"Specified disease coverage" means a policy which meets one of the following definitions:

(a) A policy which provides coverage, for each person insured under the policy, for a specifically named disease or diseases with a deductible amount not in excess of $250, an overall aggregate benefit limit of no less than $10,000 and a benefit period of not less than two years for the following incurred expenses:

(1) Hospital room and board and any other hospital-furnished medical services or supplies;
(2) treatment by a legally qualified physician or surgeon;
(3) private duty services of a registered nurse (R.N.);
(4) x-ray, radium and other therapy procedures used in diagnosis and treatment;
(5) professional ambulance for local service to and from a local hospital;
(6) blood transfusions, including expense incurred for blood donors;
(7) drugs and medicines prescribed by a physician;
(8) rental of an iron lung or similar mechanical apparatus;
(9) braces, crutches and wheelchairs, as deemed necessary by the attending physician, for the treatment of the disease; and
(10) emergency transportation, if in the opinion of the attending physician, the insured requires transportation to another locality for treatment of the disease.

(b) A specified disease policy may include coverage of other expenses necessarily incurred in the treatment of the disease.

(c) A policy which provides coverage, for each person insured under the policy, for a specifically named disease or diseases with no deductible amount, an overall aggregate benefits limit of not less than $25,000, payable at the rate of not less than $50 a day while confined in a hospital, and a benefit period of not less than 500 days.

(Authorized by K.S.A. 40-103, 40-2218; implementing K.S.A. 40-2218; effective Feb. 15, 1977; amended May 1, 1984; amended May 1, 1986)