CHAPTER 62A

ACCIDENT AND HEALTH INSURANCE

62A.01 POLICY OF ACCIDENT AND SICKNESS INSURANCE DEFINED. The term "policy of accident and sickness insurance" as used herein includes any policy covering the kind of insurance described in section 60A.06, subdivision 1, clause (5) (a).

[*1967 c 395 art 3 s 1*]

62A.02 POLICY FORMS. Subdivision 1. **Filing.** No policy of accident and sickness insurance shall be issued or delivered to any person in this state, nor shall any application, rider, or endorsement be used in connection therewith, until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto have been filed with the commissioner. The filing for nongroup policies shall include a statement of acturarial reasons and data to support the need for any premium rate increase.

Subd. 2. **Approval.** No such policy shall be issued, nor shall any application, rider, or endorsement be used in connection therewith, until the expiration of 30 days after it has been so filed unless the commissioner shall sooner give his written approval thereto.

Subd. 3. **Disapproval.** The commissioner shall, within 30 days after the filing of any form, disapprove the form:

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

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

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

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

from disapproving a form which meets the requirements of this paragraph but which the commissioner determines still provides benefits which are unreasonable in relation to the benefits charged. The commissioner may until December 31, 1978, exercise emergency power for the purpose of implementing the minimum anticipated loss ratio requirement, and for this purpose may adopt emergency rules as provided in section 15.0412, subdivision 5. Notwithstanding the expiration of the commissioner's emergency power, any emergency rule adopted by him prior to the expiration of his emergency power may remain effective for the periods authorized in section 15.0412, subdivision 5.

If the commissioner notifies an insurer which has filed any form that the form does not comply with the provisions of this section or sections 62A.03 to 62A.05 and section 72A.20, subdivision 1, it shall be unlawful thereafter for the insurer to issue the form or use it in connection with any policy. In the notice the commissioner shall specify the reasons for his disapproval and state that a hearing will be granted within 20 days after request in writing by the insurer.

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

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

Subd. 6. **Court review.** Any order or decision of the commissioner under this section shall be subject to review by writ of certiorari at the instance of any party in interest. In the case of disapproval or withdrawal of approval of a form previously in use the court shall determine whether the petition for such writ shall operate as a stay of any such order or decision. The court may, in disposing of the issue before it, modify, affirm, or reverse the order or decision of the commissioner in whole or in part.

[*1967 c 395 art 3 s 2; 1976 c 296 art 2 s 10,11; 1977 c 409 s 1*]

62A.025 UNIFORM HEALTH INSURANCE CLAIM FORMS. The commissioner of insurance shall prescribe uniform health insurance claim forms for each class of provider which shall be used by all insurers issuing in this state policies of accident and sickness insurance, all service plan corporations issuing in this state subscriber contracts, and all state agencies that require health insurance claims for their records. The forms shall be scannable where required and provide information as required to insure maximum federal participation in program and administrative costs. Whenever feasible, the commissioner shall utilize the standardized claim form of the provider or an association to which the provider belongs.

[*1975 c 387 s 1*]

62A.03 GENERAL PROVISIONS OF POLICY. Subdivision 1. **Conditions.** No policy of individual accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless the following conditions are met:

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

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

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

(a) husband

(b) wife

(c) dependent children

(d) any children under a specified age which shall not exceed 19 years

(e) any other person dependent upon the policyholder.

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

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

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

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

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

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

(10) **Osteopath, optometrist or chiropractor services.** With respect to any policy of individual accident and sickness insurance issued or entered into subsequent to August 1, 1974, notwithstanding the provisions of any such policy, wherever therein there is a provision providing for reimbursement for any service which is in the lawful scope of practice of a duly licensed osteopath, optometrist or chiropractor, the person entitled to benefits or person performing services under such policy shall be entitled to reimbursement on an equal basis for such service, whether the said service is performed by a physician, osteopath, optometrist or chiropractor duly licensed under the laws of this state.

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

[*1967 c 395 art 3 s 3; 1969 c 985 s 1; 1974 c 30 s 1*]

62A.04 STANDARD PROVISIONS. Subdivision 1. **Reference.** Any reference to "standard provisions" which may appear in other sections and which refer to accident and sickness or accident and health insurance shall hereinafter be construed as referring to accident and sickness policy provisions.

Subd. 2. **Required provisions.** Except as provided in subdivision 4 each such policy delivered or issued for delivery to any person in this state shall contain the pro-

visions specified in this subdivision in the words in which the same appear in this section. The insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this subdivision or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

(1) A provision as follows:

ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

(2) A provision as follows:

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

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

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

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

(3) A provision as follows:

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

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

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

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

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

(4) A provision as follows:

REINSTATEMENT: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. If the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day fol-

lowing the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement. The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age 50, or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue.

(5) A provision as follows:

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

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

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

(6) A provision as follows:

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

(7) A provision as follows:

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

(8) A provision as follows:

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

(9) A provision as follows:

PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

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

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

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

(10) A provision as follows:

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

(11) A provision as follows:

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

(12) A provision as follows:

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

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

(1) A provision as follows:

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

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

(2) A provision as follows:

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

(3) A provision as follows:

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

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

(4) A provision as follows:

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

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

(5) A provision as follows:

INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense in-

curred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro-rata portion for the indemnities thus determined.

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

(6) A provision as follows:

RELATION OF EARNINGS TO INSURANCE: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall exceed the pro-rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of $200 or the sum of the monthly benefits specified in such coverages, whichever is the lesser, not shall it operate to reduce benefits other than those payable for loss of time.

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

(7) A provision as follows:

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

(8) A provision as follows:

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

(9) A provision as follows:

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

(10) A provision as follows:

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

(11) A provision as follows:

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

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

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

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

Subd. 7. **Reciprocal provisions; foreign insurer.** Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of sections 62A.01 to 62A.09 hereof, and which is prescribed or required by the law of the state under which the insurer is organized.

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

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

[*1967 c 395 art 3 s 4; 1975 c 359 s 23*]

62A.041 MATERNITY BENEFITS; UNMARRIED WOMEN. Each group policy of accident and health insurance issued or renewed after June 4, 1971, shall provide the same coverage for maternity benefits to unmarried women and minor female dependents that it provides to married women including the wives of employees choosing dependent family coverage. If an insured is a parent or an acknowledged or adjudicated parent of a dependent illegitimate child each group policy issued or renewed after July 1, 1976, shall provide the same coverage for that child as that provided for the child of an employee choosing dependent family coverage if the insured elects dependent family coverage.

Each individual policy of accident and health insurance shall provide the same coverage for maternity benefits to unmarried women and minor female dependents as that provided for married women. If the insured is a parent or an acknowledged or adjudicated parent of a dependent illegitimate child, each individual policy issued or renewed after July 1, 1976, shall also provide the same coverage for that child as that provided for the child of an insured choosing dependent family coverage if the insured elects dependent family coverage.

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

[*1971 c 680 s 1; 1973 c 651 s 1; 1976 c 121 s 3*]

62A.042 FAMILY COVERAGE; COVERAGE OF NEWBORN INFANTS. Subdivision 1. **Individual family policies; renewals.** No policy of individual accident and sickness insurance which provides for insurance for more than one person under section 62A.03, subdivision 1, clause (3), shall be renewed to insure any person in this state or be delivered or issued for delivery to any person in this state unless such policy includes as insured members of the family any newborn infants immediately from the moment of birth and thereafter which insurance shall provide coverage for illness, injury, congenital malformation or premature birth.

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

[*1973 c 303 s 1*]

62A.043 DENTAL PROCEDURES. Subdivision 1. The provisions of this section shall apply to all individual or group policies or subscriber contracts providing payment for care in this state, which policies or contracts are issued or renewed after August 1, 1976 by an accident and health insurance company regulated under this chapter, or a nonprofit health service plan corporation regulated under chapter 62C.

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

[*1973 c 430 s 1; 1976 c 207 s 1*]

62A.044 PAYMENTS TO GOVERNMENTAL INSTITUTIONS. No group or individual policy of accident and sickness insurance issued or renewed after May 22, 1973 pursuant to this chapter, and no group or individual service plan or subscriber contract issued or renewed after May 22, 1973 pursuant to chapter 62C, shall contain any provision denying or prohibiting payments for services rendered by a hospital or medical institution owned or operated by the federal, state, or local government or practitioners therein in any instance wherein charges for such services are imposed against the policy holder or subscriber. The unit of government operating the institution may maintain an action for recovery of such charges.

[*1973 c 471 s 1*]

62A.045 PAYMENTS TO WELFARE RECIPIENTS. No policy of accident and sickness insurance issued or renewed after August 1, 1975, shall contain any provision denying or reducing benefits because services are rendered to an insured or dependent

who is eligible for or receiving medical assistance pursuant to chapter 256B.

[*1975 c 247 s 1*]

62A.05 CONSTRUCTION OF PROVISIONS. Subdivision 1. No policy provision which is not subject to section 62A.04 shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to sections 62A.01 to 62A.09 hereof.

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

[*1967 c 395 art 3 s 5*]

62A.06 STATEMENTS IN APPLICATION. Subdivision 1. **Inclusion in policy.** The insured shall not be bound by any statement made in an application for a policy unless a copy of such application is attached to or endorsed on the policy when issued as a part thereof. If any such policy delivered or issued for delivery to any person in this state shall be reinstated or renewed, and the insured or the beneficiary or assignee of such policy shall make written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall within 15 days after the receipt of such request at its home office or any branch office of the insurer, deliver or mail to the person making such request, a copy of such application. If such copy shall not be so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action or proceeding based upon or involving such policy or its reinstatement or renewal.

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

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

[*1967 c 395 art 3 s 6*]

62A.07 RIGHTS OF INSURER, WHEN NOT WAIVED. The acknowledgment by an insurer of the receipt of notice given under any policy covered by sections 62A.01 to 62A.09 hereof, or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under such policy.

[*1967 c 395 art 3 s 7*]

62A.08 COVERAGE OF POLICY, CONTINUANCE IN FORCE. If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

[*1967 c 395 art 3 s 8*]

62A.081 PAYMENTS TO FACILITIES OPERATED BY STATE OR LOCAL GOVERNMENT. Every group or individual policy of accident and sickness insurance issued or renewed after July 1, 1973 regulated by this chapter, and every group or in-

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

[*1973 c 765 s 24*]

62A.09 LIMITATION. Nothing in sections 62A.01 to 62A.08 shall apply to or affect:

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

(2) any policy or contract of reinsurance; or

(3) any blanket or group policy of insurance; or

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

[*1967 c 395 art 3 s 9; 1975 c 359 s 23*]

62A.10 GROUP INSURANCE. Subdivision 1. **Requirements.** Group accident and health insurance is hereby declared to be that form of accident and health insurance covering not less than two employees nor less than ten members, and which may include the employee's or member's dependents, consisting of husband, wife, children, and actual dependents residing in the household, written under a master policy issued to any governmental corporation, unit, agency, or department thereof, or to any corporation, copartnership, individual, employer, or to any association having a constitution or bylaws and formed in good faith for purposes other than that of obtaining insurance under the provisions of this chapter, where officers, members, employees, or classes or divisions thereof, may be insured for their individual benefit.

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

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

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

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

(3) **New insureds.** A provision that to the group or class thereof originally insured may be added, from time to time, all new employees of the employer or

members of the association eligible to and applying for insurance in that group or class and covered or to be covered by the master policy.

[*1967 c 395 art 3 s 10; 1973 c 303 s 2*]

62A.11 BLANKET ACCIDENT AND SICKNESS INSURANCE. Subdivision 1. **Requirements.** Blanket accident and sickness insurance is hereby declared to be that form of accident and sickness insurance covering special groups of persons as enumerated in one of the following paragraphs:

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

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

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

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

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

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

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

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

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

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

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

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

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

[*1967 c 395 art 3 s 11*]

62A.12 TRANSITION PROVISION AS TO INDIVIDUAL POLICIES, RIDERS OR ENDORSEMENTS. A policy, rider or endorsement, which could have been lawfully used or delivered or issued for delivery to any person in this state immediately before April 18, 1957, may be used or delivered or issued for delivery to any such person until January 1, 1959, without being subject to the provisions of sections 62A.03, 62A.04, or 62A.05.

[*1967 c 395 art 3 s 12*]

62A.13 COMMERCIAL TRAVELER INSURANCE COMPANIES. Any domestic assessment, health or accident association now licensed to do business in this state, which confines its membership to commercial travelers, professional men, and others whose occupation is of such character as to be ordinarily classified as no more hazardous than commercial travelers, and which does not pay any other commissions or compensations, other than prizes to members of nominal value in proportion to the membership fees charged for securing new members, may issue certificates of membership, which, with the application of the member and the bylaws of the association, shall constitute the contract between the association and the member. A printed copy of the bylaws and a copy of the application shall be attached to the membership certificate when issued, and a copy of any amendment to the bylaws shall be mailed to the members following their adoption. Certified copies of certificate, bylaws and amendments shall be filed with the commissioner of insurance and subject to his approval. The bylaws shall conform to the requirements of this chapter, so far as applicable, and wherever the word "policy" appears in this chapter, it shall, for the purpose of this section, be construed to mean the contract as herein defined.

[*1967 c 395 art 3 s 13*]

62A.14 HANDICAPPED CHILDREN. Subdivision 1. **Individual family policies.** An individual hospital or medical expense insurance policy delivered or issued for delivery in this state more than 120 days after May 16, 1969, which provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (b) chiefly dependent upon the policyholder for support and maintenance, provided proof of such incapacity and dependency is furnished to the insurer by the policyholder within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer but not more frequently than annually after the two year period following the child's attainment of the limiting age.

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

[*1969 c 436 s 1*]

62A.145 SURVIVORS OF DECEASED EMPLOYEE; DEFINITIONS. Subdivision 1. For the purposes of this section and section 62A.146, the terms defined in this section shall have the meanings here given them.

Subd. 2. "Covered employee" means any person who, at the time of his death, was employed by any employer providing, offering or contributing to group insurance coverage for that employee who was so enrolled for the coverage.

Subd. 3. "Group insurance" means any policy or contract of accident and health protection, regardless of by whom underwritten, paid for in full or in part by an employer, which provides benefits, including cash payments for reimbursement of expen-

ses and the provision of usual and needed health care and medical services as the result of any injury, sickness, disability or disease suffered by a group of employees, or any one of them, and the dependents of such employees.

Subd. 4. "Employer" means any natural person, company, corporation, partnership, association or firm which employs any employee.

Subd. 5. "Survivor" means any person who would be entitled to and be dependent upon economic support by an employee if that employee were alive; including any spouse and/or child or children as defined by the group insurance policy.

[*1973 c 339 s 1*]

62A.146 GROUP INSURANCE; CONTINUATION OF BENEFITS TO SURVIVORS. Every employer providing a policy or plan of accident and health protection and benefits for his employees, or any of them, and the dependents of such employees shall not, except upon the written consent of the survivor or survivors of any deceased covered employee, terminate, suspend or otherwise restrict the participation in or the receipt of benefits otherwise payable under such policy or plan of group insurance to such survivor or survivors within one year of the covered employee's death. Provided, however, that any survivor or survivors, in order to have the coverage and benefits extended for such one year period, as herein provided, may be required to pay the entire cost of such protection. Failure of the survivor to make premium payments in advance to the employer shall be a basis in itself for the termination of the coverage without the written consent heretofore required for such termination, but in event of termination by reason of the survivor's failure to make required premium payments, if any, written notice of such cancellation must be sent by the policyholder by mail to said survivor's last known address at least 15 days prior to such cancellation.

[*1973 c 339 s 2*]

62A.147 DISABLED EMPLOYEES' BENEFITS; DEFINITIONS. Subdivision 1. For the purposes of this section and section 62A.148, the terms defined in this section shall have the meanings here given them.

Subd. 2. "Covered employee" means any person who, at the time he suffered an injury resulting in total disability or became totally disabled by reason of illness, was employed by and receiving a salary, commission, hourly wage, or other remuneration for his services by any employer providing, offering or contributing to group insurance coverage for that employee who was so enrolled for the coverage.

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

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

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

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

[*1973 c 340 s 1*]

62A.148 GROUP INSURANCE; PROVISION OF BENEFITS FOR DISABLED EMPLOYEES. No employer or insurer of that employer shall terminate, suspend or otherwise restrict the participation in or the receipt of benefits otherwise payable under any program or policy of group insurance to any covered employee who becomes totally disabled while employed by the employer solely on account of absence caused by such total disability. If the employee is required to pay all or any part of the pre-

mium for the extension of coverage, payment shall be made to the employer, by the employee.

[*1973 c 340 s 2*]

62A.149 BENEFITS FOR ALCOHOLICS AND DRUG DEPENDENTS. Subdivision 1. The provisions of this section shall apply to all group policies of accident and health insurance and group subscriber contracts offered by nonprofit health service plan corporations regulated under chapter 62C, and to a plan or policy that is individually underwritten or provided for a specific individual and the members of his family as a nongroup policy unless the individual elects in writing to refuse benefits under this subdivision in exchange for an appropriate reduction in premiums or subscriber charges under the policy or plan, when the policies or subscriber contracts are issued or delivered in Minnesota or provide benefits to Minnesota residents enrolled thereunder.

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

(1) a licensed hospital,

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

(3) a non-residential treatment program approved or licensed by the state of Minnesota.

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

[*1973 c 585 s 1,2; 1976 c 262 s 1; 1978 c 793 s 60*]

62A.15 CHIROPRATIC SERVICES IN ACCIDENT AND HEALTH AND NONPROFIT HEALTH SERVICE POLICIES. Subdivision 1. **Applicability.** The provisions of this section shall apply to all group policies or subscriber contracts providing payment for care in this state, which are issued or renewed after August 1, 1973, and after August 1, 1976, for optometric services, by accident and health insurance companies regulated under this chapter, and nonprofit health service plan corporations regulated under chapter 62C.

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

Subd. 3. **Optometric services.** All benefits provided by any policy or contract referred to in subdivision 1, relating to expenses incurred for medical treatment or services of a physician shall also include optometric treatment and services of an optometrist to the extent that the optometric services and treatment are within the scope of optometric licensure. This subdivision is intended to provide equal payment of benefits for optometric treatment and services and is not intended to change or add to the benefits provided for in such policies or contracts.

Subd. 4. **Denial of benefits.** No carrier referred to in subdivision 1 shall, in the payment of claims to employees in this state, deny benefits payable for services covered by the policy or contract if the services are lawfully performed by a duly licensed chiropractor.

[*1973 c 252 s 1; 1976 c 192 s 1,2; 1976 c 242 s 1*]

62A.151 HEALTH INSURANCE BENEFITS FOR EMOTIONALLY HANDICAPPED CHILDREN. No policy or plan of health, medical, hospitalization, or accident and sickness insurance regulated under this chapter, or nonprofit health service plan corporation regulated under chapter 62C, or health maintenance organization regulated under chapter 62D which provides coverage of or reimbursement for inpatient hospital and medical expenses shall be delivered, issued, executed or renewed in this state, or approved for issuance or renewal in this state by the commissioner of insur-

ance, after July 1, 1975 unless the policy or plan includes and provides health service benefits to any subscriber or other person covered thereunder, on the same basis as other benefits, for the treatment of emotionally handicapped children in a residential treatment facility licensed by the commissioner of public welfare. For purposes of this section "emotionally handicapped child" shall have the meaning set forth by the commissioner of public welfare in the rules and regulations relating to residential treatment facilities. The restrictions and requirements of this section shall not apply to any plan or policy which is individually underwritten or provided for a specific individual and the members of his family as a nongroup policy. The mandatory coverage under this section shall be on the same basis as inpatient hospital medical coverage provided under the policy or plan.

[*1975 c 40 s 1*]

62A.152 BENEFITS FOR AMBULATORY MENTAL HEALTH SERVICES. Subdivision 1. The provisions of this section shall apply to all group policies or subscriber contracts which are issued or renewed within this state after August 1, 1975 by accident and health insurance companies regulated under this chapter, and nonprofit health service plan corporations regulated under chapter 62C.

Subd. 2. All group policies and all group subscriber contracts providing benefits for mental or nervous disorder treatments in a hospital shall also provide coverage, to at least the extent of 90 percent of the first $600 of the cost of the usual and customary charges incurred over a 12-month period, for mental or nervous disorder consultation, diagnosis and treatment services delivered while the insured person is not a bed patient in a hospital, if such services are furnished by (1) a licensed or accredited hospital, (2) a community mental health center or mental health clinic approved or licensed by the commissioner of public welfare or other authorized state agency, or (3) by a consulting psychologist licensed under the provisions of sections 148.87 to 148.99, or by a psychiatrist licensed under chapter 147.

[*1975 c 89 s 1*]

62A.153 FREE STANDING AMBULATORY SURGICAL CENTERS. No policy or plan of health, medical, hospitalization, or accident and sickness insurance regulated under this chapter, or subscriber contract provided by a nonprofit health service plan corporation regulated under chapter 62C shall be issued, renewed, continued, delivered, issued for delivery or executed in this state, or approved for issuance or renewal in this state by the commissioner of insurance unless the policy, plan or contract specifically provides coverage for a health care treatment or service rendered by a free standing ambulatory surgical center or facilities offering ambulatory medical service 24 hours a day seven days a week, which are not part of a hospital, but have been reviewed and approved by the state commissioner of health to provide the treatment or service, on the same basis as coverage provided for the same health care treatment or service rendered by a hospital.

[*1976 c 45 s 1; 1977 c 305 s 45*]

62A.16 GROUP HOSPITAL AND MEDICAL COVERAGE AND HEALTH CARE PLANS, APPLICABILITY. The provisions of sections 62A.16 and 62A.17 shall apply to all group insurance policies or group subscriber contracts providing coverage for hospital or medical expenses incurred by a Minnesota resident employed within this state. Sections 62A.16 and 62A.17 shall also apply to health care plans established by employers in this state through health maintenance organizations certified under chapter 62D.

[*1974 c 101 s 1; 1976 c 142 s 1*]

62A.17 TERMINATION OF EMPLOYMENT. Subdivision 1. **Continuation of coverage.** Every group insurance policy, group subscriber contract and health care plan included within the provisions of section 62A.16, except policies, contracts or health care plans covering employees of an agency of the federal government, shall contain a provision which permits every eligible employee whose employment is terminated, if the policy, contract or health care plan remains in force for active employees of the employer, to elect to continue the coverage for himself and his dependents.

Subd. 2. **Responsibility of employee.** Every eligible employee electing to continue coverage shall pay his former employer, on a monthly basis, the cost of the continued coverage. If the policy, contract or health care plan is administered by a trust every eligible employee electing to continue coverage shall pay the trust the cost

of continued coverage according to the eligibility rules established by the trust. The employee shall be eligible to continue the coverage until he becomes re-employed and eligible for health care coverage under a group policy, contract or plan sponsored by the same or another employer, or for a period of six months after the termination of employment, whichever is shorter.

Subd. 3. **Eligibility for continued coverage.** An employee shall be eligible to make the election for himself and his dependents provided for in subdivision 1 if:

(a) In the period preceding the termination of his employment, he and his dependents were covered through his employment by a group insurance policy, subscriber's contract or health care plan included within the provisions of section 62A.16;

(b) The termination of employment was for reasons other than the discontinuance of the business, bankruptcy, the employee's disability or retirement.

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

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

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

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

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

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

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

Notice may be in writing and sent by first class mail to the employee's last known address which the employee has provided the employer or trust. If the employer or trust fails to so notify the employee who is properly enrolled in the program, the employee shall have the option to retain coverage provided he makes this election within 60 days of the date his employment is terminated by making the proper payment to the employer or trust to provide continuous coverage.

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

Subd. 6. **Conversion to individual policy.** A group insurance policy that provides post termination coverage as required by this section shall also include a provision allowing a covered employee or surviving spouse or dependent at the expiration of the post termination coverage provided by subdivision 2 to obtain from the insurer offering the group policy or group subscriber contract, at the employee's, spouse's or dependent's option and expense, without further evidence of insurability and without interruption of coverage, an individual policy of insurance or an individual subscriber contract providing at least the minimum benefits of a qualified plan as prescribed by section 62E.06 and the option of a number three qualified plan, a number two qualified plan, and a number one qualified plan as provided by section 62E.06, subdivisions 1 to 3. A policy providing reduced benefits at a reduced premium rate may be accepted by the employee, the spouse or a dependent in lieu of the optional coverage otherwise required by this subdivision.

The individual policy shall be renewable at the option of the individual as long as the individual is not covered under another qualified plan as defined in section 62E.02, subdivision 4, up to age 65 or to the day before the date of eligibility for coverage under Title XVIII of the Social Security Act, as amended. Any revisions in the table of

rate for the individual policy shall apply to the covered person's original age at entry, and shall apply equally to all similar policies issued by the insurer.

[*1974 c 101 s 2; 1975 c 100 s 1-3; 1976 c 142 s 2,3; 1977 c 409 s 2*]

62A.18 PROHIBITION AGAINST DISABILITY OFFSETS. No individual or group policy of accident and health insurance issued, amended, renewed, or delivered in this state on or after January 1, 1976 shall contain any provision offsetting, or in any other manner reducing, any benefit under the policy by the amount of, or in proportion to, any increase in disability benefits received or receivable under the federal Social Security Act, the Railroad Retirement Act, any Veteran's Disability Compensation and Survivor Benefits Act, Workers' Compensation, or any similar federal or state law, as amended subsequent to the date of commencement of such benefit.

[*1975 c 323 s 1*]

62A.21 CONVERSION PRIVILEGES FOR INSURED FORMER SPOUSES. Subdivision 1. No policy of accident and health insurance providing coverage of hospital or medical expense on either an expense incurred basis or other than an expense incurred basis, which in addition to covering the insured also provides coverage to the spouse of the insured shall contain a provision for termination of coverage for a spouse covered under the policy solely as a result of a break in the marital relationship except by reason of an entry of a valid decree of dissolution of marriage.

Subd. 2. Every policy described in subdivision 1 which contains a provision for termination of coverage of the spouse upon dissolution of marriage shall contain a provision to the effect that upon the entry of a valid decree of dissolution of marriage between the insured parties the spouse shall be entitled to have issued to him or her, without evidence of insurability, upon application made to the company within 30 days following the entry of the decree, and upon the payment of the appropriate premium, an individual policy of accident and health insurance. The policy shall provide the coverage then being issued by the insurer which is most nearly similar to, but not greater than, the terminated coverages. Any and all probationary or waiting periods set forth in the policy shall be considered as being met to the extent coverage was in force under the prior policy.

Subd. 3. This section applies to every policy of accident and health insurance which is delivered, issued for delivery, renewed or amended on or after the effective date of this section.

[*1977 c 186 s 1*]