MINNESOTA

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Accident Only and A D & D Checklist

The following information has been compiled as a Checklist Guide for Commerce Department analysts to use in reviewing Accident Only and Accidental Death and Dismemberment product filings submitted to the Department for approval in Minnesota on a case-by-case basis. The Checklist Guide is designed as an internal Commerce Department resource to outline certain state or federal laws that could apply to provisions typically found in Accident Only and AD&D certificates or policy forms. It may be periodically updated to reflect statutory changes. Additional state or federal law requirements may exist to the extent they apply to provisions not typically found in policy forms or certificates. Compliance with these additional requirements, if applicable to the product filing, would still be required even though they are not listed in this Checklist Guide.

NOTE: While the Department is making this Checklist Guide publicly available, health plan companies should refer to all relevant Minnesota Statutes and Rules and applicable federal law in developing the product filings that they submit to the Department for approval. To the extent the provisions in this Checklist Guide conflict with state or federal law, companies making filings should comply with the language of the state or federal law. This Checklist Guide is a representation of general provisions and should not be construed as a legal opinion or advice.

Additional Information

60A.02 DEFINITIONS

Subd. 1a. **Association or associations.**

(a) "Association" or "associations" means an organized body of people who have some interest in common and that has at the onset a minimum of 100 persons; is organized and maintained in good faith for purposes other than that of obtaining insurance; and has a constitution and bylaws which provide that: (1) the association or associations hold regular meetings not less frequently than annually to further purposes of the members; (2) except for credit unions, the association or associations collect dues or solicit contributions from members; (3) the members have voting privileges and representation on the governing board and committees, which provide the members with control of the association including the purchase and administration of insurance products offered to members; and (4) the members are not, within the first 30 days of membership, directly solicited, offered, or sold an insurance policy if the policy is available as an association benefit.

Benefits and Services

Benefits provided must be reasonable in relation to the premium charged.

Coverage levels must be provided at a value greater than zero to be considered insurance.

Exclusion Language

62A.02, Policy Forms, Subd 3. Standards for disapproval. (a) The commissioner shall disapprove the form or rate
(2) if it contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of the health plan form, or otherwise does not comply with this chapter, chapter 62L, or chapter 72A;

The Department reviews policies on a case-by-case basis to determine if any provisions are unjust, unfair, inequitable, deceptive, or encourage misrepresentation.
Examples of exclusions that may be considered unjust, unfair, inequitable, misleading, deceptive, or encourage misrepresentation include:

- Assault – This exclusion may be too vague to allow for equitable and fair claims administration,
- An intoxication or under the influence of alcohol exclusion in these policies limiting coverage if a person is driving or operating a motor vehicle and is determined to have a blood alcohol level exceeding the legal limit as defined by state law may be acceptable,
- Involuntary ingestion or inhalation of poison, drugs, narcotics, gas or fumes, or other deleterious substances,
- Accidental or hostile gun-shot wounds – This exclusion may be unjust as an employer or enrollee purchasing insurance would expect coverage for all covered health services,
- War – whether declared or undeclared – This exclusion may be unjust as an employer or enrollee purchasing insurance would expect coverage for all covered health services, or
- Motorized speed contests or races- Such an exclusion may be acceptable if it is the insured's occupation or if it is an organized speed contest or race.

Exclusions should be specific and include a list of the activities or avocations. Open-ended exclusions may be considered unjust, unfair, inequitable, misleading, or deceptive.

Portability of Coverage

Minn. Stat. § 62Q.18 requires health plan companies issuing group health plans to make coverage available on a guaranteed basis to individuals who maintain continuous coverage and who qualify under the group's eligibility requirements coverage that is designed solely to provide payments on a per diem, fixed indemnity, or non-expense-incurred basis.

Use of Brackets

If a submitted form contains brackets requesting variability, filer must submit a Memorandum of Variability (MOV)/Statement of Variability (SOV) that thoroughly explains the extent of variability. Department approval is limited to the language provided in the MOV/SOV. Minn. Stat. § 62A.02, subd. 2 ("No health plan shall be issued or delivered to any person in this state, nor shall any application, rider, or endorsement be used in connection with the health plan, until a copy of its form and of the classification of risks and the premium rates pertaining to the form have been filed with the commissioner."). Attach the MOV/SOV to the Supporting Documentation tab.

Accident Only and A D & D Requirements	Accident Only	A D & D
60A.06 KINDS OF INSURANCE PERMITTED *Individual Only* **Subd 3. Limitation on Combination Policies.** (a) Unless specifically authorized by subdivision 1, clause (4), it is unlawful to combine in one policy coverage permitted by subdivision 1, clauses (4) and (5)(a). This subdivision does not prohibit the simultaneous sale of these products, but the sale must involve two separate and distinct policies. (b) This subdivision does not apply to group policies.	✓	✓
60A.08 CONTRACTS OF INSURANCE *Mandated* **Subd 5. Signatures required**. All insurance policies shall be signed by the secretary or an assistant secretary, and by the president or vice-president, or in their absence, by two directors of the insurer. The signatures may be facsimile signatures.	✓	✓
60A.082 GROUP INSURANCE; BENEFITS CONTINUED IF INSURER CHANGED A person covered under group life, group accidental death and dismemberment, group disability income or group medical expense insurance, shall not be denied benefits to which the person is otherwise entitled solely because of a change in the insurance company writing the coverage or in the group contract applicable to the person. In the case of one or more carriers replacing or remaining in place after one or more plans have been discontinued, each carrier shall accept any person who was covered under the discontinued plan or plans without denial of benefits to which other persons in the group covered by that carrier are entitled. "Insurance company" shall include a service plan corporation under chapter 62C or 62D. For purposes of satisfying any preexisting condition limitation, the insurance company shall credit the period of time the person was covered by the prior plan, if the person has maintained continuous coverage. *See also* Minn. R. Chapter 2755 (Group Insurance Coverage Replacement) listed below.	✓	✓
60A.084 NOTIFICATION ON GROUP POLICIES An employer providing life or health benefits may not change benefits, limit coverage, or otherwise restrict participation until the certificate holder or enrollee has been notified of any changes, limitations, or restrictions.	✓	✓

60A.085 CANCELLATION OF GROUP COVERAGE; NOTIFICATION TO COVERED PERSONS No cancellation of any group … policy, … is effective unless the insurer has made a good faith effort to notify all covered persons of the cancellation at least 30 days before the effective cancellation date. For purposes of this section, an insurer has made a good faith effort to notify all covered persons if the insurer has notified all the persons included on the list required by paragraph (b) at the home address given and only if the list has been updated within the last 12 months.	✓	✓
60A.086 RETROACTIVE TERMINATION PROHIBITED **Subd 2. Requirement.** No plan of coverage described in subdivision 1 shall permit the issuer to retroactively cancel, retroactively rescind, or otherwise retroactively terminate the coverage of an employee, dependent, or other covered person under the group coverage, without the written consent of that employee, dependent, or other covered person. For purposes of this subdivision, "covered person" includes a person on continuation coverage or eligible for continuation coverage. **Subd 3. Non-applicability.** This section does not apply where the group policy or contract is lawfully terminated retroactively due to fraud or material misrepresentation.	✓	✓
62A.01 REQUIREMENTS; CERTIFICATIONS OF COVERAGE UNDER POLICY OF ACCIDENT AND SICKNESS INSURANCE **Subd 1. Definition.** The term "policy of accident and sickness insurance" as used herein includes any policy covering the kind of insurance described in section 60A.06, subdivision 1, clause (5)(a), or the paid family and medical leave benefits as described in section 268B.10. **Subd 2. Equal protection.** A certificate of insurance or similar evidence of coverage issued to a Minnesota resident shall provide coverage for all benefits required to be covered in group policies in Minnesota by this chapter.	✓	✓
62A.011 DEFINITIONS Subd. 2 **Health Carrier** means an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; **Subd 3 Health Plan** does not include (8) accident-only coverage.	✓	✓
62A.02 POLICY FORMS **Subd 3. Standards for Disapproval**: a. The commissioner shall, within 60 days after the filing of any form or rate, disapprove the form or rate: 1. If the benefits provided are not reasonable in relation to the premium charged; 2. If it contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of the health plan form, or otherwise does not comply with this chapter, chapter 62L, or chapter 72A. 3. If the proposed premium rate is excessive or not adequate; or 4. The actuarial reasons and data submitted do not justify the rate.		

62A.021 HEALTH CARE POLICY RATES Subdivision 1. **Loss ratio standards.** All filings of rates and rating schedules shall demonstrate that actual expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards, and aggregate loss ratio from inception of the policy form or certificate form shall equal or exceed the appropriate loss ratio standards.	✓	✓
62A.023 NOTICE OF RATE CHANGE A health insurer or service plan corporation must send written notice to its policyholders and contract holders at their last known address at least 30 days in advance of the effective date of proposed rate change. This notice requirement does not apply to individual certificate holders covered by group insurance policies or group subscriber contracts.	✓	✓
62A.024 EXPLANATIONS OF RATE INCREASES; ATTRIBUTION TO STATUTORY CHANGES If any health carrier, as defined in section 62A.011, informs a policyholder or contract holder that a rate increase is due to a statutory change, the health carrier must disclose the specific amount of the rate increase directly due to the statutory change and must identify the specific statutory change. This disclosure must also separate any rate increase due to medical inflation or other reasons from the rate increase directly due to statutory changes in this chapter, chapter 62C, 62D, 62E, 62H, 62J, 62L, or 64B	✓	✓
62A.03 GENERAL PROVISIONS OF POLICY *Mandated – Individual Only* All individual contracts of accident and sickness insurance **Subd. 1. Conditions.** No policy of individual accident and sickness insurance may be delivered or issued for delivery to a person in this state unless: (1) Premium (2) Time effective (3) One person (4) Appearance (5) Description of policy (6) Exceptions in policy (7) Form number (8) No incorporation by reference (9) Medical benefits (10) Osteopathic physician, optometrist, chiropractor, or registered nurse services Subd 2. **Delivery of policy to nonresident.**	✓	✓

62A.04 STANDARD PROVISIONS *Mandated* Subd 2. **Required Provisions** **(1) ENTIRE CONTRACT; CHANGES** This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions. **(2) TIME LIMIT ON CERTAIN DEFENSES:** (a) After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period. *(Incontestability)* **(3) GRACE PERIOD** A grace period of ..... (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force. **(4) REINSTATEMENT** If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. If the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. **(5) NOTICE OF CLAIM** Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at ..... (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer. **(6) CLAIM FORMS** The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. **(7) PROOFS OF LOSS** Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is	✓	✓

liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. **(8) TIME OF PAYMENT OF CLAIMS** Indemnities payable under this policy for any loss other than loss for which this policy provides periodic payment will be paid immediately upon receipt of due written proof of such loss… **(9) PAYMENT OF CLAIMS** **(10) PHYSICAL EXAMINATION AND AUTOPSY:** The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law**.** **(11) LEGAL ACTIONS:** No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished. **(12) CHANGE OF BENEFICIARY**		
62A.04 STANDARD PROVISIONS **Subd 3. Optional Provisions** Except as provided in subdivision 4, no such policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section… **(1) CHANGE OF OCCUPATION** **(2) MISSTATEMENT OF AGE** **(3) OTHER INSURANCE IN THIS INSURER** **(4) INSURANCE WITH OTHER INSURERS:** "expense incurred benefit." **(5) INSURANCE WITH OTHER INSURERS:** "other benefits" **(6) RELATION OF EARNINGS TO INSURANCE** **(7) UNPAID PREMIUM** Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom. **(8) CANCELLATION:** The insurer may cancel this policy at any time by written notice delivered to the insured or mailed to the insured's last address as shown by the records of the insurer, stating when, not less than five days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. Regardless	✓	✓

of whether it is the insurer or the insured who cancels, the earned premium shall be computed pro rata, unless the mode of payment is monthly or less, or if the unearned amount is for less than one month. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation. **(9) CONFORMITY WITH STATE STATUTE:** Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes. **(10) ILLEGAL OCCUPATION** The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation. **(11) NARCOTICS**: The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being under the influence of any narcotic unless administered on the advice of a physician. **Subd 10. Return of Premium** (Limitation) A policy of accident and sickness insurance as defined in section 62A.01 may contain or may be amended by rider to provide for a return of premium benefit so long as: (1) the return of premium benefit is not applicable until the policy has been in force for five years (2) the return of premium benefit is not reduced by an amount greater `than the aggregate of any claims paid under the policy (3) the return of premium benefit is not included in or used with a policy with benefits that are reduced based on an insured's age (4) the return of premium benefit is not payable in lieu of benefits at the option of the insurer (5) the insurer demonstrates that the reserve basis for such benefit is adequate; and (2) (6) the cost of the benefit is disclosed to the insured and the insured is given the option of the coverage.		
62A.042 FAMILY COVERAGE; COVERAGE OF NEWBORN INFANTS *Mandated if Dependents are covered* **Subd 1. Individual family policies. & Subd 2 Group policies.** No group/ individual accident and sickness insurance policy ... shall be renewed ... unless the policy or contract includes as insured or covered family members or dependents any newborn infants immediately from the moment of birth and thereafter which insurance or contract shall provide coverage for illness, injury, congenital malformation, or premature birth. "**Newborn infants**" includes grandchildren who are financially dependent upon a covered grandparent and who reside with that covered grandparent continuously from birth. No policy or contract covered by this section may require notification to a health carrier as a condition for this dependent coverage. **Individual Policies**: The health carrier may withhold payment of any health benefits for the new dependent until it has been compensated with the applicable premium which would have been owed if the health carrier had been informed of the additional dependent immediately. **Group Polices**: The health carrier may reduce the health benefits owed to the insured, certificate holder, member, or subscriber by the amount of past due premiums applicable to the additional dependent.	✓	✓

62A.044 PAYMENTS TO GOVERNMENTAL INSTITUTIONS No group or individual policy of accident and sickness insurance issued or renewed after May 22, 1973, pursuant to this chapter, no group or individual service plan or subscriber contract issued or renewed after May 22, 1973, pursuant to chapter 62C, and no group or individual health maintenance contract issued or renewed after August 1, 1984, pursuant to chapter 62D, shall contain any provision excluding, denying, or prohibiting payments for covered and authorized services rendered or paid by a hospital or medical institution owned or operated by the federal, state, or local government, including correctional facilities, or practitioners therein in any instance wherein charges for such services are imposed against the policyholder, subscriber, or enrollee. The unit of government operating the institution may maintain an action for recovery of such charges.	✓	✓
62A.081 PAYMENTS TO FACILITIES OPERATED BY STATE OR LOCAL GOVERNMENT Every group or individual policy of accident and sickness insurance issued or renewed after July 1, 1973 regulated by this chapter, and every group or individual service plan or subscriber contract issued or renewed after July 1, 1973 regulated by chapter 62C, providing care or payment for care in this state, shall provide payments for services rendered by a hospital or medical facility owned or operated by, or on behalf of, the state or any unit of local government, or practitioners therein, on the same basis as are made for like care in other facilities. The unit of government concerned may maintain an action for recovery of such payments.	✓	✓
62A.095 SUBROGATION CLAUSES REGULATED *If Included, then* **Subd 1. Applicability** **Subd 2. Subrogation clause; limits**	✓	✓
62A.096 NOTICE TO INSURER OF SUBROGATION CLAIMS REQUIRED *If Included, then* A person covered by a health carrier who makes a claim against a collateral source for damages that include repayment for medical and medically related expenses incurred for the covered person's benefit shall provide timely notice, in writing, to the health carrier of the pending or potential claim. Notwithstanding any other law to the contrary, the statute of limitations applicable to the rights with respect to reimbursement or subrogation by the health carrier against the covered person does not commence to run until the notice has been given.	✓	✓
62A.10 GROUP INSURANCE *Mandated Group Only* **Subd 1. Requirements**. **Subd 2. Group accidental death and group disability income policies.** Group accidental death insurance and group disability income insurance policies may be issued in connection with first real estate mortgage loans to cover groups of not less than ten debtors of a creditor written under a master policy issued to a creditor to insure its debtors in connection with first real estate mortgage loans, in amounts not to exceed the actual or scheduled amount of their indebtedness. No other accident and health coverages may be issued in connection with first real estate mortgage loans on a group basis to a debtor-creditor group.	✓	✓

Subd 4. Policy Forms. No policy or certificate of group accident and health insurance may be issued or delivered in this state unless the same has been approved by the commissioner in accordance with section 62A.02, subdivisions 1 to 6. These forms shall contain the standard provisions relating and applicable to health and accident insurance and shall conform with the other requirements of law relating to the contents and terms of policies of accident and sickness insurance insofar as they may be applicable to group accident and health insurance, and the following provisions: **1. Entire contract.** A provision that the policy and the application of the creditor, employer, trustee, or executive officer or trustee of any association, and the individual applications, if any, of the debtors, employees, or members, insured, shall constitute the entire contract between the parties, and that all statements made by the creditor, employer, trustee, or any executive officer or trustee on behalf of the group to be insured, shall, in the absence of fraud, be deemed representations and not warranties, and that no such statement shall be used in defense to a claim under the policy, unless it is contained in the written application; **2. Master policy-certificates.** A provision that the insurer will issue a master policy to the creditor, employer, trustee, or to the executive officer or trustee of the association; and the insurer shall also issue to the creditor, the employer, trustee, or to the executive officer or trustee of the association, for delivery to the debtor, employee, or member, who is insured under the policy, an individual certificate setting forth a statement as to the insurance protection to which the debtor, employee, or member is entitled and to whom payable, together with a statement as to when and where the master policy, or a copy thereof, may be seen for inspection by the individual insured. The individual certificate may contain the names of, and insure the dependents of, the employee, or member, as provided for herein; **3. New insureds.** A provision that to the group or class thereof originally insured may be added, from time to time, all new employees of the employer, members of the association, or debtors of the creditor eligible to and applying for insurance in that group or class and covered or to be covered by the master policy. **4. Conversion privilege.** In the case of accidental death insurance and disability income insurance issued to debtors of a creditor, the policy must contain a conversion privilege permitting an insured debtor to convert, without evidence of insurability, to an individual policy within 30 days of the date the insured debtor's group coverage is terminated, and not replaced with other group coverage, for any reason other than nonpayment of premiums. The individual policy must provide the same amount of insurance and be subject to the same terms and conditions as the group policy and the initial premium for the individual policy must be the same premium the insured debtor was paying under the group policy. This provision does not apply to a group policy which provides that the certificate holder may, upon termination of coverage under the group policy for any reason other than nonpayment of premium, retain coverage provided under the group policy by paying premiums directly to the insurer.		
62A.105 COVERAGES; TRANSFERS TO SUBSTANTIALLY SIMILAR PRODUCTS *Mandated Group Only* **Subd. 2. Requirement.** If an issuer of policies …ceases to offer a particular policy or subscriber contract to the general public or otherwise stops adding new insureds to the group of covered persons, the issuer shall allow any covered person to transfer to another substantially similar policy or	✓	✓

contract currently being sold by the issuer. The issuer shall permit the transfer without any preexisting condition limitation, waiting period, or other restriction of any type other than those which applied to the insured under the prior policy or contract. This section does not apply to persons who were covered under an individual policy or contract prior to July 1, 1994.		
62A.135 FIXED INDEMNITY POLICIES: MINIMUM LOSS RATIO **Subd 1. Definitions** "Fixed indemnity policy" is a policy form, other than an accidental death and dismemberment policy, a disability income policy, or a long-term care policy as defined in section 62A.46, subdivision 2, that pays a predetermined, specified, fixed benefit for services provided. For policy forms providing both expense-incurred and fixed benefits, the policy form is a fixed indemnity policy if 50 percent or more of the total claims are for predetermined, specified, fixed benefits.	✓	✓
62A.14 DISABLED CHILDREN *Mandated for hospital or medical expense provided* A hospital or medical expense insurance policy ... which provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy or contract shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability and (b) chiefly dependent upon the policyholder for support and maintenance, provided proof of such incapacity and dependency is furnished to the insurer or health maintenance organization by the policyholder or enrollee within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer or organization but not more frequently than annually after the two-year period following the child's attainment of the limiting age. Any notice regarding termination of coverage due to attainment of the limiting age must include all the information in this section.	✓	✓
62A.141 COVERAGE FOR DISABLED DEPENDENTS. *Mandated Group Only* No group policy or group plan of health and accident insurance regulated under this chapter, chapter 62C, or 62D, which provides for dependent coverage may be issued or renewed in this state after August 1, 1983, unless it covers the disabled dependents of the insured, subscriber, or enrollee of the policy or plan. For purposes of this section, a disabled dependent is a person that is and continues to be both: (1) incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability; and (2) chiefly dependent upon the policyholder for support and maintenance. Consequently, the policy or plan shall not contain any provision concerning preexisting condition limitations, insurability, eligibility, or health underwriting approval concerning disabled dependents.	✓	✓
62A.146 CONTINUATION OF BENEFITS TO SURVIVORS *Mandated* No policy, contract, or plan of accident and health protection issued by an insurer, nonprofit health service plan corporation, or health maintenance organization, providing coverage of hospital or medical expense on either an expense incurred basis or other than an expense incurred basis which in addition to coverage of the insured, subscriber, or enrollee, also provides coverage to dependents, shall, except upon the written consent of the survivor or survivors of the deceased insured, subscriber, or enrollee, terminate,		

suspend, or otherwise restrict the participation in or the receipt of benefits otherwise payable under the policy, contract, or plan to the survivor or survivors until the earlier of the following dates: (a) the date the surviving spouse becomes covered under another group health plan; or (b) the date coverage would have terminated under the policy, contract, or plan had the insured, subscriber, or enrollee lived. The survivor or survivors, in order to have the coverage and benefits extended, may be required to pay the entire cost of the protection on a monthly basis. The policy, contract, or plan must require the group policyholder or contract holder to, upon request, provide the insured, subscriber, or enrollee with written verification from the insurer of the cost of this coverage promptly at the time of eligibility for this coverage and at any time during the continuation period. In no event shall the amount of premium or fee contributions charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouses and dependent children who are not the survivors of a deceased insured, without regard to whether such cost is paid by the employer or employee. Failure of the survivor to make premium or fee payments within 90 days after notice of the requirement to pay the premiums or fees shall be a basis for the termination of the coverage without written consent. In event of termination by reason of the survivor's failure to make required premium or fee contributions, written notice of cancellation must be mailed to the survivor's last known address at least 30 days before the cancellation. If the coverage is provided under a group policy, contract, or plan, any required premium or fee contributions for the coverage shall be paid by the survivor to the group policyholder or contract holder for remittance to the insurer, nonprofit health service plan corporation, or health maintenance organization.	✓	✓
62A.15 COVERAGE OF CERTAIN LICENSED HEALTH PROFESSIONAL SERVICES Subd. 2**. Chiropractic services.** Subd. 3**. Optometric services.** Subd. 3a**. Nursing services.** Subd. 3b**. Acupuncture services.** Subd. 3c**. Physician assistant services** Subd. 3d. **Pharmacist.**	✓	✓
62A.151 HEALTH INSURANCE BENEFITS FOR EMOTIONALLY DISABLED CHILDREN. *Mandated for non-indemnity expense coverage* No policy or plan of health, medical, hospitalization, or accident and sickness insurance regulated under this chapter, or nonprofit health service plan corporation regulated under chapter 62C, or health maintenance organization regulated under chapter 62D which provides coverage of or reimbursement for inpatient hospital and medical expenses shall be delivered, issued, executed or renewed in this state, or approved for issuance or renewal in this state by the commissioner of commerce, after July 1, 1975 unless the policy or plan includes and provides health service benefits to any subscriber or other person covered thereunder, on the same basis as other benefits, for the treatment of emotionally disabled children in a residential treatment facility licensed by the commissioner of human	✓	✓

services. For purposes of this section "emotionally disabled child" shall have the meaning set forth by the commissioner of human services in the rules relating to residential treatment facilities. The restrictions and requirements of this section shall not apply to any plan or policy which is individually underwritten or provided for a specific individual and family members as a nongroup policy. The mandatory coverage under this section shall be on the same basis as inpatient hospital medical coverage provided under the policy or plan.		
62A.17 TERMINATION OF OR LAYOFF FROM EMPLOYMENT; CONTINUATION AND CONVERSION RIGHTS. *Mandated Group Only* Subdivision 1. **Continuation of coverage.** Subd. 2. **Responsibility of employee.** Subd. 4. **Responsibility of employer.** Subd. 5. **Notice of options.**	✓	✓
62A.18 PROHIBITION AGAINST DISABILITY OFFSETS. No individual or group policy of accident and health insurance issued, amended, renewed, or delivered in this state on or after January 1, 1976 shall contain any provision offsetting, or in any other manner reducing, any benefit under the policy by the amount of, or in proportion to, any increase in disability benefits received or receivable under the federal Social Security Act, the Railroad Retirement Act, any Veteran's Disability Compensation and Survivor Benefits Act, Workers' Compensation, or any similar federal or state law, as amended subsequent to the date of commencement of such benefit.	✓	✓
62A.20 CONTINUATION COVERAGE OF CURRENT SPOUSE AND CHILDREN *Mandated* **Subdivision 1. Requirement.** Every policy of accident and health insurance providing coverage of hospital or medical expense on either an expense-incurred basis or other than an expense-incurred basis, which in addition to covering the insured also provides coverage to the spouse and dependent children of the insured shall contain: (1) a provision which allows the spouse and dependent children to elect to continue coverage when the insured becomes enrolled for benefits under Title XVIII of the Social Security Act (Medicare); and (2) a provision which allows the dependent children to continue coverage when they cease to be dependent children under the generally applicable requirement of the plan. Upon request by the insured or the insured's spouse or dependent child, a health carrier must provide the instructions necessary to enable the spouse or child to elect continuation of coverage. **Subd. 2. Continuation privilege.** The coverage described in subdivision 1 may be continued until the earlier of the following dates: (1) the date coverage would otherwise terminate under the policy; (2) 36 months after continuation by the spouse or dependent was elected; or (3) the spouse or dependent children become covered under another group health plan.	✓	✓

If coverage is provided under a group policy, any required premium contributions for the coverage shall be paid by the insured on a monthly basis to the group policyholder for remittance to the insurer. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouse and dependent children to whom subdivision 1 is not applicable, without regard to whether such cost is paid by the employer or employee.		
62A.21 CONTINUATION AND CONVERSION PRIVILEGES FOR INSURED FORMER SPOUSES AND CHILDREN. *Mandated* **Subdivision 1. Break in marital relationship, termination of coverage prohibited.** No policy of accident and health insurance providing coverage of hospital or medical expense on either an expense incurred basis or other than an expense incurred basis, which in addition to covering the insured also provides coverage to the spouse of the insured shall contain a provision for termination of coverage for a spouse covered under the policy solely as a result of a break in the marital relationship. **Subd. 2a. Continuation privilege.** Every policy described in subdivision 1 shall contain a provision which permits continuation of coverage under the policy for the insured's dependent children, which is defined as required by section 62A.302, and former spouse, who was covered on the day before the entry of a valid decree of dissolution of marriage. The coverage shall be continued until the earlier of the following dates: (a) the date the insured's former spouse becomes covered under any other group health plan; or (b) the date coverage would otherwise terminate under the policy. If the coverage is provided under a group policy, any required premium contributions for the coverage shall be paid by the insured on a monthly basis to the group policyholder for remittance to the insurer. The policy must require the group policyholder to, upon request, provide the insured with written verification from the insurer of the cost of this coverage promptly at the time of eligibility for this coverage and at any time during the continuation period. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouses and dependent children with respect to whom the marital relationship has not dissolved, without regard to whether such cost is paid by the employer or employee. Upon request by the insured's former spouse, who was covered on the day before the entry of a valid decree of dissolution, or dependent child, a health carrier must provide the instructions necessary to enable the child or former spouse to elect continuation of coverage. **Subd. 3. Application.** Subdivision 1 applies to every policy of accident and health insurance which is delivered, issued for delivery, renewed or amended on or after July 19, 1977. Subdivisions 2a and 2b apply to every policy of accident and health insurance which is delivered, issued for delivery, renewed, or amended on or after August 1, 1981.	✓	✓

62A.22 REFUSAL TO PROVIDE COVERAGE BECAUSE OF OPTION UNDER WORKERS' COMPENSATION. *Prohibited* No insurer offering an individual or group policy of accident or health coverage in this state shall refuse to provide or renew accident or health coverage because the insured has an option to elect workers' compensation coverage pursuant to section 176.041, subdivision 1a.	✓	✓
62A.3021 COVERAGE OF DEPENDENTS BY PLANS OTHER THAN HEALTH PLANS. *Mandated if Dependents are Covered* Subdivision 1. **Scope of coverage.** This section applies to coverage described in section 62A.011, subdivision 3, clauses (4), (6), (7), (8), (9), and (10). Subd. 2. **Dependent.** "Dependent" means an eligible employee's spouse, unmarried child who is under the age of 25, dependent child of any age who is disabled and who meets the eligibility criteria in section 62A.14, subdivision 2, or any other person whom state or federal law requires to be treated as a dependent for purposes of health plans. For the purpose of this definition, a child includes a child for whom the employee or the employee's spouse has been appointed legal guardian and an adoptive child as provided in section 62A.27. A child also includes grandchildren as provided in section 62A.042 with continued eligibility of grandchildren as provided in section 62A.302, subdivision 4.	✓	✓
62A.307 PRESCRIPTION DRUGS; EQUAL TREATMENT OF PRESCRIBERS. *Mandated if Covered* Subd. 2. **Requirement.** Coverage described in subdivision 1 that covers prescription drugs must provide the same coverage for a prescription written by a health care provider authorized to prescribe the particular drug covered by the health coverage described in subdivision 1, regardless of the type of health care provider that wrote the prescription. This section is intended to prohibit denial of coverage based on the prescription having been written by an advanced practice registered nurse under section 148.235, a physician assistant under section 147A.185, or any other nonphysician health care provider authorized to prescribe the particular drug.	✓	✓
62A.3091 NONDISCRIMINATE COVERAGE OF TESTS. Subdivision 1. **Scope of requirement.** Subd. 2. **Requirement.**	✓	✓
62A.3092 EQUAL TREATMENT OF SURGICAL FIRST ASSISTING SERVICES. Subdivision 1. **Scope of requirement.** Subd. 2. **Requirement.**	✓	✓
62A.48 LONG-TERM CARE POLICIES. *Prohibited Coordination with Long Term Care* **Subd. 6.Coordination of benefits.**	✓	✓

A long-term care policy may be secondary coverage for services provided under sections 62A.46 to 62A.56. Nothing in sections 62A.46 to 62A.56 shall require the secondary payor to pay the obligations of the primary payor nor shall it prevent the secondary payor from recovering from the primary payor the amount of any obligation of the primary payor that the secondary payor elects to pay. There shall be no coordination of benefits between a long-term care policy and a policy designed primarily to provide coverage payable on a per diem, fixed indemnity or non-expense-incurred basis, or a policy that provides only accident coverage.	✓	✓
62A.60 RETROACTIVE DENIAL OF EXPENSES. In cases where the subscriber or insured is liable for costs beyond applicable co-payments or deductibles, no insurer may retroactively deny payment to a person who is covered when the services are provided for health care services that are otherwise covered, if the insurer or its representative failed to provide prior or concurrent review or authorization for the expenses when required to do so under the policy, plan, or certificate. If prior or concurrent review or authorization was provided by the insurer or its representative, and the preexisting condition limitation provision, the general exclusion provision and any other coinsurance, or other policy requirements have been met, the insurer may not deny payment for the authorized service or time period except in cases where fraud or substantive misrepresentation occurred.	✓	✓
62Q.471 EXCLUSION FOR SUICIDE ATTEMPTS PROHIBITED. *Prohibited* (a) No health plan may exclude or reduce coverage for health care for an enrollee who is otherwise covered under the health plan on the basis that the need for the health care arose out of a suicide or suicide attempt by the enrollee. (b) For purposes of this section, "health plan" has the meaning given in section 62Q.01, subdivision 3, but includes the coverages described in section 62A.011, subdivision 3, clauses (4), (6), and (7) through (10).	✓	✓
65B.61 BENEFITS PRIMARY; SUBTRACTIONS; COORDINATION. Subd. 3. **General right to coordinate benefits.** Any legal entity, other than a reparation obligor obligated to pay benefits under a plan of reparation security or an insurer or employer obligated to pay benefits under a workers' compensation law, may coordinate any benefits it is obligated to pay for loss incurred as a result of injury arising out of the maintenance or use of a motor vehicle with basic economic loss benefits. No entity may coordinate benefits pursuant to this subdivision, unless it provides an appropriately reduced premium rate. The amount of this rate reduction shall be not less than the amount of the projected reduction in benefits and claims for which the entity will be liable on that class of risks, less the additional reasonable expenses incurred to administer the plan coordinating benefits. The projected reduction in benefits and claims shall be based upon sound actuarial principle.	✓	✓

72A.51 RIGHT TO CANCEL. *Mandated Individual Only* Subdivision 1. **Date of purchase defined.** Subd. 2. **Return of policy or contract; notice.** Subd. 3. **Refund of consideration.** Subd. 4. **Waiver or surrender prohibited**	✓	✓
72A.52 NOTICE REQUIREMENTS. *Mandated Individual Only* Subdivision 1. **Contents.** Subd. 2. **Noncompliance; cancellation.**	✓	✓
72C.05 COVER SHEET. **Subd. 2. Form and content.**	✓	✓
72C.06 READABILITY. Subdivision 1. **Requirement.** All insurance policies filed with the commissioner pursuant to section 72C.11 shall be written in language easily readable and understandable by a person of average intelligence and education. Subd. 2. **Compliance factors**	✓	✓
72C.08 FORMAT REQUIREMENTS. *Mandated Individual Only* Subdivision 1. **Requirement.** All insurance policies and contracts covered by section 72C.11 shall be written in a logical, clear, and understandable order and form and shall contain at least the following items: (a) on the cover or first or an insert page of the policy a statement that the policy is a legal contract between the policy owner and the company and the statement, printed in larger or other contrasting type or color, "Read your policy carefully"	✓	✓
CHAPTER 2755, GROUP INSURANCE COVERAGE REPLACEMENT 2755.0100 DEFINITION. 2755.0200 AUTHORITY AND SCOPE. 2755.0300 PURPOSE. 2755.0400 LIABILITY OF PRIOR CARRIER. 2755.0500 LIABILITY OF SUCCEEDING CARRIER.	✓	✓