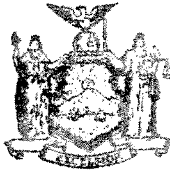


STATE OF NEW YORK
INSURANCE DEPARTMENT
324 STATE STREET
ALBANY 12210

Thomas A. Harnett
SUPERINTENDENT OF INSURANCE

Circular Letter No. 18 (1975)
November 28, 1975

TO: ALL INSURERS, OTHER THAN ARTICLE IX-C CORPORATIONS, LICENSED TO WRITE ACCIDENT AND HEALTH INSURANCE

SUBJECT: ACCIDENT AND HEALTH INSURANCE CONVERSION POLICIES

Chapter 49, Laws of 1975, which amended Section 162, New York Insurance Law, takes effect January 1, 1976 and requires insurers where applicable to offer conversion to individual or family major medical policies and, in addition, mandates higher hospital and surgical benefit levels than is now required by law for the three statutory plans set forth in Section 162.

To assure timely compliance with the amended law by all insurers, this Circular Letter sets forth Insurance Department guidelines for conversion policies relating to (1) policy form approval, (2) over-insurance standards, and (3) premium rates.

1. Policy Form Approval

Attached as Appendices A and B to this Circular Letter are sample benefit provisions which can be used as a guide in the drafting of conversion policies designed to include the benefits required by sub-section 8 of Section 162, New York Insurance Law. Appendix A sets forth the sample provisions for a major medical policy providing benefits on an "all cause plan" and Appendix B sets forth such provisions for an "each cause plan".

In anticipation of questions by insurers that may arise in the implementation of Chapter 49, Laws of 1975, the following guidelines for approval of policy forms apply:

a) The minimum standards for a major medical conversion policy are set forth in subsections 5 and 8 of Section 162, New York Insurance Law, and Sections 52.20, 52.54(a) and all other applicable requirements of Department Regulation 62. It should be noted that sub-section 5(c) of Section 162 states that the converted policy need not provide maternity benefits, however, the Department does not consider coverage of "complications of pregnancy" as a maternity benefit and unless previously excluded under the group contract should be covered in the conversion policy.

b) Major medical expense benefit, exclusion, restriction and limitation provisions which are no less favorable to the insured than the provisions set forth in Appendices A and B are approvable when supplemented by definitions, general and other provisions which are consistent with the Insurance Law, Regulation 62, and other Department requirements. If an insurer elects to use the provisions set forth in Appendices A and B, policy forms approval can be expedited by a specific reference in the insurer's letter of submission that it has so elected. If the insurer deviates from the provisions set forth in the Appendices A and B, only to the extent of providing additional benefits for out of hospital drugs, private duty nursing, and in-hospital psychiatric care and removal of inside limits for in-hospital physician visits, these deviations and the appropriate rate adjustment should be noted in the submission letter. A policy including only the above-mentioned deviations will be considered by the Department as a complying statutory major medical policy.

c) At the insurer's option, it may elect to offer either or both of the major medical plans described in Section 162.8, the "all cause plan" or the "each cause plan".

d) Previously-approved hospital and surgical conversion policies can continue to be used on or after January 1, 1976, if they comply with subsections 5 and 7 of Section 162, New York Insurance Law, and Sections 52.20 and 52.54(a) of Regulation No. 62 and all other applicable requirements of Department Regulation No. 62. It should be noted again that subsection 5(c) of Section 162 states that the converted policy need not provide maternity, however, the Department does not consider "complications of pregnancy" as a maternity benefit and unless previously excluded under the group contract should be covered in the conversion policy.

e) Where an applicant for a conversion policy is entitled to basic coverage and major medical coverage, the insurer may elect to issue separate policies or a single policy, at its option. If, however, the insurer elects to issue separate conversion policies, and if its major medical policy contains a surgical schedule, the surgical schedules of the two policies must be compatible. Preferably, the same schedule should be used for surgical benefits and major medical benefits, whether provided in separate policies or a single policy, and it should vary only as to the applicable statutory maximums.

f) Attention is called to the new restrictions set forth in Section 162.5(e), which limits the insurer's right to request information concerning other insurance coverage to the period of the first two years of the policy. An insurer may non-renew the conversion policy for overinsurance only during this two year period and can do so only on the basis of standards of overinsurance on file with the Superintendent. After two years an insurer is permitted to refuse renewal on a class basis only if the Superintendent finds, as in the event of enactment of a federal or state health care program, that non-renewal is in the public interest. To the extent that any group accident and health insurance policy's conversion provisions refer to the insurer's right to refuse renewal, those provisions should be amended on or before January 1, 1976, to reflect the foregoing.

g) If a person insured under a New York group major medical policy applies for conversion when a resident of another state, the insurer must offer conversion to major medical coverage if the applicant's state of residence has a major medical conversion law. Otherwise, the insurer must offer conversion to its most liberal hospital and surgical plan then being offered for conversions in that state.

h) The conversion privilege required by Chapter 49, Laws of 1975, should be made available under group policies issued to policyholders recognized under Section 221.2(h).

i) Insurers must offer to group major medical convertees one of the statutory major medical plans and, in addition, may voluntarily offer other conversion plans approved by the Superintendent.

j) Insurers should note that effective April 1, 1976, policies providing coverage for in-patient hospital care must also include coverage for home care in accordance with the requirements of Chapter 647 of the Laws of 1975. Insurers submitting conversion policies for approval may desire to include the home care coverage in the policies at this time.

2. Overinsurance Standards

The amended Section 162 contemplates that each insurer will file with the Superintendent its standards for determining overinsurance or duplication of benefits. Standards no less favorable to insureds than the standards in Appendix C are acceptable and any insurer electing to use them should so state in their submission letter.

3. Premium Rates

Pursuant to Section 162.6 of the New York Insurance Law, the Department hereby gives notice of its intent to amend Regulation 62, Section 52.40(i) to substitute Appendix D Schedule of Maximum Group Conversion Rates for persons converting from group coverage at age 60 and over. Rates to be used with conversion policies which do not exceed the rates set forth in Appendix D will be approved by the Department as reasonable in relation to the benefits provided.

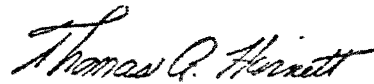
In addition to the rates established by the previous paragraph, attached as Appendices E-I, E-II, E-III and E-MM are schedules of acceptable annual group conversion rates for persons converting from group coverage at ages under 60. Appendices E-I, E-II and E-III set forth the above mentioned schedules for basic statutory Plans I, II and III, respectively. Appendix E-MM sets forth the schedule for the major medical statutory plans. The schedules represent one acceptable rate structure for the statutory plans. Other rate structures, such as individual attained age or grouped attained age step rates, and one year preliminary term rates based on individual ages, may be constructed on a basis consistent with the rates set forth in the Appendices.

If an insurer offers a plan with level premiums to age 65, it must also offer as an option to the insured a one year preliminary term premium rate for statutory plans in the first policy year.

The reference in the Appendices to surgical schedules is to the 1957 Relative Value Schedule developed by the Society of Actuaries and set forth in Volume X (page 489), Transactions of the Society of Actuaries.

The premium rates set forth in the Appendices for Miscellaneous Expense Benefits are calculated on the assumption that normal out-patient services are covered expenses.

Please acknowledge receipt of this Circular Letter to Mr. James W. Clyne, Chief of the Health and Life Policy Bureau, New York State Insurance Department, 324 State Street, Albany, New York 12210



THOMAS A HARNETT
Superintendent of Insurance

Appendix A

MAJOR MEDICAL ALL CAUSE PLAN

Major Medical Benefits

Major Medical Benefits shall be equal to the product of the Major Medical Benefit Percentage shown in the Major Medical Schedule of Insurance multiplied by the excess of the Covered Expenses over the Deductible, incurred for all sicknesses and injuries combined during the Benefit Period, subject to the Maximum Benefit and the Exclusions, Limitations and Reductions.

Major Medical Schedule of Insurance

Minimum Dollar Deductible of Covered Expenses for All Sicknesses and Injuries Combined	$500
Major Medical Benefit Percentage	80%
Major Medical Hospital Daily Room and Board Maximum	$65
Major Medical Surgical Schedule Maximum	$1000
Major Medical In-Hospital-Medical Daily Maximum	$6.25
Major Medical Maximum Benefit for All Sicknesses and Injuries Combined	$20,000

Covered Expenses

Covered Expenses consist of the reasonable charges incurred as a result of accidental bodily injury or sickness, as follows:

A. Charges made by a hospital for room and board, including general nursing and special diets, up to the Major Medical Hospital Daily Room and Board Maximum as shown in the Major Medical Schedule of Insurance, for each day of confinement for which a room and board charge is made, but the Major Medical Hospital Daily Room and Board Maximum will not apply to charges for confinement in an intensive care unit;

B. Charges made by a hospital for miscellaneous hospital services and supplies, consisting of:

a. the use of operating, recovery and cystoscopic rooms and equipment;

b. the use of intensive care or special care units and equipment to the extent not otherwise provided in the policy;

c. diagnostic and therapeutic items such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes for care in hospitals, and administration thereof, but

not including those which are not commercially available for purchase and readily obtainable by the hospital;

d) dressings and plaster casts;

e) supplies and use of equipment in connection with oxygen, anesthesia, physiotherapy, electrocardiographs, electroencephalographs, X-ray examinations, laboratory and pathological examinations, blood products, except when participation in a volunteer blood replacement program is available to the covered person;

f) radiation therapy and chemotherapy, and

g) any other medical services and supplies which are customarily provided by hospitals unless specifically excluded in the Exclusions, Limitations and Reductions,

C. Charges made by a doctor for performing a surgical procedure, up to the applicable amount for the procedure determined in accordance with the Schedule of Surgical Procedures;

D. Charges made by a doctor, up to 15% of the applicable amount for the surgery determined in accordance with item (C) above, for the administration of anesthesia (except local infiltration anesthesia administered by the operating surgeon), in connection with a surgical procedure for which Major Medical Benefits are payable, if the anesthesia is ordered by the operating surgeon and is administered by another doctor;

E. Charges made by a doctor for visits to a covered person while the person is confined in a hospital for a reason other than a reason for which surgical care is required, up to the Major Medical In-Hospital Medical Daily Maximum shown in the Major Medical Schedule of Insurance for each day that person is so confined;

F. Other charges made by a doctor for doctor's services rendered to a covered person on an ambulatory basis for diagnosis and treatment of sickness or injury; and charges for diagnostic x-rays, laboratory services, radiation therapy and hemodialysis, when ordered by a doctor;

Charges for any of the following, when no charge is made for them under A through F above:

i. prosthetic devices for the initial replacement of natural limbs or eyes or to replace all or part of internal body organs,

ii. rental or, at the insurer's option, purchase of durable medical equipment required for therapeutic use.

Deductible

The deductible for each Benefit Period shall be the greater of:

a. The Minimum Dollar Deductible of Covered Expenses as shown on the Major Medical Schedule of Insurance, and

b. The amount or value of any benefits provided on an expense incurred basis with respect to Covered Expenses * by any other hospital, surgical or medical insurance policy, or by any hospital or medical service subscriber contract or by any medical practice or other prepayment plan, or by any other plan or program whether on an insured or uninsured basis whether voluntary or required by statute.

*If the Major Medical conversion plan and the basic hospital and/or surgical conversion plan are written in a single policy, add the words "by the basic hospital and surgical provisions of this policy, or"

Benefit Period

The Benefit Period shall commence retroactively on the first date on which was incurred a Covered Expense included in the Deductible. The Benefit Period shall terminate at the end of the calendar year in which was incurred the first Covered Expense in excess of the Deductible. Termination of a Benefit Period, in accordance with the previous sentence, shall not affect establishment of a new Benefit Period.

Maximum Benefit

The Major Medical Maximum Benefit shown on the Major Medical Schedule of Insurance shall be the maximum amount payable under the policy for all sicknesses and injuries combined for all Benefit Periods combined, subject to restoration on each January first while coverage is in force of the lesser of one thousand dollars or any benefits previously incurred and not previously restored.

Exclusions, Limitations and Reductions

A. Charges for services or supplies rendered for the following care, treatment, conditions, illnesses or injuries shall not be Covered Expenses:

1. Preexisting conditions or diseases excluded by the policy from which conversion was made, except for congenital anomalies of a covered dependent child;

2. Mental or emotional disorders, alcoholism or drug addiction;

3. Pregnancy, except complications of pregnancy;

4. Illness, treatment or medical condition arising out of:

   i. war or act of war (whether declared or undeclared);
   ii. participation in a felony, riot or insurrection;
   iii. service in the armed forces or units auxiliary thereto; subject to a refund of unearned premium for the period of such service, upon written request;
   iv. suicide, attempted suicide or intentionally self-inflicted injury; or
   v. aviation;

5. Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, nor reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect;

6. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet;

7. Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion misalignment or subluxation of or in the vertebral column;

8. Treatment provided in a government hospital unless there is a legal obligation to pay for such treatment, or services rendered by employees of hospitals, laboratories or other institutions;

9. Services performed by a member of the covered person's immediate family and services for which no charge is normally made;

10. Dental care or treatment unless due to accidental injury;

11. Eye glasses (including contact lenses), hearing aids and examination for the prescription or fitting thereof;

12. Rest cures, custodial care and transportation;

B. Charges for services or supplies rendered for illnesses or injuries shall not be Covered Expenses, but shall be applied to satisfy the deductible to the extent benefits are or could be provided to the covered person under or pursuant to:

   i. Medicare or any other federal or state program except Medicaid (Title XIX of the Social Security Act); or

   ii. Any state or federal workmen's compensation, employer's liability, occupational disease, or similar law;

iii. Any mandatory automobile "no-fault" or similar law.

C. The following reductions of benefits under this policy shall apply with respect to benefits under the policy from which conversion was made.

1. Benefits payable for Covered Expenses under this policy shall be reduced by the amount of any benefits payable for such expenses under the policy from which conversion was made after the termination of the covered person's insurance thereunder.

2. If this policy arises, directly or indirectly from a conversion from a group insurance policy, benefits payable under this policy, during the first year after termination of insurance under the group policy, shall be reduced so that they are not in excess of the benefits that would have been payable had the individual's insurance under the group policy remained in full force and effect.

Appendix B

MAJOR MEDICAL EACH CAUSE PLAN

Major Medical Benefits

Major Medical Benefits shall be equal to the product of the Major Medical Benefit Percentage shown in the Major Medical Schedule of Insurance multiplied by the excess of the Covered Expenses over the Deductible, incurred for each unrelated sickness or injury during the Benefit Period, subject to the Maximum Benefit and the Exclusions, Limitations and Reductions.

Major Medical Schedule of Insurance

Minimum Dollar Deductible of Covered Expenses for Each Unrelated Sickness or Injury	$500
Major Medical Benefit Percentage	80%
Major Medical Hospital Daily Room and Board Maximum	$65
Major Medical Surgical Schedule Maximum	$1,000
Major Medical In-Hospital-Medical Daily Maximum	$6.25
Major Medical Maximum Benefit for Each Unrelated Sickness or Injury	$20,000

Covered Expenses

Covered Expenses consist of the reasonable charges incurred as a result of accidental bodily injury or sickness, as follows:

A. Charges made by a hospital for room and board, including general nursing and special diets, up to the Major Medical Hospital Daily Room and Board Maximum as shown in the Major Medical Schedule of Insurance, for each day of confinement, for which a room and board charge is made, but the Major Medical Hospital Daily Room and Board Maximum will not apply to charges for confinement in an intensive care unit;

B. Charges made by a hospital for miscellaneous hospital services and supplies, consisting of:

a. the use of operating, recovery and cystoscopic rooms and equipment;

b. the use of intensive care or special care units and equipment to the extent not otherwise provided in the policy;

c. diagnostic and therapeutic items such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes for care in hospitals, and administration thereof, but not including those which are not commercially available for purchase and readily obtainable by the hospital;

d. dressings and plaster casts;

e. supplies and use of equipment in connection with oxygen, anesthesia, physiotherapy, electrocardiographs, electroencephalographs, X-ray examinations, laboratory and pathological examinations, blood products, except when participation in a volunteer blood replacement program is available to the covered person;

f. radiation therapy and chemotherapy, and

g. any other medical services and supplies which are customarily provided by hospitals unless specifically excluded in the Exclusions, Limitations and Reductions.

C. Charges made by a doctor for performing a surgical procedure, up to the applicable amount for the procedure determined in accordance with the Schedule of Surgical Procedures;

D. Charges made by a doctor, up to 15% of the applicable amount for the surgery determined in accordance with item (C) above, for the administration of anesthesia (except local infiltration anesthesia administered by the operating surgeon), in connection with a surgical procedure for which Major Medical Benefits are payable, if the anesthesia is ordered by the operating surgeon and is administered by another doctor;

E. Charges made by a doctor for visits to a covered person while the person is confined in a hospital for a reason other than a reason for which surgical care is required, up to the Major Medical In-Hospital Medical Daily Maximum shown in the Major Medical Schedule of Insurance for each day that person is so confined;

F. Other charges made by a doctor for doctor's services rendered to a covered person on an ambulatory basis for diagnosis and treatment of sickness or injury; and charges for diagnostic x-rays, laboratory services, radiation therapy and hemodialysis, when ordered by a doctor;

Charges for any of the following, when no charge is made for them under A through F above:

i. prosthetic devices for the initial replacement of natural limbs or eyes or to replace all or part of internal body organs,

ii. rental or, at the insurer's option, purchase of durable medical equipment required for therapeutic use.

Deductible

The Deductible for each Benefit Period shall be the greater of:

a. The Minimum Dollar Deductible of Covered Expenses as shown on the Major Medical Schedule of Insurance, and

b. The amount or value of any benefits provided on an expense incurred basis with respect to Covered Expenses * by any other hospital, surgical or medical insurance policy or by any hospital or medical service subscriber contract or by any medical practice or other prepayment plan, or by any other plan or program whether on an insured or uninsured basis whether voluntary or required by statute.

The minimum dollar deductible amount must be accumulated within three consecutive calendar months separately with respect to each unrelated sickness or injury.

*If the Major Medical conversion plan and the basic hospital and/or surgical conversion plan are written in a single policy, add the words "by the basic hospital and surgical provisions of this policy, or".

Benefit Period

The Benefit Period shall commence retroactively on the first date on which was incurred a Covered Expense included in the Deductible. The Benefit Period for each unrelated sickness or injury shall terminate at the end of twenty four consecutive months from the date it commenced. Termination of a Benefit Period, in accordance with the previous sentence, shall not affect establishment of a new Benefit Period, except that if the Maximum Benefit has been paid for a particular sickness or injury, no new Benefit Period shall be established for that particular sickness or injury.

Maximum Benefit

The Major Medical Maximum Benefit shown on the Major Medical Schedule of Insurance shall be the maximum amount payable under the policy for each unrelated sickness or injury for all Benefit Periods combined.

Exclusions, Limitations and Reductions

A. Charges for services or supplies rendered for the following care, treatment, conditions, illnesses or injuries shall not be Covered Expenses:

1. Preexisting conditions or diseases excluded by the policy from which conversion was made, except for congenital anomalies of a covered dependent child;

2. Mental or emotional disorders, alcoholism or drug addiction;

3. Pregnancy, except complications of pregnancy;

4. Illness, treatment or medical condition arising out of:

   i. war or act of war (whether declared or undeclared);
   ii. participation in a felony, riot or insurrection;
   iii. service in the armed forces or units auxiliary thereto; subject to a refund of unearned premium for the period of such service, upon written request;
   iv. suicide, attempted suicide or intentionally self-inflicted injury; or
   v. aviation;

5. Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, nor reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect;

6. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet;

7. Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion misalignment or subluxation of or in the vertebral column;

8. Treatment provided in a government hospital unless there is a legal obligation to pay for such treatment, or services rendered by employees of hospitals, laboratories or other institutions;

9. Services performed by a member of the covered person's immediate family and services for which no charge is normally made;

10. Dental care or treatment, unless due to accidental injury;

11. Eye glasses (including contact lenses), hearing aids and examination for the prescription or fitting thereof;

12. Rest cures, custodial care and transportation;

B. Charges for services or supplies rendered for illnesses or injuries shall not be Covered Expenses, but shall be applied to satisfy the deductible to the extent benefits are or could be provided to the covered person under or pursuant to:

i. Medicare or any other federal or state program except Medicaid (Title XIX of the Social Security Act); or

ii. Any state or federal workmen's compensation, employer's liability, occupational disease, or similar law;

iii. Any mandatory automobile "no-fault" or similar law.

C. The following reductions of benefits under this policy shall apply with respect to benefits under the policy from which conversion was made.

1. Benefits payable for Covered Expenses under this policy shall be reduced by the amount of any benefits payable for such expenses under the policy from which conversion was made after the termination of the covered person's insurance thereunder.

2. If this policy arises, directly or indirectly from a conversion from a group insurance policy, benefits payable under this policy, during the first year after termination of insurance under the group policy, shall be reduced so that they are not in excess of the benefits that would have been payable had the individual's insurance under the group policy remained in full force and effect.

Appendix C

Standards For Overinsurance Involving Converted Policies Issued Under Section 162 & Section 164, N.Y. Ins. Law

Definitions. As used in these standards:

1. "health care coverage" means coverage for charges made or services provided for hospital, surgical or medical care, treatment, services or supplies.

2. "converted policy" means any policy or contract issued on exercise of any conversion privilege which has been approved by the applicable governmental agency which regulates insurance as complying with a statute mandating such a privilege to convert terminating health care coverage.

3. "duplicating plan" means any one or more of the following plans which pays benefits or provides services for health care coverage: any other hospital, surgical or medical expense insurance policy, any hospital or medical service subscriber contract, any medical practice or other prepayment plan, any other voluntary plan or program whether insured or uninsured, or any other plan or program established to comply with any federal or state law (except Medicaid).

4. "overinsured" means, with respect to any person, that his or her health care coverage under the converted policy and all duplicating plans would be more than the applicable maximum set forth below:

   (a) As to hospital room and board expense coverage, $10 a day in excess of the average cost of semiprivate accommodations in the area where that person lives;

   (b) As to surgical expense coverage, the usual and customary charges made for surgical procedures in the area where that person lives; and

   (c) As to major medical expense coverage, another major medical policy other than one providing high deductible catastrophic coverage.

Overinsurance will be determined separately for hospital expense, surgical expense and major medical expense coverage.

Issue Standard. An Insurer may refuse to cover under a converted policy any person or persons who, if so covered at the date of conversion, would be overinsured.

Renewal Standard. An Insurer may refuse to renew an in-force converted policy if any person or persons covered by it is overinsured, would be overinsured, subject to the following conditions:

1. The Insurer must give the Insured written notice at least 31 days in advance of a renewal date that the Insured may elect, prior to that renewal date, (a) to have such person or persons eliminated from the converted policy's coverage or (b) to have the converted

policy terminated or (c) to have the total coverage reduced below the overinsurance standards. If the Insured elects elimination or reduction of benefits, this election or reduction must be evidenced by a rider signed by the Insured and by an appropriate adjustment in premium for the converted policy.

2. The elimination, termination or reduction of coverage will take effect after notice to the Insured and on the first renewal date after such notice in accordance with the provisions of the policy.

3. After the converted policy has been in force for two years, the Insurer can refuse to renew coverage only if: (a) each person whose coverage is to be non-renewed is eligible for Medicare coverage or (b) the governmental agency which regulates insurance in the jurisdiction where the Insured resided on the date of issuance of the converted policy has given advance approval to the non-renewal.

Appendix D

Schedule of Maximum Annual Group Conversion Rates for Persons Converting at Age 60 and Over

Plan I	Male	Female
$20 Daily Hospital Room & Board (21 days maximum)	$ 55	$ 48
$200 Miscellaneous Hospital Expense Benefit	61	51
$300 Surgical Schedule	22	18
Total	$138	$117

Plan II	Male	Female
$35 Daily Hospital Room & Board (30 days Maximum)	$106	$ 88
$350 Miscellaneous Hospital Expense Benefit	95	78
$500 Surgical Schedule	36	30
Total	$237	$196

Plan III	Male	Female
$50 Daily Hospital Room & Board (70 Days maximum)	$171	$134
$500 Miscellaneous Hospital Expense Benefit	119	95
$750 Surgical Schedule	54	45
Total	$344	$274

Major Medical	Male	Female
$500 Deductible; $20,000 Maximum; Each Cause Plan	$487	$362

Increase rates 8% for all cause plan. Reduce rates 10% if coverage for private duty nursing, in-hospital psychiatric care, and out-of-hospital drugs are not provided; and there is an inside limit on in-hospital physicians fees.

Appendix E-I

Schedule of Acceptable Annual Group Conversion Rates for Persons Converting to Basic Plan I at Ages Under 60

Age at Conversion	Sex	$20 Daily R & B 21 day maximum		$200 Misc. Exp.		$300 Surgical		Total	
		1st* yr.	Renewal**	1st yr.	Renewal	1st yr.	Renewal	1st yr.	Renewal
<25	M	$ 15	$ 17	$ 27	$ 29	$ 9	$ 9	$ 51	$ 55
	F	21	25	41	45	13	15	75	85
25-29	M	15	18	27	30	9	9	51	57
	F	24	30	43	49	14	17	81	96
30-34	M	16	22	28	35	9	10	53	67
	F	29	33	49	55	17	20	95	108
35-39	M	20	27	33	41	9	12	62	80
	F	31	39	55	59	20	22	106	120
40-44	M	25	32	40	47	11	14	76	93
	F	42	45	61	61	22	23	125	129
45-49	M	31	39	46	53	14	17	91	109
	F	45	47	61	60	23	23	129	130
50-54	M	39	47	53	60	17	20	109	127
	F	46	49	59	58	23	23	128	130
55-59	M	44	52	56	61	19	21	119	134
	F	44	48	52	53	20	20	116	121
Children		16		41		11		68	

* These rates represent a yearly renewable term premium for the central age of each quinquennial group.

**These rates represent a level premium to age 65 for one age above the central age of each quinquennial group.

Appendix E-II

Schedule of Acceptable Annual Group Conversion Rates for Persons Converting to Basic Plan II at Ages Under 60

Age at Conversion	Sex	$35 Daily R & B 30 day maximum		$350 Misc. Exp.		$500 Surgical		Total	
		1st yr.*	Renewal**	1st yr.	Renewal	1st yr.	Renewal	1st yr.	Renewal
<25	M	$ 28	$ 32	$ 39	$ 42	$ 15	$ 15	$ 82	$ 89
	F	38	46	59	66	21	25	118	137
25-29	M	28	34	39	45	15	15	82	94
	F	43	54	63	74	24	29	130	157
30-34	M	31	41	41	52	13	16	85	109
	F	54	61	73	82	28	33	155	176
35-39	M	39	51	49	61	15	19	103	131
	F	56	72	83	89	33	36	172	197
40-44	M	48	61	60	71	18	24	126	156
	F	76	82	91	92	37	38	204	212
45-49	M	60	74	70	82	23	28	153	184
	F	82	86	94	91	39	38	215	215
50-54	M	74	90	82	93	29	34	185	217
	F	84	89	89	89	39	38	212	216
55-59	M	84	99	86	95	32	35	202	229
	F	81	88	79	81	34	33	194	202
Children		30		54		18		102	

* These rates represent a yearly renewable term premium for the central age of each quinquennial group.

**These rates represent a level premium to age 65 for one age above the central age of each quinquennial group.

Appendix E-III

Schedule of Acceptable Annual Group Conversion Rates for Persons Converting to Basic Plan III at Ages Under 60

Age at Conversion	Sex	$50 Daily R & B 70 day maximum 1st yr.*	Renewal**	$500 Misc. Exp. 1st. yr.	Renewal	$750 Surgical 1st yr.	Renewal	Total 1st yr.	Renewa
<25	M	$ 45	$50	$45	$50	$ 22	$ 22	$112	$122
	F	59	71	68	78	32	38	159	187
25-29	M	45	54	45	53	22	22	112	129
	F	67	83	73	88	36	43	176	214
30-34	M	50	65	48	62	22	23	120	150
	F	83	93	88	99	43	49	214	241
35-39	M	62	81	58	74	22	29	142	184
	F	86	111	101	108	50	54	237	273
40-44	M	77	98	72	87	27	35	176	220
	F	117	125	111	112	55	57	283	294
45-49	M	95	119	84	101	34	43	213	263
	F	126	131	114	111	57	57	297	299
50-54	M	117	143	101	115	43	51	261	309
	F	130	137	109	109	57	57	296	303
55-59	M	134	159	106	118	48	53	288	330
	F	125	134	97	100	50	50	272	284
Children		46		60		27		133	

* These rates represent a yearly renewable term premium for the central age of each quinquennial group.

**These rates represent a level premium to age 65 for one age above the central age of each quinquennial group.

Appendix E-MM

Schedule of Acceptable Annual Group Conversion Rates for Persons Converting to Major Medical Plan at Ages Under 60

Age at Conversion	Sex	\$500 Deductible \$20,000 Maximum Each cause plan 1st yr.*	Renewal**
<25	M	\$ 75	\$ 93
	F	69	116
25-29	M	80	112
	F	106	154
30-34	M	99	142
	F	144	193
35-39	M	130	178
	F	185	234
40-44	M	150	222
	F	230	272
45-49	M	191	297
	F	263	311
50-54	M	292	406
	F	312	355
55-59	M	408	467
	F	334	362
Children		82	

Increase rates 8% for all cause plan. Reduce rates 10% if coverage for private duty nursing, in-hospital psychiatric care, and out-of-hospital drugs are not provided; and there is an inside limit on in-hospital physicians fees.

* These rates represent a yearly renewable term premium for the central age of each quinquennial group.

**These rates represent a level premium to age 65 for one age above the central age of each quinquennial group.