444*

62A.07 RIGHTS OF INSURER, WHEN NOT WAIVED.

The acknowledgment by an insurer of the receipt of notice given under any policy covered by sections 62A.01 to 62A.09 hereof, or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under such policy.

History: *1967 c 395 art 3 s 7*

62A.08 COVERAGE OF POLICY, CONTINUANCE IN FORCE.

If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the policy would not have been issued, the insurer may, within 90 days of discovering the misstatement, limit its liability to a refund of all premiums paid. In all other instances the insurer may either adjust the premium to reflect the actual age of the insured or adjust the benefits to reflect the actual age and the premium.

History: *1967 c 395 art 3 s 8; 1989 c 330 s 11*

62A.081 PAYMENTS TO FACILITIES OPERATED BY STATE OR LOCAL GOVERNMENT.

Every group or individual policy of accident and sickness insurance issued or renewed after July 1, 1973 regulated by this chapter, and every group or individual service plan or subscriber contract issued or renewed after July 1, 1973 regulated by chapter 62C, providing care or payment for care in this state, shall provide payments for services rendered by a hospital or medical facility owned or operated by, or on behalf of, the state or any unit of local government, or practitioners therein, on the same basis as are made for like care in other facilities. The unit of government concerned may maintain an action for recovery of such payments.

History: *1973 c 765 s 24*

62A.09 LIMITATION.

Nothing in sections 62A.01, 62A.02, 62A.03, 62A.04, 62A.05, 62A.06, 62A.07, and 62A.08 shall apply to or affect:

(1) any policy of workers' compensation insurance or any policy of casualty or fire and allied lines insurance with or without supplementary coverage therein; or

(2) any policy or contract of reinsurance; or

(3) any group policy of insurance, except when specifically referred to; or

(4) life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance as (a) provide additional benefits in case of death or dismemberment or loss of sight by accident, or as (b) operate to safeguard such contracts against lapse or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract.

History: *1967 c 395 art 3 s 9; 1975 c 359 s 23; 1989 c 330 s 12*

62A.10 GROUP INSURANCE.

Subdivision 1. **Requirements.** Group accident and health insurance is hereby declared to be that form of accident and health insurance covering not less than two employees nor less than ten members, and which may include the employee's or member's dependents, consisting of husband, wife, children, and actual dependents residing in the household, written under a master policy issued to any governmental corporation, unit, agency, or department thereof, or to any corporation, copartnership, individual, employer, or to any association having a constitution or bylaws and formed in good faith for purposes other than that of obtaining insurance under the provisions of this chapter, where officers, members, employees, or classes or divisions thereof, may be insured for their individual benefit.

Any insurer authorized to write accident and health insurance in this state shall have power to issue group accident and health policies.

Subd. 2. **Policy forms.** No policy of group accident and health insurance may be issued or delivered in this state unless the same has been approved by the commissioner in accordance with section 62A.02, subdivisions 1 to 6. These forms shall contain the standard provisions relating and applicable to health and accident insurance and shall conform with the other requirements of law relating to the contents and terms of policies of accident and sickness insurance in so far as they may be applicable to group accident and health insurance, and also the following provisions:

(1) **Entire contract.** A provision that the policy and the application of the employer, or executive officer or trustee of any association, and the individual applications, if any, of the employees or members insured, shall constitute the entire contract between the parties, and that all statements made by the employer or any executive officer or trustee in behalf of the group to be insured, shall, in the absence of fraud, be deemed representations and not warranties, and that no such statement shall be used in defense to a claim under the policy, unless it is contained in the written application;

(2) **Master policy-certificates.** A provision that the insurer will issue a master policy to the employer, or to the executive officer or trustee of the association; and the insurer shall also issue to the employer or to the executive officer or trustee of the association, for delivery to the employee or member who is insured under the policy, an individual certificate setting forth a statement as to the insurance protection to which the employee or member is entitled and to whom payable, together with a statement as to when and where the master policy, or a copy thereof, may be seen for inspection by the individual insured; this individual certificate may contain the names of, and insure the dependents of, the employee or member, as provided for herein;

(3) **New insureds.** A provision that to the group or class thereof originally insured may be added, from time to time, all new employees of the employer or members of the association eligible to and applying for insurance in that group or class and covered or to be covered by the master policy.

History: *1967 c 395 art 3 s 10; 1973 c 303 s 2; 1986 c 444*

62A.11 BLANKET ACCIDENT AND SICKNESS INSURANCE.

Subdivision 1. **Requirements.** Blanket accident and sickness insurance is hereby declared to be that form of accident and sickness insurance covering special groups of persons as enumerated in one of the following paragraphs:

(1) Under a policy issued to any common carrier, which shall be deemed the policyholder, covering a group defined as all or any class of persons who may become passengers on such common carrier.

(2) Under a policy issued to an employer, who shall be deemed the policyholder, covering all employees or any group of employees defined by reference to exceptional hazards incident to such employment.

(3) Under a policy issued to a college, school, or other institution of learning or to the head or principal thereof, who or which shall be deemed the policyholder, covering students or teachers.

(4) Under a policy issued in the name of any volunteer fire department, first aid, or other such volunteer group, which shall be deemed the policyholder, covering all of the members of such department or group.

(5) Under a policy issued to a sports team or to a camp, which team or camp or sponsor thereof shall be deemed the policyholder, covering members or campers.

(6) Under a policy issued to any other substantially similar group which, in the discretion of the commissioner, may be subject to the issuance of a blanket accident and sickness policy.

Subd. 2. **Authority.** Any insurer authorized to write accident and sickness insurance in this state shall have the power to issue blanket accident and sickness policies.

Subd. 3. **Policy forms.** No policy of blanket accident and sickness insurance may be issued or delivered in this state unless a copy of the form thereof has been approved by the commissioner and it contains in substance such of the provisions required for individual policies as may be applicable to blanket accident and sickness insurance and the following provisions:

(1) A provision that the policy and the application of the policyholder shall constitute the entire contract between the parties, and that, in the absence of fraud, all statements made by the policyholder shall be deemed representations and not warranties, and that no statement made for the purpose of affecting insurance shall avoid such insurance or reduce benefits unless contained in a written instrument signed by the policyholder, a copy of which has been furnished to such policyholder.

(2) A provision that to the group or class originally insured shall be added from time to time all new persons eligible for coverage.

Subd. 4. **Application; certificate.** An individual application shall not be required from a person covered under a blanket accident and sickness policy, nor shall it be necessary for the insurer to furnish each person a certificate.

Subd. 5. **Benefits.** All benefits under any blanket accident and sickness policy shall be payable to the person insured, or to a designated beneficiary, or beneficiaries, or to the insured's estate, except that if the person insured be a minor, such benefits may be made payable to the insured's parent, guardian, or other person actually supporting the insured. Provided further, however, that the policy may provide that all or any portion of any indemnities provided by any such policy on account of hospital, nursing, medical or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering such services; but the policy may not require that the services be rendered by a particular hospital or person. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.

Subd. 6. **Legal liability.** Nothing contained in this section shall be deemed to affect the legal liability of policyholders for the death of, or injury to, any such member of such group.

History: *1967 c 395 art 3 s 11; 1986 c 444*

62A.12 [Repealed, 1987 c 337 s 131]

62A.13 COMMERCIAL TRAVELER INSURANCE COMPANIES.

Any domestic assessment, health or accident association now licensed to do business in this state, which confines its membership to commercial travelers, professionals, and others whose occupation is of such character as to be ordinarily classified as no more hazardous than commercial travelers, and which does not pay any other commissions or compensations, other than prizes to members of nominal value in proportion to the membership fees charged for securing new members, may issue certificates of membership, which, with the application of the member and the bylaws of the association, shall constitute the contract between the association and the member. A printed copy of the bylaws and a copy of the application shall be attached to the membership certificate when issued, and a copy of any amendment to the bylaws shall be mailed to the members following their adoption. Certified copies of certificate, bylaws and amendments shall be filed with the commissioner of commerce and subject to the commissioner's approval. The bylaws shall conform to the requirements of this chapter, so far as applicable, and wherever the word "policy" appears in this chapter, it shall, for the purpose of this section, be construed to mean the contract as herein defined.

History: *1967 c 395 art 3 s 13; 1983 c 289 s 114 subd 1; 1984 c 655 art 1 s 92; 1986 c 444*

62A.14 HANDICAPPED CHILDREN.

Subdivision 1. **Individual family policies.** An individual hospital or medical expense insurance policy delivered or issued for delivery in this state more than 120 days after May 16, 1969, or an individual health maintenance contract delivered or issued for delivery in this state after August 1, 1984, which provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy or contract shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (b) chiefly dependent upon the policyholder for support and maintenance, provided proof of such incapacity and dependency is furnished to the insurer or health maintenance organization by the policyholder or enrollee within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer or organization but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Subd. 2. **Group policies.** A group hospital or medical expense insurance policy delivered or issued for delivery in this state more than 120 days after May 16, 1969, or a group health maintenance contract delivered or issued for delivery in this state after August 1, 1984, which provides that coverage of a dependent child of an employee or other member of the covered group shall terminate upon attainment of the limiting age for dependent children specified in the policy or contract shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (b) chiefly dependent upon the employee or member for support and maintenance, provided proof of such incapacity and dependency is furnished to the insurer or organization by the employee or member within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer or organization but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

History: *1969 c 436 s 1; 1984 c 464 s 5*

62A.141 COVERAGE FOR HANDICAPPED DEPENDENTS.

No group policy or plan of health and accident insurance regulated under this

chapter, chapter 62C, or 62D, which provides for dependent coverage may be issued or renewed in this state after August 1, 1983, unless it covers the handicapped dependents of the insured, subscriber, or enrollee of the policy or plan. Consequently, the policy or plan shall not contain any provision concerning preexisting condition limitations, insurability, eligibility, or health underwriting approval concerning handicapped dependents.

If ordered by the commissioner of commerce, the insurer of a Minnesota-domiciled nonprofit association which is composed solely of agricultural members may restrict coverage under this section to apply only to Minnesota residents.

History: *1983 c 263 s 8; 1Sp1985 c 10 s 58; 1987 c 337 s 47*

62A.145 SURVIVORS; DEFINITION.

For the purposes of section 62A.146, "survivor" means a person who would be entitled to and be dependent upon economic support by an insured, subscriber or enrollee if that person were alive; including a spouse, child or children as defined by the policy or plan of accident and health protection.

History: *1973 c 339 s 1; 1982 c 555 s 5; 1986 c 444*

62A.146 CONTINUATION OF BENEFITS TO SURVIVORS.

No policy or plan of accident and health protection issued by an insurer, nonprofit health service plan corporation, or health maintenance organization, providing coverage of hospital or medical expense on either an expense incurred basis or other than an expense incurred basis which in addition to coverage of the insured, subscriber, or enrollee, also provides coverage to dependents, shall, except upon the written consent of the survivor or survivors of the deceased insured, subscriber, or enrollee, terminate, suspend, or otherwise restrict the participation in or the receipt of benefits otherwise payable under the policy or plan to the survivor or survivors until the earlier of the following dates:

(a) the date the surviving spouse becomes covered under another group health plan; or

(b) the date coverage would have terminated under the policy or plan had the insured, subscriber, or enrollee lived.

The survivor or survivors, in order to have the coverage and benefits extended, may be required to pay the entire cost of the protection on a monthly basis. In no event shall the amount of premium or fee contributions charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouses and dependent children who are not the survivors of a deceased insured, without regard to whether such cost is paid by the employer or employee. Failure of the survivor to make premium or fee payments within 90 days after notice of the requirement to pay the premiums or fees shall be a basis for the termination of the coverage without written consent. In event of termination by reason of the survivor's failure to make required premium or fee contributions, written notice of cancellation must be mailed to the survivor's last known address at least 30 days before the cancellation. If the coverage is provided under a group policy or plan, any required premium or fee contributions for the coverage shall be paid by the survivor to the group policyholder or contract holder for remittance to the insurer, nonprofit health service plan corporation, or health maintenance organization.

History: *1973 c 339 s 2; 1982 c 555 s 6; 1Sp1985 c 10 s 59; 1986 c 444; 1987 c 337 s 48*

62A.147 DISABLED EMPLOYEES' BENEFITS; DEFINITIONS.

Subdivision 1. For the purposes of this section and section 62A.148, the terms defined in this section shall have the meanings here given them.

Subd. 2. "Covered employee" means any person who, at the time that person suffered an injury resulting in total disability or became totally disabled by reason of ill-

ness, was employed by and receiving a salary, commission, hourly wage, or other remuneration for services by any employer providing, offering or contributing to group insurance coverage or group coverage through a health maintenance contract, for that employee who was so enrolled for the coverage.

Subd. 3. "Total disability" means (a) the inability of an injured or ill employee to engage in or perform the duties of the employee's regular occupation or employment within the first two years of such disability and (b) after the first two years of such disability, the inability of the employee to engage in any paid employment or work for which the employee may, by education and training, including rehabilitative training, be or reasonably become qualified.

Subd. 4. "Group insurance" means any policy or contract of accident and health protection, including health maintenance contracts, regardless of by whom underwritten, which provides benefits, including cash payments for reimbursement of expenses or the provision of usual needed health care and medical services as the result of any injury, sickness, disability or disease suffered by a group of employees, or any one of them, and which protection is paid for or otherwise provided in full or in part by an employer.

Subd. 5. "Employer" means any natural person, company, corporation, partnership, association, firm, or franchise which employs any employee.

Subd. 6. "Insurer" means any person, company, corporation including a nonprofit corporation and a health maintenance organization, partnership, association, firm or franchise which underwrites or is by contract or other agreement obligated to provide accident and health protection benefits to any group of employees of any employer.

History: *1973 c 340 s 1; 1984 c 464 s 6; 1986 c 444*

62A.148 GROUP INSURANCE; PROVISION OF BENEFITS FOR DISABLED EMPLOYEES.

No employer or insurer of that employer shall terminate, suspend or otherwise restrict the participation in or the receipt of benefits otherwise payable under any program or policy of group insurance to any covered employee who becomes totally disabled while employed by the employer solely on account of absence caused by such total disability. If the employee is required to pay all or any part of the premium for the extension of coverage, payment shall be made to the employer, by the employee.

History: *1973 c 340 s 2*

62A.149 BENEFITS FOR ALCOHOLICS AND DRUG DEPENDENTS.

Subdivision 1. The provisions of this section apply to all group policies of accident and health insurance and group subscriber contracts offered by nonprofit health service plan corporations regulated under chapter 62C, and to a plan or policy that is individually underwritten or provided for a specific individual and family members as a nongroup policy unless the individual elects in writing to refuse benefits under this subdivision in exchange for an appropriate reduction in premiums or subscriber charges under the policy or plan, when the policies or subscriber contracts are issued or delivered in Minnesota or provide benefits to Minnesota residents enrolled thereunder.

This section does not apply to policies designed primarily to provide coverage payable on a per diem, fixed indemnity or nonexpense incurred basis or policies that provide accident only coverage.

Every insurance policy or subscriber contract included within the provisions of this subdivision, upon issuance or renewal, shall provide for payment of benefits for the treatment of alcoholism, chemical dependency or drug addiction to any Minnesota resident entitled to coverage thereunder on the same basis as coverage for other benefits when treatment is rendered in

(1) a licensed hospital,

(2) a residential treatment program as licensed by the state of Minnesota pursuant to diagnosis or recommendation by a doctor of medicine,

(3) a nonresidential treatment program approved or licensed by the state of Minnesota.

Subd. 2. Coverage under subdivision 1, clauses (1) and (2) shall be for at least 20 percent of the total patient days allowed by the policy and in no event shall coverage be for less than 28 days in each 12-month benefit year. Coverage under subdivision 1, clause (3), shall be for at least 130 hours of treatment in a 12-month benefit year.

History: *1973 c 585 s 1,2; 1976 c 262 s 1; 1978 c 793 s 60; 1980 c 496 s 2; 1986 c 444*

62A.15 LICENSED HEALTH PROFESSIONAL SERVICES IN ACCIDENT AND HEALTH AND NONPROFIT HEALTH SERVICE POLICIES.

Subdivision 1. **Applicability.** The provisions of this section apply to all group policies or subscriber contracts providing payment for care in this state, which are issued by accident and health insurance companies regulated under this chapter and nonprofit health service plan corporations regulated under chapter 62C.

Subd. 2. **Chiropractic services.** All benefits provided by any policy or contract referred to in subdivision 1, relating to expenses incurred for medical treatment or services of a physician must also include chiropractic treatment and services of a chiropractor to the extent that the chiropractic services and treatment are within the scope of chiropractic licensure.

This subdivision is intended to provide equal access to benefits for insureds and subscribers who choose to obtain treatment for illness or injury from a doctor of chiropractic, as long as the treatment falls within the chiropractor's scope of practice. This subdivision is not intended to change or add to the benefits provided for in these policies or contracts.

Subd. 3. **Optometric services.** All benefits provided by any policy or contract referred to in subdivision 1, relating to expenses incurred for medical treatment or services of a physician must also include optometric treatment and services of an optometrist to the extent that the optometric services and treatment are within the scope of optometric licensure.

This subdivision is intended to provide equal payment of benefits for optometric treatment and services and is not intended to change or add to the benefits provided for in those policies or contracts.

Subd. 3a. **Nursing services.** All benefits provided by a policy or contract referred to in subdivision 1, relating to expenses incurred for medical treatment or services of a duly licensed physician must include services provided by a registered nurse who is licensed pursuant to section 148.171 and who is certified by the profession to engage in advanced nursing practice. "Advanced nursing practice" means the performance of health services by professional nurses who have gained additional knowledge and skills through an organized program of study and clinical experience preparing nurses for advanced practice roles as nurse anesthetists, nurse midwives, nurse practitioners, or clinical specialists in psychiatric or mental health nursing. The program of study must be beyond the education required for registered nurse licensure and must meet criteria established by the professional nursing organization having authority to certify the registered nurse in advanced nursing practice. For the purposes of this subdivision, the board of nursing shall, by rule, adopt a list of professional nursing organizations which have the authority to certify nurses in advanced nursing practice.

This subdivision is intended to provide payment of benefits for treatment and services by a licensed registered nurse certified in advanced nursing practice as defined in this subdivision and is not intended to add to the benefits provided for in these policies or contracts.

Subd. 4. **Denial of benefits.** (a) No carrier referred to in subdivision 1 may, in the payment of claims to employees in this state, deny benefits payable for services covered by the policy or contract if the services are lawfully performed by a licensed chiropractor, licensed optometrist, or a registered nurse meeting the requirements of subdivision 3a.

(b) When carriers referred to in subdivision 1 make claim determinations concerning the appropriateness, quality, or utilization of chiropractic health care for Minnesotans, any of these determinations that are made by health care professionals must be made by, or under the direction of, or subject to the review of licensed doctors of chiropractic.

History: *1973 c 252 s 1; 1976 c 192 s 1,2; 1976 c 242 s 1; 1983 c 221 s 2; 1988 c 441 s 1; 1988 c 642 s 2-4; 1989 c 330 s 13,14*

62A.151 HEALTH INSURANCE BENEFITS FOR EMOTIONALLY HANDICAPPED CHILDREN.

No policy or plan of health, medical, hospitalization, or accident and sickness insurance regulated under this chapter, or nonprofit health service plan corporation regulated under chapter 62C, or health maintenance organization regulated under chapter 62D which provides coverage of or reimbursement for inpatient hospital and medical expenses shall be delivered, issued, executed or renewed in this state, or approved for issuance or renewal in this state by the commissioner of commerce, after July 1, 1975 unless the policy or plan includes and provides health service benefits to any subscriber or other person covered thereunder, on the same basis as other benefits, for the treatment of emotionally handicapped children in a residential treatment facility licensed by the commissioner of human services. For purposes of this section "emotionally handicapped child" shall have the meaning set forth by the commissioner of human services in the rules relating to residential treatment facilities. The restrictions and requirements of this section shall not apply to any plan or policy which is individually underwritten or provided for a specific individual and family members as a nongroup policy. The mandatory coverage under this section shall be on the same basis as inpatient hospital medical coverage provided under the policy or plan.

History: *1975 c 40 s 1; 1983 c 289 s 114 subd 1; 1984 c 654 art 5 s 58; 1984 c 655 art 1 s 92; 1985 c 248 s 70; 1986 c 444*

62A.152 BENEFITS FOR AMBULATORY MENTAL HEALTH SERVICES.

Subdivision 1. **Scope.** The provisions of this section apply (a) to all group policies or subscriber contracts which provide benefits for at least 100 certificate holders who are residents of this state or groups of which more than 90 percent are residents of this state and are issued, delivered, or renewed by accident and health insurance companies regulated under this chapter, or by nonprofit health service plan corporations regulated under chapter 62C and (b), unless waived by the commissioner to the extent applicable to holders who are both nonresidents and employed outside this state, to all group policies or subscriber contracts which are issued, delivered, or renewed within this state by accident and health insurance companies regulated under this chapter, or by nonprofit health service plan corporations regulated under chapter 62C.

Subd. 2. **Minimum benefits.** (a) All group policies and all group subscriber contracts providing benefits for mental or nervous disorder treatments in a hospital shall also provide coverage on the same basis as coverage for other benefits for at least 80 percent of the cost of the usual and customary charges of the first ten hours of treatment incurred over a 12-month benefit period, for mental or nervous disorder consultation, diagnosis and treatment services delivered while the insured person is not a bed patient in a hospital, and at least 75 percent of the cost of the usual and customary charges for any additional hours of treatment during the same 12-month benefit period for serious or persistent mental or nervous disorders, if the services are furnished by (1) a licensed or accredited hospital, (2) a community mental health center or mental health clinic approved or licensed by the commissioner of human services or other authorized state agency, (3) a licensed psychologist licensed under the provisions of sections 148.88 to 148.98, (4) a licensed consulting psychologist licensed under the provisions of sections 148.88 to 148.98, or (5) a psychiatrist licensed under chapter 147. Prior authorization from an accident and health insurance company, or a nonprofit health service corporation, shall be required for an extension of coverage beyond ten hours of treatment. This

prior authorization must be based upon the severity of the disorder, the patient's risk of deterioration without ongoing treatment and maintenance, degree of functional impairment, and a concise treatment plan. Authorization for extended treatment may be limited to a maximum of 30 visit hours during any 12-month benefit period.

(b) For purposes of this section, covered treatment for a minor includes treatment for the family if family therapy is recommended by a provider listed in paragraph (a). For purposes of determining benefits under this section, "hours of treatment" means treatment rendered on an individual or single-family basis. If treatment is rendered on a group basis, the hours of covered group treatment must be provided at a ratio of no less than two group treatment sessions to one individual treatment hour.

Subd. 3. **Provider discrimination prohibited.** All group policies and group subscriber contracts that provide benefits for mental or nervous disorder treatments in a hospital must provide direct reimbursement for those services if performed by a licensed psychologist or a licensed consulting psychologist to the extent that the services and treatment are within the scope of licensed psychologist or licensed consulting psychologist licensure. The order of the physician requesting the services of the licensed psychologist or licensed consulting psychologist may be required to be submitted with the claim for payment.

This subdivision is intended to provide payment of benefits for mental or nervous disorder treatments performed by a licensed psychologist or a licensed consulting psychologist in a hospital and is not intended to change or add benefits for those services provided in policies or contracts to which this subdivision applies.

History: *1975 c 89 s 1; 1981 c 265 s 1; 1Sp1981 c 4 art 1 s 49; 1983 c 354 s 1; 1984 c 654 art 5 s 58; 1987 c 337 s 49; 1987 c 384 art 2 s 1; 1988 c 689 art 2 s 7; 1989 c 330 s 15,16*

62A.153 FREE STANDING AMBULATORY SURGICAL CENTERS.

No policy or plan of health, medical, hospitalization, or accident and sickness insurance regulated under this chapter, or subscriber contract provided by a nonprofit health service plan corporation regulated under chapter 62C shall be issued, renewed, continued, delivered, issued for delivery or executed in this state, or approved for issuance or renewal in this state by the commissioner of commerce unless the policy, plan or contract specifically provides coverage for a health care treatment or service rendered by a free standing ambulatory surgical center or facilities offering ambulatory medical service 24 hours a day seven days a week, which are not part of a hospital, but have been reviewed and approved by the state commissioner of health to provide the treatment or service, on the same basis as coverage provided for the same health care treatment or service rendered by a hospital.

History: *1976 c 45 s 1; 1977 c 305 s 45; 1983 c 289 s 114 subd 1; 1984 c 655 art 1 s 92*

62A.154 BENEFITS FOR DES RELATED CONDITIONS.

Subdivision 1. **Definitions.** For the purposes of this section, the terms defined in this section have the meanings given them.

(a) "Covered person" means a natural person who is covered under a policy.

(b) "Insurer" means an insurer providing health, medical, hospitalization, or accident and sickness insurance regulated under this chapter, a nonprofit health services plan corporation regulated under chapter 62C, a health maintenance organization regulated under chapter 62D or a fraternal beneficiary association regulated under chapter 64B.

(c) "Policy" means a policy or plan of health, medical, hospitalization or accident and sickness insurance, a health maintenance contract, or a health benefit certificate provided by an insurer which provides coverage of, or reimbursement for, hospital, medical, or surgical expenses on a group or individual basis, but does not include a policy designed primarily to provide coverage payable on a per diem, fixed indemnity or nonexpense incurred basis, or a policy that provides only accident coverage.

Subd. 2. **Required coverage.** No policy shall be issued or renewed in this state after August 1, 1981 if it provides an exclusion, reduction, or other limitation as to coverage, deductible, coinsurance or copayment applicable solely to conditions attributable to diethylstilbestrol or exposure to diethylstilbestrol, unless the covered person has been diagnosed as having diethylstilbestrol-related cancer prior to the date on which coverage for that person begins. In the absence of credible evidence of a higher morbidity rate due to exposure to diethylstilbestrol, no insurer shall surcharge or in any other manner increase the premium. If there is credible evidence of a higher morbidity rate due to exposure to diethylstilbestrol, no insurer shall surcharge or in any other manner increase the premium without the prior approval of the commissioner.

Subd. 3. **Refusal to issue or renew.** No insurer shall refuse to issue or renew a policy, or to provide coverage under a policy, in this state after August 1, 1981 solely because of conditions attributable to diethylstilbestrol or exposure to diethylstilbestrol, unless the covered person has been diagnosed as having diethylstilbestrol-related cancer prior to the date on which an initial premium payment is received by the insurer.

History: *1981 c 350 s 1; 1985 c 49 s 41*

62A.155 COVERAGE FOR SERVICES PROVIDED TO A VENTILATOR-DEPENDENT PERSON.

Subdivision 1. **Scope of coverage.** This section applies to all policies of accident and health insurance, group subscriber contracts offered by nonprofit health service plan corporations regulated under chapter 62C, health maintenance contracts regulated under chapter 62D, and health benefit certificates offered through a fraternal beneficiary association regulated under chapter 64B. This section does not apply to policies designed primarily to provide coverage payable on a per diem, fixed indemnity or nonexpense incurred basis, or policies that provide only accident coverage.

Subd. 2. **Required coverage.** If a policy, plan, certificate, or contract referred to in subdivision 1 issued or renewed after August 1, 1988, provides coverage for services provided by a private duty nurse or personal care assistant to a ventilator-dependent person in the person's home, it must provide coverage for up to 120 hours of services provided by a private duty nurse or personal care assistant to the ventilator-dependent person during the time the ventilator-dependent person is in a hospital licensed under chapter 144. The personal care assistant or private duty nurse shall perform only the services of communicator or interpreter for the ventilator-dependent patient during a transition period of up to 120 hours to assure adequate training of the hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the patient.

History: *1988 c 656 s 3*

62A.16 GROUP HOSPITAL AND MEDICAL COVERAGE AND HEALTH CARE PLANS, APPLICABILITY.

The provisions of this section and section 62A.17 shall apply to all group insurance policies or group subscriber contracts providing coverage for hospital or medical expenses incurred by a Minnesota resident employed within this state. This section and section 62A.17 shall also apply to health care plans established by employers in this state through health maintenance organizations certified under chapter 62D.

History: *1974 c 101 s 1; 1976 c 142 s 1*

62A.17 TERMINATION OF OR LAYOFF FROM EMPLOYMENT.

Subdivision 1. **Continuation of coverage.** Every group insurance policy, group subscriber contract, and health care plan included within the provisions of section 62A.16, except policies, contracts, or health care plans covering employees of an agency of the federal government, shall contain a provision which permits every covered employee who is voluntarily or involuntarily terminated or laid off from employment, if the policy, contract, or health care plan remains in force for active employees of the employer, to elect to continue the coverage for the employee and dependents.

An employee shall be considered to be laid off from employment if there is a reduction in hours to the point where the employee is no longer eligible under the policy, contract, or health care plan. Termination shall not include discharge for gross misconduct.

Subd. 2. **Responsibility of employee.** Every covered employee electing to continue coverage shall pay the former employer, on a monthly basis, the cost of the continued coverage. If the policy, contract, or health care plan is administered by a trust, every covered employee electing to continue coverage shall pay the trust the cost of continued coverage according to the eligibility rules established by the trust. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for similarly situated employees with respect to whom neither termination nor layoff has occurred, without regard to whether such cost is paid by the employer or employee. The employee shall be eligible to continue the coverage until the employee becomes covered under another group health plan, or for a period of 18 months after the termination of or lay off from employment, whichever is shorter. If the employee becomes covered under another group policy, contract, or health plan and the new group policy, contract, or health plan contains any preexisting condition limitations, the employee may, subject to the 18-month maximum continuation limit, continue coverage with the former employer until the preexisting condition limitations have been satisfied. The new policy, contract, or health plan is primary except as to the preexisting condition. In the case of a newborn child who is a dependent of the employee, the new policy, contract, or health plan is primary upon the date of birth of the child, regardless of which policy, contract, or health plan coverage is deemed primary for the mother of the child.

Subd. 3. [Repealed by amendment, 1987 c 337 s 50]

Subd. 4. **Responsibility of employer.** After timely receipt of the monthly payment from a covered employee, if the employer, or the trustee, if the policy, contract, or health care plan is administered by a trust, fails to make the payment to the insurer, nonprofit health service plan corporation, or health maintenance organization, with the result that the employee's coverage is terminated, the employer or trust shall become liable for the employee's coverage to the same extent as the insurer, nonprofit health service plan corporation, or health maintenance organization would be if the coverage were still in effect.

In the case of a policy, contract or plan administered by a trust, the employer must notify the trustee within 30 days of the termination or layoff of a covered employee of the name and last known address of the employee.

If the employer or trust fails to notify a covered employee, the employer or trust shall continue to remain liable for the employee's coverage to the same extent as the insurer would be if the coverage were still in effect.

Subd. 5. **Notice of options.** Upon the termination of or lay off from employment of an eligible employee, the employer shall inform the employee within ten days after termination or lay off of:

(a) the right to elect to continue the coverage;

(b) the amount the employee must pay monthly to the employer to retain the coverage;

(c) the manner in which and the office of the employer to which the payment to the employer must be made; and

(d) the time by which the payments to the employer must be made to retain coverage.

If the policy, contract, or health care plan is administered by a trust, the employer is relieved of the obligation imposed by clauses (a) to (d). The trust shall inform the employee of the information required by clauses (a) to (d).

The employee shall have 60 days within which to elect coverage. The 60-day period shall begin to run on the date plan coverage would otherwise terminate or on the date upon which notice of the right to coverage is received, whichever is later.

Notice must be in writing and sent by first class mail to the employee's last known address which the employee has provided the employer or trust.

A notice in substantially the following form shall be sufficient: "As a terminated or laid off employee, the law authorizes you to maintain your group medical insurance for a period of up to 18 months. To do so you must notify your former employer within 60 days of your receipt of this notice that you intend to retain this coverage and must make a monthly payment of $..... to ..... at ..... by the ..... of each month."

Subd. 6. **Conversion to individual policy.** A group insurance policy that provides posttermination or layoff coverage as required by this section shall also include a provision allowing a covered employee, surviving spouse, or dependent at the expiration of the posttermination or layoff coverage provided by subdivision 2 to obtain from the insurer offering the group policy or group subscriber contract, at the employee's, spouse's, or dependent's option and expense, without further evidence of insurability and without interruption of coverage, an individual policy of insurance or an individual subscriber contract providing at least the minimum benefits of a qualified plan as prescribed by section 62E.06 and the option of a number three qualified plan, a number two qualified plan, and a number one qualified plan as provided by section 62E.06, subdivisions 1 to 3, provided application is made to the insurer within 30 days following notice of the expiration of the continued coverage and upon payment of the appropriate premium. The required conversion contract must treat pregnancy the same as any other covered illness under the conversion contract. A health maintenance contract issued by a health maintenance organization that provides posttermination or layoff coverage as required by this section shall also include a provision allowing a former employee, surviving spouse, or dependent at the expiration of the posttermination or layoff coverage provided in subdivision 2 to obtain from the health maintenance organization, at the former employee's, spouse's, or dependent's option and expense, without further evidence of insurability and without interruption of coverage, an individual health maintenance contract. Effective January 1, 1985, enrollees who have become nonresidents of the health maintenance organization's service area shall be given the option, to be arranged by the health maintenance organization, of a number three qualified plan, a number two qualified plan, or a number one qualified plan as provided by section 62E.06, subdivisions 1 to 3. This option shall be made available at the enrollee's expense, without further evidence of insurability and without interruption of coverage.

A policy providing reduced benefits at a reduced premium rate may be accepted by the employee, the spouse, or a dependent in lieu of the optional coverage otherwise required by this subdivision.

The individual policy or contract shall be renewable at the option of the individual as long as the individual is not covered under another qualified plan as defined in section 62E.02, subdivision 4. Any revisions in the table of rate for the individual policy shall apply to the covered person's original age at entry and shall apply equally to all similar policies issued by the insurer.

History: *1974 c 101 s 2; 1975 c 100 s 1-3; 1976 c 142 s 2,3; 1977 c 409 s 2; 1983 c 44 s 1,2; 1983 c 263 s 9; 1984 c 464 s 7; 1Sp1985 c 10 s 60; 1986 c 444; 1987 c 337 s 50; 1988 c 434 s 2; 1989 c 330 s 17; 1990 c 403 s 1*

62A.18 PROHIBITION AGAINST DISABILITY OFFSETS.

No individual or group policy of accident and health insurance issued, amended, renewed, or delivered in this state on or after January 1, 1976 shall contain any provision offsetting, or in any other manner reducing, any benefit under the policy by the amount of, or in proportion to, any increase in disability benefits received or receivable under the federal Social Security Act, the Railroad Retirement Act, any Veteran's Disability Compensation and Survivor Benefits Act, Workers' Compensation, or any similar federal or state law, as amended subsequent to the date of commencement of such benefit.

History: *1975 c 323 s 1*

62A.20 COVERAGE OF CURRENT SPOUSE AND CHILDREN.

Subdivision 1. **Requirement.** Every policy of accident and health insurance providing coverage of hospital or medical expense on either an expense-incurred basis or other than an expense-incurred basis, which in addition to covering the insured also provides coverage to the spouse and dependent children of the insured shall contain:

(1) a provision which permits the spouse and dependent children to elect to continue coverage when the insured becomes enrolled for benefits under Title XVIII of the Social Security Act (Medicare); and

(2) a provision which permits the dependent children to continue coverage when they cease to be dependent children under the generally applicable requirement of the plan.

Subd. 2. **Continuation privilege.** The coverage described in subdivision 1 may be continued until the earlier of the following dates:

(1) the date coverage would otherwise terminate under the policy;

(2) 36 months after continuation by the spouse or dependent was elected; or

(3) the spouse or dependent children become covered under another group health plan.

If coverage is provided under a group policy, any required premium contributions for the coverage shall be paid by the insured on a monthly basis to the group policyholder for remittance to the insurer. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouse and dependent children to whom subdivision 1 is not applicable, without regard to whether such cost is paid by the employer or employee.

History: *1987 c 337 s 51*

62A.21 CONVERSION PRIVILEGES FOR INSURED FORMER SPOUSES AND CHILDREN.

Subdivision 1. No policy of accident and health insurance providing coverage of hospital or medical expense on either an expense incurred basis or other than an expense incurred basis, which in addition to covering the insured also provides coverage to the spouse of the insured shall contain a provision for termination of coverage for a spouse covered under the policy solely as a result of a break in the marital relationship.

Subd. 2. [Repealed, 1981 c 329 s 4]

Subd. 2a. **Continuation privilege.** Every policy described in subdivision 1 shall contain a provision which permits continuation of coverage under the policy for the insured's former spouse and dependent children upon entry of a valid decree of dissolution of marriage. The coverage shall be continued until the earlier of the following dates:

(a) The date the insured's former spouse becomes covered under any other group health plan; or

(b) The date coverage would otherwise terminate under the policy.

If the coverage is provided under a group policy, any required premium contributions for the coverage shall be paid by the insured on a monthly basis to the group policyholder for remittance to the insurer. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouses and dependent children with respect to whom the marital relationship has not dissolved, without regard to whether such cost is paid by the employer or employee.

Subd. 2b. **Conversion privilege.** Every policy described in subdivision 1 shall contain a provision allowing a former spouse and dependent children of an insured, without providing evidence of insurability, to obtain from the insurer at the expiration of any continuation of coverage required under subdivision 2a or sections 62A.146 and 62A.20, conversion coverage providing at least the minimum benefits of a qualified

plan as prescribed by section 62E.06 and the option of a number three qualified plan, a number two qualified plan, a number one qualified plan as provided by section 62E.06, subdivisions 1 to 3, provided application is made to the insurer within 30 days following notice of the expiration of the continued coverage and upon payment of the appropriate premium. A policy providing reduced benefits at a reduced premium rate may be accepted by the former spouse and dependent children in lieu of the optional coverage otherwise required by this subdivision. The individual policy shall be renewable at the option of the former spouse as long as the former spouse is not covered under another qualified plan as defined in section 62E.02, subdivision 4. Any revisions in the table of rate for the individual policy shall apply to the former spouse's original age at entry and shall apply equally to all similar policies issued by the insurer.

Subd. 3. Subdivision 1 applies to every policy of accident and health insurance which is delivered, issued for delivery, renewed or amended on or after July 19, 1977.

Subdivisions 2a and 2b apply to every policy of accident and health insurance which is delivered, issued for delivery, renewed, or amended on or after August 1, 1981.

History: *1977 c 186 s 1; 1981 c 329 s 1-3; 1982 c 555 s 7,8; 1987 c 337 s 52; 1990 c 403 s 2*

62A.22 REFUSAL TO PROVIDE COVERAGE BECAUSE OF OPTION UNDER WORKERS' COMPENSATION.

No insurer offering an individual or group policy of accident or health coverage in this state shall refuse to provide or renew accident or health coverage because the insured has an option to elect workers' compensation coverage pursuant to section 176.041, subdivision 1a.

History: *1979 c 92 s 1; 1989 c 209 art 2 s 1*

62A.23 GROUP DISABILITY INCOME COVERAGE; TERMINATION WITHOUT PREJUDICE; DEFINITIONS.

Subdivision 1. For the purposes of this section and section 62A.24, the terms defined in this section have the meanings given them in this section.

Subd. 2. "Employer" means any natural person, company, corporation, partnership, association, firm or franchise which employs any employee.

Subd. 3. "Insurer" means any person, company, corporation, including a nonprofit corporation, partnership, association, firm or franchise which underwrites or is by contract or other agreement obligated to provide group disability income insurance benefits to any group of employees of any employer.

History: *1980 c 377 s 1*

62A.24 CONTINUATION OF BENEFITS.

No employer or insurer of that employer may offer or provide a policy of group disability income insurance unless the master policy provides that the termination of the policy shall be without prejudice to any claims originating prior to the time of the termination.

Section 62A.23 and this section may be superseded by a rule promulgated by the commissioner of commerce.

History: *1980 c 377 s 2; 1983 c 289 s 114 subd 1; 1984 c 655 art 1 s 92*

62A.25 RECONSTRUCTIVE SURGERY.

Subdivision 1. This section applies to all policies of accident and health insurance, health maintenance contracts regulated under chapter 62D, health benefit certificates offered through a fraternal beneficiary association regulated under chapter 64B, and group subscriber contracts offered by nonprofit health service plan corporations regulated under chapter 62C but does not apply to policies designed primarily to provide coverage payable on a per diem, fixed indemnity or nonexpense incurred basis, or policies that provide only accident coverage.

Subd. 2. Every policy, plan, certificate or contract to which this section applies shall provide benefits for reconstructive surgery when such service is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part or when such service is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician.

History: *1980 c 496 s 1; 1985 c 49 s 41*

62A.26 COVERAGE FOR PHENYLKETONURIA TREATMENT.

Subdivision 1. **Scope of coverage.** This section applies to all policies of accident and health insurance, health maintenance contracts regulated under chapter 62D, health benefit certificates offered through a fraternal beneficiary association regulated under chapter 64B, and group subscriber contracts offered by nonprofit health service plan corporations regulated under chapter 62C, but does not apply to policies designed primarily to provide coverage payable on a per diem, fixed indemnity or nonexpense incurred basis, or policies that provide only accident coverage.

Subd. 2. **Required coverage.** Every policy, plan, certificate, or contract referred to in subdivision 1 issued or renewed after August 1, 1985, must provide coverage for special dietary treatment for phenylketonuria when recommended by a physician.

History: *1985 c 49 s 41; 1Sp1985 c 9 art 2 s 1*

62A.27 COVERAGE FOR ADOPTED CHILDREN.

An individual or group policy or plan of health and accident insurance regulated under this chapter or chapter 64B, subscriber contract regulated under chapter 62C, or health maintenance contract regulated under chapter 62D, that provides coverage to a Minnesota resident must cover adopted children of the insured, subscriber, or enrollee on the same basis as other dependents. Consequently, the policy or plan shall not contain any provision concerning preexisting condition limitations, insurability, eligibility, or health underwriting approval concerning adopted children.

The coverage required by this section is effective from the date of placement for the purpose of adoption and continues unless the placement is disrupted prior to legal adoption and the child is removed from placement.

History: *1983 c 56 s 1; 1985 c 49 s 41; 1987 c 337 s 53; 1988 c 656 s 4*

62A.28 COVERAGE FOR SCALP HAIR PROSTHESES.

Subdivision 1. **Scope of coverage.** This section applies to all policies of accident and health insurance, health maintenance contracts regulated under chapter 62D, health benefit certificates offered through a fraternal beneficiary association regulated under chapter 64B, and group subscriber contracts offered by nonprofit health service plan corporations regulated under chapter 62C. This section does not apply to policies designed primarily to provide coverage payable on a per diem, fixed indemnity or nonexpense incurred basis, or policies that provide only accident coverage.

Subd. 2. **Required coverage.** Every policy, plan, certificate, or contract referred to in subdivision 1 issued or renewed after August 1, 1987, must provide coverage for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata.

The coverage required by this section is subject to a policy's copayment requirement and is limited to a maximum of $350 in any benefit year, exclusive of any deductible.

History: *1987 c 202 s 1*

62A.29 SURETY BOND OR SECURITY FOR CERTAIN HEALTH BENEFIT PLANS.

Subdivision 1. **Surety bond or security requirement.** Any employer, except the state and its political subdivisions as defined in section 65B.43, subdivision 20, who pro-

vides a health benefit plan to its Minnesota employees, which is to some extent self-insured by the employer, and who purchases stop-loss insurance coverage, or any other insurance coverage, in connection with the health benefit plan, shall annually file with the commissioner, within 60 days of the end of the employer's fiscal year, security acceptable to the commissioner in an amount specified under subdivision 2, or a surety bond in the form and amount prescribed by subdivisions 2 and 3. An acceptable surety bond is one issued by a corporate surety authorized by the commissioner to transact this business in the state of Minnesota for the purposes of this section. The term "Minnesota employees" includes any Minnesota resident who is employed by the employer.

Subd. 2. **Amount of surety bond or security.** The amount of surety bond or acceptable security required by subdivision 1 shall be equal to one-fourth of the projected annual medical and hospital expenses to be incurred by the employer or $1,000, whichever is greater, with respect to its Minnesota employees by reason of the portion of the employer's health benefit plan which is self-insured by the employer.

Subd. 3. **Form of the surety bond.** The surety bond shall provide as follows:

SURETY BOND

KNOW ALL PERSONS BY THESE PRESENTS: That (entity to be bonded), of (location), (hereinafter called the "principal"), as principal, and (bonding company name), a (name of state) corporation, of (location) (hereinafter called the "surety"), as surety are held and firmly bound unto the commissioner of commerce of the state of Minnesota for the use and benefit of Minnesota residents entitled to health benefits from the principal in the sum of ($.....), for the payment of which well and truly to be made, the principal binds itself, its successor and assigns, and the surety binds itself and its successors and assigns, jointly and severally, firmly by these presents.

WHEREAS, in accordance with section (.....) of the Minnesota Statute, principal is required to file a surety bond with the commissioner of commerce of the state of Minnesota.

NOW, THEREFORE, the condition of this obligation is such that if the said principal shall, according to the terms, provisions, and limitations of principals' health benefit program for its Minnesota employees, pay all of its liabilities and obligations, including all benefits as provided in the attached plan, then, this obligation shall be null and void, otherwise to remain in full force and effect, subject, however, to the following terms and conditions:

1. The liability of the surety is limited to the payment of the benefits of the employee benefit plan which are payable by the principal and within the amount of the bond. The surety shall be bound to payments owed by the principal for obligations arising from a default of the principal or any loss incurred during the period to which the bond applies.

2. In the event of any default on the part of the principal to abide by the terms and provision of the attached plan, the commissioner of commerce may, upon ten-days notice to the surety and opportunity to be heard, require the surety to pay all of the principal's past and future obligations under the attached plan with respect to the principal's Minnesota employees.

3. Service on the surety shall be deemed to be service on the principals.

4. This bond shall be in effect from ..... to ....., and may not be canceled by either the surety or the principal.

5. Any Minnesota employee of principal aggrieved by a default of principal under the attached plan, and/or the commissioner of commerce on behalf of any such employee, may enforce the provisions of this bond.

6. This bond shall become effective at (time of day, month, day, year).

IN TESTIMONY WHEREOF, said principals and said surety have caused this instrument to be signed by their respective, duly authorized officers and their corporate seals to be hereunto affixed this (day, month, year).

Signed, sealed and delivered in the presence of:

_____

_____

_____

_____

Corporation Name

_____

_____

Bonding Company Name

By:_____

Subd. 4. **Penalty for failure to comply.** The commissioner of revenue shall deny any business tax deduction to an employer for the employer's contribution to a health plan for the period which the employer fails to comply with this section. This section does not apply to trusts established under chapter 62H which have been approved by the commissioner.

Subd. 5. **Petition to reduce bond or security amount.** An employer subject to this section may petition the commissioner to, and the commissioner may, allow the use of a surety bond not in the form specified in subdivision 3, or grant a reduction in the amount of the surety bond or security required.

In reviewing a petition submitted under this subdivision, the commissioner must consider, in addition to any other factors, information provided by the petitioner in regard to the following:

(1) the size of the petitioner's business;

(2) the number of employees;

(3) the cost of providing the bond or security and the effect the cost will have on the petitioner's financial condition;

(4) whether the cost of the bond or security will impair the petitioner's ability to self-insure; and

(5) the petitioner's likelihood of being able to meet the petitioner's future obligations in regard to the health plan.

History: *1987 c 337 s 54*

62A.30 COVERAGE FOR DIAGNOSTIC PROCEDURES FOR CANCER.

Subdivision 1. **Scope of coverage.** This section applies to all policies of accident and health insurance, health maintenance contracts regulated under chapter 62D, health benefit certificates offered through a fraternal beneficiary association regulated under chapter 64B, and group subscriber contracts offered by nonprofit health service plan corporations regulated under chapter 62C, but does not apply to policies designed primarily to provide coverage payable on a per diem, fixed indemnity or nonexpense incurred basis, or policies that provide only accident coverage.

Subd. 2. **Required coverage.** Every policy, plan, certificate, or contract referred to in subdivision 1 issued or renewed after August 1, 1988, that provides coverage to a Minnesota resident must provide coverage for routine screening procedures for cancer, including mammograms and pap smears, when ordered or provided by a physician in accordance with the standard practice of medicine.

History: *1988 c 642 s 5*

NOTE: This section was also added by Laws 1988, chapter 441, section 2, to read as follows:

"62A.30 **Coverage for diagnostic procedures for cancer.**

Subdivision 1. **Scope of coverage.** This section applies to all policies of accident and health insurance, health maintenance contracts regulated under chapter 62D, health benefit certificates offered through a fraternal beneficiary association regulated under chapter 64B, and group subscriber contracts offered by nonprofit health service plan corporations regulated under chapter 62C, but does not apply to policies designed primarily to provide coverage payable on a per diem, fixed indemnity or nonexpense incurred basis, or policies that provide only accident coverage.

Subd. 2. **Required coverage.** Every policy, plan, certificate, or contract referred to in subdivision 1 issued or renewed after August 1, 1988, must provide coverage for routine screening procedures for cancer, including mammograms and Pap smears, when ordered or performed by a physician in accordance with the standard practice of medicine."

MEDICARE SUPPLEMENT INSURANCE

62A.31 MEDICARE SUPPLEMENT BENEFITS; MINIMUM STANDARDS.

Subdivision 1. **Policy requirements.** No individual or group policy, certificate, subscriber contract or other evidence of accident and health insurance issued or delivered in this state shall be sold or issued to an individual age 65 or older covered by Medicare unless the following requirements are met:

(a) The policy must provide a minimum of the coverage set out in subdivision 2;

(b) The policy must cover preexisting conditions during the first six months of coverage if the insured was not diagnosed or treated for the particular condition during the 90 days immediately preceding the effective date of coverage;

(c) The policy must contain a provision that the plan will not be canceled or nonrenewed on the grounds of the deterioration of health of the insured;

(d) Before the policy is sold or issued, an offer of both categories of Medicare supplement insurance has been made to the individual, together with an explanation of both coverages; and

(e) An outline of coverage as provided in section 62A.39 must be delivered at the time of application and prior to payment of any premium.

Subd. 1a. **Application to certain policies.** The requirements of sections 62A.31 to 62A.44 shall not apply to disability income protection insurance policies, long-term care policies issued pursuant to sections 62A.46 to 62A.56, or group policies of accident and health insurance which do not purport to supplement Medicare issued to any of the following groups:

(a) A policy issued to an employer or employers or to the trustee of a fund established by an employer where only employees or retirees, and dependents of employees or retirees, are eligible for coverage.

(b) A policy issued to a labor union or similar employee organization.

(c) A policy issued to an association, a trust or the trustee of a fund established, created or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of 100 persons; shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have a constitution and bylaws which provide that (1) the association or associations hold regular meetings not less frequently than annually to further purposes of the members, (2) except for credit unions, the association or associations collect dues or solicit contributions from members, (3) the members have voting privileges and representation on the governing board and committees, and (4) the members are not, within the first 30 days of membership, directly solicited, offered, or sold a long-term care policy or Medicare supplement policy if the policy is available as an association benefit. This clause does not prohibit direct solicitations, offers, or sales made exclusively by mail.

An association may apply to the commissioner for a waiver of the 30-day waiting period as to that association. The commissioner may grant the waiver upon a finding of all of the following: (1) that the association is in full compliance with this section; (2) that sanctions have not been imposed against the association as a result of significant disciplinary action by the department of commerce; and (3) that at least 90 percent of the association's income comes from dues, contributions, or sources other than income from the sale of insurance.

Subd. 2. **General coverage.** For a policy to meet the requirements of this section it must contain (1) a designation specifying whether the policy is an extended basic Medicare supplement plan or a basic Medicare supplement plan, (2) a caption stating that the commissioner has established two categories of Medicare supplement insurance and minimum standards for each, with the extended basic Medicare supplement being the most comprehensive and the basic Medicare supplement being the least comprehensive, and (3) the policy must provide the coverage prescribed in sections 62A.315 and 62A.316.

History: *1981 c 318 s 1; 1983 c 263 s 10; 1986 c 397 s 2; 1987 c 337 s 55; 1989 c 258 s 3,4; 1990 c 403 s 3; 1990 c 415 s 3*

62A.315 EXTENDED BASIC MEDICARE SUPPLEMENT PLAN; COVERAGE.

The extended basic Medicare supplement plan must have a level of coverage so that it will be certified as a qualified plan pursuant to chapter 62E, and will provide:

(1) coverage for all of the Medicare part A inpatient hospital deductible and coinsurance amounts, and 100 percent of all Medicare part A eligible expenses for hospitalization not covered by Medicare for the calendar year;

(2) coverage for the daily copayment amount of Medicare part A eligible expenses for the calendar year incurred for skilled nursing facility care;

(3) coverage for the 20 percent copayment amount of Medicare eligible expenses excluding outpatient prescription drugs under Medicare part B regardless of hospital confinement for Medicare part B and coverage of the Medicare deductible amount;

(4) 80 percent of usual and customary hospital and medical expenses, supplies, and prescription drug expenses, not covered by Medicare's eligible expenses;

(5) coverage for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells as defined under federal regulations under Medicare parts A and B, unless replaced in accordance with federal regulations; and

(6) 100 percent of the cost of immunizations.

History: *1989 c 258 s 5; 1990 c 403 s 4*

62A.316 BASIC MEDICARE SUPPLEMENT PLAN; COVERAGE.

(a) The basic Medicare supplement plan must have a level of coverage that will provide:

(1) coverage for all of the Medicare part A inpatient hospital coinsurance amounts, and 100 percent of all Medicare part A eligible expenses for hospitalization not covered by Medicare for the calendar year, after satisfying the Medicare part A deductible;

(2) coverage for the daily copayment amount of Medicare part A eligible expenses for the calendar year incurred for skilled nursing facility care;

(3) coverage for the 20 percent copayment amount of Medicare eligible expenses excluding outpatient prescription drugs under Medicare part B regardless of hospital confinement for Medicare part B after the Medicare deductible amount;

(4) coverage for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells as defined under federal regulations under Medicare parts A and B, unless replaced in accordance with federal regulations; and

(5) 100 percent of the cost of immunizations.

(b) Only the following optional benefit riders may be added to this plan:

(1) coverage for all of the Medicare part A inpatient hospital deductible amount;

(2) a minimum of 80 percent of usual and customary eligible medical expenses and supplies not covered by Medicare part B. This does not include outpatient prescription drugs;

(3) coverage for all of the Medicare part B annual deductible; and

(4) coverage for at least 50 percent, or the equivalent of 50 percent, of usual and customary prescription drug expenses.

Nothing in this section prohibits the plan from requiring that services be received from providers designated as preferred providers or participating providers in order to receive coverage under optional benefit riders.

History: *1989 c 258 s 6; 1990 c 403 s 5; 1990 c 612 s 5*

62A.32 [Repealed, 1989 c 258 s 14]
62A.33 [Repealed, 1989 c 258 s 14]
62A.34 [Repealed, 1989 c 258 s 14]
62A.35 [Repealed, 1989 c 258 s 14]

62A.36 LOSS RATIO STANDARDS.

Subdivision 1. **Minimum loss ratios.** Notwithstanding section 62A.02, subdivision 3, relating to loss ratios, Medicare supplement policies shall be required to return to Minnesota policyholders in the form of aggregate benefits under the policy, for each year excluding the year of issuance and the first year thereafter, on the basis of incurred claims experience and earned premiums in Minnesota and in accordance with accepted actuarial principles and practices:

(a) At least 75 percent of the aggregate amount of premiums collected in the case of group policies, and

(b) At least 65 percent of the aggregate amount of premiums collected in the case of individual policies.

Subd. 1a. **Supplement to annual statements.** Each insurer that has Medicare supplement policies in force in this state shall, as a supplement to the annual statement required by section 60A.13, submit, in a form prescribed by the commissioner, data showing its incurred claims experience, its earned premiums, and the aggregate amount of premiums collected and losses incurred for each Medicare policy form in force. If the data submitted does not confirm that the insurer has satisfied the loss ratio requirements of this section, the commissioner shall notify the insurer in writing of the deficiency. The insurer shall have 30 days from the date of the commissioner's notice to file amended rates that comply with this section. If the insurer fails to file amended rates within the prescribed time, the commissioner shall order that the insurer's filed rates for the nonconforming policy be reduced to an amount that would have resulted in a loss ratio that complied with this section had it been in effect for the reporting period of the supplement. The insurer's failure to file amended rates within the specified time or the issuance of the commissioner's order amending the rates does not preclude the insurer from filing an amendment of its rates at a later time. The commissioner shall annually make the submitted data available to the public at a cost not to exceed the cost of copying. The data must be compiled in a form useful for consumers who wish to compare premium charges and loss ratios.

Subd. 1b. **Penalties.** Each sale of a policy that does not comply with the loss ratio requirements of this section is an unfair or deceptive act or practice in the business of insurance and is subject to the penalties in sections 72A.17 to 72A.32.

Subd. 2. **Solicitations by mail or media advertisement.** For purposes of this section, medicare supplement policies issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, shall be treated as individual policies.

History: *1981 c 318 s 6; 1990 c 403 s 6-8*

62A.37 SEALS AND EMBLEM PROHIBITED.

Subdivision 1. No graphic seal or emblem shall be displayed on any policy or promotional literature to indicate or give the impression that there is any connection, certification, approval or endorsement from medicare or any governmental body of this state or any agency thereof or of the United States of America or any agency thereof.

Subd. 2. Any false statement or representation printed on the policy or on promotional literature that indicates the policy has a connection with, is certified by, or has the approval or endorsement of any agency of this state or of the United States of America shall be unlawful.

History: *1981 c 318 s 7*

62A.38 NOTICE OF FREE EXAMINATION.

Medicare supplement policies or certificates, other than those issued pursuant to direct response solicitation, shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded in full if, after examination of the policy or cer-

tificate, the insured person is not satisfied for any reason. Medicare supplement policies or certificates, issued pursuant to a direct response solicitation to persons eligible for medicare by reason of age, shall have a notice prominently printed on the first page or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination, the insured person is not satisfied for any reason.

History: *1981 c 318 s 8*

62A.39 DISCLOSURE.

No individual medicare supplement plan shall be delivered or issued in this state and no certificate shall be delivered pursuant to a group medicare supplement plan delivered or issued in this state unless an outline containing at least the following information is delivered to the applicant at the time the application is made:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the exceptions, reductions, and limitations contained in the policy including the following language, as applicable, in bold print: "THIS POLICY DOES NOT COVER ALL MEDICAL EXPENSES BEYOND THOSE COVERED BY MEDICARE. THIS POLICY DOES NOT COVER ALL SKILLED NURSING HOME CARE EXPENSES AND DOES NOT COVER CUSTODIAL OR RESIDENTIAL NURSING CARE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH NURSING HOME FACILITIES AND EXPENSES ARE COVERED BY YOUR POLICY.";

(c) A statement of the renewal provisions including any reservations by the insurer of a right to change premiums;

(d) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions; and

(e) A statement of the policy's loss ratio as follows: "This policy provides an anticipated loss ratio of (..%). This means that, on the average, policyholders may expect that ($....) of every $100.00 in premium will be returned as benefits to policyholders over the life of the contract."

History: *1981 c 318 s 9; 1983 c 263 s 11*

62A.40 REPLACEMENT.

No insurer or agent shall replace a medicare supplement plan with another medicare supplement plan of the same category unless there is a substantial difference in cost favorable to the policyholder, or the insured has previously demonstrated a dissatisfaction with the service presently being received from the current insurer. An insurer or agent may replace a medicare supplement plan with a less comprehensive plan only if the prospective insured signs an acknowledgment that it is understood that the prospective insured will receive less benefits under the new policy than under the policy presently in force.

History: *1981 c 318 s 10; 1986 c 444*

62A.41 PENALTIES.

Subdivision 1. **Generally.** Any insurer, general agent, agent, or other person who knowingly or willfully, either directly or indirectly, makes or causes to be made or induces or seeks to induce the making of any false statement or representation of a material fact with respect to compliance of any policy with the standards and requirements set forth in this section; falsely assumes or pretends to be acting, or misrepresents in any way, including a violation of section 62A.37, that the person is acting, under the authority or in association with Medicare, or any federal agency, for the purpose of selling or attempting to sell insurance, or in such pretended character demands, or obtains money, paper, documents, or anything of value; or knowingly sells a health insurance

policy to an individual entitled to benefits under part A or part B of Medicare with the knowledge that such policy substantially duplicates health benefits to which such individual is otherwise entitled under a requirement of state or federal law other than under Medicare shall be guilty of a felony and subject to a civil penalty of not more than $5,000 per violation, and the commissioner may revoke or suspend the license of any company, association, society, other insurer, or agent thereof.

Subd. 2. **Sales of replacement policies.** An insurer or general agent, agent, manager's general agent, or other representative, who knowingly or willfully violates section 62A.40 is guilty of a felony and is subject to a civil penalty of not more than $5,000 per violation.

Subd. 3. **Sales of duplicate policies.** An agent who knowingly or willfully violates section 62A.43, subdivision 1, is guilty of a felony and is subject to a civil penalty of not more than $5,000 per violation.

Subd. 4. **Unlicensed sales.** Notwithstanding section 60A.17, subdivision 1, paragraph (d), a person who acts or assumes to act as an insurance agent without a valid license for the purpose of selling or attempting to sell Medicare supplement insurance, and the person who aids or abets the actor, is guilty of a felony and is subject to a civil penalty of not more than $5,000 per violation.

History: *1981 c 318 s 11; 1986 c 444; 1989 c 258 s 7*

62A.42 RULEMAKING AUTHORITY.

To carry out the purposes of sections 62A.31 to 62A.44, the commissioner may promulgate rules pursuant to chapter 14. These rules may:

(a) prescribe additional disclosure requirements for medicare supplement plans, designed to adequately inform the prospective insured of the need and extent of coverage offered;

(b) prescribe uniform policy forms in order to give the insurance purchaser a reasonable opportunity to compare the cost of insuring with various insurers; and

(c) establish other reasonable standards to further the purpose of sections 62A.31 to 62A.44.

History: *1981 c 318 s 12; 1982 c 424 s 130; 1983 c 263 s 12*

62A.43 LIMITATIONS ON SALES.

Subdivision 1. **Duplicate coverage prohibited.** No agent shall sell a Medicare supplement plan, as defined in section 62A.31, to a person who currently has one plan in effect; however, an agent may sell a replacement plan in accordance with section 62A.40, provided that the second plan is not made effective any sooner than necessary to provide continuous benefits for preexisting conditions. Every application for Medicare supplement insurance shall require a listing of all health and accident insurance maintained by the applicant as of the date the application is taken.

Subd. 2. **Refunds.** Notwithstanding the provisions of section 62A.38, an insurer which issues a Medicare supplement plan to any person who has one plan then in effect, except as permitted in subdivision 1, shall, at the request of the insured, either refund the premiums or pay any claims on the policy, whichever is greater. Any refund of premium pursuant to this section or section 62A.38 shall be sent by the insurer directly to the insured within 15 days of the request by the insured.

Subd. 3. **Action by commissioner.** If the commissioner determines after an investigation that an insurer has issued a Medicare supplement plan to a person who already has one plan, except as permitted in subdivision 1, the commissioner shall notify the insurer in writing of the determination. If the insurer thereafter fails to take reasonable action to prevent overselling, the commissioner may, in the manner prescribed in chapter 14, revoke or suspend the insurer's authority to sell accident and health insurance in this state or impose a civil penalty not to exceed $10,000, or both.

Subd. 4. **Other policies not prohibited.** The prohibition in this section against the

sale of duplicate Medicare supplement coverage does not preclude the sale of insurance coverage, such as travel, accident and sickness coverage, the effect or purpose of which is not to supplement Medicare coverage. Notwithstanding this provision, if the commissioner determines that the coverage being sold is in fact Medicare supplement insurance, the commissioner shall notify the insurer in writing of the determination. If the insurer does not thereafter comply with sections 62A.31 to 62A.44, the commissioner may, pursuant to chapter 14, revoke or suspend the insurer's authority to sell accident and health insurance in this state or impose a civil penalty not to exceed $10,000, or both.

History: *1983 c 263 s 13; 1986 c 444; 1987 c 337 s 56,57*

62A.436 COMMISSIONS.

The commission, sales allowance, service fee, or compensation to an agent for the sale of a Medicare supplement plan must be the same for each of the first four years of the policy. The commissioner may grant a waiver of this restriction on commissions when the commissioner believes that the insurer's fee structure does not encourage deceptive practices.

In no event may the rate of commission, sales allowance, service fee, or compensation for the sale of a basic Medicare supplement plan exceed that which applies to the sale of an extended basic Medicare supplement plan.

This section also applies to sales of replacement policies.

History: *1989 c 258 s 8*

62A.44 APPLICATIONS.

No individual medicare supplement plan shall be issued or delivered in this state unless a signed and completed copy of the application for insurance is left with the applicant at the time application is made.

History: *1983 c 263 s 14*

LONG-TERM CARE POLICIES

62A.46 DEFINITIONS.

Subdivision 1. **Applicability.** The definitions in this section apply to sections 62A.46 to 62A.56.

Subd. 2. **Long-term care policy.** "Long-term care policy" means an individual or group policy, certificate, subscriber contract, or other evidence of coverage that provides benefits for prescribed long-term care, including nursing facility services and home care services, pursuant to the requirements of sections 62A.46 to 62A.56. A long-term care policy must contain a designation specifying whether the policy is a long-term care policy AA or A and a caption stating that the commissioner has established two categories of long-term care insurance and the minimum standards for each.

Sections 62A.46, 62A.48, and 62A.52 to 62A.56 do not apply to a long-term care policy issued to (a) an employer or employers or to the trustee of a fund established by an employer where only employees or retirees, and dependents of employees or retirees, are eligible for coverage or (b) to a labor union or similar employee organization. The associations exempted from the requirements of sections 62A.31 to 62A.44 under 62A.31, subdivision 1, clause (c) shall not be subject to the provisions of sections 62A.46 to 62A.56 until July 1, 1988.

Subd. 3. **Nursing facility.** "Nursing facility" means (1) a facility that is licensed as a nursing home under chapter 144A; (2) a facility that is both licensed as a boarding care home under sections 144.50 to 144.56 and certified as an intermediate care facility for purposes of the medical assistance program; and (3) in states other than Minnesota, a facility that meets licensing and certification standards comparable to those that apply to the facilities described in clauses (1) and (2).

Subd. 4. **Home care services.** "Home care services" means one or more of the following prescribed services for the long-term care and treatment of an insured that are provided by a home health agency in a noninstitutional setting according to a written diagnosis or assessment and plan of care:

(1) nursing and related personal care services under the direction of a registered nurse, including the services of a home health aide;

(2) physical therapy;

(3) speech therapy;

(4) respiratory therapy;

(5) occupational therapy;

(6) nutritional services provided by a licensed dietitian;

(7) homemaker services, meal preparation, and similar nonmedical services;

(8) medical social services; and

(9) other similar medical services and health-related support services.

Subd. 5. **Prescribed long-term care.** "Prescribed long-term care" means a service, type of care, or procedure that could not be omitted without adversely affecting the patient's illness or condition and is specified in a plan of care prepared by either: (1) a physician and a registered nurse and is appropriate and consistent with the diagnosis; or (2) a registered nurse or licensed social worker based on an assessment of the insured's ability to perform the activities of daily living and to perform basic cognitive functions appropriately.

Subd. 6. **Qualified insurer.** "Qualified insurer" means an entity licensed under chapter 62A or 62C.

Subd. 7. **Physician.** "Physician" means a medical practitioner licensed under sections 147.02, 147.03, 147.031, and 147.037.

Subd. 8. **Plan of care.** "Plan of care" means a written document prepared and signed by either: (1) a physician and registered nurse that specifies medically prescribed long-term care services or treatment that are consistent with the diagnosis; or (2) by a registered nurse or licensed social worker that specifies prescribed long-term care services or treatment that are consistent with an assessment of the insured's ability to perform the activities of daily living and to perform basic cognitive functions appropriately. The plan of care must be prepared in accordance with accepted standards of practice and must contain services or treatment that could not be omitted without adversely affecting the patient's illness or condition.

Subd. 9. **Insured.** "Insured" means a person covered under a long-term care policy.

Subd. 10. **Home health agency.** "Home health agency" means an entity that provides home care services and is (1) certified for participation in the medicare program; or (2) licensed as a home health agency where a state licensing statute exists, or is otherwise acceptable to the insurer if licensing is not required.

Subd. 11. **Benefit period.** "Benefit period" means one or more separate or combined periods of confinement covered by a long-term care policy in a nursing facility or at home while receiving home care services. A benefit period begins on the first day the insured receives a benefit under the policy and ends when the insured has received no benefits for the same or related cause for an interval of 180 consecutive days.

Subd. 12. **Homebound or house confined.** "Homebound or house confined" means that a person is physically unable to leave the home without another person's aid because the person has lost the capacity of independent transportation or is disoriented.

History: *1986 c 397 s 3; 1987 c 337 s 58; 1989 c 330 s 18; 1990 c 551 s 1-4*

62A.48 LONG-TERM CARE POLICIES.

Subdivision 1. **Policy requirements.** No individual or group policy, certificate, subscriber contract, or other evidence of coverage of nursing home care or other long-term care services shall be offered, issued, delivered, or renewed in this state, whether or not

the policy is issued in this state, unless the policy is offered, issued, delivered, or renewed by a qualified insurer and the policy satisfies the requirements of sections 62A.46 to 62A.56. A long-term care policy must cover prescribed long-term care in nursing facilities and at least the prescribed long-term home care services in section 62A.46, subdivision 4, clauses (1) to (5), provided by a home health agency. Coverage under a long-term care policy AA must include: a maximum lifetime benefit limit of at least $100,000 for services, and nursing facility and home care coverages must not be subject to separate lifetime maximums. Coverage under a long-term care policy A must include: a maximum lifetime benefit limit of at least $50,000 for services, and nursing facility and home care coverages must not be subject to separate lifetime maximums. Prior hospitalization may not be required under a long-term care policy.

Coverage under either policy designation must cover preexisting conditions during the first six months of coverage if the insured was not diagnosed or treated for the particular condition during the 90 days immediately preceding the effective date of coverage. Coverage under either policy designation may include a waiting period of up to 90 days before benefits are paid, but there must be no more than one waiting period per benefit period. No policy may exclude coverage for mental or nervous disorders which have a demonstrable organic cause, such as Alzheimer's and related dementias. No policy may require the insured to be homebound or house confined to receive home care services. The policy must include a provision that the plan will not be canceled or renewal refused except on the grounds of nonpayment of the premium, provided that the insurer may change the premium rate on a class basis on any policy anniversary date. A provision that the policyholder may elect to have the premium paid in full at age 65 by payment of a higher premium up to age 65 may be offered. A provision that the premium would be waived during any period in which benefits are being paid to the insured during confinement in a nursing facility must be included. A nongroup policyholder may return a policy within 30 days of its delivery and have the premium refunded in full, less any benefits paid under the policy, if the policyholder is not satisfied for any reason.

No individual long-term care policy shall be offered or delivered in this state until the insurer has received from the insured a written designation of at least one person, in addition to the insured, who is to receive notice of cancellation of the policy for nonpayment of premium. The insured has the right to designate up to a total of three persons who are to receive the notice of cancellation, in addition to the insured. The form used for the written designation must inform the insured that designation of one person is required and that designation of up to two additional persons is optional and must provide space clearly designated for listing between one and three persons. The designation shall include each person's full name, home address, and telephone number. Each time an individual policy is renewed or continued, the insurer shall notify the insured of the right to change this written designation.

The insurer may file a policy form that utilizes a plan of care prepared as provided under section 62A.46, subdivision 5, clause (1) or (2).

Subd. 2. **Per diem coverage.** If benefits are provided on a per diem basis, the minimum daily benefit for care in a nursing facility must be the lesser of $60 or actual charges under a long-term care policy AA or the lesser of $40 or actual charges under a long-term care policy A and the minimum benefit per visit for home care under a long-term care policy AA or A must be the lesser of $25 or actual charges. The home care services benefit must cover at least seven paid visits per week.

Subd. 3. **Expense-incurred coverage.** If benefits are provided on an expense-incurred basis, a benefit of not less than 80 percent of covered charges for prescribed long-term care must be provided.

Subd. 4. **Loss ratio.** The anticipated loss ratio for long-term care policies must not be less than 65 percent for policies issued on a group basis or 60 percent for policies issued on an individual or mass-market basis.

Subd. 5. **Solicitations by mail or media advertisement.** For purposes of this section, long-term care policies issued as a result of solicitations of individuals through mail or

mass media advertising, including both print and broadcast advertising, shall be treated as individual policies.

Subd. 6. **Coordination of benefits.** A long-term care policy may be secondary coverage for services provided under sections 62A.46 to 62A.56. Nothing in sections 62A.46 to 62A.56 shall require the secondary payor to pay the obligations of the primary payor nor shall it prevent the secondary payor from recovering from the primary payor the amount of any obligation of the primary payor that the secondary payor elects to pay.

There shall be no coordination of benefits between a long-term care policy and a policy designed primarily to provide coverage payable on a per diem, fixed indemnity or non-expense-incurred basis, or a policy that provides only accident coverage.

Subd. 7. **Existing policies.** Nothing in sections 62A.46 to 62A.56 prohibits the renewal of the following long-term care policies:

(1) policies sold outside the state of Minnesota to persons who at the time of sale were not residents of the state of Minnesota;

(2) policies sold before August 1, 1986; and

(3) policies sold before July 1, 1988, by associations exempted from sections 62A.31 to 62A.44 under section 62A.31, subdivision 1a.

Subd. 8. **Cancellation for nonpayment of premium.** No individual long-term care policy shall be canceled for nonpayment of premium unless the insurer, at least 30 days before the effective date of the cancellation, has given notice to the insured and to those persons designated pursuant to section 62A.48, subdivision 1, at the address provided by the insured for purposes of receiving notice of cancellation.

History: *1986 c 397 s 4; 1987 c 337 s 59-62; 1988 c 689 art 2 s 8; 1989 c 209 art 2 s 1; 1989 c 330 s 19; 1990 c 551 s 5-7*

62A.50 DISCLOSURES AND REPRESENTATIONS.

Subdivision 1. **Seal or emblems.** No graphic seal or emblem shall be displayed on any policy, or in connection with promotional materials on policy solicitations, that may reasonably be expected to convey to the purchaser that the policy form is approved, endorsed, or certified by a state or local unit of government or agency, the federal government, or a federal agency.

Subd. 2. **Cancellation notice.** Long-term care policies issued on a nongroup basis must have a notice prominently printed on the first page of the policy stating that the policyholder may return the policy within 30 days of its delivery and have the premium refunded in full if the policyholder is not satisfied for any reason. A solicitation for a long-term care policy to be issued on a nongroup basis pursuant to a direct-response solicitation must state in substance that the policyholder may return the policy within 30 days of its delivery and have the premium refunded in full if the policyholder is not satisfied for any reason.

Subd. 3. **Disclosures.** No long-term care policy shall be offered or delivered in this state, whether or not the policy is issued in this state, and no certificate of coverage under a group long-term care policy shall be offered or delivered in this state, unless a statement containing at least the following information is delivered to the applicant at the time the application is made:

(1) a description of the benefits and coverage provided by the policy and the differences between this policy, a supplemental Medicare policy and the benefits to which an individual is entitled under parts A and B of Medicare and the differences between policy designations A and AA;

(2) a statement of the exceptions and limitations in the policy including the following language, as applicable, in bold print: "THIS POLICY DOES NOT COVER ALL NURSING CARE FACILITIES OR NURSING HOME, HOME CARE, OR ADULT DAY CARE EXPENSES AND DOES NOT COVER RESIDENTIAL CARE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH FACILITIES AND EXPENSES ARE COVERED BY YOUR POLICY.";

(3) a statement of the renewal provisions including any reservation by the insurer of the right to change premiums;

(4) a statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions;

(5) an explanation of the policy's loss ratio including at least the following language: "This means that, on the average, policyholders may expect that $..... of every $100 in premium will be returned as benefits to policyholders over the life of the contract.";

(6) a statement of the out-of-pocket expenses, including deductibles and copayments for which the insured is responsible, and an explanation of the specific out-of-pocket expenses that may be accumulated toward any out-of-pocket maximum as specified in the policy;

(7) the following language, in bold print: "YOUR PREMIUMS CAN BE INCREASED IN THE FUTURE. THE RATE SCHEDULE THAT LISTS YOUR PREMIUM NOW CAN CHANGE.";

(8) the following language, if applicable, in bold print: "IF YOU ARE NOT HOSPITALIZED PRIOR TO ENTERING A NURSING HOME OR NEEDING HOME CARE, YOU WILL NOT BE ABLE TO COLLECT ANY BENEFITS UNDER THIS PARTICULAR POLICY."; and

(9) a signed and completed copy of the application for insurance is left with the applicant at the time the application is made.

History: *1986 c 397 s 5; 1987 c 337 s 63; 1988 c 689 art 2 s 9*

62A.52 REVIEW OF PLAN OF CARE.

The insurer may review an insured's plan of care at reasonable intervals, but not more frequently than once every 30 days.

History: *1986 c 397 s 6*

62A.54 PROHIBITED PRACTICES.

Unless otherwise provided for in Laws 1986, chapter 397, sections 2 to 8, the solicitation or sale of long-term care policies is subject to the requirements and penalties applicable to the sale of Medicare supplement insurance policies as set forth in sections 62A.31 to 62A.44.

It is misconduct for any agent or company to make any misstatements concerning eligibility or coverage under the medical assistance program, or about how long-term care costs will or will not be financed if a person does not have long-term care insurance. Any agent or company providing information on the medical assistance program shall also provide information about how to contact the county human services department or the state department of human services.

History: *1986 c 397 s 7; 1988 c 689 art 2 s 10*

62A.56 RULEMAKING.

Subdivision 1. **Permissive.** The commissioner may adopt rules pursuant to chapter 14 to carry out the purposes of sections 62A.46 to 62A.56. The rules may:

(1) establish additional disclosure requirements for long-term care policies designed to adequately inform the prospective insured of the need and extent of coverage offered;

(2) prescribe uniform policy forms in order to give the purchaser of long-term care policies a reasonable opportunity to compare the cost of insuring with various insurers; and

(3) establish other reasonable minimum standards as needed to further the purposes of sections 62A.46 to 62A.56.

Subd. 2. **Mandatory.** The commissioner shall adopt rules under chapter 14 establishing general standards to ensure that assessments used in the prescribing of long-term care are reliable, valid, and clinically appropriate.

History: *1986 c 397 s 8; 1990 c 551 s 8*

62A.60 RETROACTIVE DENIAL OF EXPENSES.

In cases where the subscriber or insured is liable for costs beyond applicable copayments or deductibles, no insurer may retroactively deny payment to a person who is covered when the services are provided for health care services that are otherwise covered, if the insurer or its representative failed to provide prior or concurrent review or authorization for the expenses when required to do so under the policy, plan, or certificate. If prior or concurrent review or authorization was provided by the insurer or its representative, the insurer may not deny payment for the authorized service or time period except in cases where fraud or substantive misrepresentation occurred.

History: *1989 c 330 s 20*

62A.62 DEMONSTRATION PROJECT.

Subdivision 1. **Establishment.** The commissioner shall establish demonstration projects to allow health insurers regulated under this chapter and nonprofit health service plan corporations regulated under chapter 62C to extend coverage for health and services to individuals or groups currently unable to afford such coverage. For purposes of this section, the commissioner may recommend legislation granting an exemption from minimum benefits required under chapter 62A, and any applicable rules if there is reasonable evidence that the rules prohibit the operation of the demonstration project. The commissioner shall provide for public comment before recommending an exemption from any statute or rule.

Subd. 2. **Application and approval.** An insurer or health service plan corporation electing to participate in a demonstration project shall apply to the commissioner for approval on a form developed by the commissioner. The application shall include at least the following:

(1) a statement identifying the population that the project is designed to serve;

(2) a description of the proposed project including a statement projecting a schedule of costs and benefits for the enrollee;

(3) reference to the sections of Minnesota Statutes and department of commerce rules for which waiver is requested;

(4) evidence that application of the requirements of applicable Minnesota Statutes and department of commerce rules would, unless waived, prohibit the operation of the demonstration project;

(5) an estimate of the number of years needed to adequately demonstrate the project's effects; and

(6) other information the commissioner may reasonably require.

Subd. 3. **Commissioner's review of application for demonstration project.** The commissioner shall approve, deny, or refer back to the insurer or health service plan corporation for modification, the application for a demonstration project within 60 days of receipt from the insurer or health service plan corporation. If the commissioner approves a project that requires legislation exempting the project from minimum benefit requirements, the commissioner shall make the approval contingent on enactment of the required legislation.

Subd. 4. **Length of project.** The commissioner may approve an application for a demonstration project for a maximum of six years, with an option to renew.

Subd. 5. **Report required.** Each insurer or health service plan corporation for which a demonstration project is approved shall annually file a report with the commissioner summarizing the project's experience at the same time it files its annual report. The report shall be on a form developed by the commissioner and shall be separate from the annual report.

Subd. 6. **Approval may be rescinded.** The commissioner may rescind approval of a demonstration project if the commissioner finds that the project's operation is contrary to the information contained in the approved application.

Subd. 7. **Applicability.** This section does not apply to the demonstration project established under section 256B.73.

History: *1990 c 568 art 3 s 2*