

**TITLE 365. INSURANCE DEPARTMENT
CHAPTER 10. LIFE, ACCIDENT AND HEALTH**

**SUBCHAPTER 1. GENERAL PROVISIONS
PART 1. GENERAL PROVISIONS**

365:10-1-1. Purpose

The rules of this chapter provide regulations relating to life, accident and health insurance.

365:10-1-2. Severability

If any provision of this chapter or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the section and the application of such provisions to the persons or circumstances shall not be affected thereby.

1 Editor's Note: In the initial codification of this agency's rules (12-31-91), this section was misnumbered as 365:105-1-2. Upon discovery of this error on 11-1-93, the number was changed to 365:10-1-2.

365:10-1-3. Uniform health insurance claim form

(a) **Purpose.** The purpose of this section is to set forth a uniform health insurance claim form which shall be accepted by all insurers transmitting health insurance in the state, state agencies and insurance trusts.

(b) **Uniform health insurance claim form.**

(1) The form in Appendix A of this chapter shall be accepted by all insurers transmitting health insurance in the state, all state agencies that require health insurance claim forms for their records and all insurance trusts or derivatives thereof.

(2) An insurer may continue to request additional information from the claimant or hospital so that the health insurance claim may be properly processed.

365:10-1-4. Blood transfusions

(a) **Purpose.** The purpose of this section is to set forth required policy provisions regarding blood transfusions.

(b) **Contract requirements regarding blood transfusions.** Accident and Health contracts containing benefits respecting blood transfusions shall clearly set forth whether or not the cost of the blood is included in the benefit. If the cost of the blood is not included, the contract shall so specify. Examples of acceptable wording shall be as follows:

(1) Blood transfusion, including materials, services and equipment (including blood cost).

(2) Blood transfusion, including materials, services and equipment (excluding blood cost).

365:10-1-5. Unfair discrimination on basis of blindness or partial blindness

(a) **Purpose.** The purpose of this section is to identify specific acts or practices which are prohibited by 36 O.S. § 1204(7).

(b) **Acts of "unfair discrimination" defined.** The following are hereby identified as acts or practices which constitute *unfair discrimination between individuals of the same class* [36:1204(7)]:

- (1) Refusing to insure, or
- (2) Refusing to continue to insure, or
- (3) Limiting the amount, extent or
- (4) Kind of coverage available to an individual, or
- (5) Charging an individual a different rate for the same coverage solely because of blindness or partial blindness.

365:10-1-6. Oklahoma Life and Health Insurance Guaranty Association notice requirements

(a) **Purpose.** The purpose of this section is to provide the contract or policyholders with information concerning the coverage or non-coverage by the Oklahoma Life and Health Insurance Guaranty Association Act.

(b) **Form of notice.** The notice for policies or contracts covered or not covered by the Guaranty Association shall be prepared as follows:

(1) The information required by 36 O.S. Section 2043(C) shall be included on the summary document required by 36 O.S. Section 2043(B). The summary document shall:

(A) Prominently warn the policy or contract holder that the Life and Health Insurance Guaranty Association may not cover the policy or, if coverage is available, it will be subject to substantial limitations, exclusions and conditioned on continued residence in the state;

(B) State that the insurer and its agents are prohibited by law from using the existence of the Life and Health Insurance Guaranty Association for the purpose of sales, solicitation or inducement to purchase any form of insurance;

(C) Emphasize that the policy or contract holder should not rely on coverage under the Life and Health Insurance Guaranty Association when selecting an insurer; and

(D) State the name and address of the Life and Health Insurance Guaranty Association and Insurance Department.

(2) The Oklahoma Life and Health Insurance Guaranty Association shall prepare and submit to the Commissioner for the Insurance Commissioner's approval the document required by (1) of this subsection. If the Guaranty Association fails to submit a document that meets with the Commissioner's approval within 30 days after this section is adopted the National Association of Insurance Commissioner Model Notice shall be used.

(3) The notice required by 36 O.S. Section 2043(D) shall be printed in bold fact type on a separate one page document, not less than eight inches by five inches, with type not less than 10-point. The notice shall be entitled, "Special Notice", and shall contain the following information:

(A) Company name and address;

(B) A statement disclosing that all or a portion of the policy or contract is not guaranteed by the insurer or all or a portion of the risk under the policy or contract is borne by the policy or contract holder and is not covered by the Oklahoma Life and Health Insurance Guaranty Association; and

(C) The statements required by (1)(B) and (1)(D) of this subsection.

(c) **Separability provision.** If any provision of this section or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the section and the application of such provisions to the persons or circumstances shall not be affected thereby.

[Source: Amended at 28 Ok Reg 1960, eff 7-14-11]

365:10-1-7. Charitable services exclusions - applicability to state owned or controlled hospitals - penalty

(a) **Purpose.** The purpose of this section is to provide that a policy exclusion limiting benefits to the insured for services rendered by a state hospital are not applicable to state owned and/or controlled hospitals which admit paying patients.

(b) **Application of charitable service exclusions to state-owned or controlled hospitals; penalties.**

(1) **Applicability.** Any exclusion or limitation contained in policies of accident and health, and/or hospitalization insurance heretofore or hereafter issued by any insurer to residents of this state, which exclusion or limitation purports to deny policy benefits to the insured for "any or all hospital, surgical and/or medical services obtained from or at state hospitals, which the insured is entitled to receive without charge", or any exclusion or limitation of similar import, however worded, shall not be applicable to state owned and/or controlled hospitals in this state, provided, and to the extent that such state hospitals are duly authorized to admit "paying patients" for hospital, surgical and/or medical services, or any of such services.

(2) **Penalties for noncompliance.** Any insurance company violating the provisions of this section in connection with claims arising in this state shall be subject to the penalties provided for by law, including, but not by way of limitation, the revocation of its license to transact business in this state.

365:10-1-8. Proof of loss

(a) **Purpose.** The purpose of this section is to define proof of loss and set forth time restraints for receipt of evidence of a claim.

(b) **Definitions.** The following words or terms, when used in this section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Proof of loss"** is defined in 36 O.S. Section 1219 as written proofs such as claim forms, medical bills, or other reasonable evidence of a claim, but shall not include information not necessary for determination of proof of loss and not pertinent to filed claims, such as any medical reports that the insurer wants to secure merely for completion of business records or files.

(2) "**Other reasonable evidence of a claim**" shall mean medical records necessary to satisfy the preexisting condition and medical necessity clauses of the policy, provided however, that such information is received within ninety (90) days after initial receipt of the claim form.

[Source: Added at 9 Ok Reg 3307, eff 7/27/92]

365:10-1-9. Eliminating unfair discrimination

(a) **Purpose.** The purpose of this section is to eliminate the act of denying benefits or coverage unfairly in the terms and conditions of insurance contracts and in the underwriting criteria of insurance carriers. It is not intended to prohibit reasonable and justifiable differences in premium rates based upon sound actuarial principles or actual or reasonably anticipated experience.

(b) **Definitions.**

(1) "**Contract**" means any insurance policy, plan or binder, including any rider or endorsement thereto offered by an insurer.

(2) "**Insurer**" includes:

(A) Every person engaged in the business of making contracts of insurance or indemnity.

(B) A nonprofit hospital service and medical indemnity corporation is an insurer within the meaning of the Code.

(C) Burial associations shall be deemed not to be insurers.

(c) **Applicability and scope.**

(1) This section shall apply to all contracts delivered or issued for delivery in this state by an insurer on or after July 1, 1993, to all existing group, franchise or blanket contracts which are amended or renewed on or after July 1, 1993 and to all policy forms submitted for approval on or after July 1, 1993, provided however that in the case of contracts issued pursuant to all collective bargaining agreements this section shall apply on the first date after July 1, 1993 upon which any new bargaining agreement first becomes effective.

(2) This section does not apply to or affect the right of fraternal benefit societies to determine eligibility requirements for membership. If a fraternal benefit society does, however, admit members of both sexes, this section is applicable to the insurance benefits available to members thereof.

(d) **Availability requirements.**

(1) Availability of any insurance contract shall not be denied to an insured or prospective insured solely on the basis of sex or marital status of the insured or prospective insured. The amount of benefits payable, or any term, conditions or type of coverage shall not be restricted, modified, excluded, or reduced solely on the basis of the sex or marital status of the insured or prospective insured except to the extent that amount of benefits, term, conditions or type of coverage vary as a result of the application of rate differentials permitted under the Oklahoma Insurance Code. However, nothing in this section shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependents benefits. Specific examples of practices prohibited by this section include but are not limited to the following:

- (A) Denying coverage to females gainfully employed at home, employed part-time or employed by relatives when coverage is offered to males similarly employed.
- (B) Denying policy riders to females when the riders are available to males.
- (C) Denying maternity benefits to unmarried females covered under a contract if maternity coverage is available to married females under such contract, provided that this shall not be construed to require that benefits must be payable for normal pregnancies under either group or individual insurance contracts.
- (D) Denying, under group contracts, dependant coverage to husbands of female employees, when dependant coverage is available to wives of male employees.
- (E) Denying disability income contracts to employed women when coverage is offered to men similarly employed.
- (F) Treating complications of pregnancy differently from any other illness or sickness under the contract. Complications of pregnancy means:
 - (i) conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, and similar conditions associated with the management of a difficult pregnancy not constituting a nosological distinct complication of pregnancy; and
 - (ii) non-elective cesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.
- (G) Restricting, reducing, modifying, or excluding benefits payable for disorders of the genital organs of only one sex.
- (H) Offering lower maximum monthly benefits to women than to men who are in the same classification under a disability income contract.
- (I) Offering more restrictive benefit periods and more restrictive definitions of disability to women than to men in the same classification under a disability income contract.
- (J) Establishing different conditions by sex under which the policyholder may renew a contract or exercise benefit options contained in the contract.
- (K) Limiting the amount of coverage an insured or prospective insured may purchase based upon the insured's or prospective insured's marital status unless such limitation is for the purpose of defining persons eligible for dependents benefits.

[Source: Added at 10 Ok Reg 1469, eff 5-1-93]

365:10-1-10. Portability form

(a) **Purpose.** The purpose of this section is to set forth a portability form which may be accepted by insurers transacting health insurance in the state, state agencies and insurance trusts.

(b) **Portability form.** The form in Appendix U of this Chapter may be accepted by all insurers transacting health insurance in the state, all employers that require proof of portability of insurance benefits for their records and all insurance trusts or derivatives thereof.

(c) **Form availability.** The portability form is to be completed by the employer and provided to the employee upon termination of employment. The form may be included with information pertaining to continuation of group coverage through COBRA.

(d) **Proof of satisfaction of preexisting conditions.** A form properly completed and signed by the previous employer may be accepted by the succeeding employer as proof of satisfaction of preexisting condition limitations or exclusions under the previous group coverage. Additional documentation should not be necessary either from the employee, the previous employer or the prior carrier, provided that the employee applies for the new coverage within 31 days of eligibility.

(e) **COBRA extension.** Electing COBRA continues group coverage and extends eligibility for continuous group coverage for purposes of portability.

(f) **Use of form.** The use of the portability form by employers is strictly voluntary. Failure to use this form will not result in civil or criminal penalties under the Insurance Code. The Portability form is designed to promote ease and uniformity of administration of health insurance benefits in compliance with 36 O.S. §4509.2.

[Source: Added at 11 Ok Reg 1835, eff 5-15-94]

365:10-1-11. Insurance policy and claim form warning.

(a) **Policies.** Every insurance policy issued or delivered in this State shall specify on its face, or by endorsement, or rider attached to the policy, printed in ten (10) point or larger type, a statement that clearly indicates in substance, as required in 36 O.S. §3613.1, the following: *WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.*

(b) **Claim forms.** Every insurance claim form shall contain a statement that clearly indicates in substance, as required in 36 O.S. §3613.1, the following:

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

[Source: Added at 11 Ok Reg 1837, eff 5-15-94]

365:10-1-12. Policy of insurance shall include insurer's complete name and street address

(a) **Purpose.** The purpose of this section is to set forth information which must be included on an insurance policy.

(b) **Insurer's name and address required on policy.**

(1) 36 O.S. §3613 (1981), entitled "Contents of Policies in General," provides that each contract of insurance shall set forth *the insurer's name and complete address* [36:3613(b)(2)].

(2) Every policy of insurance issued or delivered in this State shall specify, on its face, or by endorsement, or rider attached to the policy:

(A) The complete name of the insurer;

(B) The complete street address of the home or principal office of the insurer.

[Source: Added at 12 Ok Reg 3135, eff 7-31-95]

365:10-1-13. Notification required upon rejection

In the event an insurer rejects an applicant seeking health insurance coverage, such rejection shall be in writing and shall state with specificity the reason(s) for the denial. The rejection notification shall contain the following language: "Although your application for health insurance coverage was rejected, you may be eligible for coverage through the Oklahoma Health Insurance High Risk Pool or the Oklahoma Temporary High Risk Pool. For more information regarding these alternatives, please call 1-877-885-3717 or access the website at www.bcbsok.com/ohrp."

[Source: Added at 14 Ok Reg 2955, eff 7-14-97; Anended at 26 Ok Reg 1529, eff 7-14-2009; Amended at 28 Ok Reg 1960, eff 7-14-11]

365:10-1-14. Notice of withdrawal or discontinuance of writing

(a) Any insurer desiring to withdraw from the state or discontinue the writing of a particular type or class of insurance in this state shall give one hundred eighty (180) days notice in writing to the Rate and Form Filing Compliance Division of the Insurance Department and shall state in writing its reasons for such action. The insurer shall also provide the following information:

(1) The number of policyholders affected;

(2) The number of insurance agents affected;

(3) The date the insurer will cease writing new business;

(4) The date the insurer will start non-renewing insurance policies;

(5) Whether the insurer has made arrangements with another insurer to cover the renewals;

(6) The lines of insurance on which the insurer plans to concentrate; and

(7) Whether the insurer anticipates re-entering the market.

(b) The provision of information required by subsection (a) of this section by an insurer electing to nonrenew all of its health benefit plans issued in this state that are subject to the Health Insurance Portability and Accountability Act, Public Law 104-194, shall constitute compliance with the obligations of the insurer to report to the Insurance Commissioner pursuant to 36 O.S. § 4502(B)(9)(d)(2).

(c) The provision of information required in this section by a small employer carrier electing to nonrenew all of its health benefit plans issued to small employers in this state shall constitute compliance with the obligations of the small employer carrier to report to the Insurance Commissioner pursuant to 36 O.S. § 6516(A)(6).

[Source: 27 Ok Reg 1531, eff 7-14-10]

365:10-1-15. Eliminating unfair discrimination on basis of children as single applicants

(a) **Purpose.** The purpose of this section is to eliminate the act of denying benefits or coverage unfairly in the issuance, terms and conditions of insurance contracts and in underwriting criteria of insurance carriers. It is not intended to prohibit reasonable and justifiable differences in premium rates based upon sound actuarial principles or actual or reasonably anticipated experience.

(b) **Definitions.**

(1) "Child only policy" means an individual health benefit policy, which provides coverage to an individual under the age of nineteen (19). This shall not include health benefit policies that cover children under the age of nineteen (19) as a dependent;

(2) "Insurer" includes:

(A) every person engaged in the business of making contracts of insurance or indemnity,

(B) a nonprofit hospital service and medical indemnity corporation, and

(C) a health maintenance organization.

(3) "Qualifying event" means adoption or loss of existing health insurance coverage, including loss of eligibility in the SoonerCare or SoonerStart programs, 56 O.S. §§ 1010.1 through 1010.13 and 1011.1 through 1011.11, for any reason other than fraud, misrepresentation or failure to pay premium. "Qualifying event" shall also mean entry of a valid court order mandating the child be covered if there is no employer sponsored coverage available to the parent ordered to provide health insurance coverage to the child.

(c) **Enrollment.**

(1) Enrollment only allowed during certain period.

(A) Insurers issuing child only policies on or after September 23, 2010 shall only accept applications for coverage during the open enrollment period outlined in this section.

(B) Enrollment outside the open enrollment period shall be prohibited, except upon the occurrence of a qualifying event.

(2) Beginning January 1, 2012, insurers offering child only policies shall hold an open enrollment period that begins on June 1 and ends on July 31 each year. During the annual enrollment period, children under the age of nineteen (19) shall be offered coverage on a guaranteed issue basis, without any limitations or riders based on health status.

(3) Notice of the open enrollment opportunity and open enrollment dates for new applicants, as well as the opportunity to enroll due to a qualifying event, shall be displayed prominently on the insurer's website throughout the year.

(4) Applications for coverage during an open enrollment period shall become effective on the first day of the month following receipt of the completed application, except that if mutually agreed upon by the applicant and the insurer an alternative effective date may be selected.

- (5) Non-health eligibility underwriting rules may be applied to child-only coverage, provided such eligibility rules are uniformly applied to all applicants applying for child-only coverage.
- (6) Insurers shall use such rates as have been filed and approved by the Insurance Commissioner.
- (d) **Insurer participation.** Only insurers that participate in the most recent open enrollment period shall be permitted to write child only policies. Any insurer not participating in the most recent open enrollment period shall be prohibited from issuing child only policies until the commencement of the next subsequent open enrollment period, regardless of whether the policy is issued as a result of a qualifying event.
- (e) **Penalty for violations.** Noncompliance with this section may result, after proper notice and hearing, in an administrative action and penalty.

[Source: Added at 28 Ok Reg 1960, eff 7-14-11; Amended 29 Ok Reg 1256, eff 7-14-12]

365:10-1-16. Providing insurance policy information

- (a) An insurer shall provide to any insurance producer authorized to sell life insurance products, whose appointment has been terminated for any reason other than the reasons set forth in 36 O.S. § 1435.13 and who is still the agent of record or servicing agent and has not been replaced by another servicing agent upon termination, information relating to the policy of the person who purchased a product from such producer if the insured has signed a form authorizing the release of the information.
- (b) This requirement does not apply to any policy sold or serviced by the insurance producer while associated with the insurer's captive distribution system.
- (c) Insurers shall use the "Policy Holder's Authorization To Release Insurance Policy Information To Agent Of Record" specified in Appendix UU or a substantially similar form to comply with this requirement.

[Source: Added at 29 Ok Reg 1256, eff 7-14-12]