1300.63.2 Combined Evidence of Coverage and Disclosure Form

Notwithstanding Sections 1300.63 and 1300.63.1 of these rules, a plan may combine the evidence of coverage and disclosure form into a single document if such plan complies with each of the following requirements:

(a)

Each plan shall furnish to each individual subscriber, and make available to group contract holders for dissemination to all persons eligible under the group contract, either a single document consisting of a combined evidence of coverage and disclosure form or a copy of the plan contract, which shall conform to the requirements of this section.

(b)

Except as may be otherwise permitted by the Director, the combined evidence of coverage and disclosure form shall conform to the following requirements: (1) It shall be clearly entitled "Combined Evidence of Coverage and Disclosure Form." (2) The text shall be printed in at least ten point block type. Titles and captions shall be in at least twelve point to fifteen point boldface type. (3) It shall be written in clear, concise, easily understood language. (4) It should relate to one form of plan contract; however, combined evidence of coverage and disclosure forms offering alternative plans or options will be permitted if presented in a manner which clearly identifies the alternatives and their effect upon the

contract. (5) It shall be presented in an easily readable format. (6) The combined evidence of coverage and disclosure form when taken as a whole, with consideration being given to format, typography and language, must constitute a fair disclosure of the provisions of the health plan.

(1)

It shall be clearly entitled "Combined Evidence of Coverage and Disclosure Form."

(2)

The text shall be printed in at least ten point block type. Titles and captions shall be in at least twelve point to fifteen point boldface type.

(3)

It shall be written in clear, concise, easily understood language.

(4)

It should relate to one form of plan contract; however, combined evidence of coverage and disclosure forms offering alternative plans or options will be permitted if presented in a manner which clearly identifies the alternatives and their effect upon the contract.

(5)

It shall be presented in an easily readable format.

(6)

The combined evidence of coverage and disclosure form when taken as a whole, with consideration being given to format, typography and language, must constitute a fair disclosure of the provisions of the health plan.

(c)

The combined evidence of coverage and disclosure form shall contain at a minimum the following information: (1) The name of the health plan, the principal address from which it conducts its business and its telephone number.

(2) A statement that the specimen of the plan contract will be furnished on request. (3) The definitions for the words contained therein that have meanings other than those attributed to them by the public in general usage. (4) The manner in which the member can determine who is or may be entitled to benefits, except that a member under group coverage may be referred to the group contract holder for such information. (5) The time and date or occurrence upon which coverage takes effect including a specification of any applicable waiting periods. (6) The time and date or occurrence upon which coverage will terminate. (7) The conditions upon which cancellation may be effected by the health plan or by the member, and a statement that a subscriber or enrollee who alleges that an enrollment or subscription has been cancelled or not renewed because of the enrollee's or subscriber's health status or requirements for health care services may request a review of cancellation by the Director. (8) The conditions for and any restrictions upon the member's right to renewal or reinstatement. (9) The caption "Prepayment Fees" followed by a statement of the methods by which such premium may be paid; the full premium charge of the plan; and a statement of the authority to change the fees during the term of the contract. (10) The amount of the periodic payment to be made by the member, the time by which the payment must be made, and the address at or to which the payment shall be made, except that a member under group coverage may be referred to the group contract holder for information regarding any sums to be withheld from the member's salary or to be paid by the member to the employer or group contract holder. (11) A complete statement of all benefits and coverages and the related limitations, exclusions, exceptions, reductions, copayments, and deductibles. (12) The caption "Other Charges," followed by a description of each copayment, coinsurance, or deductible requirement that may be incurred by the member or

the member's family in obtaining coverage under the plan. (13) A statement of any restriction on assignment of sums payable to the member by the health plan. (14) The exact procedure for obtaining benefits including the procedure for filing claims. The procedure for filing claims must state the time by which the claim must be filed, the form in which it is to be filed, and the address at or to which it shall be delivered or mailed. (15) Any procedures required to be followed by the member in the event any dispute arises under the contract, including any requirement for arbitration. (16) The address and telephone number designated by the health plan to which complaints from members are to be directed, and a description of the plan's grievance procedure. (17) The caption "Choice of Physicians and Providers," followed by description of the nature, extent and circumstances under which choice is permitted. This section shall include, if applicable, a subcaption "Liability of Subscriber or Enrollee for Payment" followed by a description of the financial liability which is, or may be, incurred by the subscriber, enrollee or a third party by reason of the exercise of such choice. (18) A statement to the effect that, by statute, every contract between the health plan and a provider shall provide that in the event the health plan fails to pay the provider, the member shall not be liable to the provider for any sums owed by the health plan. (19) A statement to the effect that in the event the health plan fails to pay noncontracting providers, the member may be liable to the noncontracting provider for the cost of services. (20) If applicable, the caption "Reimbursement Provisions," followed by a description of the circumstances under which reimbursements are made under the plan contract, the extent of reimbursement, and the method of claim for reimbursement. (21) The caption "Renewal Provisions," followed by a statement of the terms under which the plan contract may be renewed by the group or the plan member, as appropriate, including any

reservation by the plan of any right to change premiums or other plan contract provisions. (22) The caption "Facilities," followed by a statement of the principal facilities available under the plan contract, including their location and description of the services provided. The hours of availability of both emergency and non-emergency services should be indicated, either specifically or by general description. However, if the Director approves in advance, a plan may provide a telephone number from which information as to the identity and location of the provider facilities defined in subsection (i)(2) of Section 1300.45 of these rules may be obtained, in lieu of listing such provider facilities. (23) In the case of group contracts, the caption "Individual Continuation of Benefits," followed by a statement of the terms and conditions under which subscribers and enrollees may remain in the plan, as provided pursuant to subdivision (g) of Section 1373 of the Act. (24) The caption "Termination of Benefits," followed by a statement of the terms and conditions for cancellation or termination of benefits, including a statement as to when benefits shall cease in the event of nonpayment of the prepaid or periodic charge and the effect of nonpayment upon a member who is hospitalized or undergoing treatment for an ongoing condition. (25) Any appropriate statement to fulfill the requirement of Section 1300.69(i)(1) of these rules, unless the plan undertakes to mail such information annually. (26) In the event that receipt of benefits or reimbursements to subscribers or enrollees under the plan contract is subject to significant delays, based upon the current experience of the plan, the combined evidence of coverage and disclosure form may be required by the Director to disclose such facts. (27) A statement which shall be set forth in boldface type not less than two points larger than the type required by subsection (b)(2): "This combined evidence of coverage and disclosure form constitutes only a summary of the health plan. The health plan contract must be

consulted to determine the exact terms and conditions of coverage."

(1)

The name of the health plan, the principal address from which it conducts its business and its telephone number.

(2)

A statement that the specimen of the plan contract will be furnished on request.

(3)

The definitions for the words contained therein that have meanings other than those attributed to them by the public in general usage.

(4)

The manner in which the member can determine who is or may be entitled to benefits, except that a member under group coverage may be referred to the group contract holder for such information.

(5)

The time and date or occurrence upon which coverage takes effect including a specification of any applicable waiting periods.

(6)

The time and date or occurrence upon which coverage will terminate.

(7)

The conditions upon which cancellation may be effected by the health plan or by the member, and a statement that a subscriber or enrollee who alleges that an enrollment or subscription has been cancelled or not renewed because of the enrollee's or subscriber's health status or requirements for health care services may request a review of cancellation by the Director.

(8)

The conditions for and any restrictions upon the member's right to renewal or

reinstatement.

(9)

The caption "Prepayment Fees" followed by a statement of the methods by which such premium may be paid; the full premium charge of the plan; and a statement of the authority to change the fees during the term of the contract.

(10)

The amount of the periodic payment to be made by the member, the time by which the payment must be made, and the address at or to which the payment shall be made, except that a member under group coverage may be referred to the group contract holder for information regarding any sums to be withheld from the member's salary or to be paid by the member to the employer or group contract holder.

(11)

A complete statement of all benefits and coverages and the related limitations, exclusions, exceptions, reductions, copayments, and deductibles.

(12)

The caption "Other Charges," followed by a description of each copayment, coinsurance, or deductible requirement that may be incurred by the member or the member's family in obtaining coverage under the plan.

(13)

A statement of any restriction on assignment of sums payable to the member by the health plan.

(14)

The exact procedure for obtaining benefits including the procedure for filing claims. The procedure for filing claims must state the time by which the claim must be filed, the form in which it is to be filed, and the address at or to which it shall be delivered or mailed.

(15)

Any procedures required to be followed by the member in the event any dispute arises under the contract, including any requirement for arbitration.

(16)

The address and telephone number designated by the health plan to which complaints from members are to be directed, and a description of the plan's grievance procedure.

(17)

The caption "Choice of Physicians and Providers," followed by description of the nature, extent and circumstances under which choice is permitted. This section shall include, if applicable, a subcaption "Liability of Subscriber or Enrollee for Payment" followed by a description of the financial liability which is, or may be, incurred by the subscriber, enrollee or a third party by reason of the exercise of such choice.

(18)

A statement to the effect that, by statute, every contract between the health plan and a provider shall provide that in the event the health plan fails to pay the provider, the member shall not be liable to the provider for any sums owed by the health plan.

(19)

A statement to the effect that in the event the health plan fails to pay noncontracting providers, the member may be liable to the noncontracting provider for the cost of services.

(20)

If applicable, the caption "Reimbursement Provisions," followed by a description of the circumstances under which reimbursements are made under the plan contract, the extent of reimbursement, and the method of claim for reimbursement.

(21)

The caption "Renewal Provisions," followed by a statement of the terms under which

the plan contract may be renewed by the group or the plan member, as appropriate, including any reservation by the plan of any right to change premiums or other plan contract provisions.

(22)

The caption "Facilities," followed by a statement of the principal facilities available under the plan contract, including their location and description of the services provided. The hours of availability of both emergency and non-emergency services should be indicated, either specifically or by general description. However, if the Director approves in advance, a plan may provide a telephone number from which information as to the identity and location of the provider facilities defined in subsection (i)(2) of Section 1300.45 of these rules may be obtained, in lieu of listing such provider facilities.

(23)

In the case of group contracts, the caption "Individual Continuation of Benefits," followed by a statement of the terms and conditions under which subscribers and enrollees may remain in the plan, as provided pursuant to subdivision (g) of Section 1373 of the Act.

(24)

The caption "Termination of Benefits," followed by a statement of the terms and conditions for cancellation or termination of benefits, including a statement as to when benefits shall cease in the event of nonpayment of the prepaid or periodic charge and the effect of nonpayment upon a member who is hospitalized or undergoing treatment for an ongoing condition.

(25)

Any appropriate statement to fulfill the requirement of Section 1300.69(i)(1) of these rules, unless the plan undertakes to mail such information annually.

(26)

In the event that receipt of benefits or reimbursements to subscribers or enrollees under the plan contract is subject to significant delays, based upon the current experience of the plan, the combined evidence of coverage and disclosure form may be required by the Director to disclose such facts.

(27)

A statement which shall be set forth in boldface type not less than two points larger than the type required by subsection (b)(2): "This combined evidence of coverage and disclosure form constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage."