

FIRST REGULAR SESSION

# SENATE BILL NO. 403

97TH GENERAL ASSEMBLY

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INTRODUCED BY SENATOR RUPP.

Read 1st time February 27, 2013, and ordered printed.

TERRY L. SPIELER, Secretary.

1801S.011

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## AN ACT

To repeal sections 354.410, 354.430, 354.603, 376.405, 376.426, 376.446, 376.777, and 376.1363, RSMo, and to enact in lieu thereof sixteen new sections relating to health insurance, with penalty provisions.

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*Be it enacted by the General Assembly of the State of Missouri, as follows:*

Section A. Sections 354.410, 354.430, 354.603, 376.405, 376.426, 376.446, 2 376.777, and 376.1363, RSMo, are repealed and sixteen new sections enacted in 3 lieu thereof, to be known as sections 354.410, 354.430, 354.603, 376.405, 376.426, 4 376.446, 376.777, 376.1363, 376.2000, 376.2002, 376.2004, 376.2006, 376.2008, 5 376.2010, 376.2012, and 376.2014, to read as follows:

354.410. 1. The director shall issue or deny a certificate of authority to 2 any person filing an application pursuant to section 354.405. Issuance of a 3 certificate of authority may then be granted upon payment of the application fee 4 prescribed in section 354.500 if the director is satisfied that the following 5 conditions are met:

6 (1) The persons responsible for the conduct of the affairs of the applicant 7 are competent, trustworthy, and possess good reputations;

8 (2) The health care organization constitutes an appropriate mechanism 9 whereby the health maintenance organization will effectively provide or arrange 10 for the provision of basic health care services on a prepaid basis through 11 insurance or otherwise, except to the extent of [reasonable] requirements for 12 co-payments, **coinsurance, or deductibles**;

13 (3) The health maintenance organization is financially responsible and 14 may reasonably be expected to meet its obligations to enrollees and prospective

**EXPLANATION—Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.**

15 enrollees. In making this determination, the director may consider:

16 (a) The financial soundness of the arrangements for health care services  
17 and the schedule of charges used in connection therewith;

18 (b) The adequacy of working capital;

19 (c) Any agreement with an insurer, a government, or any other  
20 organization for insuring the payment of the cost of health care services or the  
21 provision for automatic applicability of an alternative coverage in the event of  
22 discontinuance of the health maintenance organization;

23 (d) Any agreement with providers for the provision of health care services;  
24 and

25 (e) Any deposit of cash or securities submitted in accordance with  
26 subsection 2;

27 (4) The health maintenance organization's arrangements for health care  
28 services and the schedule of charges used in connection therewith are financially  
29 sound;

30 (5) The working capital be adequate;

31 (6) Any agreement with an insurer, a health service corporation, a  
32 government, or any other organization for insuring the payment of the cost of  
33 health care services contain a provision for the automatic applicability of  
34 alternative coverage in the event of discontinuance of the health maintenance  
35 organization;

36 (7) There be an agreement with providers for the provision of health care  
37 services;

38 (8) The enrollees shall be afforded an opportunity to participate in  
39 matters of policy and operation pursuant to section 354.420;

40 (9) Nothing in the proposed method of operation, as shown by the  
41 information submitted pursuant to section 354.405 or by independent  
42 investigation, is contrary to the public interest;

43 (10) The health maintenance organization is able to provide its enrollees  
44 with adequate access to health care providers.

45 2. Unless otherwise provided below, each health maintenance organization  
46 shall deposit with the director, or with any organization or trustee acceptable to  
47 the director through which a custodial or controlled account is utilized, cash,  
48 securities, or any combination of these or other measures that is acceptable to the  
49 director in the amount set forth in this subsection:

50 (1) The amount for an organization that is beginning operation shall be

51 the greater of: (a) five percent of its estimated expenditures for health care  
52 services for its first year of operation, (b) twice its estimated average monthly  
53 uncovered expenditures for its first year of operation, or (c) one hundred fifty  
54 thousand dollars for a medical group/staff model, or three hundred thousand  
55 dollars for an individual practice association. At the beginning of each succeeding  
56 year, unless not applicable, the organization shall deposit with the director, or  
57 organization or trustee, cash, securities, or any combination of these or other  
58 measures acceptable to the director, in an amount equal to four percent of its  
59 estimated annual uncovered expenditures for that year.

60 (2) Unless not applicable, an organization that is in operation on  
61 September 28, 1983, shall make a deposit equal to the larger of: (a) one percent  
62 of the preceding twelve months' uncovered expenditures, or (b) one hundred fifty  
63 thousand dollars for a medical group/staff model, or three hundred thousand  
64 dollars for an individual practice association on the first day of the first calendar  
65 year beginning six months or more after September 28, 1983. In the second  
66 calendar year, if applicable, the amount of the additional deposit shall be equal  
67 to two percent of its estimated annual uncovered expenditures. In the third  
68 calendar year, if applicable, the additional deposit shall be equal to three percent  
69 of its estimated annual uncovered expenditures for that year, and in the fourth  
70 calendar year and subsequent years, if applicable, the additional deposit shall be  
71 equal to four percent of its estimated annual uncovered expenditures for each  
72 year. Each year's estimate, after the first year of operation, shall reasonably  
73 reflect the prior years' operating experience and delivery arrangements. The  
74 director may waive any of the deposit requirements set forth in subdivisions (1)  
75 and (2) above, whenever satisfied that the organization has sufficient net worth  
76 and an adequate history of generating net income to assure its financial viability  
77 for the next year, or its performance and obligations are guaranteed by an  
78 organization with sufficient net worth and an adequate history of generating net  
79 income, or the assets of the organization or its contracts with insurers, hospital  
80 or medical service corporations, governments, or other organizations are sufficient  
81 to reasonably assure the performance of its obligations.

82 3. When an organization has achieved a net worth not including land,  
83 buildings, and equipment, of at least one million dollars or has achieved a net  
84 worth including organization-related land, buildings, and equipment of at least  
85 five million dollars, the annual deposit requirements shall not apply. The annual  
86 deposit requirement shall not apply to an organization if the total amount of the

87 deposit is equal to twenty-five percent of its estimated annual uncovered  
88 expenditures for the next calendar year, or the capital and surplus requirements  
89 for the formation or admittance of an accident and health insurer in this state,  
90 whichever is less. If the organization has a guaranteeing organization which has  
91 been in operation for at least five years and has a net worth not including land,  
92 buildings, and equipment of at least one million dollars or which has been in  
93 operation for at least ten years and has a net worth including  
94 organization-related land, buildings, and equipment of at least five million  
95 dollars, the annual deposit requirement shall not apply; provided, however, that  
96 if the guaranteeing organization is sponsoring more than one organization, the  
97 net worth requirement shall be increased by a multiple equal to the number of  
98 such organizations. This requirement to maintain a deposit in excess of the  
99 deposit required of an accident and health insurer shall not apply during any  
100 time that the guaranteeing organization maintains a net worth at least equal to  
101 the capital and surplus requirements for an accident and health insurer for each  
102 organization it sponsors.

103         4. All income from deposits shall belong to the depositing organization  
104 and shall be paid to it as it becomes available. A health maintenance  
105 organization that has made a securities deposit may withdraw the securities  
106 deposit or any part thereof, first having deposited, in lieu thereof, a deposit of  
107 cash, securities, or any combination of these or other measures of equal amount  
108 and value to that withdrawn. Any securities shall be approved by the director  
109 before being substituted.

110         5. In any year in which an annual deposit is not required of an  
111 organization, at its request the director shall reduce the required deposit by one  
112 hundred thousand dollars for each two hundred fifty thousand dollars of net  
113 worth in excess of the amount that allows it not to make an annual deposit. If  
114 the amount of net worth no longer supports a reduction of its required deposit,  
115 the organization shall immediately redeposit one hundred thousand dollars for  
116 each two hundred fifty thousand dollars of reduction in net worth, provided that  
117 its total deposit shall not exceed the maximum required under this  
118 section. Notwithstanding any provisions of sections 354.400 to 354.636, the  
119 deposit held by the director shall in no case be less than one hundred fifty  
120 thousand dollars for a group staff/model or three hundred thousand dollars for an  
121 individual practice association model.

122         6. Each health maintenance organization that obtains a certificate of

123 authority after September 28, 1983, shall have and maintain a capital account of  
124 at least one hundred fifty thousand dollars for a medical group/staff model, or  
125 three hundred thousand dollars for an individual practice association in addition  
126 to any deposit requirements under this section. The capital account shall be net  
127 of any accrued liabilities and be in the form of cash, securities or any combination  
128 of these or other measures acceptable to the director.

129 7. A certificate of authority shall be denied only after compliance with the  
130 requirements of section 354.490.

354.430. 1. Every enrollee residing in this state is entitled to evidence of  
2 coverage. If the enrollee obtains coverage through an insurance policy or a  
3 contract issued by a health services corporation, whether by option or otherwise,  
4 the insurer or the health services corporation shall issue the evidence of  
5 coverage. Otherwise the health maintenance organization shall issue the  
6 evidence of coverage.

7 2. No evidence of coverage, or amendment thereto, shall be issued or  
8 delivered to any person in this state until a copy of the form of the evidence of  
9 coverage, or amendment thereto, has been filed with the director.

10 3. An evidence of coverage shall contain:

11 (1) No provisions or statements which are unjust, unfair, inequitable,  
12 misleading, or deceptive, or which encourage misrepresentation, or which are  
13 untrue, misleading, or deceptive as defined in subsection 1 of section 354.460; and

14 (2) A clear and complete statement, if a contract, or a reasonably complete  
15 summary, if a certificate, of:

16 (a) The health care services and the insurance or other benefits, if any,  
17 to which the enrollee is entitled;

18 (b) Any limitations on the services, kind of services, benefits or kinds of  
19 benefits to be provided, including any deductible or co-payment, **coinsurance,**  
20 **or other cost-sharing feature as requested by the group contract holder**  
21 **or, in the case of nongroup coverage, the individual certificate holder;**

22 (c) Where and in what manner information is available as to how services  
23 may be obtained;

24 (d) The total amount of payment for health care services and the  
25 indemnity or service benefits, if any, which the enrollee is obligated to pay with  
26 respect to individual contracts; and

27 (e) A clear and understandable description of the health maintenance  
28 organization's method for resolving enrollee complaints, including the health

29 maintenance organization's toll-free customer service number and the department  
30 of insurance, financial institutions and professional registration's consumer  
31 complaint hot line number.

32 4. Any subsequent change in an evidence of coverage may be made in a  
33 separate document issued to the enrollee.

34 5. A copy of the form of the evidence of coverage to be used in this state,  
35 and any amendment thereto, shall be subject to the filing of subsection 2 of this  
36 section unless it is subject to the jurisdiction of the director under the laws  
37 governing health insurance or health services corporations, in which event the  
38 filing provisions of those laws shall apply.

354.603. 1. A health carrier shall maintain a network that is sufficient  
2 in number and types of providers to assure that all services to enrollees shall be  
3 accessible without unreasonable delay. In the case of emergency services,  
4 enrollees shall have access twenty-four hours per day, seven days per week. The  
5 health carrier's medical director shall be responsible for the sufficiency and  
6 supervision of the health carrier's network. Sufficiency shall be determined by  
7 the director in accordance with the requirements of this section and by reference  
8 to any reasonable criteria, including but not limited to provider-enrollee ratios by  
9 specialty, primary care provider-enrollee ratios, geographic accessibility,  
10 reasonable distance accessibility criteria for pharmacy and other services, waiting  
11 times for appointments with participating providers, hours of operation, and the  
12 volume of technological and specialty services available to serve the needs of  
13 enrollees requiring technologically advanced or specialty care.

14 (1) In any case where the health carrier has an insufficient number or  
15 type of participating providers to provide a covered benefit, the health carrier  
16 shall ensure that the enrollee obtains the covered benefit at no greater cost than  
17 if the benefit was obtained from a participating provider, or shall make other  
18 arrangements acceptable to the director.

19 (2) The health carrier shall establish and maintain adequate  
20 arrangements to ensure reasonable proximity of participating providers, including  
21 local pharmacists, to the business or personal residence of enrollees. In  
22 determining whether a health carrier has complied with this provision, the  
23 director shall give due consideration to the relative availability of health care  
24 providers in the service area under, especially rural areas, consideration.

25 (3) A health carrier shall monitor, on an ongoing basis, the ability, clinical  
26 capacity, and legal authority of its providers to furnish all contracted benefits to

27 enrollees. The provisions of this subdivision shall not be construed to require any  
28 health care provider to submit copies of such health care provider's income tax  
29 returns to a health carrier. A health carrier may require a health care provider  
30 to obtain audited financial statements if such health care provider received ten  
31 percent or more of the total medical expenditures made by the health carrier.

32 (4) A health carrier shall make its entire network available to all  
33 enrollees unless a contract holder has agreed in writing to a different or reduced  
34 network.

35 2. A health carrier shall file with the director, in a manner and form  
36 defined by rule of the department of insurance, financial institutions and  
37 professional registration, an access plan meeting the requirements of sections  
38 354.600 to 354.636 for each of the managed care plans that the health carrier  
39 offers in this state. The health carrier may request the director to deem sections  
40 of the access plan as proprietary or competitive information that shall not be  
41 made public. For the purposes of this section, information is proprietary or  
42 competitive if revealing the information will cause the health carrier's  
43 competitors to obtain valuable business information. The health carrier shall  
44 provide such plans, absent any information deemed by the director to be  
45 proprietary, to any interested party upon request. The health carrier shall  
46 prepare an access plan prior to offering a new managed care plan, and shall  
47 update an existing access plan whenever it makes any change as defined by the  
48 director to an existing managed care plan. The director shall approve or  
49 disapprove the access plan, or any subsequent alterations to the access plan,  
50 within sixty days of filing. The access plan shall describe or contain at a  
51 minimum the following:

52 (1) The health carrier's network;

53 (2) The health carrier's procedures for making referrals within and  
54 outside its network;

55 (3) The health carrier's process for monitoring and assuring on an ongoing  
56 basis the sufficiency of the network to meet the health care needs of enrollees of  
57 the managed care plan;

58 (4) The health carrier's methods for assessing the health care needs of  
59 enrollees and their satisfaction with services;

60 (5) The health carrier's method of informing enrollees of the plan's  
61 services and features, including but not limited to the plan's grievance  
62 procedures, its process for choosing and changing providers, and its procedures

63 for providing and approving emergency and specialty care;

64 (6) The health carrier's system for ensuring the coordination and  
65 continuity of care for enrollees referred to specialty physicians, for enrollees using  
66 ancillary services, including social services and other community resources, and  
67 for ensuring appropriate discharge planning;

68 (7) The health carrier's process for enabling enrollees to change primary  
69 care professionals;

70 (8) The health carrier's proposed plan for providing continuity of care in  
71 the event of contract termination between the health carrier and any of its  
72 participating providers, in the event of a reduction in service area or in the event  
73 of the health carrier's insolvency or other inability to continue operations. The  
74 description shall explain how enrollees shall be notified of the contract  
75 termination, reduction in service area or the health carrier's insolvency or other  
76 modification or cessation of operations, and transferred to other health care  
77 professionals in a timely manner; and

78 (9) Any other information required by the director to determine  
79 compliance with the provisions of sections 354.600 to 354.636.

80 3. In reviewing an access plan filed pursuant to subsection 2 of this  
81 section, the director shall deem a managed care plan's network to be adequate if  
82 it meets one or more of the following criteria:

83 (1) The managed care plan is a Medicare **[+ Choice] Advantage**  
84 coordinated care plan offered by the health carrier pursuant to a contract with  
85 the federal Centers for Medicare and Medicaid Services;

86 (2) The managed care plan is being offered by a health carrier that has  
87 been accredited by the National Committee for Quality Assurance at a level of  
88 "accredited" or better, and such accreditation is in effect at the time the access  
89 plan is filed;

90 (3) The managed care plan's network has been accredited by the Joint  
91 Commission on the Accreditation of Health Organizations for Network Adequacy,  
92 and such accreditation is in effect at the time the access plan is filed. If the  
93 accreditation applies to only a portion of the managed care plan's network, only  
94 the accredited portion will be deemed adequate; or

95 (4) The managed care plan is being offered by a health carrier that has  
96 been accredited by the Utilization Review Accreditation Commission at a level of  
97 "accredited" or better, and such accreditation is in effect at the time the access  
98 plan is filed.



99           4. **Notwithstanding any other provision of law to the contrary,**  
100 **a health carrier, as defined in section 354.600, may offer a health**  
101 **benefit plan that is a managed care plan that requires all health care**  
102 **services to be delivered by a participating provider in the health**  
103 **carrier's network, except for emergency services, as defined in section**  
104 **354.600, and the services described in subsection 4 of section**  
105 **376.811. Such a provision shall be disclosed in the policy form.**

376.405. 1. No insurance company licensed to transact business in this  
2 state shall deliver or issue for delivery in this state any policy of group accident  
3 or group health insurance, or group accident and health insurance, including  
4 insurance against hospital, medical or surgical expenses, covering a group in this  
5 state, unless such policy form shall have been approved by the director of the  
6 department of insurance, financial institutions and professional registration of  
7 the state of Missouri.

8           2. The director of the department of insurance, financial institutions and  
9 professional registration shall have authority to make such reasonable rules and  
10 regulations concerning the filing and submission of [such policy forms] **policies**  
11 as are necessary, proper or advisable. Such rules and regulations shall provide,  
12 among other things, that if a policy form is disapproved, [the reasons therefor]  
13 **all specific reasons for noncompliance** shall be stated in writing **within**  
14 **forty-five days from the date of filing**; that a hearing shall be granted upon  
15 such disapproval, if so requested; and that the failure of the director of the  
16 department of insurance, financial institutions and professional registration to  
17 take action approving or disapproving a submitted policy form within [a  
18 stipulated time, not to exceed sixty] **forty-five** days from the date of filing, shall  
19 be deemed an approval thereof [until such time as the director of the department  
20 of insurance, financial institutions and professional registration shall notify the  
21 submitting company, in writing, of his disapproval thereof]. **If at any time after**  
22 **a policy form is approved or deemed approved, the director determines**  
23 **that any provision of the filing is contrary to state law, the director**  
24 **shall notify the health carrier of the specific provision that is contrary**  
25 **to state law and request that the health carrier file an amendment form**  
26 **that modifies the provision to conform to state law. The failure of the**  
27 **director of the department of insurance, financial institutions and**  
28 **professional registration to take action approving or disapproving a**  
29 **submitted amendment form within forty-five days from the date of**

30 **filing shall be deemed an approval thereof. In the event that a policy**  
31 **form is approved or deemed approved and is subsequently amended for**  
32 **state law compliance upon the department's request as provided herein,**  
33 **the department shall not retroactively enforce the amended policy**  
34 **form.**

35 3. The director of the department of insurance, financial institutions and  
36 professional registration shall approve only those policy forms which are in  
37 compliance with the insurance laws of this state and which contain such words,  
38 phraseology, conditions and provisions which are specific, certain and  
39 unambiguous and reasonably adequate to meet needed requirements for the  
40 protection of those insured. The disapproval of any policy form shall be based  
41 upon the requirements of the laws of this state or of any regulation lawfully  
42 promulgated thereunder.

43 4. The director of the department of insurance, financial institutions and  
44 professional registration may, by order or bulletin, exempt from the approval  
45 requirements of this section for so long as he deems proper any insurance policy,  
46 document, or form or type thereof, as specified in such order or bulletin, to which,  
47 in his opinion, this section may not practicably be applied, or the approval of  
48 which is, in his opinion, not desirable or necessary for the protection of the public.

376.426. No policy of group health insurance shall be delivered in this  
2 state unless it contains in substance the following provisions, or provisions which  
3 in the opinion of the director of the department of insurance, financial  
4 institutions and professional registration are more favorable to the persons  
5 insured or at least as favorable to the persons insured and more favorable to the  
6 policyholder; except that: provisions in subdivisions (5), (7), (12), (15), and (16)  
7 of this section shall not apply to policies insuring debtors; standard provisions  
8 required for individual health insurance policies shall not apply to group health  
9 insurance policies; and if any provision of this section is in whole or in part  
10 inapplicable to or inconsistent with the coverage provided by a particular form of  
11 policy, the insurer, with the approval of the director, shall omit from such policy  
12 any inapplicable provision or part of a provision, and shall modify any  
13 inconsistent provision or part of the provision in such manner as to make the  
14 provision as contained in the policy consistent with the coverage provided by the  
15 policy:

16 (1) A provision that the policyholder is entitled to a grace period of  
17 thirty-one days for the payment of any premium due except the first, during

18 which grace period the policy shall continue in force, unless the policyholder shall  
19 have given the insurer written notice of discontinuance in advance of the date of  
20 discontinuance and in accordance with the terms of the policy. The policy may  
21 provide that the policyholder shall be liable to the insurer for the payment of a  
22 pro rata premium for the time the policy was in force during such grace period;

23 (2) A provision that the validity of the policy shall not be contested, except  
24 for nonpayment of premiums, after it has been in force for two years from its date  
25 of issue, and that no statement made by any person covered under the policy  
26 relating to insurability shall be used in contesting the validity of the insurance  
27 with respect to which such statement was made after such insurance has been in  
28 force prior to the contest for a period of two years during such person's lifetime  
29 nor unless it is contained in a written instrument signed by the person making  
30 such statement; except that, no such provision shall preclude the assertion at any  
31 time of defenses based upon the person's ineligibility for coverage under the  
32 policy or upon other provisions in the policy;

33 (3) A provision that a copy of the application, if any, of the policyholder  
34 shall be attached to the policy when issued, that all statements made by the  
35 policyholder or by the persons insured shall be deemed representations and not  
36 warranties and that no statement made by any person insured shall be used in  
37 any contest unless a copy of the instrument containing the statement is or has  
38 been furnished to such person or, in the event of the death or incapacity of the  
39 insured person, to the individual's beneficiary or personal representative;

40 (4) A provision setting forth the conditions, if any, under which the  
41 insurer reserves the right to require a person eligible for insurance to furnish  
42 evidence of individual insurability satisfactory to the insurer as a condition to  
43 part or all of the individual's coverage;

44 (5) A provision specifying the additional exclusions or limitations, if any,  
45 applicable under the policy with respect to a disease or physical condition of a  
46 person, not otherwise excluded from the person's coverage by name or specific  
47 description effective on the date of the person's loss, which existed prior to the  
48 effective date of the person's coverage under the policy. Any such exclusion or  
49 limitation may only apply to a disease or physical condition for which medical  
50 advice or treatment was received by the person during the twelve months prior  
51 to the effective date of the person's coverage. In no event shall such exclusion or  
52 limitation apply to loss incurred or disability commencing after the earlier of:

53 (a) The end of a continuous period of twelve months commencing on or

54 after the effective date of the person's coverage during all of which the person has  
55 received no medical advice or treatment in connection with such disease or  
56 physical condition; or

57 (b) The end of the two-year period commencing on the effective date of the  
58 person's coverage;

59 (6) If the premiums or benefits vary by age, there shall be a provision  
60 specifying an equitable adjustment of premiums or of benefits, or both, to be made  
61 in the event the age of the covered person has been misstated, such provision to  
62 contain a clear statement of the method of adjustment to be used;

63 (7) A provision that the insurer shall issue to the policyholder, for delivery  
64 to each person insured, a certificate setting forth a statement as to the insurance  
65 protection to which that person is entitled, to whom the insurance benefits are  
66 payable, and a statement as to any family member's or dependent's coverage;

67 (8) A provision that written notice of claim must be given to the insurer  
68 within twenty days after the occurrence or commencement of any loss covered by  
69 the policy. Failure to give notice within such time shall not invalidate nor reduce  
70 any claim if it shall be shown not to have been reasonably possible to give such  
71 notice and that notice was given as soon as was reasonably possible;

72 (9) A provision that the insurer shall furnish to the person making claim,  
73 or to the policyholder for delivery to such person, such forms as are usually  
74 furnished by it for filing proof of loss. If such forms are not furnished before the  
75 expiration of fifteen days after the insurer receives notice of any claim under the  
76 policy, the person making such claim shall be deemed to have complied with the  
77 requirements of the policy as to proof of loss upon submitting, within the time  
78 fixed in the policy for filing proof of loss, written proof covering the occurrence,  
79 character, and extent of the loss for which claim is made;

80 (10) A provision that in the case of claim for loss of time for disability,  
81 written proof of such loss must be furnished to the insurer within ninety days  
82 after the commencement of the period for which the insurer is liable, and that  
83 subsequent written proofs of the continuance of such disability must be furnished  
84 to the insurer at such intervals as the insurer may reasonably require, and that  
85 in the case of claim for any other loss, written proof of such loss must be  
86 furnished to the insurer within ninety days after the date of such loss. Failure  
87 to furnish such proof within such time shall not invalidate nor reduce any claim  
88 if it was not reasonably possible to furnish such proof within such time, provided  
89 such proof is furnished as soon as reasonably possible and in no event, except in

90 the absence of legal capacity of the claimant, later than one year from the time  
91 proof is otherwise required;

92 (11) A provision that all benefits payable under the policy other than  
93 benefits for loss of time shall be payable not more than thirty days after receipt  
94 of proof and that, subject to due proof of loss, all accrued benefits payable under  
95 the policy for loss of time shall be paid not less frequently than monthly during  
96 the continuance of the period for which the insurer is liable, and that any balance  
97 remaining unpaid at the termination of such period shall be paid as soon as  
98 possible after receipt of such proof;

99 (12) A provision that benefits for accidental loss of life of a person insured  
100 shall be payable to the beneficiary designated by the person insured or, if the  
101 policy contains conditions pertaining to family status, the beneficiary may be the  
102 family member specified by the policy terms. In either case, payment of these  
103 benefits is subject to the provisions of the policy in the event no such designated  
104 or specified beneficiary is living at the death of the person insured. All other  
105 benefits of the policy shall be payable to the person insured. The policy may also  
106 provide that if any benefit is payable to the estate of a person, or to a person who  
107 is a minor or otherwise not competent to give a valid release, the insurer may pay  
108 such benefit, up to an amount not exceeding two thousand dollars, to any relative  
109 by blood or connection by marriage of such person who is deemed by the insurer  
110 to be equitably entitled thereto;

111 (13) A provision that the insurer shall have the right and opportunity, at  
112 the insurer's own expense, to examine the person of the individual for whom  
113 claim is made when and so often as it may reasonably require during the  
114 pendency of the claim under the policy and also the right and opportunity, at the  
115 insurer's own expense, to make an autopsy in case of death where it is not  
116 prohibited by law;

117 (14) A provision that no action at law or in equity shall be brought to  
118 recover on the policy prior to the expiration of sixty days after proof of loss has  
119 been filed in accordance with the requirements of the policy and that no such  
120 action shall be brought at all unless brought within three years from the  
121 expiration of the time within which proof of loss is required by the policy;

122 (15) A provision specifying the conditions under which the policy may be  
123 terminated. Such provision shall state that except for nonpayment of the  
124 required premium or the failure to meet continued underwriting standards, the  
125 insurer may not terminate the policy prior to the first anniversary date of the

126 effective date of the policy as specified therein, and a notice of any intention to  
127 terminate the policy by the insurer must be given to the policyholder at least  
128 thirty-one days prior to the effective date of the termination. Any termination by  
129 the insurer shall be without prejudice to any expenses originating prior to the  
130 effective date of termination. An expense will be considered incurred on the date  
131 the medical care or supply is received;

132 (16) A provision stating that if a policy provides that coverage of a  
133 dependent child terminates upon attainment of the limiting age for dependent  
134 children specified in the policy, such policy, so long as it remains in force, shall  
135 be deemed to provide that attainment of such limiting age does not operate to  
136 terminate the hospital and medical coverage of such child while the child is and  
137 continues to be both incapable of self-sustaining employment by reason of mental  
138 or physical handicap and chiefly dependent upon the certificate holder for support  
139 and maintenance. Proof of such incapacity and dependency must be furnished to  
140 the insurer by the certificate holder at least thirty-one days after the child's  
141 attainment of the limiting age. The insurer may require at reasonable intervals  
142 during the two years following the child's attainment of the limiting age  
143 subsequent proof of the child's incapacity and dependency. After such two-year  
144 period, the insurer may require subsequent proof not more than once each  
145 year. This subdivision shall apply only to policies delivered or issued for delivery  
146 in this state on or after one hundred twenty days after September 28, 1985;

147 (17) A provision stating that if a policy provides that coverage of a  
148 dependent child terminates upon attainment of the limiting age for dependent  
149 children specified in the policy, such policy, so long as it remains in force, until  
150 the dependent child attains the limiting age, shall remain in force at the option  
151 of the certificate holder. Eligibility for continued coverage shall be established  
152 where the dependent child is:

- 153 (a) Unmarried and no more than that twenty-five years of age; and  
154 (b) A resident of this state; and  
155 (c) Not provided coverage as a named subscriber, insured, enrollee, or  
156 covered person under any group or individual health benefit plan, or entitled to  
157 benefits under Title XVIII of the Social Security Act, P.L. 89-97, 42 U.S.C. Section  
158 1395, et seq.;

159 (18) In the case of a policy insuring debtors, a provision that the insurer  
160 shall furnish to the policyholder for delivery to each debtor insured under the  
161 policy a certificate of insurance describing the coverage and specifying that the

162 benefits payable shall first be applied to reduce or extinguish the indebtedness.

163 **(19) Notwithstanding any other provision of law to the contrary,**  
164 **a health carrier, as defined in section 376.1350, may offer a health**  
165 **benefit plan that is a managed care plan that requires all health care**  
166 **services to be delivered by a participating provider in the health**  
167 **carrier's network, except for emergency services, as defined in section**  
168 **354.600, and the services described in subsection 4 of section**  
169 **376.811. Such a provision shall be disclosed in the policy form.**

376.446. 1. Notwithstanding any other law or regulation to the  
2 contrary, any health carrier, as defined in section 376.1350, may offer  
3 as an option one or more health benefit plans which contain  
4 deductibles, coinsurance, coinsurance differentials, or variable  
5 copayments. Health benefit plans which contain deductibles may be  
6 combined with any health savings accounts (HSA) as described in the  
7 Medicare Reform Act, P.L. No. 108-173, Title XII, Section 1201.

8 **2.** Health carriers shall permit individuals to learn the amount of  
9 cost-sharing, including deductibles, copayments, and coinsurance, under the  
10 individual's health benefit plan or coverage that the individual would be  
11 responsible for paying with respect to the furnishing of a specific item or service  
12 by a participating provider in a timely manner upon the request of the individual.  
13 At a minimum, such information shall be made available to such individual  
14 through an internet website and such other means for individuals without access  
15 to the internet. As used in this section, the terms "health carrier" and "health  
16 benefit plans" shall have the same meanings assigned to them in section  
17 376.1350.

18 **[2.] 3.** This section shall not apply to a supplemental insurance policy,  
19 including a life care contract, accident-only policy, specified disease policy,  
20 hospital policy providing a fixed daily benefit only, Medicare supplement policy,  
21 long-term care policy, hospitalization-surgical care policy, short-term major  
22 medical policy of six months or less duration, or any other supplemental policy.

23 **[3.] 4.** The provisions of subsections [1 and] 2 and 3 shall become  
24 effective on January 1, 2014.

376.777. 1. Required provisions. Except as provided in subsection 3 of  
2 this section each such policy delivered or issued for delivery to any person in this  
3 state shall contain the provisions specified in this subsection in the words in  
4 which the same appear in this section; provided, however, that the insurer may,

5 at its option, substitute for one or more of such provisions corresponding  
6 provisions of different wording approved by the director of the department of  
7 insurance, financial institutions and professional registration which are in each  
8 instance not less favorable in any respect to the insured or the beneficiary. Such  
9 provisions shall be preceded individually by the caption appearing in this  
10 subsection or, at the option of the insurer, by such appropriate individual or  
11 group captions or subcaptions as the director of the department of insurance,  
12 financial institutions and professional registration may approve.

13 (1) A provision as follows:

14 "ENTIRE CONTRACT; CHANGES:

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

20 (When under the provisions of subdivision (2) of subsection 1 of section  
21 376.775 the effective and termination dates are stated in the premium receipt, the  
22 insurer shall insert in the first sentence of the foregoing policy provision  
23 immediately following the comma after the word "any", the following words: "and  
24 the insurer's official premium receipt when executed").

25 (2) A provision as follows:

26 "TIME LIMIT ON CERTAIN DEFENSES:

27 (a) After two years from the date of issue of this policy no misstatements,  
28 except fraudulent misstatements, made by the applicant in the application for  
29 such policy shall be used to void the policy or to deny a claim for loss incurred or  
30 disability (as defined in the policy) commencing after the expiration of such  
31 two-year period".

32 (The foregoing policy provision shall not be so construed as to affect any  
33 legal requirements for avoidance of a policy or denial of a claim during such  
34 initial two-year period, nor to limit the application of subdivisions (1), (2), (3), (4)  
35 and (5) of subsection 2 of this section in the event of misstatement with respect  
36 to age or occupation or other insurance.)

37 (A policy which the insured has the right to continue in force subject to its  
38 terms by the timely payment of premium (1) until at least age fifty or, (2) in the  
39 case of a policy issued after age forty-four, for at least five years from its date of  
40 issue, may contain in lieu of the foregoing the following provision (from which the



41 clause in parentheses may be omitted at the insurer's option) under the caption  
42 "UNCONTESTABLE":

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

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

51 (3) A provision as follows:

52 "GRACE PERIOD:

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

57 (A policy which contains a cancellation provision may add, at the end of  
58 the above provision, subject to the right of the insurer to cancel in accordance  
59 with the cancellation provision hereof. A policy in which the insurer reserves the  
60 right to refuse any renewal shall have, at the beginning of the above provision,  
61 "Unless not less than five days prior to the premium due date the insurer has  
62 delivered to the insured or has mailed to his last address as shown by the records  
63 of the insurer written notice of its intention not to renew this policy beyond the  
64 period for which the premium has been accepted").

65 (4) A provision as follows:

66 "REINSTATEMENT:

67 If any renewal premium be not paid within the time granted the insured  
68 for payment, a subsequent acceptance of premium by the insurer or by any agent  
69 duly authorized by the insurer to accept such premium, without requiring in  
70 connection therewith an application for reinstatement, shall reinstate the policy;  
71 provided, however, that if the insurer or such agent requires an application for  
72 reinstatement and issues a conditional receipt for the premium tendered, the  
73 policy will be reinstated upon approval of such application by the insurer, or,  
74 lacking such approval, upon the forty-fifth day following the date of such  
75 conditional receipt unless the insurer has previously notified the insured in  
76 writing of its disapproval of such application. The reinstated policy shall cover

77 only loss resulting from such accidental injury as may be sustained after the date  
78 of reinstatement and loss due to such sickness as may begin more than ten days  
79 after such date. In all other respects the insured and insurer shall have the same  
80 rights thereunder as they had under the policy immediately before the due date  
81 of the defaulted premium, subject to any provisions endorsed hereon or attached  
82 hereto in connection with the reinstatement. Any premium accepted in  
83 connection with a reinstatement shall be applied to a period for which premium  
84 has not been previously paid, but not to any period more than sixty days prior to  
85 the date of reinstatement".

86 (The last sentence of the above provision may be omitted from any policy  
87 which the insured has the right to continue in force subject to its terms by the  
88 timely payment of premiums (1) until at least age fifty or, (2) in the case of a  
89 policy issued after age forty-four, for at least five years from its date of issue.)

90 (5) A provision as follows:

91 "NOTICE OF CLAIM:

92 Written notice of claim must be given to the insurer within twenty days  
93 after the occurrence or commencement of any loss covered by the policy, or as  
94 soon thereafter as is reasonably possible. Notice given by or on behalf of the  
95 insured or the beneficiary to the insured at ..... (insert the location of such  
96 office as the insurer may designate for the purpose), or to any authorized agent  
97 of the insurer, with information sufficient to identify the insured, shall be deemed  
98 notice to the insurer".

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

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

112 (6) A provision as follows:

113

**"CLAIM FORMS:**

114 The insurer upon receipt of a notice of claim, will furnish to the claimant  
115 such forms as are usually furnished by it for filing proofs of loss.

116 If such forms are not furnished within fifteen days after the giving of such notice  
117 the claimant shall be deemed to have complied with the requirements of this  
118 policy as to proof of loss upon submitting, within the time fixed in the policy for  
119 filing proofs of loss, written proof covering the occurrence, the character and the  
120 extent of the loss for which claim is made".

121 (7) A provision as follows:

122

**"PROOFS OF LOSS:**

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

132 (8) A provision as follows:

133

**"TIME OF PAYMENT OF CLAIMS:**

134 Indemnities payable under this policy for any loss other than loss for  
135 which this policy provides any periodic payment will be paid immediately upon  
136 receipt of due written proof of such loss. Subject to due written proof of loss, all  
137 accrued indemnities for loss for which this policy provides periodic payment will  
138 be paid ..... (insert period for payment which must not be less frequently than  
139 monthly) and any balance remaining unpaid upon the termination of liability will  
140 be paid immediately upon receipt of due written proof".

141 (9) A provision as follows:

142

**"PAYMENT OF CLAIMS:**

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

149 other indemnities will be payable to the insured".

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

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

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

166 (10) A provision as follows:

167 "PHYSICAL EXAMINATIONS AND AUTOPSY:

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

172 (11) A provision as follows:

173 "LEGAL ACTIONS:

174 No action at law or in equity shall be brought to recover on this policy  
175 prior to the expiration of sixty days after written proof of loss has been furnished  
176 in accordance with the requirements of this policy. No such action shall be  
177 brought after the expiration of three years after the time written proof of loss is  
178 required to be furnished".

179 (12) A provision as follows:

180 "CHANGE OF BENEFICIARY:

181 Unless the insured makes an irrevocable designation of beneficiary, the  
182 right to change of beneficiary is reserved to the insured and the consent of the  
183 beneficiary or beneficiaries shall not be requisite to surrender or assignment of  
184 this policy or to change of beneficiary or beneficiaries, or to any other changes in

185 this policy".

186 (The first clause of this provision, relating to the irrevocable designation  
187 of beneficiary, may be omitted at the insurer's option).

188 2. Other provisions. Except as provided in subsection 3 of this section, no  
189 such policy delivered or issued for delivery to any person in this state shall  
190 contain provisions respecting the matters set forth below unless such provisions  
191 are in the words in which the same appear in this section; provided, however,  
192 that the insurer may, at its option, use in lieu of any such provision a  
193 corresponding provision of different wording approved by the director of the  
194 department of insurance, financial institutions and professional registration  
195 which is not less favorable in any respect to the insured or the beneficiary. Any  
196 such provision contained in the policy shall be preceded individually by the  
197 appropriate caption appearing in this subsection or, at the option of the insurer,  
198 by such appropriate individual or group captions or subcaptions as the director  
199 of the department of insurance, financial institutions and professional  
200 registration may approve.

201 (1) A provision as follows:

202 "CHANGE OF OCCUPATION:

203 If the insured be injured or contract sickness after having changed his  
204 occupation to one classified by the insurer as more hazardous than that stated in  
205 this policy or while doing for compensation anything pertaining to an occupation  
206 so classified, the insurer will pay only such portion of the indemnities provided  
207 in this policy as the premium paid would have purchased at the rates and within  
208 the limits fixed by the insurer for such more hazardous occupation. If the insured  
209 changes his occupation to one classified by the insurer as less hazardous than  
210 that stated in this policy, the insurer, upon receipt of proof of such change of  
211 occupation, will reduce the premium rate accordingly, and will return the excess  
212 pro rata unearned premium from the date of change of occupation or from the  
213 policy anniversary date immediately preceding receipt of such proof, whichever  
214 is the more recent. In applying this provision, the classification of occupational  
215 risk and the premium rates shall be such as have been last filed by the insurer  
216 prior to the occurrence of the loss for which the insurer is liable or prior to date  
217 of proof of change in occupation with the state official having supervision of  
218 insurance in the state where the insured resided at the time this policy was  
219 issued; but if such filing was not required, then the classification of occupational  
220 risk and the premium rates shall be those last made effective by the insurer in

221 such state prior to the occurrence of the loss or prior to the date of proof of  
222 change in occupation".

223 (2) A provision as follows:

224 "MISSTATEMENT OF AGE:

225 If the age of the insured has been misstated, all amounts payable under  
226 this policy shall be such as the premium paid would have purchased at the  
227 correct age".

228 (3) A provision as follows:

229 "OTHER INSURANCE IN THIS INSURER:

230 If an accident or sickness or accident and sickness policy or policies  
231 previously issued by the insurer to the insured be in force concurrently herewith,  
232 making the aggregate indemnity for ..... (insert type of coverage or coverages)  
233 in excess of \$..... (insert maximum limit of indemnity or indemnities) the excess  
234 insurance shall be void and all premiums paid for such excess shall be returned  
235 to the insured or to his estate, or in lieu thereof.

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

240 (4) A provision as follows:

241 "INSURANCE WITH OTHER INSURERS:

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

255 (If the foregoing policy provision is included in a policy which also contains  
256 the next following policy provision there shall be added to the caption of the

257 foregoing provision the phrase "EXPENSE INCURRED BENEFITS". The insurer  
258 may, at its option, include in this provision a definition of "other valid coverage",  
259 approved as to form by the director of the department of insurance, financial  
260 institutions and professional registration, which definition shall be limited in  
261 subject matter to coverage provided by organizations subject to regulation by  
262 insurance law or by insurance authorities of this or any other state of the United  
263 States or any province of Canada, and by hospital or medical service  
264 organizations, and to any other coverage the inclusion of which may be approved  
265 by the director of the department of insurance, financial institutions and  
266 professional registration. In the absence of such definition such term shall not  
267 include group insurance, automobile medical payments insurance, or coverage  
268 provided by hospital or medical service organizations or by union welfare plans  
269 or employer or employees benefit organizations. For the purpose of applying the  
270 foregoing policy provision with respect to any insured, any amount of benefit  
271 provided for such insured pursuant to any compulsory benefit statute (including  
272 any workers' compensation or employer's liability statute whether provided by a  
273 governmental agency or otherwise shall in all cases be deemed to be "other valid  
274 coverage" of which the insurer has had notice. In applying the foregoing policy  
275 provision no third party liability coverage shall be included as "other valid  
276 coverage").

277 (5) A provision as follows:

278 "INSURANCE WITH OTHER INSURERS:

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

288 (If the foregoing policy provision is included in a policy which also contains  
289 the next preceding policy provision there shall be added to the caption of the  
290 foregoing provision the phrase "OTHER BENEFITS". The insurer may, at its  
291 option, include in this provision a definition of "other valid coverage", approved  
292 as to form by the director of the department of insurance, financial institutions

293 and professional registration which definition shall be limited in subject matter  
294 to coverage provided by organizations subject to regulation by insurance law or  
295 by insurance authorities of this or any other state of the United States or any  
296 province of Canada, and to any other coverage the inclusion of which may be  
297 approved by the director of the department of insurance, financial institutions  
298 and professional registration. In the absence of such definition such term shall  
299 not include group insurance, or benefits provided by union welfare plans or by  
300 employer or employee benefit organizations. For the purpose of applying the  
301 foregoing policy provision with respect to any insured, any amount of benefit  
302 provided for such insured pursuant to any compulsory benefit statute (including  
303 any workers' compensation or employer's liability statute) whether provided by  
304 a governmental agency or otherwise shall in all cases be deemed to be "other  
305 valid coverage", of which the insurer has had notice. In applying the foregoing  
306 policy provision no third party liability coverage shall be included as "other valid  
307 coverage").

308 (6) A provision as follows:

309 "RELATION OF EARNINGS TO INSURANCE:

310 If the total monthly amount of loss of time benefits promised for the same  
311 loss under all valid loss of time coverage upon the insured, whether payable on  
312 a weekly or monthly basis, shall exceed the monthly earnings of the insured at  
313 the time disability commenced or his average monthly earnings for the period of  
314 two years immediately preceding a disability for which claim is made, whichever  
315 is the greater, the insurer will be liable only for such proportionate amount of  
316 such benefits under this policy as the amount of such monthly earnings or such  
317 average monthly earnings of the insured bears to the total amount of monthly  
318 benefits for the same loss under all such coverage upon the insured at the time  
319 such disability commences and for the return of such part of the premiums paid  
320 during such two years as shall exceed the pro rata amount of the premiums for  
321 the benefits actually paid hereunder; but this shall not operate to reduce the total  
322 monthly amount of benefits payable under all such coverage upon the insured  
323 below the sum of two hundred dollars or the sum of the monthly benefits specified  
324 in such coverages, whichever is the lesser, nor shall it operate to reduce benefits  
325 other than those payable for loss of time".

326 (The foregoing policy provision may be inserted only in a policy which the  
327 insured has the right to continue in force subject to its terms by the timely  
328 payment of premiums (1) until at least age fifty or, (2) in the case of a policy



329 issued after age forty-four, for at least five years from this date of issue. The  
330 insurer may, at its option, include in this provision a definition of "valid loss of  
331 time coverage", approved as to form by the director of the department of  
332 insurance, financial institutions and professional registration, which definition  
333 shall be limited in subject matter to coverage provided by governmental agencies  
334 or by organizations subject to regulation by insurance law or by insurance  
335 authorities of this or any other state of the United States or any province of  
336 Canada, or to any other coverage the inclusion of which may be approved by the  
337 director of the department of insurance, financial institutions and professional  
338 registration or any combination of such coverages. In the absence of such  
339 definition such term shall not include any coverage provided for such insured  
340 pursuant to any compulsory benefit statute (including any workers' compensation  
341 or employer's liability statute), or benefits provided by union welfare plans or by  
342 employer or employee benefit organizations).

343 (7) A provision as follows:

344 "UNPAID PREMIUM:

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

347 (8) A provision as follows:

348 "CANCELLATION:

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

362 (9) A provision as follows:

363 "CONFORMITY WITH STATE STATUTES:

364 Any provision of this policy which, on its effective date, is in conflict with

365 the statutes of the state in which the insured resides on such date is hereby  
366 amended to conform to the minimum requirements of such statutes".

367 (10) A provision as follows:

368 "ILLEGAL OCCUPATION:

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

372 (11) A provision as follows:

373 "INTOXICANTS AND NARCOTICS:

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

377 3. Inapplicable or inconsistent provisions. If any provision of this section  
378 is in whole or in part inapplicable to or inconsistent with the coverage provided  
379 by a particular form of policy the insurer, with the approval of the director of the  
380 department of insurance, financial institutions and professional registration, shall  
381 omit from such policy an inapplicable provision or part of a provision, and shall  
382 modify any inconsistent provision or part of the provision, in such manner as to  
383 make the provision as contained in the policy consistent with the coverage  
384 provided by the policy.

385 4. Order of certain policy provisions. The provisions which are the subject  
386 of subsections 1 and 2 of this section, or any corresponding provisions which are  
387 used in lieu thereof in accordance with such subsections, shall be printed in the  
388 consecutive order of the provisions in such subsections or, at the option of the  
389 insurer, any such provision may appear as a unit in any part of the policy, with  
390 other provisions to which it may be logically related, provided the resulting policy  
391 shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or  
392 likely to mislead a person to whom the policy is offered, delivered or issued.

393 5. Third party ownership. The word "insured" as used in sections 376.770  
394 to 376.800, shall not be construed as preventing a person other than the insured  
395 with a proper insurable interest from making application for and owning a policy  
396 covering the insured or from being entitled under such a policy to any  
397 indemnities, benefits and rights provided therein.

398 6. Requirements of other jurisdictions.

399 (1) Any policy of a foreign or alien insurer, when delivered or issued for  
400 delivery to any person in this state, may contain any provision which is not less

401 favorable to the insured or the beneficiary than the provisions of sections 376.770  
402 to 376.800 and which is prescribed or required by the law of the state under  
403 which the insurer is organized.

404 (2) Any policy of a domestic insurer may, when issued for delivery in any  
405 other state or country, contain any provision permitted or required by the laws  
406 of such other state or country.

407 7. Approval of policies.

408 (1) No policy subject to sections 376.770 to 376.800 shall be delivered or  
409 issued for delivery to any person in this state unless such policy, including any  
410 rider, endorsement or other provisions, supplementary thereto, shall have been  
411 approved by the director of the department of insurance, financial institutions  
412 and professional registration.

413 (2) The director of the department of insurance, financial institutions and  
414 professional registration shall have authority to make such reasonable rules and  
415 regulations concerning the filing and submission of policies as are necessary,  
416 proper or advisable. Such rules and regulations shall provide, among other  
417 things, that if a policy form is disapproved, [the reasons therefor] **all specific**  
418 **reasons for noncompliance** shall be stated in writing **within forty-five days**  
419 **from the date of filing**; that a hearing shall be granted upon such disapproval,  
420 if so requested; and that the failure of the director of the department of  
421 insurance, financial institutions and professional registration to take action  
422 approving or disapproving a submitted policy form within [a stipulated time, not  
423 to exceed sixty] **forty-five** days from the date of filing, shall be deemed an  
424 approval thereof [until such time as the director of the department of insurance,  
425 financial institutions and professional registration shall notify the submitting  
426 company, in writing, of his disapproval thereof]. **If at any time after a policy**  
427 **form is approved or deemed approved, the director determines that any**  
428 **provision of the filing is contrary to state law, the director shall notify**  
429 **the health carrier of the specific provision that is contrary to state law**  
430 **and request that the health carrier file an amendment form that**  
431 **modifies the provision to conform to state law. The failure of the**  
432 **director of the department of insurance, financial institutions and**  
433 **professional registration to take action approving or disapproving a**  
434 **submitted amendment form within forty-five days from the date of**  
435 **filing shall be deemed an approval thereof. In the event that a policy**  
436 **form is approved or deemed approved and is subsequently amended for**

437 **state law compliance upon the department's request as provided herein,**  
438 **the department shall not retroactively enforce the amended policy**  
439 **form.**

440 (3) The director of the department of insurance, financial institutions and  
441 professional registration shall approve only those policies which are in compliance  
442 with the insurance laws of this state and which contain such words, phraseology,  
443 conditions and provisions which are specific, certain and unambiguous and  
444 reasonably adequate to meet needed requirements for the protection of those  
445 insured. The disapproval of any policy form shall be based upon the  
446 requirements of the laws of this state or of any regulation lawfully promulgated  
447 thereunder.

448 (4) The director of the department of insurance, financial institutions and  
449 professional registration may, by order or bulletin, exempt from the approval  
450 requirements of this section for so long as he deems proper any insurance policy,  
451 document, or form or type thereof, as specified in such order or bulletin, to which,  
452 in his opinion, this section may not practicably be applied, or the approval of  
453 which is, in his opinion, not desirable or necessary for the protection of the public.

376.1363. 1. A health carrier shall maintain written procedures for  
2 making utilization review decisions and for notifying enrollees and providers  
3 acting on behalf of enrollees of its decisions. For purposes of this section,  
4 "enrollee" includes the representative of an enrollee.

5 2. For initial determinations, a health carrier shall make the  
6 determination within two working days of obtaining all necessary information  
7 regarding a proposed admission, procedure or service requiring a review  
8 determination. For purposes of this section, "necessary information" includes the  
9 results of any face-to-face clinical evaluation or second opinion that may be  
10 required:

11 (1) In the case of a determination to certify an admission, procedure or  
12 service, the carrier shall notify the provider rendering the service by telephone  
13 **or electronically** within twenty-four hours of making the initial certification,  
14 and provide written or electronic confirmation of [the] a telephone **or electronic**  
15 notification to the enrollee and the provider within two working days of making  
16 the initial certification;

17 (2) In the case of an adverse determination, the carrier shall notify the  
18 provider rendering the service by telephone **or electronically** within twenty-four  
19 hours of making the adverse determination; and shall provide written or

20 electronic confirmation of [the] a telephone **or electronic** notification to the  
21 enrollee and the provider within one working day of making the adverse  
22 determination.

23           3. For concurrent review determinations, a health carrier shall make the  
24 determination within one working day of obtaining all necessary information:

25           (1) In the case of a determination to certify an extended stay or additional  
26 services, the carrier shall notify by telephone **or electronically** the provider  
27 rendering the service within one working day of making the certification, and  
28 provide written or electronic confirmation to the enrollee and the provider within  
29 one working day after [the] telephone **or electronic** notification. The written  
30 notification shall include the number of extended days or next review date, the  
31 new total number of days or services approved, and the date of admission or  
32 initiation of services;

33           (2) In the case of an adverse determination, the carrier shall notify by  
34 telephone **or electronically** the provider rendering the service within  
35 twenty-four hours of making the adverse determination, and provide written or  
36 electronic notification to the enrollee and the provider within one working day of  
37 [the] a telephone **or electronic** notification. The service shall be continued  
38 without liability to the enrollee until the enrollee has been notified of the  
39 determination.

40           4. For retrospective review determinations, a health carrier shall make  
41 the determination within thirty working days of receiving all necessary  
42 information. A carrier shall provide notice in writing of the carrier's  
43 determination to an enrollee within ten working days of making the  
44 determination.

45           5. A written notification of an adverse determination shall include the  
46 principal reason or reasons for the determination, the instructions for initiating  
47 an appeal or reconsideration of the determination, and the instructions for  
48 requesting a written statement of the clinical rationale, including the clinical  
49 review criteria used to make the determination. A health carrier shall provide  
50 the clinical rationale in writing for an adverse determination, including the  
51 clinical review criteria used to make that determination, to any party who  
52 received notice of the adverse determination and who requests such information.

53           6. A health carrier shall have written procedures to address the failure  
54 or inability of a provider or an enrollee to provide all necessary information for  
55 review. In cases where the provider or an enrollee will not release necessary

56 information, the health carrier may deny certification of an admission, procedure  
57 or service.

376.2000. 1. Sections 376.2000 to 376.2014 shall be known and  
2 may be cited as the "Health Insurance Marketplace Innovation Act of  
3 2013".

4 2. As used in sections 376.2000 to 376.2014, the following terms  
5 mean:

6 (1) "Department", the department of insurance, financial  
7 institutions and professional registration;

8 (2) "Director", the director of the department of insurance,  
9 financial institutions and professional registration;

10 (3) "Exchange", any health benefit exchange established or  
11 operating in this state, including any exchange established or operated  
12 by the United States Department of Health and Human Services.

13 (4) "Navigator", a person selected to perform the activities and  
14 duties identified in 42 U.S.C. 18031(i) in this state, any person who  
15 receives grant funds from the United States Department of Health and  
16 Human Services to perform any of the activities and duties identified  
17 in 42 U.S.C. 18031(i), and any person performing any such defined or  
18 related duties irrespective of whether such person is identified as a  
19 navigator, certified application counselor, in-person assister, or other  
20 title.

376.2002. 1. No individual or entity shall perform, offer to  
2 perform, or advertise any service as a navigator in this state, or receive  
3 navigator funding from the state or an exchange unless licensed as a  
4 navigator by the department under sections 376.2000 to 376.2014.

5 2. A navigator shall not:

6 (1) Engage in any activities that would require an insurance  
7 producer license;

8 (2) Provide advice concerning the benefits, terms, and features  
9 of a particular health plan or offer advice about which health plan is  
10 better or worse for a particular individual or employer;

11 (3) Recommend or endorse a particular health plan or advise  
12 consumers about which health plan to choose; or

13 (4) Provide any information or services related to health benefit  
14 plans or other products not offered in the exchange.

15 3. Only a person licensed as an insurance producer in this state

16 **may:**

- 17       **(1) Sell, solicit, or negotiate health insurance;**  
18       **(2) Provide advice concerning the benefits, terms, and features**  
19 **of a particular health plan or offer advice about which health plan is**  
20 **better or worse for a particular individual or employer; or**  
21       **(3) Recommend a particular health plan or advise consumers**  
22 **about which health plan to choose.**

**376.2004. 1. An individual applying for a navigator license shall**  
2 **make application to the department on a form developed by the**  
3 **director and declare under penalty of refusal, suspension, or revocation**  
4 **of the license that the statements made in the application are true,**  
5 **correct, and complete to the best of the individual's knowledge and**  
6 **belief. Before approving the application, the director shall find that**  
7 **the individual:**

- 8       **(1) Is eighteen years of age or older;**  
9       **(2) Resides in this state or maintains his or her principal place**  
10 **of business in the state;**  
11       **(3) Is not disqualified for having committed any act that would**  
12 **be grounds for refusal to issue, renew, suspend, or revoke an insurance**  
13 **producer license under section 375.141;**  
14       **(4) Has successfully passed the written examination prescribed**  
15 **by the director;**  
16       **(5) When applicable, has the written consent of the director**  
17 **under 18 U.S.C. 1033 or any successor statute regulating crimes by or**  
18 **affecting persons engaged in the business of insurance whose activities**  
19 **affect interstate commerce;**  
20       **(6) Has identified the entity with which he or she is affiliated**  
21 **and supervised; and**  
22       **(7) Has paid the fees prescribed by the director.**

23       **2. An entity that acts as a navigator, supervises the activities of**  
24 **individual navigators, or receives funding to perform such activities**  
25 **shall obtain a navigator entity license. An entity applying for an entity**  
26 **navigator license shall make application on a form containing the**  
27 **information prescribed by the director.**

28       **3. The director may require any documents deemed necessary to**  
29 **verify the information contained in an application submitted in**  
30 **accordance with subsections 1 and 2 of this section.**

31           4. Entities licensed as navigators shall, in a manner prescribed  
32 by the director, provide a list of all individual navigators that are  
33 employed by or in any manner affiliated with the navigator entity and  
34 shall report any changes in employment or affiliation within twenty  
35 days of such change.

36           5. The director shall require that each navigator obtain a surety  
37 bond in an amount acceptable to the director or otherwise demonstrate  
38 a level of financial responsibility capable of protecting all persons  
39 against the wrongful acts, misrepresentations, errors, omissions, or  
40 negligence of the navigator. The director may ask for a copy of the  
41 bond or other evidence of financial responsibility at any time.

42           6. Prior to any exchange becoming operational in this state, the  
43 director shall prescribe initial training, continuing education, and  
44 written examination standards and requirements for navigators.

          376.2006. 1. A navigator license shall be valid for two years.

2           2. A navigator may file an application for renewal of a license  
3 and pay the renewal fee as prescribed by the director. Any navigator  
4 who fails to timely file for license renewal shall be charged a late fee  
5 in an amount prescribed by the director.

6           3. Prior to the filing date for an application for renewal of a  
7 license, an individual licensee shall comply with any ongoing training  
8 and continuing education requirements established by the  
9 director. Such navigator shall file with the director, by a method  
10 prescribed by the director, proof of satisfactory certification of  
11 completion of the continuing education requirements. Any failure to  
12 fulfill the ongoing training and continuing education requirements  
13 shall result in the expiration of the license.

          376.2008. Upon contact with a person who acknowledges having  
2 existing health insurance coverage obtained through an insurance  
3 producer, a navigator shall refer the person back to that insurance  
4 producer for information, assistance, and any other services.

          376.2010. 1. The director may place on probation, suspend,  
2 revoke, or refuse to issue, renew, or reinstate a navigator license or  
3 may levy a fine not to exceed one thousand dollars for each violation,  
4 or any combination of actions, for any one or more of the causes listed  
5 in section 375.141, 375.936 or for other good cause. In the event that the  
6 action by the director is not to renew or to deny an application for a



7 license, the director shall notify the applicant or licensee in writing  
8 and shall advise the applicant or licensee of the reason for the denial  
9 or nonrenewal. Appeal of the nonrenewal or denial of the application  
10 for a navigator license shall be made under the provisions of chapter  
11 621.

12       2. In addition to imposing the penalties authorized by subsection  
13 1 of this section, the director may require that restitution be made to  
14 any person who has suffered financial injury because of a violation of  
15 this section.

16       3. The director shall have the power to examine and investigate  
17 the business affairs and records of any navigator to determine whether  
18 the individual or entity has engaged or is engaging in any violation of  
19 this section.

20       4. The navigator license held by an entity may be suspended or  
21 revoked, renewal or reinstatement thereof may be refused, or a fine  
22 may be levied, with or without a suspension, revocation, or refusal to  
23 renew a license, if the director finds that an individual licensee's  
24 violation was known or should have been known by the employing or  
25 supervising entity and the violation was not reported to the director  
26 and no corrective action was undertaken on a timely basis.

376.2012. 1. Each licensed navigator shall report to the director  
2 within thirty calendar days of the final disposition of the matter of any  
3 administrative action taken against him or her in another jurisdiction  
4 or by another governmental agency in this state. This report shall  
5 include a copy of the order, consent to order, or other relevant legal  
6 documents.

7       2. Within thirty days of the initial pretrial hearing date, a  
8 navigator shall report to the director any criminal prosecution of the  
9 navigator in any jurisdiction. The report shall include a copy of the  
10 initial complaint filed, the order resulting from the hearing, and any  
11 other relevant legal documents.

12       3. An entity that acts as a navigator that terminates the  
13 employment, engagement, affiliation, or other relationship with an  
14 individual navigator shall notify the director within twenty days  
15 following the effective date of the termination, using a format  
16 prescribed by the director if the reason for termination is one of the  
17 reasons set forth in section 375.141 or 375.936 or if the entity has

18 knowledge that the navigator was found by a court or governmental  
19 body to have engaged in any such activities. Upon the written request  
20 of the director, the entity shall provide additional information,  
21 documents, records, or other data pertaining to the termination or  
22 activity of the individual.

376.2014. 1. The requirements of sections 379.930 to 379.952 and  
2 chapters 375, 376, 407 and any related rules shall apply to  
3 navigators. The activities and duties of a navigator shall be deemed to  
4 constitute transacting the business of insurance.

5 2. If any provision of sections 376.2000 to 376.2014 or its  
6 application to any person or circumstance is held invalid by a court of  
7 competent jurisdiction or by federal law, the invalidity does not affect  
8 other provisions or applications of sections 376.2000 to 376.2014 that  
9 can be given effect without the invalid provision or application. The  
10 provisions of sections 376.2000 to 376.2014 are severable, and the valid  
11 provisions or applications shall remain in full force and effect.

12 3. The director may promulgate rules and regulations to  
13 implement and administer the provisions of sections 376.2000 to  
14 376.2014. Any rule or portion of a rule, as that term is defined in  
15 section 536.010, that is created under the authority delegated in  
16 sections 376.2000 to 376.2014 shall become effective only if it complies  
17 with and is subject to all of the provisions of chapter 536 and, if  
18 applicable, section 536.028. Sections 376.2000 to 376.2014 and chapter  
19 536 are nonseverable and if any of the powers vested with the general  
20 assembly pursuant to chapter 536 to review, to delay the effective date,  
21 or to disapprove and annul a rule are subsequently held  
22 unconstitutional, then the grant of rulemaking authority and any rule  
23 proposed or adopted after August 28, 2013, shall be invalid and void.

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