

PRODUCT OUTLINE
INDIVIDUAL SPECIFIED DISEASE COVERAGE
RECURRING (Conditions benefits on ongoing treatment)
As of 8/1/03

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I. Overview of Specified Disease Coverage in New York State

A product outline dealing with specified disease coverage should explain the development of the coverage in New York State. The overview will attempt to explain for the reader how specified disease coverage came to be a recognized category of health insurance in New York State, where specified disease coverage fits in the health insurance market place of New York State and why it is regulated in the manner set forth in this product outline.

Coverage of one or a few illnesses or diseases began to be offered nationally on a more prevalent basis sometime during the middle of the 1970s. The trend spread to New York State during this time period, but New York State took the position that “stand alone” coverage of this nature did not meet the statutory requirements set forth in Section 3217(b)(5) of the Insurance Law. The provision of coverage for one or a few illnesses or diseases was considered too limited in scope and to be of no substantial economic value for policyholders/certificateholders. The health insurance consumer was considered much better off if he/she devoted his/her premium dollars toward more comprehensive coverages which covered any illness or disease or injury.

There were arguments at the time that specified disease coverage provided coverage for certain needs which every comprehensive coverage may not meet. For example, arguments were made that large deductible amounts or co-pays of comprehensive coverages could be defrayed by a specified disease coverage. Consequential expenses of a serious illness or disease not covered by a comprehensive coverage (e.g.- room and board expenses associated with family members accompanying an ill insured for treatments in distant cities, extended income losses of an insured or family member due to serious illnesses or diseases, catastrophic expenses of a serious illness or disease exceeding the limits of comprehensive coverages) could be covered by a specified disease coverage.

In view of the above arguments, the Department did permit coverage for specified diseases on a supplemental basis. In keeping with Section 3217(b)(5) the Department did not allow “stand alone” policies/certificates providing specified disease coverage. However, the Department was willing to allow specified disease riders or optional benefits to be attached to comprehensive coverage meeting at least the minimum benefit levels of Section 52.5 (basic hospital insurance), Section 52.6 (basic medical insurance) or Section 52.7 (major medical insurance) of Regulation 62. Thus, the treatment of specified disease coverage as strictly a supplemental health insurance coverage in New York’s regulations took root.

During the middle of the 1990s, the Department again undertook a review of specified disease coverage. The health insurance market place was very different from the 1970s. Individual health insurance coverage and small group health insurance coverage of a comprehensive nature were mandated to be open enrolled and community rated by the mid-1990s. In addition to the concerns raised above under Section 3217(b)(5), there was now an apprehension that underwritten specified disease coverage which was not community rated could serve as a way for healthier and younger insureds to obtain some coverage for more catastrophic diseases and avoid the open enrolled and community rated comprehensive health insurance markets. This avoidance of the community rated markets by healthier and younger insureds would adversely impact the community rates for more comprehensive coverages.

The draft regulations of the Department to allow specified disease coverage were controversial and even subjected to a legislative hearing. The eventual final regulations of the Department (Twenty-Second Amendment to Regulation 62 (11 NYCRR 52), Fifth Amendment to Regulation 145 (11 NYCRR 360), and Second Amendment to Regulation 146 (11 NYCRR 361)) took into account the concerns noted above.

The Twenty-Second Amendment to Regulation 62 contains provisions to aid in ensuring that specified disease coverage is only issued to persons covered by more comprehensive coverages (see Section 52.15(b)(12)(13)(14) of Regulation 62). The same amendment makes clear that specified disease coverage is an indemnity coverage which pays benefits on a basis unrelated to hospital, medical or surgical expenses incurred, and it contains provisions intended to ensure the consumer realizes the coverage is limited and covers only one disease or a few diseases (see Section 52.15 (b)(5)(9)(10)(15), (c) and (d). These provisions aid in assuring that younger and healthier lives in the health insurance market should only have specified disease coverage as an adjunct to open enrolled and community rated comprehensive health insurance. Also, specified disease coverage is regulated as a coverage supplemental to comprehensive health coverage.

Since specified disease coverage is regulated as supplemental coverage to comprehensive and open enrolled and community rated coverage, that fact is recognized in Regulation 145 (11 NYCRR 360 – Sections 360.2(c) and 360.2(f)) which sets standards for open enrolled and community rated coverages. That fact is also recognized in Regulation 146 (11 NYCRR 361 – Sections 361.2(j) and 361.2(p)) which sets standards for market stabilization mechanisms in the open enrolled and community rated health insurance markets.

II. Key References

Key Insurance Law Sections –3102, 3105, 3201 (form approval issues), 3216 especially 3216(d)(1) and (2) (standard provisions), 3204 (contract/application issues).

Key Applicable Regulations – Regulation 62 (11 NYCRR 52) minimum standards for form, content and sale of health insurance including Sections 52.2 (definitions), 52.15 (specified disease coverage), 52.16 (permissible exclusions), 52.17 (individual form content), 52.31 (form submission), 52.33 (submission letter), 52.40 (rate filing), 52.41 (gross premium differentials based on sex), 52.43 (experience maintenance standards), 52.44 (experience filing standards), 52.45 (minimum loss ratio standards), 52.47 (experience monitoring), 52.51 (applications), 52.53 (conditional receipts/interim insurance agreements), Sections 52.15(b)(5) and 52.66 (disclosure statement requirements), 52.70(a), (b) and (c) (special rules for franchise insurance); Regulation 169 (11 NYCRR 420) privacy of consumer financial and health information including Section 420.18

Key Circular Letters – Circular Letter No. 3 (1989), Circular Letter No. 5 (1997)

III. Cover Page

1. The cover page must prominently indicate the licensed New York insurer's name and full address. Full street address of the company's home office in prominent place (generally front and back of policy form) for disclosure purposes. No unlicensed entity in New York State should appear on the form. Section 3201(c)(1)
2. Include name of product as "Specified Disease Coverage" on the form within the defined category of Section 52.15(a) of Regulation 62.
3. Include as required by Section 52.15(b)(9) on the first page of the policy in boldface type in at least 14-point size, but not less than the size of type used for policy captions, a prominent statement as follows:

“This is a limited policy. It pays benefits for (name of specified disease) treatment only. Read it carefully with the Required Disclosure Statement.”

4. Include “free look” provision of 10-20 days within parameters of Section 3216(c)(10). A 30 day provision is acceptable since it is more favorable to the insured than the statute.
5. Unique form identification number in lower left-hand corner of form. Section 52.31(d)
6. Renewability provisions of form must be placed on the front page of the policy form. Sections 52.17(a)(1) and (2)
7. The policy must be “Guaranteed Renewable for Life”. The term “guaranteed renewable” as defined in Section 52.17(a)(6)(7) as modified by Section 52.15(b)(3) means the insured has the right to continue the policy in force for life by the timely payment of premiums. While the insured continues to timely pay premiums, the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.

A second option for the insurer would be to make the specified disease coverage “Noncancellable and Guaranteed Renewable for Life.” In that instance Section 52.15(b)(3) and Section 52.17(a)(5) would be relevant. This term means the insured has the right to continue the policy in force for life by the timely payment of premiums. While the insured continues to timely pay premiums, the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.

Since Section 52.15(b)(3) does not require any specified disease policy to be “Noncancellable for Life”, a possible third option for the insurer would be to make the specified disease coverage “Noncancellable to Age 65 but Guaranteed Renewable For Life”. This term means the insured has the right to continue the policy in force for life by the timely payment of premiums. While the insured continues to timely pay premiums, the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes commencing with the policy anniversary on or after the insured's 65th birthday.

Unlike a non-recurring (lump sum) specified disease coverage model, it is difficult to conceive of a situation where a recurring specified disease coverage model terminates by its own terms. This is due to Section 52.15(c)(6)(iii) of Regulation 62 (11 NYCRR 52). This regulatory section requires a recurring specified disease coverage model to provide a benefit period of at least two years for the minimum benefits stated in Section 52.15(c)(6). It also requires a restoration of the benefit period (new benefit period) if benefits under the recurring specified disease coverage model are not payable for a period of 180 days.

In a recurring specified disease coverage model which must be “Guaranteed Renewable for Life”, the insurer cannot take the position the recurring coverage has terminated by its own terms upon exhaustion of benefits (as stated in Section 52.15(c)(6)) in a benefit period. If benefits are not payable for a period of 180 days (e.g.- the insured recovers to a point where benefits are not payable for 180 days), the insured is entitled to receive a new benefit period with new benefits. Thus, in the recurring specified disease coverage model, it is the insured's decision whether to end coverage for the Section 52.15(c)(6) benefits (assuming timely premium payments by the insured) because the insured may be able to trigger the benefit period restoration requirement at some point.

8. If the policy will be issued to persons eligible for Medicare (due to age or disability), the policy must have a notice printed on or attached to the first page of the disclosure statement

delivered to insureds to comply with Section 52.66 or to the first page of the policy which notifies the buyer as follows:

“THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company”. Section 52.17(a)(33)(i).

The notice shall be in no less than 12-point type.

9. The signature of one or more company officers should appear on the face page to execute the contract on behalf of the company.
10. If the policy is participating, the cover page must contain a statement to that effect. Section 3216(c)(1)

IV. Policy Schedule Page

1. Complete with hypothetical data. Section 52.31(f)
2. Premium summary amounts should appear. Section 52.31(f) and Section 3216(c)(1)
3. Choices of insured as to fixed sum payments payable upon hospital confinements, medically appropriate out patient treatment, resultant costs coverage, probationary period time provisions complying with Section 52.15(c)(3) and similar varying elements of the policy should be set forth. Section 52.31(f) and 3204(a).
4. Name of insured space. Section 52.31(f) and Section 3216(c)(3)
5. Spaces for effective date of insurance, renewal dates and renewal terms. Section 52.31(f) and Section 3216(c)(2)
6. Optional choices of insured regarding certain benefits and/or riders should be set forth – originates from Section 52.31(f) and Section 3204(a)(1)

V. Table of Contents

1. Table of Contents must be included when required. – Section 3102(c)(1)(G)

VI. Regulatory Requirements for Specified Disease Coverage- General Rules

The Twenty-Second Amendment to Regulation 62 which, in part, sets minimum benefit standards for specified disease coverage in New York State became effective on April 15, 1998. The portion of the Twenty-Second Amendment which contains the core requirements for specified disease coverage is found in Section 52.15 of Regulation 62.

1. Definition –Specified disease coverage is defined in Section 52.15(a). In that regulatory section, specified disease coverage is defined as a policy which pays benefits on an indemnity basis for the diagnosis and treatment of a specifically named disease or diseases, which are life threatening in nature and could cause a person to incur substantial financial out of pocket expenses for the diagnosis and treatment of a specifically named disease or diseases.

The Department views this definition as proscribing specified disease coverages which would attempt to cover illnesses or diseases of a more routine nature. For example, an insurer which

attempted to design a policy for the common cold would not be designing coverage for a disease which is life threatening in nature and results in substantial financial out-of-pocket expenses. Usual comprehensive coverages would satisfactorily cover such an illness, and the need for a limited supplemental coverage to the comprehensive coverage would be questionable. Such a policy design would be contrary to Section 3217(b)(5) of the Insurance Law.

It should be noted that the recurring specified disease coverage model in Section 52.15(c) (opening language) and in Section 52.15(c)(5)(6) indicates that such coverage is written on an indemnity basis and pays fixed sum or limited lump sum payments. Although such an indemnity model conditions payment of these fixed sums and limited lump sum payments on ongoing treatment, the indemnity model is unrelated to the charges actually incurred for treatment and pays its benefits when treatment is received unrelated to charges for the treatment. In essence, the indemnity recurring model uses treatment(s) as a trigger for benefit payment, but the benefit payments are calculated without regard to the actual charges incurred for treatment(s).

2. Section 52.15(b)(1) of Regulation 62 requires that all forms of the specified disease or diseases must be covered.

This requirement is intended to assure that the limited specified disease coverage does not become unduly fragmented by only covering certain types of a disease. This would be contrary to Section 3217(b)(5) of the Insurance Law.

3. Any specified disease policy that conditions payments upon pathological diagnosis of a covered disease, shall also provide that if such a pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted in lieu thereof. Any type of medically appropriate diagnosis shall be accepted by the insurer.

In general, the Department requires a policy to contain this three tiered explanation of diagnoses. A specified disease insurer should not be able to deny benefits due to a fragmented definition of diagnoses. A method of diagnosis generally accepted by the medical community for a particular disease should be accepted by a specified disease insurer. (Section 52.15 (b)(2))

In general, a recurring model specified disease policy requires a specified disease to be diagnosed in a certain manner before benefits will be paid. The diagnosis is an anti-selection mechanism to be certain the insured actually has the specified disease covered by the policy. In addition to diagnosis, the recurring model specified disease policy generally requires certain treatment services to be received before fixed sum benefits are paid.

4. Section 52.15(b)(3) of Regulation 62 requires that an individual policy containing specified disease coverage must be at least guaranteed renewable for life.
5. Section 52.15(b)(4) of Regulation 62 requires that benefits for specified disease coverage will be paid regardless of other coverage, except for any policy provision regarding other insurance with the insurer. Section 3216(d)(2)(C) of the Insurance Law sets forth the optional standard provision for "Other Insurance in This Insurer". This regulatory section indicates the specified disease policy does not coordinate benefits with other group or individual specified disease coverage, and always pays its benefits regardless of what other comprehensive coverage an insured has. See XI.2 and 3 also.
6. Except in the case of direct response insurers, no specified disease policy will be delivered or issued for delivery in New York State unless the appropriate disclosure form in Section 52.66

of Regulation 62 describing the policy's benefits, limitations and exclusions, and expected benefit ratio is delivered to the applicant at the time application is made and written acknowledgement of receipt or certification of delivery of such disclosure form is provided to the insurer. Direct response insurers will deliver the requisite disclosure form at the time the policy is delivered. 52.15(b)(5)

Please note that Section 52.66 contains two disclosure statement formats. One format is for persons less than 65 years of age, and the other format is for persons who are age 65 or older. The format for persons less than age 65 clarifies that specified disease coverage does not provide basic hospital, basic medical or major medical coverage. The format for persons age 65 and older clarifies that specified disease coverage does not provide Medicare supplement insurance, long term care insurance, nursing home insurance only, home care insurance only or nursing home and home care insurance. The format for persons age 65 and older also indicates an applicant may contact the local Social Security Office or the insurer to obtain a copy of the Guide to Health Insurance for People with Medicare.

7. Section 52.15(b)(8) of Regulation 62 requires an insurer to file its overinsurance rules with the Insurance Department. Overinsurance is deemed to exist when an insured has more than one specified disease policy or certificate for the same specified disease whether it is with the same or a different insurer. Also, in no event may an insurer issue a specified disease policy to any person that will result in that person being covered for eight or more specified diseases. Therefore, the maximum number of specified diseases for which an individual may be covered is seven, regardless of the number of insurers. See XIII below for insurer requirements to inquire about these issues on the application form.
8. No advertisement of a policy will imply coverage beyond the terms of the policy. Synonymous terms will not be used to refer to any disease so as to imply broader coverage than is the fact. 52.15(b)(10)
9. A specified disease policy where a benefit is a lump sum payment for the diagnosis of a specified disease without further coverage conditioned upon treatment of the disease can only be offered if it meets the requirements set forth in Section 52.15(d) of Regulation 62. Such a lump sum policy must also meet the requirements of Section 52.15(a)(b). See the pertinent outline and checklist dealing with that type of specified disease coverage.
10. Specified disease coverage will only be issued to persons who are covered by either at least major medical insurance as defined in Section 52.7 of Regulation 62 or at least basic hospital insurance and basic medical insurance as defined in Sections 52.5 and 52.6 of Regulation 62. 52.15(b)(12). See XIII below for insurer requirements to inquire about these issues on the application form.
11. No later than 30 days following delivery of the policy, the insurer must ask the insured person(s) in a written request whether the insured person(s) has in force at least major medical insurance or at least basic hospital insurance and basic medical insurance on the effective date of the specified disease coverage. Where the insured person(s) responds to the insurer in writing that such underlying coverage is not in force on the effective date of the specified disease coverage, the policy will be voided from its beginning with a full premium refund. The method by which the insurer implements these requirements must be approved by the Superintendent. 52.15(b)(14)

In reviewing the method used by any specified disease insurer to implement Section 52.15(b)(14), the Department requires that every insured person covered by the policy be asked in writing about underlying coverage in force on the effective date of the specified disease coverage. For example, where family coverage is issued under Section 3216(c)(3) of

the Insurance Law, a spouse and dependent children as well as the primary policyholder must be asked in writing about underlying coverage in force on the effective date of the specified disease coverage. When underlying coverage is not in force for the primary policyholder on the effective date of the specified disease coverage, the policy will be voided from the beginning with a full premium refund. When the primary policyholder has underlying coverage in force but one or more dependents do not, the coverage for the dependents without underlying coverage in force on the effective date of the specified disease coverage will be voided with a commensurate premium refund.

12. Reductions in specified disease benefits such as when certain events occur or ages are reached are not permissible. For example, benefits cannot be reduced by 50% because the insured is age 70 at the time triggering services are received. 52.15(b)(16)

VII. Regulatory Rules Relating to Specified Disease Coverage Written on an Indemnity and Recurring Basis

1. Section 52.15(c)(1) of Regulation 62 indicates that a policy shall provide benefits to any covered person not only for the specified disease(s) but also for any other condition(s) or disease(s) directly caused or aggravated by the specified disease(s) or the treatment of the specified disease(s).

The Department promulgated this regulatory section to avoid undue fragmentation of the benefit trigger(s) causing a recurring specified disease policy to pay benefits. In a recurring specified disease model, a person who is hospitalized for cancer surgery would trigger payment of the fixed sum for hospital confinement required by Section 52.15(c)(6)(i)(a) of Regulation 62.

The Department became aware that in other jurisdictions some specified disease insurers would not pay for days of hospital confinement when the confinement was only related to the specified disease. For example, a person readmitted to the hospital after cancer surgery due to adverse effects of chemotherapy might have payment of the fixed sum denied because the specified disease insurer indicated the confinement was triggered by chemotherapy and not the specified disease of cancer. The person was receiving chemotherapy due to the presence of cancer, and the Department believes such a denial would be contrary to Sections 3201(c)(3) and 3217(b)(5) of the Insurance Law. This regulatory section was promulgated so specified disease insurers could not engage in artificial and strained distinctions regarding benefit triggers to avoid benefit payments under a limited policy.

2. Section 52.15(c)(2) indicates that payments made under a specified disease recurring model policy may be conditioned upon a covered person receiving medically necessary care or treatment, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment.

This regulatory section was promulgated to address legitimate anti-selection concerns of specified disease insurers. It provides clarification for the benefit triggers stated in the opening language of Section 52.15(c) and Section 52.15(c)(5)(6). Although payments made under a recurring specified disease model are unrelated to actual charges incurred by an insured and treatment(s) are only a trigger for benefit payments, specified disease insurers have indicated that those triggers can be manipulated by the unscrupulous insured to obtain specified disease recurring model benefit payments.

For example, the Section 52.15(c)(6)(ii) fixed sum payment for home health care could be manipulated by the unscrupulous insured. In order to obtain these fixed sum payments for at least 100 days, the unscrupulous insured might attempt to have such care even though it is not

medically necessary or not given in a medically appropriate location or not a course of treatment accepted by the medical community. Payment of the fixed sum in such inappropriate circumstances worsens policy experience needlessly causing premiums to rise. Therefore, Section 52.15(c)(2) permits the recurring model specified disease insurer to protect itself against such unscrupulous behavior of an insured.

3. Section 52.15(c)(3) contains a permissive probationary period requirement. The recurring model specified disease insurer is free to use or not use a probationary period requirement, but, if a probationary period is used, it must be at least as favorable as the one contained in this regulatory section.

The recurring model specified disease probationary period requires a probationary period of no greater than 30 days from the coverage effective date. The Section 52.15(c)(3) requirement is, therefore, consistent with the Section 52.16(d)(1) permissive probationary period for health coverages not subject to the open enrollment requirements of Section 3231 of the Insurance Law.

During the 30 day probationary period, the recurring model specified disease insurer can take one of two described actions for a specified disease diagnosed within the initial 30 days of coverage. One such action is to void the policy from its beginning with a full premium refund to the insured. The other action is to delay coverage for the specified disease diagnosed within the initial 30 days of coverage for a period not to exceed 12 months from the coverage effective date. The recurring model specified disease insurer must describe both actions in its probationary period language, and this language must allow the insured the option to elect whether coverage is voided with a full premium refund or coverage is delayed.

This regulatory section indicates that no other probationary period can be imposed past 30 days from the coverage effective date. The Department considered the arguments for a probationary period in view of the other alternatives a specified disease insurer may use to protect against anti-selection (e.g. – pre-existing condition limit—see below—and the ability to extensively medically underwrite). A probationary period of no greater than 30 days from the coverage effective date was considered to be reasonable so that an insurer could void coverage with a full premium refund or delay coverage for a period not to exceed 12 months when a specified disease covered by the policy was diagnosed within the initial 30 days of coverage.

The recurring specified disease model may be subject to insured manipulation when an applicant is not truthful on an application, and/or he/she may know or suspect the presence of a specified disease before seeking medical treatment. These techniques may be particularly problematic in a specified disease policy where medical underwriting is limited. Without some type of probationary period to protect against antiselection, some specified disease insurers have indicated fraud may be encouraged.

The recurring model probationary period allows coverage avoidance with a full premium refund or a delay in coverage up to 12 months because the recurring model conditions benefits on ongoing treatment, allows a 2 year benefit period and allows a restoration of the 2 year benefit period. Unlike the non-recurring (lump sum) model, the recurring model may pay fixed benefits over a long time period rather than a substantial monetary sum on initial diagnosis. Therefore, the added option of coverage delay takes account of the possible longer term payout of the recurring model. Also, giving the insured the choice of coverage avoidance or coverage delay allows the insured to control the probationary period penalty. The insured with an expected long term disease thus has an option of coverage even if provided on a delayed basis.

4. Section 52.15(c)(4) requires that benefits in a specified disease recurring model begin with the first day of medical care or hospital confinement if such care or confinement is for a covered disease, even though the diagnosis is made at some later date.

This regulatory section clarifies that the fixed sum payments of a recurring specified disease model are conditioned upon ongoing treatment, and not only diagnosis of the specified disease. (Diagnosis of the specified disease is also relevant in the non-recurring (lump sum) specified disease model. See that product outline for details.) Assuming that the ongoing treatment is medically necessary and appropriate, when the actual diagnosis is made should not result in denial of fixed sum payments only because ongoing treatment benefit triggers occurred before diagnosis.

For example, a recurring model specified disease policy which covers heart disease should not deny payment of fixed sum benefits for days of hospital confinement occurring before heart disease diagnosis. An insured with chest pain might be hospitalized and tested for a time period before an exact diagnosis of heart disease occurs. Section 52.15(c)(6)(i)(a) fixed sum payments should be made for the days of hospital confinement occurring before the official diagnosis. To do otherwise is violative of Section 3217(b)(2)(5) of the Insurance Law.

5. Section 52.15(c)(5) indicates that a lump sum payment no greater than \$5,000 may be made to cover resultant costs such as travel, lodging, household costs and other living expenses. This type of benefit is sometimes referred to as a “First Occurrence” benefit, and it is paid upon diagnosis of the specified disease(s) covered by the recurring model specified disease coverage. The lump sum of money paid out is intended to allow an insured to have money to pay those consequential expenses noted in I. above.

When promulgating the Twenty-Second Amendment to Regulation 62, the Department became aware that the specified disease market as currently structured generally offered the recurring model coverage described in this outline, and the non-recurring (lump sum) model described in another outline. The industry approached the provision of specified disease coverage by paying large fixed sums upon diagnosis of a specified disease (essentially to be used at the insured’s discretion), or the specified disease coverage paid smaller fixed sum amounts over a longer time period (unrelated to actual charges for treatments) conditioned upon ongoing treatments and diagnosis. The smaller fixed sum amounts payable over time could be used at the insured’s discretion.

A lump sum payment of any amount in a recurring model coverage would begin to offer both the recurring model and non-recurring model together. Large lump sum payments would be paid upon diagnosis, and smaller fixed sum payments would be paid over a longer time period. Such a design would give the impression to a consumer the coverage is more comprehensive than it actually is. This is contrary to Section 3201(c)(3) of the Insurance Law.

Giving the illusion of comprehensive benefits in such a limited policy for one or a few diseases would be contrary to the supplemental nature of the coverage, and it would be contrary to the requirements in Section 52.15(b) that a person have actual underlying comprehensive coverage in order to purchase the limited specified disease coverage. Such an illusion of comprehensiveness might convince an insured to lapse his/her actual underlying comprehensive coverage and keep only the specified disease coverage with ongoing and substantial “lump sum” fixed payments unrelated to actual charges incurred. This would be contrary to Section 52.1(c) of Regulation 62 and Section 3217(b)(1)(2)(3) of the Insurance Law while adversely affecting the community rated pools of actual comprehensive coverages

marketed in New York State.

Therefore, the Department sets a \$5,000 monetary maximum on any lump sum payments to be paid in a recurring model specified disease coverage in Section 52.15(c)(5).

6. Section 52.15(c)(6) consists of several elements. Each element sets a minimum standard for the payment of a fixed sum benefit triggered by a particular type of ongoing treatment for a covered specified disease under the recurring model.

Section 52.15(c)(6)(i)(a) requires a fixed sum payment of at least \$200 for each day of triggering hospital confinement caused by a specified disease for at least 365 days.

Section 52.15(c)(6)(i)(b) requires a fixed sum payment of at least one-half of the benefit noted for Section 52.15(c)(6)(i)(a) for at least 365 days when triggering treatment occurs for hospital or non-hospital out-patient surgery. The fixed sum payment of Section 52.15(c)(6)(i)(b) is calculated for each day of triggering hospital or non-hospital out-patient surgery, and the one half fraction is applied to the actual fixed sum payment issued under Section 52.15(c)(6)(i)(a) which cannot be less than \$200 per day. (\$100 per day after application of the one-half fraction)

Section 52.15(c)(6)(i)(b)(1) requires a fixed sum payment of at least one-half of the benefit noted for Section 52.15(c)(6)(i)(a) for at least 365 days when triggering treatment occurs for chemotherapy and radiation therapy in a cancer only specified disease coverage. The fixed sum payment of Section 52.15(c)(6)(i)(b)(1) is calculated for each day of triggering chemotherapy and radiation therapy, and the one-half fraction is applied to the actual fixed sum payment issued under Section 52.15(c)(6)(i)(a) which cannot be less than \$200 per day. (\$100 per day after application of the one-half fraction)

Section 52.15(c)(6)(i)(b)(2) requires a fixed sum payment of at least one-half of the benefit noted for Section 52.15(c)(6)(i)(a) for at least 365 days when triggering treatment occurs for medically appropriate outpatient treatment for specified disease coverages other than for cancer only. The fixed sum payment of Section 52.15(c)(6)(i)(b)(2) is calculated for each day of triggering medically appropriate outpatient treatment, and the one-half fraction is applied to the actual fixed sum payment issued under Section 52.15(c)(6)(i)(a) which cannot be less than \$200 per day. (\$100 per day after application of the one-half fraction).

Section 52.15(c)(6)(ii) indicates the requirements for the triggering benefits of confinement in a skilled nursing home or for home health care. The triggering benefits of confinement in a skilled nursing home or for home health care are optional, but when these triggering benefits are included by an insurer the insurer must follow these requirements. If the specified disease coverage provides either of these options, the coverage must equal a fixed sum payment of at least one-fourth of the benefit noted for Section 52.15(c)(6)(i)(a) for at least 100 days. The minimum one-hundred days of payment is applied separately to the triggering benefits of confinement in a skilled nursing home or for home health care. The fixed sum payment is calculated for each day of skilled nursing home confinement or home health care, and the one-fourth fraction is applied to the actual fixed sum payment issued under Section 52.15(c)(6)(i)(a) which cannot be less than \$200 per day. (\$50 per day after application of the one-fourth fraction)

Section 52.15(c)(6)(ii) also imposes its own requirement regarding the restrictions or limitations which a recurring model specified disease insurer may impose on the triggering optional benefits of skilled nursing home confinement or home health care. Such restrictions or limitations can be no more restrictive than those imposed by the federal Medicare program notwithstanding any other provision of Regulation 62. For example, any such restriction or

limitation must be the more lenient of those allowed by the federal Medicare program or Section 52.16(c).

Section 52.15(c)(6)(iii) contains requirements for the recurring model specified disease product which pertain to deductible amounts, overall aggregate benefit limits for certain triggering services and benefit periods. The overall aggregate benefits limits described in Section 52.15(c)(6)(iii) are those which pertain to triggering services other than those triggering services described in Section 52.15(c)(6)(i)(ii).

Section 52.15(c)(6)(iii) does not allow a deductible amount in excess of \$250 in a recurring model specified disease policy. This same regulatory section requires that any recurring model specified disease policy contains no benefit period of less than two years. In addition, any recurring model specified disease policy with a benefit period must provide for a restoration of the benefit period of at least two years once benefits are not payable under the policy for a period of 180 days.

Section 52.15(c)(6)(iii) indicates that a recurring model specified disease policy must contain an overall aggregate benefit limit (for triggering services of the policy other than those described in Section 52.15(c)(6)(i)(ii)) of not less than \$10,000, per person. Any triggering services of the recurring model specified disease policy beyond those triggering services required by Section 52.15(c)(6)(i)(ii) would be subject to this minimum overall aggregate benefit limit.

7. Section 52.15(c)(7) sets forth minimum loss ratios for recurring model specified disease coverages. Those loss ratios are 60% in the case of individual insurance issued under the age of 65. In the case of individual insurance issued at ages 65 and over, the minimum loss ratio is 65% unless one rate is charged for all ages under 65 and 65 and over, and the policy is issued at all ages 25 and over, then the minimum loss ratio is 60%. For franchise insurance, the minimum loss ratio is 65%.

VIII. Regulatory Rules Relating to the Content of Forms for Individual Insurance that Must be Applied to Specified Disease Coverage

1. Reductions in benefits such as when certain events occur or ages are reached are not permissible. For example, benefits cannot be reduced by 50% because the insured is age 70 at the time triggering services are received. 52.15(b)(16)
2. Insurer must comply with Section 52.17(a)(9) of Regulation 62 and Sections 3216(c)(13) and (14) of the Insurance Law for insureds entitled to suspend coverage during periods of military service. When the statute and regulation are read together, an insured is entitled to the right to resumption upon termination of military service of no longer than five years.
3. Family policies may provide a new contestable period for each new member added, but shall not provide for a new contestable period for the policy – Section 52.17(a)(10) of Regulation 62. For example, if a spouse is added as a dependent to an inforce specified disease policy, a new contestable period for the spouse runs from the later spousal issuance date, but not a new contestable period for the primary insured previously issued coverage.
4. Insurer attaching any rider or endorsement that reduces or eliminates coverage after policy issuance shall provide for signed acceptance by the insured – Section 52.17(a)(12) of Regulation 62. See also Section 52.16(e)(2), however, for waivers issued as a condition of issuance, renewal or reinstatement.

5. Riders or endorsements providing a benefit for which a specific premium is charged shall show the premium on the application, rider or elsewhere in the policy – Section 52.17(a)(14) of Regulation 62.
6. Policies based upon attained age shall include the applicable schedule of rates – Section 52.17(a)(29) of Regulation 62.
7. No specified disease insurer shall refuse to issue coverage, cancel coverage or decline to renew coverage because of the sex or marital status of the applicant or policyholder – Section 2607 of the Insurance Law.
8. Section 52.17(a)(30) requires that a family policy shall provide for coverage for adopted children and stepchildren dependent upon the insured on the same basis as natural children.
9. Section 52.17(a)(31) requires that a family policy covering a proposed adoptive parent, on whom the child is dependent, shall provide that such child be eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption.
10. When applicable, Section 3216(c)(4)(C) of the Insurance Law contains requirements regarding coverage of newborns.

IX. Permissible Exclusions and Limitations on Coverage

The only permissible limitations or exclusions are those set forth in Sections 52.15(b)(6) and 52.16(c) of Regulation 62. In general, the exclusionary or limiting language can be no less favorable to the insured than these regulations.

1. The only permissible pre-existing condition limits are those that exclude coverage for no more than six months after the effective date of coverage under the policy for a condition for which medical advice was given or treatment was recommended by, or received from, a licensed health care provider within six months before the effective date of the coverage pursuant to Section 52.15(b)(6) of Regulation 62.

Some insurers have chosen to rely solely upon medical underwriting in specified disease coverage and not place any pre-existing condition limitations in policy language. The Department finds this approach acceptable.

Some insurers providing recurring model specified disease coverage may seek to impose a preexisting condition limit on a specified disease(s) covered by the policy. In the recurring model, the specified disease insurer essentially is indicating that, even if the insured has ongoing treatment for a covered specified disease and the fixed sum payments would otherwise be payable, the insurer will not pay those fixed sums for a covered specified disease meeting the Section 52.15(b)(6) requirements for a preexisting condition. The recurring model specified disease insurer availing itself of this preexisting condition mechanism desires protection from unscrupulous insureds who may have made misstatements on the application for coverage in order to obtain the fixed sum payments payable by the recurring model over a time period.

Although the recurring model specified disease coverage generally pays benefits once the triggering services of Section 52.15(c) occur, the recurring model may introduce the concept of “diagnosis” in determining whether a specified disease is a preexisting condition or not. (Also, see above where recurring model may use the concept of “diagnosis” to be certain the insured actually has the specified disease.) For example, the recurring model insurer may use the word “diagnosis” in describing a condition for which medical advice was given or

treatment was recommended by, or received from, a licensed health care provider within six months before the effective date of the coverage and which occurred within the first six months after the coverage effective date. “Diagnosis” in the recurring model is not necessarily only a trigger for benefit payment (unless the diagnosis occurs with a Section 52.15(c) triggering service), but “diagnosis” may also be the determining event of whether a preexisting condition limit is imposed to deny payment of fixed sums for ongoing receipt of triggering services.

Some recurring model insurers may desire to use the phrase “first diagnosed” or words of similar import when specifying the policy criteria to impose a preexisting condition limit. In brief, the words “first diagnosed” or similar terminology are used to indicate only diseases “first diagnosed” after the policy effective date will escape the imposition of the preexisting condition limitation of the recurring model.

For example, suppose an insured received medical treatment for a condition one year before the coverage effective date. Then assume the insurer took no underwriting action concerning the condition based upon a truthful application of the insured (i.e. – the insurer did not ask about the condition or otherwise took no action) and issued coverage. Also assume the insured received no further treatment for the condition after the treatment one year before the coverage effective date. Then assume the insured received treatment again one year after the coverage effective date.

A recurring model insurer predicating the imposition of a pre-existing condition limitation on “first diagnosis” would indicate fixed sum benefits will not be paid even though triggering services of Section 52.15(c) are ongoing. The insurer would equate the medical treatment one year before the coverage effective date with a diagnosis and deny benefits since the specified disease was not “first diagnosed” after the coverage effective date. However, this process does not comply with Section 52.15(b)(6). The treatment for the condition one year before the coverage effective date would be outside the six month time frame of Section 52.15(b)(6). The treatment for the condition one year after the coverage effective date would be outside the six month time frame of Section 52.15(b)(6). Thus, the condition would not be a “preexisting condition” and should be covered by the insurer. Insurers should use the term “diagnosed”, and rely upon wording in Section 52.15(b)(6) to have a permissible preexisting condition limitation.

2. Section 52.16(b) of Regulation 62 prohibits a specified disease policy from providing a return of premium or cash value benefit except return of unearned premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds.
3. If an insurer chooses to place an exclusion or limitation on coverage for mental or emotional disorders, it must comply with Section 52.16(c)(2) of Regulation 62.
4. If an insurer chooses to place an exclusion or limitation on coverage for treatment arising out of alcoholism or drug addiction it must comply with Section 52.16(c)(2) of Regulation 62 and Section 3216(d)(2)(K) as pertinent.
5. If insurer chooses to place an exclusion or limitation on coverage for pregnancy, it must comply with Section 52.16 (c)(3) of Regulation 62.
6. If an insurer chooses, it may place an exclusion or limitation on illness or medical condition arising out of:
 - war or act of war (whether declared or undeclared)

- participation in a felony, riot or insurrection
- service in the Armed Forces or units auxiliary thereto
- suicide, attempted suicide or intentionally self-inflicted injury
- aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline. These exclusions or limitations must comply with Section 52.16 (c)(4) of Regulation 62.

For felony participation, see also Section 3216(d)(2)(J) of the Insurance Law. For service in the armed forces, an insurer must also include a “suspension” provision complying with Sections 3216(c)(13)(14) of the Insurance Law and Section 52.17(a)(9).

7. If insurer chooses to place an exclusion or limitation on coverage for cosmetic surgery, must comply with Section 52.16(c)(5) of Regulation 62.
8. If insurer chooses to place an exclusion or limitation on coverage for foot care, must comply with Section 52.16(c)(6) of Regulation 62.
9. If insurer chooses to place an exclusion or limitation on coverage for care in connection with structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference must comply with Section 52.16(c)(7) of Regulation 62.
10. If insurer chooses, Section 52.16(c)(8) of Regulation 62 allows an insurer to place exclusions or limitations on coverage for any of the following:
 - Treatment provided in a government hospital;
 - Benefits provided under Medicare or other governmental program (except Medicaid), any state or Federal workers’ compensation, employers’ liability or occupational disease law;
 - Benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are covered or recoverable;
 - Services rendered and separately billed by employees of hospitals, laboratories or other institutions;
 - Services performed by a member of the covered person’s immediate family;
 - Services for which no charge is normally made.
11. If insurer chooses to place an exclusion or limitation on coverage for dental care or treatment, must comply with Section 52.16(c)(9) of Regulation 62.
12. If insurer chooses to place an exclusion or limitation on coverage for eyeglasses, hearing aids, and exams for their prescription or fitting, must comply with Section 52.16(c)(10) of Regulation 62.
13. If insurer chooses to place an exclusion or limitation on coverage for rest cures, custodial care and transportation, must comply with Section 52.16(c)(11) of Regulation 62.
14. If insurer chooses to place an exclusion or limitation on coverage related to territorial restrictions, must comply with Section 52.16(c)(12) of Regulation 62. For Section 52.16(c)(12) compliance, insurer must provide coverage within the United States, its possessions and the countries of Canada and Mexico.
15. No specified disease policy will contain provisions establishing a probationary or similar period longer than 30 days. 52.16(d)(1) See above concerning Section 52.15(c)(3) as well.

16. For compliance with Sections 52.16(e)(2) and 52.2(i) of Regulation 62, insurers should note that Regulation 62 recognizes only aviation and its related activities and participation as a professional in sports as extra-hazardous activities which can be initially underwritten. These extra-hazardous activities may be excluded from coverage by means of prominently disclosed waivers (see Section 52.16(e)(2)) at coverage issuance or extra premium (“rate up”) may be charged for coverage of such extra-hazardous activities or standard coverage may be issued when an applicant indicates participation in such extra-hazardous activities or coverage may be declined based upon participation in such extra-hazardous activities. Sections 52.16(e)(2) and 52.2(i) do not recognize any other avocations, vocations or activities as extra hazardous. Therefore, the insurer may only issue standard coverage or decline coverage for applicants participating in avocations, vocations or activities other than those defined in Section 52.2(i).
17. Individual accident and health coverages, including specified disease coverage, are not plans which can contain coordination of benefit provisions (Section 52.23(e)(3)(i)). Insurers have the ability to financially underwrite for other coverage before issuance. Under Section 52.15(b)(4), benefits for specified disease coverage must be paid regardless of other coverage, except for a policy provision regarding other insurance with the insurer, for which the optional standard provision of “Other Insurance in This Insurer” is set forth in Section 3216(d)(2)(C) to handle an excess insurance situation after issuance.

Please note specified disease insurers are precluded from issuing coverage when issuance would result in any insured having more than one specified disease policy or certificate for the same specified disease whether with the same or different insurer. Specified disease insurers must ask questions on their applications to elicit this fact. See Sections 52.15(b)(8) and (b)(15). Also see discussion above and below.

Please note specified disease insurers are precluded from issuing coverage when issuance would result in any insured being covered for eight or more specified diseases from all sources. Specified disease insurers must ask questions on their applications to elicit this fact. See Sections 52.15(b)(8) and (b)(15). Also see discussion above and below.

Please note specified disease insurers can only issue coverage when any specified disease insured is also covered by at least major medical insurance as defined in Section 52.7 of Regulation 62, or at least basic hospital insurance and basic medical insurance as defined in Sections 52.5 and 52.6 of Regulation 62. Specified disease insurers must ask questions on their applications to elicit this fact. Specified diseases insurers must formulate a method to ascertain from any insured whether any insured has in force on the effective date of the specified disease coverage major medical insurance (Section 52.7), or at least basic hospital and basic medical insurance (Sections 52.5 and 52.6). See Sections 52.15(b)(12)(13)(14) of Regulation 62. Also see discussion above and below.

X. Mandatory Standard Contract Provisions

These provisions are required in each policy. The provision must be no less favorable to the insured than the following statutory provisions.

1. Must include a “Entire Contract; Changes” provision with no incorporation by reference to writings not part of the form – Section 3216 (d)(1)(A), Section 3204(a)(1).
2. In dealing with application misstatements, the specified disease insurer has two options as set forth in Section 3216(d)(1)(B)(i) of the Insurance Law. The first option allows the insurer to void the policy or deny a claim due to misstatements for “loss incurred” within the first two

years of the policy issuance. For fraudulent misstatements in the application, there is no two year limit on the ability of the insurer to void the policy or deny a claim for “loss incurred” from the date of policy issuance. Since Section 52.15(c) requires that fixed sum benefits be payable upon the occurrence of ongoing triggering services during treatment regardless of disability, the words “loss incurred” are the relevant words in Section 3216(d)(1)(B)(i) in determining the ability of the insurer to void the policy or deny a claim for application misstatements. A specified disease for which fixed sum payments are payable within the first two years of policy issuance is a “loss incurred”, but such a claim can be denied or the policy voided if the policy was issued based upon application misstatements. A specified disease for which fixed sum payments are payable after the first two years from the policy effective date is a “loss incurred”, and the claim cannot be denied or the policy voided on the basis of application misstatements unless they were fraudulent misstatements.

The second option is available only for a policy which the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age 50 or, in the case of a policy issued after age 44, for at least five years from its date of issue. This option is available because the specified disease policy must be “Guaranteed Renewable for Life” pursuant to Section 52.15(b)(3). This option requires the insurer to label the option “Incontestable” and not “Time Limit on Certain Defenses”. This option indicates that, once the policy has been in force for two years during the lifetime of the insured, the policy is incontestable as to any statements contained in the application. At the insurer’s option, the insurer may add a statutory phrase extending the calculation of the two year period by any period of disability of the insured.

Insurers are reminded these are two distinct statutory options, and the most favorable aspects for an insurer cannot be made into a third option not sanctioned by statute. For example, the fraudulent misstatement exception of the first option cannot be added to the second option.

3. Must include a “Grace Period” provision for premium payment in accordance with the statutory options.
4. Must include a “Reinstatement” provision in case of policy lapse in accordance with statutory options. Section 3216(d)(1)(D) of the Insurance Law makes reference to a conditional receipt when premium is tendered with an application for reinstatement. Insurers are reminded that the conditional receipt used for reinstatement of policies has its own statutory requirements for use in the reinstatement situation. For example, Section 3216(d)(1)(D) of the Insurance Law places a maximum 45-day time limit following the date of the conditional receipt for insurer action on a reinstatement application where the insurer or its agent issued a conditional receipt for premium tendered. The policy is reinstated on the 45th day following the conditional receipt date if the insurer has not approved or disapproved the reinstatement application in writing within that time period. - Section 3216(d)(1)(D).
5. Must include “Notice of Claim” provision in accordance with statutory options – Section 3216 (d)(1)(E).
6. Must include “Claim Forms” provision – Section 3216 (d)(1)(F).
7. Must include “Proofs of Loss” provision – Section 3216 (d)(1)(G).
8. Must include “Time of Payment of Claims” provision in accordance with statutory options – Section 3216 (d)(1)(H).
9. Must include “Payment of Claims” provision in accordance with statutory options – Section 3216 (d)(1)(I). Section 3216(d)(1)(I) contains several scenarios and/or options for the

insurer. Each scenario and/or option chosen must be as favorable or more favorable than Section 3216(d)(1)(I).

10. Must include “Physical Examinations and Autopsy” provision – Section 3216 (d)(1)(J).
11. Must include “Legal Actions” provision – Section 3216 (d)(1)(K).
12. When applicable, must include “Change of Beneficiary” provision in accordance with statutory options – Section 3216 (d)(1)(L).

XI. Optional Standard Provisions

These provisions may be included, at the insurer’s option; but, if they are included, they must be no less favorable to the insured than the following statutory provisions.

1. If insurer chooses to place a “Misstatement of Age” provision in the coverage, must comply with Section 3216 (d)(2)(B).
2. If insurer chooses to place an “Other Insurance in this Insurer” provision in the coverage, must comply with Section 3216 (d)(2)(C). However, please see Sections 52.15(b)(4),(8),(12),(13),(14), and (15), and the discussion in this outline concerning those sections.
3. If insurer chooses to place an “Insurance with Other Insurers” provision in the coverage, must comply with Section 3216 (d)(2)(E). However, please see Sections 52.15(b)(4),(8),(12),(13),(14), and (15), and the discussion in this outline concerning those sections. Section 3216(d)(2)(E) language is only permissible because it allows the insurer a remedy where the insurer has not been given written notice of other specified disease coverage prior to the occurrence or commencement of loss.
4. If insurer chooses to place an “Unpaid Premium” provision in the coverage, must comply with Section 3216 (d)(2)(G).
5. If insurer chooses to place a “Cancellation” provision in the coverage, must comply with Section 3216(d)(2)(H) of the Insurance Law.
6. If insurer chooses to place a “Conformity with State Statutes” provision in the coverage, must comply with Section 3216 (d)(2)(I).
7. If insurer chooses to place an “Illegal Occupation” provision in the coverage, must comply with Section 3216(d)(2)(J).
8. If insurer chooses to place an “Intoxicants and Narcotics” provision in the coverage, must comply with Section 3216(d)(2)(K).

XII. Other Provisions

1. Policy definition of “hospital” as used in an individual specified disease policy must comply with Section 52.2(m) of Regulation 62.
2. Policy definition of “pre-existing condition” must be meaningful as used in a specified disease policy, fair to the consumer and fully disclosed in the policy language – originates

from Sections 3201(c)(3), 3217(b) of the Insurance Law and Sections 52.1(c), 52.1(d) of Regulation 62. See also discussion above about Section 52.15(b)(6).

3. Reductions in benefits such as when certain events occur or ages are reached are not permissible. Section 52.15(b)(16)
4. Policy definition of “mental disorders” must be meaningful as used in a specified disease coverage policy, fair to the consumer, and fully disclosed in the policy language – originates from Sections 3201(c)(3), Sections 3217(b), 4224(b)(2) of the Insurance Law and Sections 52.1(c), 52.1(d), 52.16(c)(2) of Regulation 62.
5. Policy definitions of “physician” and similar terms cannot unduly limit access of the insured to benefits under the policy – originates from Sections 3201(c)(3), 3217(b) of the Insurance Law and Sections 52.1(c), 52.1(d) and 52.15 of Regulation 62.
6. Section 3216(d)(1)(K) is governed by “lead in” wording present in Section 3216(d)(1). The “lead in” wording proscribes approval of language which would be less favorable in any respect to an insured than the wording in Section 3216(d)(1)(K). Section 3216(d)(1)(K) sets forth parameters in a specified disease policy to allow an insured to bring an action at law or equity. Arbitration provisions set forth as a contractual right of an insurer generally preclude an insured from bringing an action at law or equity. Therefore, the Department is under a statutory constraint because arbitration provisions in a policy which preclude an insured from bringing an action at law or equity would be less favorable in many respects to an insured than the parameters set forth in Section 3216(d)(1)(K).

The Department addresses here its statutory inability to approve arbitration provisions in a specified disease policy. The Department does not address in this product outline other reasonable and appropriate mechanisms which an insurer may be able to use in its ongoing relationship with an insured.

7. Insurers are reminded of their obligations under Section 3228 of the Insurance Law regarding refund of premium upon death of insured and/or any covered dependents.
8. The Department has on occasion received individual recurring specified disease submissions which contain benefits additional to the specified disease coverage. For example, some specified disease insurers have wanted to add accident benefits and/or other sickness benefits.

Section 52.15(a) contains the definition of specified disease coverage. (See the discussion of this section in this outline.) That definition does not indicate that accident benefits, sickness benefits or any other benefit are part of a specified disease coverage. Adding benefits unrelated to specified diseases to a specified disease coverage gives the impression to a consumer the coverage is more comprehensive than it actually is. This is contrary to Section 3201(c)(3) of the Insurance Law. Giving the illusion of comprehensive benefits in such a limited policy would be contrary to the supplemental nature of the coverage, and it would be contrary to the requirements in Section 52.15(b) that a person have actual underlying comprehensive coverage in order to purchase the limited specified disease coverage. Such an illusion of comprehensiveness might convince an insured to lapse his/her actual underlying comprehensive coverage and keep only the specified disease coverage with “add-on” benefits. This would be contrary to Section 52.1(c) of Regulation 62 and Section 3217(b)(1)(2)(3) of the Insurance Law while adversely affecting the community rated pools of actual comprehensive coverages marketed in New York State.

XIII. Applications

1. If more than one application will be used, objective criteria is required to avoid unfair discrimination under Section 4224(b) of the Insurance Law. An example of unfair discrimination would be that, if two applications offer different levels of underwriting, two individuals would receive the same policy but undergo different levels of underwriting.

Insurers are reminded of their obligations under Section 4224(b)(1) as they pertain to the use of application forms with specified disease coverage policies. Objective and rational criteria must be used by the specified disease insurer to avoid unfair discrimination if the insurer is using multiple application forms so different applicants are subjected to different medical and financial underwriting in attempting to obtain coverage. When a submission is made of multiple application forms where the Department could reasonably inquire about such obligations, the insurer should provide a detailed and prominent explanation in the submission letter about the use of multiple application forms with a specified disease coverage product.

2. Section 52.51(a) of Regulation 62 requires that an application cannot contain questions as to race of the applicant.
3. Section 52.51(b) of Regulation 62 requires that questions regarding past or present health of any person that refers to a specific disease or general health must be asked to the best of the applicant's knowledge and belief. Questions regarding factual information, such as doctor's visits or hospital confinements, do not require this qualification.
4. Section 52.51(c) of Regulation 62 requires that no application will contain a provision that changes the terms of the policy to which it is attached.
5. Section 52.51(d) of Regulation 62 requires that no application will contain a statement that the applicant has not withheld any information or concealed any facts.
6. Section 52.51(e) of Regulation 62 requires that no application will contain an agreement that an untrue or false answer material to the risk shall render the contract void.
7. Section 52.51(f) of Regulation 62 requires that no application will contain an agreement that acceptance of any policy issued upon the application will constitute a ratification of any changes or amendments made by the insurer and inserted in the application, except in conformity with Section 3204 of the Insurance Law.
8. Section 52.51(g) of Regulation 62 requires that applications for conversion policies may not contain questions as to the health of the person or persons entitled to conversion.
9. Section 52.51(h) of Regulation 62 requires that applications for policies subject to Section 3216(d)(2)(E), "Insurance with Other Insurers", will contain a question or questions requiring information with respect to such other insurance. However, please see Sections 52.15(b)(8),(12),(13),(14) and (15), and the discussion in this outline concerning those sections. Also see Section 52.15(b)(4), and the discussion in this outline about it. Also see the discussion of Section 3216(d)(2)(E) in the portion of this outline dealing with "Optional Standard Provisions".
10. Section 52.51(i) of Regulation 62 requires that if an insurer includes in a policy the optional standard provision under Section 3216(d)(2)(C), "Other Insurance in this Insurer", a statement describing the provision in the policy must be included in the application, or provided at the time of application by separate notice. However, please see Sections

52.15(b)(4),(8),(12),(13),(14) and (15), and the discussion in this outline concerning those sections.

11. Section 52.51(j) of Regulation 62 requires that if a policy contains a provision with respect to “pre-existing conditions”, a statement describing the policy provision must be included in the application OR provided at the time of application by delivery of the disclosure statement required by Section 52.54.
12. Section 52.15(b)(13) of Regulation 62 requires that an application form for specified disease coverage include a question designed to elicit information as to whether any applicant has at least major medical insurance or at least basic hospital insurance and basic medical insurance in force on the date of the application.
13. Section 52.15(b)(15) of Regulation 62 requires that application forms for specified disease coverage include questions designed to elicit:
 - whether, as of the date of the application, any applicant (includes primary applicant and all dependents) has in force or application(s) pending for another specified disease policy or certificate for the same specified disease with the same or a different insurer, and
 - the number of specified diseases for which either any applicant (includes primary applicant and all dependents) has coverage in force as of the date of application or application(s) pending as of the date of application.
14. Previous HIV test results are NOT questioned, sought or used per Sections 3217(b) and 52.1 of Regulation 62. Information regarding the diagnosis or treatment of AIDS or ARC may be sought and used. Also, the insurer has the right to conduct its own medical tests as part of the underwriting process.
15. Individual insurers are reminded of their obligations under Section 2611 of the Insurance Law and Section 2782 of the Public Health Law regarding written informed consent, authorization and disclosure of confidential information when the insurer uses an HIV antibody test in underwriting. Circular Letters No. 3 (1989) and No. 5 (1997) are relevant.
16. If this filing contains a reference to a telephone or in-person interview, the interview is conducted in the following manner:

Any questions raised during the interview are limited to those questions appearing on the application (i.e., questions over the phone would be no different than those being asked in the application).

The applicant will have an opportunity to review and make corrections to those statements that were attributed to him/her in the interview.

Any information obtained in the interview that will be used in the underwriting process will be reduced to writing, signed by the applicant and attached to the policy in compliance with Section 3204 of the Insurance Law.
17. If an Investigative Consumer Report will be prepared or procured, the insurer complies with Section 380-c of the General Business Law by providing notice in the application or in a separate form.
18. If a Medical Information Exchange Center (such as a Medical Information Bureau) will be used, the insurer complies with Section 321 of the Insurance Law.

19. Section 420.18(b) of Regulation 169 requires that an authorization to disclose nonpublic personal health information specifies the length of time the authorization will remain valid (maximum 24 months).
20. Section 403(d) of the Insurance Law requires a fraud warning on the application form.
21. Section 3204 of the Insurance Law contains requirements that apply to application forms for individual specified disease coverage policies. An insurer may make insertions for administrative purposes only as long as the insertions are clearly not ascribed to the applicant. No other insertions or alterations of a written application will be made by anyone other than the applicant without his written consent.

XIV. Conditional Receipts/Interim Insurance Agreements

Section 52.53 of Regulation 62 requires that, if premium is paid prior to policy delivery and the insurer requires a determination of insurability as a condition precedent to the issuance of a policy, an insurer must issue either a conditional receipt or interim insurance agreement. In general, Section 52.53 sets forth two permissible methods for money to be accepted with an application – conditional receipt or interim insurance agreement. A “determination of insurability” means a determination by the insurer as to whether the proposed insured is insurable under its underwriting rules and practices for the plan and amount of insurance applied for and at the insurer’s standard premium rate. Section 52.53(c) sets forth the meaning of “determination of insurability”.

1. A conditional receipt sets an effective date for the policy if the applicant successfully completes the underwriting process. The conditional receipt shall contain an agreement to provide coverage subject to any reasonable limit regarding the amount of insurance specified in the receipt, contingent upon insurability, and provides that such insurability be determined as of a date no later than:

The date of completion of all parts of the application, including completion of the first medical examination if one is required by the company’s underwriting rules,
AND

The required premium has been paid.

Completion of a second medical examination may be required as a condition precedent to coverage if initially required by the company’s underwriting rules because of the amount of insurance applied for or the age of the proposed insured.

If the proposed insured is insurable as of the above date, coverage under the issued policy begins not later than such date, except as provided in paragraph 4 below. Section 52.53(a) of Regulation 62

2. Although the proposed insured dies, undergoes a change in health or otherwise becomes uninsurable according to the insurer’s underwriting standards for the insurance plan for which application was made after the date provided in paragraph 1 above but before the application is approved or rejected and before the expiration of any time limit specified in the receipt, an insurer may determine that the proposed insured is not insurable only as of the date stated in paragraph 1. Information relating to an event or physical condition that is the subject of a question in any part of the application cannot be considered for underwriting purposes if the event or accident occurred or sickness first manifested itself after completion of that part of the application. Adverse changes in insurer underwriting rules after the date stated in paragraph 1 cannot be taken into account when such adverse changes in underwriting rules take effect after the date stated in paragraph 1 but before the application is approved or rejected and before the expiration of any

time limit specified in the receipt. (In summary, policy underwriting can only be based on the insured's health status as of the date provided for in paragraph 1.) Section 52.53(e) of Regulation 62.

Suppose a specified disease applicant pays premium with his/her application, and the insurer issues a conditional receipt to the applicant on December 1, 2002. The applicant completes all parts of the application truthfully on December 1, 2002, and the applicant awaits the insurer's underwriting decision. Then assume on January 1, 2003 (which is before the expiration of a 60 day time limit in the receipt), the applicant begins receiving triggering services which would cause fixed sum payments to be paid under the specified disease policy applied for (but not yet issued because the insurer is in the process of underwriting). Then assume the applicant dies on January 27, 2003. The insurer would be using its underwriting rules in effect on December 1, 2002, and the insurer would be assessing the insured's health as of December 1, 2002 based upon a truthful application submitted by the applicant on December 1, 2002. The insurer would issue a specified disease policy dated effective December 1, 2002. The insurer would be obligated to pay the fixed sum payments commencing on January 1, 2003 because it is past any 30 day probationary period the policy might have as (Section 52.15(c)(3)) measured from December 1, 2002. This might all occur retrospectively if the insurer used the full 60 day period mentioned in the conditional receipt and did not issue the specified disease policy with a December 1, 2002 effective date until January 29, 2003.

3. An interim insurance agreement provides some type of immediate limited insurance coverage as of the application date. The agreement provides coverage in accordance with the policy and plan of insurance described in the application subject to any reasonable limit regarding the amount or duration of insurance specified in the agreement. Coverage is provided as of the application date and must provide at least 60 days coverage unless:

The policy applied for is issued prior to the end of the 60 days, OR

The applicant receives actual notice that coverage under the agreement is cancelled because the application has been declined. If notice is given by mail, it may be deemed received on the fifth day after mailing such notice to the applicant. Section 52.53(b) of Regulation 62

4. An insurer may honor a written request from the applicant that coverage begins as of a specified date later than the date provided for in the conditional receipt or interim insurance agreement. In other than replacement situations, the applicant's written request for a later effective date must contain a statement signed by the applicant that he/she understands that he/she may be waiving certain rights and guarantees under the conditional receipt or interim insurance agreement. Section 52.53(f) of Regulation 62
5. If coverage is provided under a conditional receipt or interim insurance agreement for two or more proposed insureds, the coverage must be determined separately for each proposed insured, except, however, all proposed insureds may be rejected in the event of fraud or material misrepresentations. Section 52.53(d)
6. If a policy is not issued within the time specified in the conditional receipt or interim insurance agreement, the application will be deemed rejected and all premiums will be refunded. Section 52.53(i) of Regulation 62
7. In mail order cases only, an insurer may postpone the effective date of coverage to the date of issuance of the policy. Section 52.53(g) of Regulation 62
8. In franchise cases, the coverage under the conditional receipt or interim insurance agreement may be made contingent upon meeting specified participation requirements. Section 52.53(h)

of Regulation 62

The Department will entertain reasonable alternatives to Section 52.53 requirements. The insurer cannot take the most favorable aspects of a conditional receipt and interim insurance agreement for an insurer and submit a hybrid form that is not as favorable for an insured as under Section 52.53. Any alternative must be as favorable for an insured as Section 52.53 requirements.

XV. Disclosure Form Requirements

1. Sections 52.15(b)(5) and 52.66 of Regulation 62 set forth the disclosure requirements for specified disease coverage policies. Section 52.15(b)(5) of Regulation 62 requires that, except in the case of direct response insurers, no specified disease policy will be delivered or issued for delivery in New York State unless the appropriate disclosure form in Section 52.66 of Regulation 62 describing the policy's benefits, limitations and exclusions, and expected benefit ratio is delivered to the applicant at the time application is made and written acknowledgement of receipt or certification of delivery of such disclosure form is provided to the insurer. Direct response insurers will deliver the requisite disclosure form at the time the policy is delivered. See also discussion above about Section 52.15(b)(5).

XVI. Marketing of Individual Specified Disease Coverage Using Group Methods

The individual specified disease coverage checklist contains items pertaining to whether a filing is individual, "list bill" or franchise. The requirements for each category are listed in the checklist, and those requirements will not be repeated here. However, this individual specified disease coverage product outline will explain the necessity of including these items on the individual specified disease coverage checklist.

These items are a recognition of how individual insurance is generally sold in the New York State marketplace by insurers and their agents, brokers or other representatives. In the sale of individual accident and health insurance, including specified disease coverage, it is generally recognized that individual sales on a "one to one" basis are the most time consuming and costly to administer. There is no ability to know beforehand the characteristics of the insureds who will purchase the individual product (as contrasted with true group coverage where, as an example, one knows the type of employer or association purchasing---e.g. coal miners vs. librarians). True individual sales only occur by individual solicitation where not many insureds are purchasing at a particular point of sale. The medical underwriting, if any, is generally detailed to obtain and process. Due to such factors, the minimum loss ratios in Regulation 62 for such coverage are generally lower than for group coverages or coverages where many sales are made at one time or where group characteristics are apparent. Similarly, the individual sale is usually an adhesion contract situation where the insurer retains most of the bargaining leverage at point of sale, and the insurer retains that superior bargaining position concerning various issues such as claim processing after individual coverage is in force. This situation aids in explaining why many of the Insurance Law provisions pertaining to individual accident and health coverages (such as standard provisions) are more detailed and protective of the individual insured. This same situation aids in explaining why many of the Regulation 62 provisions pertaining to individual accident and health coverage are also more detailed and protective of the individual insured.

Over the years, however, insurers have developed mechanisms in the individual accident and health insurance marketplace which are not solely individual sales. These mechanisms seek to market or offer the individual product using group or quasi-group type methods. Often, however, the insurer does not want to pass on all or some of the savings or advantages of marketing an individual product in a group or quasi-group type manner. Thus, insurance regulations become necessary to protect the consumer. In addition, even when the insurer seeks to pass on some of the savings or advantages, the group or quasi-group type arrangement is not present forever. Sometimes the individual product group-type sales

arrangement does not meet statutory requirements in New York State. Statutory and regulatory requirements can determine whether the group or quasi-group type marketing methods for an individual product are appropriate, and how much of the advantage of those methods should be passed on to the insured and for how long. The integrity of the New York statute recognizing groups is important when considering the appropriateness of marketing or offering an individual product with group or quasi-group methods. The integrity of that statute is important so the public is not misled into believing an individual product (without all or some of the advantages of a group product) is a group product as recognized by law with the consequential advantages of a group product.

Based upon the foregoing, the individual specified disease coverage checklist has set forth the mechanisms through which individual specified disease coverage products can be marketed using group or quasi-group methods. The first method which is a step toward group or quasi-group methods is a payroll deduction arrangement. When this arrangement is used for premium payments with no discounts at all and no other type of group or quasi-group methods, the individual specified disease product remains subject to regulation as an individual product. No group or quasi-group savings or advantages to any significant degree are claimed by the insurer, and the individual insured has the convenience of payroll deduction as long as the employer is willing to provide that convenience. Here the insurer will accept premium payments directly from an insured should the insured lose the convenience of payroll deduction or choose not to use payroll deduction to pay premiums.

The second method, which is the next step toward group, or quasi-group methods is "list bill." One will not find this method as a statutory or regulatory exception to the statute that recognizes permissible groups in New York State. It has been a method recognized by the Insurance Department as an accommodation to insurers for over 30 years.

Essentially, insurers desiring to use this method must differentiate it from franchise insurance (see below) to retain the exclusive treatment as an individual product, including but not limited to the generally lower individual minimum loss ratio more favorable to the insurer. The Insurance Department views this method as the sale of very few individual policies at a common site or address (usually an employer or some association) with no exclusivity granted to the insurer, no sponsorship by the employer or association, no mass marketing (i.e. - agent or representative engages in the "one on one" sale) and no contribution of premiums by the employer or association. The employer or association may remit or not remit premiums through the sending of a single bill to the common address of the employer or association where the few individual insureds work or have a membership. Generally, this situation goes further than the payroll deduction arrangement because there are a few sales at a small employer or association site, and the insurer provides actuarial justification to the Insurance Department that the "list bill" arrangement is worth some small discount.

It is important to note that the "list bill" discount is dependent upon the factual circumstances noted here for its continued existence. Since the "list bill" arrangement as understood by the Insurance Department provides such marginal savings and advantages of a group or quasi-group nature and a rather small discount, the Insurance Department regulates the individual specified disease coverage product as still an individual product with the generally more favorable individual minimum loss ratio. However, due to the marginal savings and advantages, the Insurance Department requires that the small discount revert to the higher individual premium if the "list bill" situation goes out of existence, and the insured continues to pay his/her premium on a direct bill basis. Once the "list bill" situation goes out of existence and the marginal savings and advantages also do not exist, the insured is a usual individual insured who should pay the undiscounted individual rate like other individual insureds to avoid "unfair discrimination" under Section 4224 (b)(1) of the Insurance Law. Prominent disclosure in the form of the increased rate when the "list bill" situation ends must occur.

The third method which is the last method and the most expansive method of marketing or offering individual specified disease coverage products with group or quasi-group savings or advantages is franchise insurance. Sections 52.2 (k), 52.19 and 52.70 of Regulation 62 (11NYCRR52) should be

consulted. Generally, individual specified disease coverage products are distributed on a mass merchandising basis, administered by group methods and provided with or without evidence of insurability. Sponsorship by an employer or association occurs and exclusivity in the marketing of the individual products is granted to a particular insurer. The individual contract mechanism is retained. So the legal relationship is directly between the insured and insurer with no group policy being issued to a group policyholder. However, the insurer is generally able to know beforehand the characteristics of the insureds (e.g. – bar association, medical society, etc.), and the insurer is generally able to obtain a significant number of insureds due to the sponsorship of the employer or association, exclusivity granted to the insurer in marketing the individual specified disease coverage product and more sizeable discounts for the insured. We are just short of marketing the product as group under New York law, but the employer or association does not enter the direct legal relationship of the insurance contract and is not the group policyholder.

In the franchise situation, the agent or insurer representative usually does less work because of the sponsorship and exclusivity. The insurer achieves economies of acquisition and administration as well as knowing there is some affinity or relationship among all the insureds purchasing the franchise individual product. Therefore, the Insurance Department requires that these factors accrue to the insured's benefit in the regulation of the franchise individual product. A higher minimum loss ratio is required, and the insurer can allow the discount on the franchise product to remain if the franchise arrangement ends because of the sizeable savings and advantages occurring at point of sale which can be recognized over the lifetime of the franchise form. (These sizeable savings and advantages do not occur with the first two methods either resulting in no discount or the reversion to the higher individual rate. The Department will allow an insurer to charge the higher individual rate upon termination of the franchise arrangement for any reason if the insurer provides actuarial justification as to why the franchise savings and advantages do not warrant continuation of the discount upon termination of the franchise arrangement. In that instance, prominent disclosure of the higher rate in the form is necessary as with the "list bill" arrangement.)

XVII. Rating Procedures and Requirements

1. Section 52.40 (a) of Regulation 62 sets forth general procedures and requirements that apply to the rating of individual specified disease coverage policies.
2. Section 52.40 (b) of Regulation 62 sets forth prohibited rating practices that may be applicable to individual specified disease coverage policies.
3. Section 52.40 (c) of Regulation 62 sets forth requirements applicable to individual specified disease coverage policies.
4. Section 52.40 (d) of Regulation 62 sets forth requirements applicable to individual specified disease coverage policies.
5. Section 52.41 of Regulation 62 sets forth gross premium differentials based on sex, which apply to individual specified disease coverage policies.
6. Section 52.43(a) of Regulation 62 sets forth standards for maintaining experience data that apply to individual specified disease coverage policies.
7. Sections 52.44(a) and (b) of Regulation 62 set forth monitoring standards that apply to individual specified disease coverage policies.
8. Section 52.45(j)(1) of Regulation 62 sets forth minimum loss ratio standards that apply to individual specified disease coverage policies written on a recurring basis.