

NATIONAL MEETING
FALL / DENVER



2024 Fall National Meeting
Denver, Colorado

**JOINT MEETING OF THE EXECUTIVE (EX) COMMITTEE
AND INTERNAL ADMINISTRATION (EX1) SUBCOMMITTEE**

Sunday, November 17, 2024
10:00 – 11:30 a.m.

Meeting Summary Report

The Executive (EX) Committee met in joint session with the Internal Administration (EX1) Subcommittee Nov. 17, 2024. The meeting was held in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC) and paragraph 6 (consultations with NAIC staff members) of the NAIC Policy Statement on Open Meetings. During this meeting, the Committee and Subcommittee:

1. Adopted their Oct. 31 and Summer National Meeting minutes, which included the following action:
 - A. Approved the release of the proposed 2025 NAIC budget for public comment prior to its consideration by the full Membership during the joint meeting of the Executive (EX) Committee and Plenary on Dec. 18.
 - B. Received an update on the property/casualty (P/C) market intelligence (PCMI) data call.
2. Adopted the Executive (EX) Committee’s Summer National Meeting minutes.
3. Adopted the report of the Audit Committee, including its Nov. 13 minutes. During this meeting, the Committee took the following action:
 - A. Received the Sept. 30 financial update.
 - B. Received an update on the 2024 year-end financial audit.
 - C. Received an update on the upcoming Service Organization Control (SOC) 1 and SOC 2 reviews.
 - D. Heard an update on the Enterprise Resource Planning (ERP) project.
 - E. Reviewed the status of Zone financials.
4. Adopted the report of the Internal Administration (EX1) Subcommittee, including its Aug. 26 minutes. During this meeting, the Subcommittee took the following action:
 - A. Received the June 30 Long-Term Investment Portfolio report.
 - B. Received the June 30 Defined Benefit Portfolio report.
 - C. Received a status update on the termination of the Defined Benefit Pension Plan.
5. Adopted a fiscal for model office testing related to the Generator of Economic Scenarios (GOES).
6. Approved the public release of a request for proposal (RFP) related to the due diligence framework for credit rating agencies.
7. Heard a technology and cybersecurity report.
8. Heard the Chief Executive Officer (CEO) report.

Adopted by the Health Insurance and Managed Care (B) Committee – Nov. 19, 2024

Adopted by the Regulatory Framework (B) Task Force – Nov. 4, 2024

Adopted by the Accident and Sickness Insurance Minimum Standards (B) Subgroup – Oct. 17, 2024

Draft: 11/19/24

Model#171

The revisions to this draft reflect changes made from the existing model. Any comments on this draft should be sent by email only to Jolie Matthews at jmatthews@naic.org.

**MODEL REGULATION TO IMPLEMENT THE ~~ACCIDENT~~
~~AND SICKNESS~~SUPPLEMENTARY AND SHORT-TERM HEALTH INSURANCE MINIMUM
STANDARDS MODEL ACT**

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Section 1. Purpose

The purpose of this regulation is to implement [insert reference to state law equivalent to the NAIC Accident and Sickness Supplementary and Short-Term Health Insurance Minimum Standards Model Act] (the Act) to standardize and simplify the terms and coverages, ~~of individual accident and sickness insurance policies, and group accident and sickness policies and certificates providing hospital confinement indemnity, accident only, specified disease specified accident or limited benefit health coverage (hereafter referred to as “group supplemental health insurance”).~~ This regulation is also intended to facilitate public understanding and comparison of coverage, to eliminate provisions ~~contained in individual accident and sickness insurance policies and group supplemental health insurance~~ that may be misleading or confusing in connection with the purchase and renewal of the coverages or with the settlement of claims; and to provide for full disclosure in the marketing and sale of ~~individual accident and sickness insurance policies and group supplemental health insurance~~ supplementary and short-term health insurance, as defined in the Act. This regulation is also intended to assert the commissioner’s jurisdiction over limited scope dental coverage and limited scope vision plans coverage, and to provide for disclosure in the sale of those plans coverages.

Drafting Note: States should determine if the phrase “individual accident and sickness insurance policies” is broad enough or particular enough to cover the array of individual health insurance issuers in the state. States that use different terminology (e.g. “subscriber contracts” or “nonprofit hospital, medical and dental associations”) to cover these plans should choose terminology conforming to state statute.

Section 2. Authority

This regulation is issued pursuant to the authority vested in the commissioner under [insert reference to state law equivalent to NAIC Accident and Sickness Supplementary and Short-Term Health Insurance Minimum Standards Model Act and any other appropriate section of law regarding authority of commissioner to issue regulations].

Section 3. Applicability and Scope

- A. This regulation applies to all individual ~~accident and sickness insurance policies~~ and group ~~supplemental health insurance~~ policies and certificates ~~providing hospital indemnity or other fixed indemnity, accident only, specified accident, specified disease, limited benefit health and disability income protection, referred to collectively in Section 1 of the Act and hereafter, as “supplementary health insurance,”~~ delivered or issued for delivery in this state on and after [insert effective date] that are not specifically exempted from this regulation. ~~This regulation applies to short-term, limited-duration insurance coverage offered, delivered or issued for delivery to residents of this state regardless of the situs of the delivery of the contract on and after [insert effective date].~~
- B. This ~~Act~~ regulation ~~shall apply~~ applies to ~~limited scope~~ dental ~~plans~~ coverage and ~~limited scope~~ vision ~~plans~~ coverage only as specified.
- C. This regulation shall not apply to:
- ~~(1) Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the group or individual policy or contract includes provisions that are inconsistent with the requirements of this regulation;~~
 - ~~(2) Policies issued to employees or members as additions to franchise plans in existence on the effective date of this regulation;~~
 - ~~(3)~~(1) Medicare supplement policies subject to [insert reference to state law equivalent to the Model Regulation to Implement the NAIC *Medicare Supplement Insurance Minimum Standards Model Act*];
 - ~~(4)~~(2) Long-term care insurance policies subject to [insert reference to state law equivalent to the NAIC *Long-Term Care Insurance Model Act*]; ~~or~~
 - ~~(5)~~(3) ~~TRICARE Civilian Health and Medical Program of the Uniformed Services~~ (Chapter 55, ~~†~~ Title 10 of the United States Code) ~~(CHAMPUS)~~ supplement insurance policies; ~~or~~
 - (4) ~~Limited long-term care insurance policies subject to [insert reference to state law equivalent to the NAIC *Limited Long-Term Care Insurance Model Act*].~~

Drafting Note: ~~CHAMPUS~~TRICARE supplement insurance is not subject to federal regulation. ~~CHAMPUS~~TRICARE supplement policies are sold only to eligible individuals as determined by the Department of Defense and are tied to ~~CHAMPUS~~TRICARE benefits. In general, states regulate ~~CHAMPUS~~TRICARE supplement insurance policies under the state group or individual insurance laws.

- D. The requirements contained in this regulation shall be in addition to any other applicable regulations previously adopted.

Section 4. Effective Date

This regulation shall be effective on [insert a date not less than 120 days after the date of adoption of the regulation]. ~~The amendments to this regulation shall apply to any policies [or certificates] issued on or after the effective date of the adoption of the amended regulation.~~

Section 5. Definitions

For purposes of this regulation:

- A. “Excepted benefits” means coverage listed at section 2791(c) of the Public Health Service Act (PHSA) or subsequently added by regulation where authorized.
- B. “Medicare” means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.
- C. “Short-term, limited-duration insurance” has the meaning stated in Section 3I of the Act.

Section 56. Policy Definitions

- A. ~~(1) Except as provided in this regulation, an individual accident and sickness insurance policy or group supplemental health insurance policy or a short-term limited duration insurance policy delivered or issued for delivery to any person in this state and to which this regulation applies shall contain definitions respecting the matters set forth below that comply with the requirements of this section.~~
- ~~(2) Except as provided in this regulation, to the extent these definitions are used in a policy [or certificate], definitions used in a policy [or certificate] may vary from the definitions in this section, but not in a manner that restricts coverage.~~
- B. ~~(1) “Accident,” “accidental injury,” and “accidental means” shall be defined to employ “result” language and shall not include words that establish an accidental means test or use words such as “external, violent, visible wounds” or similar words of description or characterization.~~
- ~~(2) The definition shall not be more restrictive than the following: “injury” or “injuries” means accidental bodily injury sustained by the insured person that is the direct cause of the condition for which benefits are provided, independent of disease or bodily infirmity or any other cause and that occurs while the insurance is in force.~~
- ~~(3) The definition may provide that injuries shall not include injuries for which benefits are provided under workers’ compensation, employers’ liability or similar law; or under a motor vehicle no fault plan, unless prohibited by law; or injuries occurring while the insured person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit.~~
- CB. “Convalescent nursing home,” “extended care facility,” ~~or~~ “skilled nursing facility,” “assisted living facility” or “continued care retirement community” shall be defined means in relation to its status, facility and available services.
- (1) A definition of the home or facility shall not be more restrictive than one requiring that it:
- (a) Be operated pursuant to law;
 - (b) Be approved for payment of Medicare and/or Medicaid benefits or be qualified to receive approval for payment of Medicare and/or Medicaid benefits, if so requested;
 - (c) Be ~~primarily~~ engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;
 - (d) ~~Provide~~provide continuous twenty-four-hour-a-day nursing service by or under the supervision of a registered nurse; and
 - (e) Maintain a daily medical record of each patient.
- (2) The definition of the home or facility ~~may provide that the term shall not be inclusive of~~ is permitted but is not required to exclude:
- (a) A home, facility or part of a home or facility used primarily for rest;
 - (b) A home or facility for the aged and/or for the care of ~~drug addicts or alcoholics~~ individuals with a substance use disorder; or
 - (c) A home or facility primarily used for the care and treatment of mental diseases or disorders, or for custodial or educational care.

Drafting Note: The laws of the states relating to nursing and extended care facilities recognized in health insurance policies are not uniform. Reference to the individual state or federal Medicare or Medicaid law may be required in structuring this definition.

C. “Home health care agency”:

- (1) Is an agency approved under Medicare;
- (2) Is licensed to provide home health care under applicable state law; or
- (3) Meets all the following requirements:
 - (a) It is primarily engaged in providing home health care services;
 - (b) Its policies are established by a group of professional personnel, including at least one physician and one licensed nurse;
 - (c) A physician or a registered nurse provides supervision of home health care services;
 - (d) It maintains clinical records on all patients; and
 - (e) It has a full-time administrator.

Drafting Note: State licensing laws vary concerning the scope of “home health care” or “home health agency services” and should be consulted. In addition, a few states have mandated benefits for home health care, including the definition of required services.

ED. “Hospital” ~~may be defined~~means in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission ~~on Accreditation of Healthcare Organizations.~~

- (1) The definition of the term “hospital” shall not be more restrictive than one requiring that the hospital:
 - (a) Be an institution licensed to operate as a hospital pursuant to law;
 - (b) Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and
 - (c) Provide twenty-four-hour nursing service by or under the supervision of registered nurses.
- (2) The definition of the term “hospital” ~~may state that the term shall not be inclusive of~~ is permitted but is not required to exclude:
 - (a) Convalescent homes or, convalescent, rest or nursing facilities;
 - (b) Facilities affording primarily custodial, educational or ~~rehabilitory~~rehabilitative care;
 - (c) Facilities for the aged, ~~drug addicts or alcoholics~~ or individuals with a substance use disorder; or
 - (d) A military or veterans’ hospital, a soldiers’ home or a hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces, except for services ~~rendered on an emergency basis~~ where a legal liability for the patient exists for charges made to the individual for the services.

Drafting Note: The laws of the states relating to the type of hospital facilities recognized in health insurance policies are not uniform. References to individual state law may be required in structuring this definition.

- E. (1) “Injury” means a bodily injury resulting from an accident, independent of disease, which occurs while the coverage is in force.
- (2) The definition shall not use words such as “external, violent, visible wounds” or similar words of characterization or description.
- (3) The definition may state that the disability shall have occurred within a specified period of time (not less than thirty (30) days) of the injury, otherwise the condition shall be considered a sickness.
- (4) The definition may provide that “injury” shall not include an injury for which benefits are provided under workers’ compensation, employers’ liability or similar law; or under a motor vehicle no-fault plan, unless prohibited by law; or injuries occurring while the insured person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit.
- E. ~~“Medicare” means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended.~~
- F. ~~“Mental or nervous disorder” shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychosis, or mental or emotional disease or disorder of any kind means any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or its successor.~~
- G. “Nurse” may be defined so that the description of nurse is restricted to a type of nurse, such as an advance practice nurse, a registered nurse, a licensed practical nurse, or a licensed vocational nurse. If the words “nurse,” “advance practice nurse,” “trained nurse” or “registered nurse” are used without specific instruction, then the use of these terms requires the insurer to recognize the services of any individual who qualifies under the terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

Drafting Note: States may want to consider whether the functions of an advance practice nurse fall under this definition or the definition of “physician” in Subsection J.

- H. “One period of confinement” means consecutive days of in-hospital service received as an in-patient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time not more than ninety (90) days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of 180 days.
- I. “Partial disability” ~~shall be defined in relation to~~ means that, due to a disability, an individual:
- (1) the individual’s inability is unable to perform one or more but not all of the “major,” “important” or “essential” duties of the individual’s employment or existing occupation, or may be related to a percentage of time worked or to a specified number of hours or to compensation; and
- (2) Is in fact engaged in work for wage or profit.
- J. (1) “Physician” may be defined by means and including includes words such as “qualified physician” or “licensed physician.” and may not be defined more narrowly than applicable state licensing laws. The use of these terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when the services are within the scope of the provider’s licensed authority and are provided pursuant to applicable laws.
- (2) The definition or concept may exclude the insured, the owner, the assignee, any person related to the insured, owner or assignee by blood or marriage, any person who shares a significant business interest with the insured, owner or assignee, or any person who is a partner in a legally sanctioned domestic partnership or civil union with the insured, owner or assignee.

Drafting Note: The laws of the states relating to the type of providers’ services recognized in health insurance policies are not uniform. References to the individual state law may be required in structuring this definition.

- K. “Preexisting condition” ~~shall not be defined more restrictively than the following: “Preexisting condition means the existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a [two] year period preceding the effective date of the coverage of the insured person or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a [two-] year period preceding the effective date of the coverage of the insured person.”~~

Drafting Note: This definition does not prohibit an insurer, using an application or enrollment form, including a simplified application form, designed to elicit the health history of a prospective insured and on the basis of the answers on that application or enrollment form, from underwriting in accordance with that insurer’s established standards and in accordance with state law. It is assumed that an insurer that elicits a health history of a prospective insured will act on the information and if the review of the health history results in a decision to exclude a condition, the policy or certificate will be endorsed or amended by including the specific exclusion. This same requirement of notice to the prospective insured of the specific exclusion will also apply to insurers that elect to use simplified application or enrollment forms containing questions relating to the prospective insured’s health. This definition does, however, prohibit an insurer that elects to use a simplified application or enrollment form, with or without a question as to the proposed insured’s health at the time of application or enrollment, from reducing or denying a claim on the basis of the existence of a preexisting condition that is defined more restrictively than above.

~~States that have specific requirements with respect to waivers or exclusionary riders or evidence of insurability requirements for group insurance should modify the preceding paragraphs by deleting group references and adding a new paragraph addressing these requirements. In states which have adopted or are operating under the “federal fallback” provisions the Health Insurance Portability and Accountability Act of 1996 (HIPAA), for major medical coverage issued to a HIPAA eligible individual, there can be no preexisting condition exclusion. In addition, states that have specific preexisting condition requirements for group insurance may need to modify section Subsection K according to applicable statutes.~~

- L. “Residual disability” ~~shall be defined~~means in relation to the individual’s reduction in earnings and may be related either to the inability to perform some part of the “major,” “important” or “essential duties” of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. A policy that provides for residual disability benefits may require a qualification period, during which the insured must be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term “residual disability,” the insurer may use “proportionate disability” or other term of similar import that in the opinion of the commissioner adequately and fairly describes the benefit.
- M. “Sickness” ~~shall not be defined to be more restrictive than the following: “Sickness~~ means sickness, illness, or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period that shall not exceed thirty (30) days from the effective date of the coverage of the insured person.”² The definition may be further modified to exclude sickness or disease for which benefits are provided under a worker’s/workers’ compensation, occupational disease, employers’ liability or similar law.
- N. “Total disability”
- (1) A general definition of total disability shall not be more restrictive than one requiring that the individual who is totally disabled not be engaged in any employment or occupation for which he or she is or becomes qualified by reason of education, training or experience; and is not in fact engaged in any employment or occupation for wage or profit.
 - (2) Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual’s inability to:
 - (a) Perform “any occupation whatsoever,” “any occupational duty,” or “any and every duty of his occupation”; or
 - (b) Engage in a training or rehabilitation program.
 - (3) An insurer may require the complete inability of the person to perform all of the substantial and material duties of his or her regular occupation or words of similar import. An insurer may require care by a physician other than the insured or a member of the insured’s immediate family.

Section ~~6~~7. Prohibited Policy Provisions

- A. ~~(1)~~ Except as provided in ~~Section 5K~~this subsection, a policy shall not contain provisions establishing a probationary or waiting period during which ~~no coverage is provided~~ under the policy ~~is excluded or restricted~~; subject to the further exception that
- ~~(2)~~ A policy, other than an accident only policy, may exclude coverage for a loss due to a preexisting condition, as defined in Section 6J, for a period not to exceed twelve (12) months following the issuance of the policy or certificate. The twelve-month limitation is not required if the condition was disclosed during the application or enrollment process and specifically excluded by the terms of the policy or certificate, or when the insured knowingly made a material misrepresentation during the application or enrollment process.
- ~~(3)~~ A policy, other than an accident only policy or a short-term, limited duration health insurance policy, may specify a probationary or waiting period not to exceed six (6) months for specified diseases or conditions and losses resulting from disease or condition related to hernia, disorder of the ~~reproduction~~reproductive organs, varicose veins, adenoids, ~~appendix~~ and tonsils, ~~except when~~. However, the permissible six month exception shall not be applicable where the specified diseases or conditions are treated on an emergency basis. ~~Accident policies shall not contain probationary or waiting periods.~~
- B. ~~(1)~~ A policy or rider for additional coverage may not be issued as a dividend unless an equivalent cash payment is offered as an alternative to the dividend policy or rider. A dividend policy or rider for additional coverage shall not be issued for an initial term of less than six (6) months.
- ~~(2)~~ The initial renewal subsequent to the issuance of a policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that the renewal is optional.
- C. ~~A policy shall not exclude coverage for a loss due to a preexisting condition for a period greater than twelve (12) months following the issuance of the policy or certificate where the application or enrollment form for the insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and the preexisting condition is not specifically excluded by the terms of the policy or certificate.~~

~~**Drafting Note:** Where the state has enacted the NAIC Individual Accident and Sickness Insurance Minimum Standard Act, Subsection C is unnecessary. States that have specific preexisting condition requirements for group supplemental insurance may need to modify the preceding subsection according to applicable statutes.~~

- ~~DB.~~ A disability income protection policy may contain a “return of premium” or “cash value benefit” option so long as the return of premium or cash value benefit is not reduced by an amount greater than the aggregate of claims paid under the policy; and the insurer demonstrates that the reserve basis for the policies is adequate. No other policy subject to the Act and this regulation shall provide a return of premium or cash value benefit, except return of unearned premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds.

Drafting Note: This provision is optional and the desirability of its use should be reviewed by the individual states.

- ~~EC.~~ Policies providing hospital ~~confinement~~ indemnity or other fixed indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.
- ~~FD.~~ A policy shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except ~~as follows~~for the following permitted exclusions:

~~**Drafting Note:** States should review the provisions of this subsection carefully to determine if any of the exceptions to limiting or excluding coverage by type of illness, accident, treatment or medical condition included in the subsection should apply to short-term, limited-duration health insurance coverage.~~

- (1) Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;

- (2) Mental or emotional disorders, alcoholism and drug ~~addition~~addiction;

Drafting Note: This provision is optional. States should review the desirability of permitting such exclusions, particularly those exclusions related to mental health and substance use, in Paragraph (2) of this subsection above and Paragraph (4) of this subsection, in short-term, limited-duration insurance policies and disability income protection insurance policies.

- (3) Pregnancy, except for complications of pregnancy, other than for policies defined in Section ~~7H8C~~ of this regulation;
- (4) Illness, treatment or medical condition arising out of:
- (a) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary to it;
 - (b) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;
 - (c) Non-commercial or recreational Aaviation;
 - (d) With respect to short-term nonrenewable policies, interscholastic sports; and
 - (e) With respect to disability income protection policies, incarceration.

Drafting Note: What should be an allowable exclusion in disability income protection insurance policies generates much debate. States should be aware that some argue for exclusion of certain diseases or conditions that are difficult to diagnose or are potentially subject to frequent claims (e.g., carpal tunnel and chronic fatigue syndromes). Others argue that carriers have the ability to detect fraudulent claims and deny payment on that basis without singling out specific conditions for blanket exclusion.

- (5) Cosmetic surgery, except ~~that “cosmetic surgery” shall not include for~~ reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly ~~of a covered dependent child~~ that has resulted in a functional defect;
- (6) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or asymptomatic complaints of the feet;
- (7) Chiropractic Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects of it, where the interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;

Drafting Note: States should examine any existing “freedom of choice” statutes that require reimbursement of treatment provided by chiropractors; and make adjustments if needed.

- (8) ~~Treatment provided in a government hospital; b~~Benefits provided under Medicare or other governmental program (except Medicaid), a state or federal ~~workmen’s~~workers’ compensation, employers liability or occupational disease law, or motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person’s immediate family; and services for which no charge is normally made in the absence of insurance;
- (9) Dental care or treatment, except where the provision of dental services is medically necessary due to the underlying covered medical condition or clinical status of the covered person, including but not limited to, reconstructive surgery;
- (10) Eye-glasses, hearing aids and examination for the prescription or fitting of them;
- (11) Rest cures, custodial care, transportation and routine physical examinations; ~~and~~

- (12) Territorial limitations, provided that they do not exclude coverage for services rendered within the United States and its territories or possessions; and
- (13) Genetic testing not ordered by a medical provider, and not used to diagnose or treat a disease.

Drafting Note: Some of the exclusions set forth in this provision may be unnecessary or in conflict with existing state legislation and should be deleted.

~~GE.~~ Notwithstanding Subsection D of this section, This this regulation shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical condition or extra hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required unless on initial issuance the full text of the waiver is contained either on the first page or specification page.

Drafting Note: ~~States with specific waiver requirements that differ for group insurance should add language in Subsection G to be consistent with applicable statutes.~~

~~HF.~~ The enumeration in this section of specific precluded Policy ~~policy~~ provisions ~~precluded in this section~~ shall not be construed as a limitation on the authority of the commissioner to disapprove other policy provisions in accordance with [cite Section ~~34~~B of the ~~Accident and Sickness~~Supplementary and Short-Term Health Insurance Minimum Standards Act] that in the opinion of the commissioner are unjust, unfair or unfairly discriminatory to the policyholder, beneficiary or a person insured under the policy.

~~G.~~ A policy providing a type of supplementary health insurance that is not defined as a “plan” under the Coordination of Benefits Model Regulation (#120) shall not include a coordination of benefits provision or any other provision that allows it to reduce its benefits based on the existence of other coverage its insured may have.

~~H.~~ A policy shall not limit an insured’s choice of health care provider if the provider is licensed or otherwise qualified under state law and the services to be provided are within the health care provider’s scope of practice.

Drafting Note: Former Subsection B in this section established provisions related to the issuance of a policy or rider for additional coverage as a dividend under specified circumstances. Subsection B was deleted because insurers rarely offer consumers policy dividends as a benefit on policies covered by this regulation. Such provisions are common in life insurance policies. If policy dividends are available on policies covered by this regulation in your state, you should look to the treatment of dividends in life insurance. Generally, consumers should be allowed to take the policy dividend as a cash payment, but insurers may offer the consumer additional policy benefits in lieu of a cash payment at the option of the consumer.

Section 78. ~~Accident and Sickness~~Supplementary and Short-Term Health Insurance Minimum Standards for Benefits

The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. ~~An individual accident and sickness insurance policy or group supplemental~~A supplementary or short-term health insurance policy or certificate shall not be delivered or issued for delivery in this state unless it meets the required minimum standards for the specified categories or the commissioner finds that the policies or contracts are approvable as limited benefit health insurance and the outline of coverage complies with the outline of coverage in Section ~~8L9H~~ of this regulation.

This section shall not preclude the issuance of any policy or contract combining two or more categories of excepted benefits set forth in [cite state law equivalent to Section 5A and B and C of the NAIC ~~Accident and Sickness~~Supplementary and Short-Term Health Insurance Minimum Standards Model Act].

A. General Rules

- (1) A “noncancellable,” “guaranteed renewable,” or “noncancellable and guaranteed renewable” individual ~~accident and sickness~~supplementary policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. In addition, the policy shall provide that in the

event of the insured's death, the spouse of the insured, if covered under the policy, shall become the insured.

Drafting Note: States should review the use of the term “spouse” in paragraph (1) above and replace it or add additional terms in accordance with state law or regulations.

- (2) (a) The terms “noncancellable,” “guaranteed renewable,” or “noncancellable and guaranteed renewable” shall not be used without further explanatory language in accordance with the disclosure requirements of Section ~~89A(1)~~.
- (b) The terms “noncancellable” or “noncancellable and guaranteed renewable” may be used only in an individual ~~accident and sickness supplementary~~ policy that the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.
- ~~(c) — An individual accident and sickness or individual accident only policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age sixty (60) if, at age sixty (60), the insured has the right to continue the policy in force at least to age sixty five (65) while actively and regularly employed.~~
- ~~(d)(c)~~ Except as provided ~~above in subparagraph (d) of this paragraph~~, the term “guaranteed renewable” may be used only in a policy that the insured has the right to continue in force by the timely payment of premiums until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.
- ~~(d) — An individual supplementary policy or individual accident-only policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may be designated as “guaranteed renewable” if it provides that the insured has the right to continue the policy, while actively and regularly employed, at least until the insured has reached full retirement and, as defined under the federal Social Security Act.~~
- (3) In an individual ~~accident and sickness supplementary~~ policy covering ~~both husband and wife~~ married couple or civil union couple, the age of the younger spouse shall be used as the basis for meeting the age and durational requirements of the definitions of “noncancellable” or “guaranteed renewable.” However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age so long as the policy may be continued in force as to the younger spouse to the age or for the durational period as specified in the policy.

Drafting Note: The references to “married couple” and “civil union couple” in paragraph (3) above are intended to apply to any legally recognized marital relationship or domestic partnership recognized in the state. States should revise the language in accordance with state law or regulations. In addition, states should review the use of the term “spouse” and replace it or add additional terms in accordance with state law or regulations.

Drafting Note: For Paragraphs (2) and (3) above, coverage ~~as defined under subject to Title XXVII of the federal Public Health Service Act (PHSA), as enacted by HIPAA and amended by the federal Affordable Care Act (ACA), or applicable state law~~ must be guaranteed renewable except for reasons stated in ~~Part B PHSA Section § 2742 (42 U.S.C. § 300gg-42) of Title XXVII (Public Health Service Act) as amended by HIPAA or applicable state law~~, unless it is an excepted benefit as described in ~~Part B Sections 2721, 2763 and 2791 of Title XXVII as amended by HIPAA PHSA § 2791(c) (42 U.S.C. § 300gg-91(c)) or~~ ~~Applicable state law~~ may impose requirements that mirror or exceed the federal requirements.

- (4) When accidental death and dismemberment coverage is part of the individual ~~accident and sickness~~supplementary insurance coverage offered under the contract, the insured shall have the option to include all insureds under the coverage and not just the principal insured.
- (5) If a policy contains a status-type military service exclusion or a provision that suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to the person on a pro rata basis.
- (6) ~~In the event the insurer cancels or refuses to renew,~~ Policies providing pregnancy benefits shall provide for an extension of benefits, in the event the insurer cancels or refuses to renew for reasons other than non-payment of premium, as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.
- (7) Policies providing convalescent or extended care benefits following hospitalization ~~shall not~~may condition the benefits upon admission to the convalescent or extended care facility within a ~~period of specified time after discharge from the hospital, as long as the required admission date is not~~ less than ~~fourteen (14) days~~thirty (30) days after discharge from the hospital.
- (8) In individual ~~accident and sickness~~supplementary or short-term health insurance policies, coverage shall continue for a dependent child who is incapable of self-sustaining employment due to ~~mental retardation or physical handicap~~intellectual or physical disability on the date that the child's coverage would otherwise terminate under the policy due to the attainment of a specified age for children and who is chiefly dependent on the insured for support and maintenance. The policy may require that within thirty-one (31) days ~~of~~after the date the ~~company~~insurer receives due proof of the ~~incapacity~~disability in order for the insured to elect to continue the policy in force with respect to the child, or that a separate converted policy be issued at the option of the insured or policyholder.
- (9) A policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy or certificate, after benefits for the recipient's own expenses have been paid.
- (10) A policy may contain a provision relating to recurrent disabilities; but a provision relating to recurrent disabilities shall not specify that a recurrent disability be separated by a period greater than six (6) months.
- (11) Accidental death and dismemberment benefits shall be payable if the loss occurs within ninety (90) days from the date of the accident, irrespective of total disability. Disability income protection benefits, if provided, shall not require the loss to commence less than thirty (30) days after the date of accident, nor shall any policy that the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the coverage was in force.
- (12) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.
- (13) An accident-only policy providing benefits that vary according to the type of accidental cause shall prominently set forth in the outline of coverage and the disclosure materials required under Section 9 of this regulation the circumstances under which benefits are payable that are lesser than the maximum amount payable under the policy.
- (14) Termination of the policy shall be without prejudice ~~of~~to the right to receive benefits for a continuous loss that commenced while the policy or certificate was in force. The continuous total disability of the insured may be a condition for the extension of benefits beyond the period the policy was in force, limited to the duration of the benefit period, if any, or payment of the maximum benefits.
- (15) A policy providing coverage for certain illnesses and injuries may not define covered illnesses and injuries in a way that is misleading or includes unfair exclusions. For example, a policy providing

~~coverage for fractures or dislocations may not provide benefits only for “full or complete” fractures or dislocations.~~

~~B. Basic Hospital Expense Coverage~~

~~“Basic hospital expense coverage” is a policy of accident and sickness insurance that provides coverage for a period of not less than thirty one (31) days during a continuous hospital confinement for each person insured under the policy, for expense incurred for necessary treatment and services rendered as a result of accident or sickness for at least the following:~~

- ~~(1) Daily hospital room and board in an amount not less than the lesser of:
 - ~~(a) [80%] of the charges for semiprivate room accommodations or~~
 - ~~(b) [\$100] per day;~~~~

Drafting Note: The commissioner may determine the level of daily room and board benefits that he or she considers appropriate as a minimum for a basic hospital contract in his state. It should be an underlying principle for the establishment of benefits that the amounts are to be minimums, not maximums. In order to accommodate those states that have a substantial differential in hospital room and board costs between urban and rural areas within a state, the following language may be used in addition to the language in Subsection B(1) above: “except that \$[insert amount] may be reduced to \$[insert amount] outside the area.” Other dollar amounts and percentages applicable to the various minimum benefits that follow are also bracketed to permit a commissioner to set the level of minimum benefits for his or her particular state.

- ~~(2) Miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies that are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than either [80%] of the charges incurred up to at least [\$3,000] or [ten] times the daily hospital room and board benefits; and~~
- ~~(3) Hospital outpatient services consisting of:
 - ~~(a) Hospital services on the day surgery is performed;~~
 - ~~(b) Hospital services rendered within seventy two (72) hours after injury, in an amount not less than [\$150]; and~~
 - ~~(c) X ray and laboratory tests to the extent that benefits for the services would have been provided in an amount of less than [\$100] if rendered to an in-patient of the hospital.~~~~
- ~~(4) Benefits provided under Paragraphs (1) and (2) of this subsection may be provided subject to a combined deductible amount not in excess of [\$100].~~

~~C. Basic Medical Surgical Expense Coverage~~

~~“Basic medical surgical expense coverage” is a policy of accident and sickness insurance that provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for at least the following:~~

- ~~(1) Surgical services:
 - ~~(a) In amounts not less than those provided on a fee schedule based on the relative values contained in the [insert reference to a fee schedule based on the Current Procedure Terminology (CPT) coding or other acceptable relative value schedule]. up to a maximum of at least [\$1000] for a one procedure; or~~
 - ~~(b) Not less than [80%] of the reasonable charges.~~~~

~~(2) Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician (or the physician assistant) performing the surgical services:~~

~~(a) In an amount not less than [80%] of the reasonable charges; or~~

~~(b) [15%] of the surgical service benefit.~~

~~(3) In hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than [80%] of the reasonable charges, or [\$50] per day for not less than twenty one (21) days during one period of confinement.~~

~~D. Basic Hospital/Medical-Surgical Expense Coverage~~

~~“Basic hospital/medical surgical expense coverage” is a combined coverage and must meet the requirements of both Subsections B and C.~~

~~EB. Hospital Confinement-Indemnity or Other Fixed Indemnity Coverage~~

~~(1) “Hospital confinement-indemnity or other fixed indemnity coverage” is a policy of accident and sickness insurance that provides daily benefits for as a result of hospital confinement or other health-related events and based on a fixed dollar amount, on an indemnity basis in an amount not less than [\$40] per day and not less than thirty one (31) days during each period of confinement for each person insured under the policy regardless of the amount of expenses incurred, without coordination with any other health coverage.~~

~~(2) “Hospital indemnity coverage” may provide a single lump sum benefit for hospital confinement of not less than \$[X], and/or daily benefit for hospital confinement on an indemnity basis in an amount not less than \$[X] per day and not less than [X] days during each period of confinement for each person insured under the policy.~~

Drafting Note: Paragraph (2) above provides a framework for the state insurance regulators to establish minimum benefit amounts they feel are appropriate for hospital indemnity coverage. When setting these minimum benefit amounts, state insurance regulators should be mindful to not set a benefit amount so low such that the product does not provide a meaningful benefit to the consumer or set a benefit amount so high that a consumer could be led to believe the product is comprehensive major medical coverage. State insurance regulators can address this issue by requiring that this coverage is not offered, marketed, or sold as a substitute for, or an alternative to, comprehensive major medical coverage, and requiring the use of disclosures that this coverage is supplementary insurance.

~~(2)(3) Coverage shall not be excluded due to a preexisting condition for a period greater than twelve (12) months following the effective date of coverage of an insured person unless the preexisting condition is specifically and expressly excluded.~~

~~(3) Except for the NAIC uniform provision regarding other insurance with the insurer, benefits shall be paid regardless of other coverage.~~

Drafting Note: Hospital confinement indemnity or other fixed indemnity coverage is ~~recognized~~ supplemental ~~supplementary~~ coverage. Any hospital confinement-indemnity or other fixed indemnity coverage, therefore, must be payable regardless of other coverage. The same general rule should apply so that group insurance cannot reduce its benefits because of the existence of hospital confinement-indemnity or other fixed indemnity coverage. Section 3H(4) of the Group Coordination of Benefits Model Regulation states that the definition of a plan (for the purposes of coordination of benefits)...shall not include individual or family insurance contracts....” States should consider using this language to prevent benefit reductions that could otherwise occur because of the existence of hospital confinement-indemnity or other fixed indemnity coverage purchased by the insured.

Drafting Note: For indemnity products that are triggered by a variety of health events and provide a variety of daily benefit dollar amounts, state insurance regulators should examine the amount payable per day and the total amount payable per year or lifetime to determine whether an indemnity product’s benefits could be mistaken for comprehensive major medical coverage.

Indemnity products should not be offered, marketed, or sold as an alternative to, or substitute for, or a replacement for major medical coverage. It is the marketing of supplementary coverage as an alternative, substitute or replacement for comprehensive major medical coverage that presents the unfair trade practice, and not the supplementary coverage itself when it is offered and marketed as supplementary excepted benefits coverage and accurately described to the consumer.

~~F. Individual Major Medical Expense Coverage~~

- ~~(1) "Individual major medical expense coverage" is an accident and sickness insurance policy that provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than [\$500,000]; coinsurance percentage per year per covered person not to exceed fifty percent (50%) of covered charges, provided that the coinsurance out-of-pocket maximum after any deductibles shall not exceed ten thousand dollars (\$10,000) per year; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of these bases not to exceed five percent (5%) of the aggregate maximum limit under the policy for each covered person for at least:~~
- ~~(a) Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides;~~
 - ~~(b) Miscellaneous hospital services;~~
 - ~~(c) Surgical services;~~
 - ~~(d) Anesthesia services;~~
 - ~~(e) In-hospital medical services;~~
 - ~~(f) Out of hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic x ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician; and~~
 - ~~(g) Not fewer than three (3) of the following additional benefits:~~
 - ~~(i) In-hospital private duty registered nurse services;~~
 - ~~(ii) Convalescent nursing home care;~~
 - ~~(iii) Diagnosis and treatment by a radiologist or physiotherapist;~~
 - ~~(iv) Rental of special medical equipment, as defined by the insurer in the policy;~~
 - ~~(v) Artificial limbs or eyes, casts, splints, trusses or braces;~~
 - ~~(vi) Treatment for functional nervous disorders, and mental and emotional disorders;~~
~~or~~
 - ~~(vii) Out of hospital prescription drugs and medications.~~
- ~~(2) If the policy is written to complement underlying basic hospital expense and basic medical-surgical expense coverage, the deductible may be increased by the amount of the benefits provided by the underlying coverage.~~
- ~~(3) The minimum benefits required by 7F(1) may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations. A major medical expense policy may also have special or internal limitations for prescription drugs, nursing facilities, intensive care facilities, mental health treatment, alcohol or substance abuse treatment, transplants, experimental treatments, mandated benefits required by law and those services covered under 7F(1)(g) and other such special or internal limitations as are authorized or approved by the commissioner. Except as authorized by~~

~~this subsection through the application of special or internal limitations, a major medical expense policy must be designed to cover, after any deductibles or coinsurance provisions are met, the usual, customary and reasonable charges, as determined consistently by the carrier and as subject to approval by the commissioner, or another rate agreed to between the insurer and provider, for covered services up to the lifetime policy maximum.~~

~~G. Individual Basic Medical Expense Coverage~~

- ~~(1) "Individual basic medical expense coverage" is an accident and sickness insurance policy that provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than \$250,000; coinsurance percentage per year per covered person not to exceed fifty percent (50%) of covered charges, provided that the coinsurance out of pocket maximum after any deductibles shall not exceed \$25,000 per year; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of these bases not to exceed ten percent (10%) of the aggregate maximum limit under the policy for each covered person for at least:
 - ~~(a) Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides or such other rate agreed to between the insurer and provider for a period of not less than thirty one (31) days during continuous hospital confinement;~~
 - ~~(b) Miscellaneous hospital services;~~
 - ~~(c) Surgical services;~~
 - ~~(d) Anesthesia services;~~
 - ~~(e) In hospital medical services;~~
 - ~~(f) Out of hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic x-ray, laboratory services, radiation therapy and hemodialysis ordered by a physician; and~~
 - ~~(g) Not fewer than three (3) of the following additional benefits:
 - ~~(i) In hospital private duty graduate registered nurse services;~~
 - ~~(ii) Convalescent nursing home care;~~
 - ~~(iii) Diagnosis and treatment by a radiologist or physiotherapist;~~
 - ~~(iv) Rental of special medical equipment, as defined by the insurer in the policy;~~
 - ~~(v) Artificial limbs or eyes, casts, splints, trusses or braces;~~
 - ~~(vi) Treatment for functional nervous disorders, and mental and emotional disorders;~~
~~or~~
 - ~~(vii) Out of hospital prescription drugs and medications.~~~~~~
- ~~(2) If the policy is written to complement underlying basic hospital expense and basic medical surgical expense coverage, the deductible may be increased by the amount of the benefits provided by the underlying coverage.~~
- ~~(3) The minimum benefits required by 7G(1) may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations. An individual basic medical expense policy may also have special or internal limitations for prescription drugs, nursing facilities, intensive care facilities, mental health treatment, alcohol or substance abuse treatment, transplants, experimental treatments,~~

~~mandated benefits required by law and those services covered under 7G(1)(g) and other such special or internal limitations as are authorized or approved by the commissioner. Except as authorized by this subsection through the application of special or internal limitations, an individual basic medical expense policy must be designed to cover, after any deductibles or coinsurance provisions are met, the usual customary and reasonable charges, as determined consistently by the carrier and as subject to approval by the commissioner, or another rate agreed to between the insurer and provider, for covered services up to the lifetime policy maximum.~~

H.C. Disability Income Protection Coverage

“Disability income protection coverage” is a policy that provides for periodic payments, ~~weekly or monthly~~ no less frequently than monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination of them that:

- (1) Provides that ~~periodic payments that are payable at ages after sixty two (62) and reduced solely on the basis of age are at least fifty percent (50%) of amounts payable immediately prior to sixty two (62) a plan is prohibited from reducing periodic payments based on age, except that a plan may reduce periodic payments provided that such reductions do not take place until the individual has reached full retirement age, as defined under the federal Social Security Act, to receive Social Security benefits;~~

Drafting Note: Age 62 was removed so that retirement age would align with the federal Social Security Act full retirement age.

- (2) Contains an elimination period no greater than:
 - (a) Fifty percent (50%) of the benefit period in the case of coverage providing a benefit of one hundred and eighty (180) days or less;
 - (b) Ninety (90) days in the case of a coverage providing a benefit of one hundred and eighty (180) days to one year or less;
 - ~~(b)~~(c) One hundred and eighty (180) days in the case of coverage providing a benefit of more than one year but not greater than two (2) years; or
 - ~~(e)~~(d) Three hundred and sixty five (365) days in all other cases during the continuance of disability resulting from sickness or injury;
- (3) Has a ~~maximum~~ period of time of at least three (3) months for which it is payable during disability ~~of at least six (6) months except in the case of a policy covering disability arising out of pregnancy, childbirth or miscarriage in which case the period for the disability may be one month.~~ No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period. ~~Section 7F does not apply to those policies providing business buy out coverage; and~~
- (4) Where a policy provides both total disability benefits and partial disability benefits, only one elimination period may be required.

H.D. Accident Only Coverage

“Accident only coverage” is a policy that provides coverage, singly or in combination, for death, dismemberment, disability, injury, or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under the policy shall be at least ~~[\$1,000]~~[\$X] and a single dismemberment amount shall be at least ~~[\$500]~~[\$X].

H.E. Specified Disease Coverage

- (1) “Specified disease coverage” pays benefits for the diagnosis and treatment of a specifically named disease or diseases. A specified disease policy must meet the following rules in paragraph (2) and one of the following sets of minimum standards for benefits:
 - (a) Insurance covering cancer only or cancer in conjunction with other conditions or diseases must meet the standards of Paragraph (4), (5) or (6) of this subsection.
 - (b) Insurance covering specified diseases other than cancer must meet the standards of Paragraphs (3) and (6) of this subsection.
- (2) General Rules

Except for cancer coverage provided on an expense-incurred basis, either as cancer-only coverage or in combination with one or more other specified diseases, the following rules shall apply to specified disease coverages in addition to all other rules imposed by this regulation. In cases of conflict between the following and other rules, the following shall govern:

- (a) Policies covering a single specified disease or combination of specified diseases may not be sold or offered for sale other than as specified disease coverage under this section.
- (b) Any policy issued pursuant to this section that conditions payment upon pathological diagnosis of a covered disease shall also provide that if the pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted instead.
- (c) Notwithstanding any other provision of this regulation, specified disease policies shall provide benefits to any covered person not only for the specified disease or diseases, but also for any other conditions or diseases, directly caused or aggravated by thea specified diseases s or the treatment of the specified disease.
- (d) Individual accident and sickness supplementary policies containing specified disease coverage shall be at least guaranteed renewable.
- (e) No policy issued pursuant to this section shall contain a waiting or probationary period greater than thirty (30) days. A specified disease policy may contain a waiting or probationary period following the issue or reinstatement date of the policy or certificate in respect to a particular covered person before the coverage becomes effective as to that covered person.
- (f) An application or enrollment form for specified disease coverage shall contain a statement above the signature of the applicant or enrollee that a person to be covered for specified disease is not covered also by any Title XIX program (Medicaid, MediCal or any similar name). The statement may be combined with any other statement for which the insurer may require the applicant’s or enrollee’s signature.

Drafting Note: States may prohibit individuals who are covered by a Title XIX program from enrolling in a specified disease policy. However, this would not prohibit an individual who purchases a specified disease policy and later becomes eligible for coverage under a Title XIX program from utilizing the benefits of the specified disease policy to which the individual may be entitled to receive.

- (g) Payments may be conditioned upon an insured person’s receiving medically necessary care, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment.
- (h) Except for the NAIC uniform provision regarding other insurance with this insurer, benefits Benefits for specified disease coverage shall be paid regardless of other coverage, except as permitted by [insert reference to state law equivalent to Section 3B(3) of the Uniform Individual Accident and Sickness Policy Provision Law (UPPL) (#180), regarding multiple policies with the same insurer].

Drafting Note: Specified disease coverage is recognized as ~~supplemental~~supplementary coverage. Any specified disease coverage, therefore, must be payable in addition to and regardless of other coverage. The same general rule should apply so that group insurance cannot reduce its benefits because of the existence of specified disease coverage. Section 3H(4) of the ~~Group~~Coordination of Benefits Model Regulation states that the definition of a “plan” (for the purpose of coordination of benefits) “shall not include individual or family insurance contracts.” States should consider using this language to prevent benefit reductions that could otherwise occur because of the existence of specified disease coverage purchased by the insured.

- (i) After the effective date of the coverage (or applicable waiting period, if any) benefits shall begin with the first day of care or confinement if the care or confinement is for a covered disease even though the diagnosis is made at some later date. The retroactive application of the coverage may not be less than ninety (90) days prior to the diagnosis.
- (j) Policies providing expense benefits shall not use the term “actual” when the policy only pays up to a limited amount of expenses. Instead, the term “charge,” “expense.” or substantially similar language should be used that does not have the misleading or deceptive effect of the phrase “actual charges.” or “actual expenses.”
- (k) “Preexisting condition” shall not be defined to be more restrictive than the following and shall be consistent with the provisions of Section 7B of the Act: “Preexisting condition means a condition for which medical advice, diagnosis, care or treatment was recommended or received from a physician within the six (6) month period preceding the effective date of coverage of an insured person.”
- (l) Coverage for specified diseases will not be excluded due to a preexisting condition for a period greater than six (6) months following the effective date of coverage of an insured person unless ~~the~~ named preexisting condition is specifically excluded.
- (m) Hospice Care.
 - (i) “Hospice” means a ~~facility~~provider licensed, certified or registered in accordance with state law that provides a formal program of care that is:
 - (I) For terminally ill patients whose life expectancy is less than six (6) months;
 - (II) Provided on an inpatient or outpatient basis; and
 - (III) Directed by a physician.
 - (ii) Hospice care is an optional benefit. However, if a specified disease insurance product offers coverage for hospice care, it shall meet the following minimum standards:
 - (I) Eligibility for payment of benefits when the attending physician of the insured provides a written statement that the insured person has a life expectancy of six (6) months or less;
 - (II) A fixed-sum payment of at least ~~\$50~~\$[X] per day; and
 - (III) A lifetime maximum benefit limit of at least ~~\$10,000~~\$[X].
 - (iii) Hospice care does not cover non-terminally ill patients who may be confined in a:
 - (I) Convalescent home;
 - (II) Rest or nursing facility;
 - (III) Skilled nursing facility;

(IV) Rehabilitation unit; or

(V) Facility providing care or treatment for persons suffering from mental ~~diseases or disorders or care for the, who are~~ aged, or ~~substance abusers who have a substance use-related disorder.~~

(3) The following minimum benefits standards apply to non-cancer coverages:

(a) Coverage for each insured person for a specifically named disease (or diseases) with a deductible amount not in excess of ~~[\$250]\$[X]~~ and an overall aggregate benefit limit of no less than ~~[\$10,000]\$[X]~~ and a benefit period of not less than [two (2) years] for at least the following incurred expenses:

(i) Hospital room and board and any other hospital furnished medical services or supplies;

(ii) Treatment by a ~~legally qualified~~licensed physician, ~~or surgeon, or other health care professional acting within the scope of their license;~~

Drafting Note: States should review their laws and regulations to determine whether to use the word “acting” or “performing” in Paragraph (3)(a)(ii) above. Some states use the word “acting,” while others use the word “performing.”

(iii) Private duty services of a ~~registered~~licensed nurse ~~(R.N.);~~

(iv) ~~X ray, radium and other therapy procedures~~Tests, procedures, and other medical services and supplies used in diagnosis and treatment;

(v) Professional ambulance for ~~local~~-service to or from a ~~local~~-hospital nearest able to appropriately treat the condition;

(vi) Blood transfusions, including expense incurred for blood donors;

(vii) Drugs and medicines prescribed by a physician;

~~(viii) The rental of an iron lung or similar mechanical apparatus;~~

~~(ix)(viii)~~Braces, crutches and wheel chairs as are Durable medical equipment deemed necessary by the attending physician for the treatment of the disease;

~~(*)~~(ix) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and

~~(*)~~(x) May include coverage of any other expenses necessarily incurred in the treatment of the disease.

(b) Coverage for each insured person for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than ~~[\$25,000]\$[X]~~ payable at the rate of not less than ~~[\$50]\$[X]~~ a day while confined in a hospital and a benefit period of not less than 500 days.

(4) A policy that provides coverage ~~for each insured person on an expense-incurred basis~~ for cancer-only coverage, or for cancer in combination with one or more other specified diseases ~~on an expense incurred basis~~ shall provide coverage for each insured person for services, supplies, care and treatment of cancer, consistent with the requirements in this paragraph.

(a) Coverage ~~may be limited to~~ amounts not in excess of the usual and customary charges, with a deductible amount not in excess of ~~[\$250]\$[X]~~, ~~and~~ an overall aggregate benefit

limit of not less than ~~[\$10,000]~~[\$X], and a benefit period of not less than three (3) years shall provide at least the following minimum provisions:

~~(b)~~ A policy shall include at least the minimum benefits specified in this subparagraph. Coverages under items (i) through (xiv) of this subparagraph may be subject to cost-sharing by the insured person not to exceed twenty percent (20%) of covered charges when rendered on an outpatient basis:

~~(a)(i)~~ Treatment by, or under the direction of, a ~~legally qualified licensed~~ physician, ~~or~~ surgeon, ~~or other health care professional acting within the scope of their license;~~

Drafting Note: States should review their laws and regulations to determine whether to use the word “acting” or “performing” in Paragraph (3)(a)(i) above. Some states use the word “acting,” while others use the word “performing.”

~~(b)(ii)~~ X-ray, radium chemotherapy and other therapy procedures Tests, procedures, and other medical services and supplies used in diagnosis and treatment;

~~(c)~~ Hospital room and board and any other hospital furnished medical services or supplies;

~~(d)(iii)~~ Blood transfusions and their administration, including expense incurred for blood donors;

~~(e)(iv)~~ Drugs and medicines prescribed by a physician, including but not limited to, chemotherapy, including both oral and IV administered, immunotherapy, targeted therapies, and chemotherapy supportive drugs;

~~(f)~~ Professional ambulance for local service to or from a local hospital;

~~(g)(v)~~ Private duty services of a ~~registered licensed~~ nurse provided in a hospital;

~~(h)~~ May include coverage of any other expenses necessarily incurred in the treatment of the disease; however, Subparagraphs (a), (b), (d), (e) and (g) plus at least the following also shall be included, but may be subject to copayment by the insured person not to exceed twenty percent (20%) of covered charges when rendered on an out-patient basis;

~~(i)(vi)~~ Braces, crutches and wheelchairs Durable medical equipment deemed necessary by the attending physician for the treatment of the disease;

~~(j)(vii)~~ Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; ~~and~~

~~(k)(viii)~~ (I) Home health care that is necessary care and treatment provided at the insured person’s residence by a home health care agency or by others under arrangements made with a home health care agency. The program of treatment shall be prescribed in writing by the insured person’s attending physician, who shall approve the program prior to its start. ~~The physician must certify that hospital confinement would be otherwise required. A “home health care agency” (1) is an agency approved under Medicare, or (2) is licensed to provide home health care under applicable state law, or (3) meets all of the following requirements:~~

~~(I)~~ It is primarily engaged in providing home health care services;

~~(II)~~ Its policies are established by a group of professional personnel (including at least one physician and one registered nurse;

~~(III)~~ A physician or a registered nurse provides supervision of home health care services;

- ~~(IV) — It maintains clinical records on all patients; and~~
- ~~(V) — It has a full time administrator.~~

Drafting Note: State licensing laws vary concerning the scope of “home health care” or “home health agency services” and should be consulted. In addition, a few states have mandated benefits for home health care including the definition of required services.

~~(ii)(II)~~ Home health care includes, but is not limited to:

- ~~(i)a.~~ Part-time or intermittent skilled nursing services provided by a registered nurse or a licensed practical nurse;
- ~~(ii)b.~~ Part-time or intermittent home health aide services that provide supportive services in the home under the supervision of a registered nurse or a physical, speech or hearing occupational therapists;
- ~~(iii)c.~~ Physical, occupational or speech and hearing therapy; and
- ~~(iv)d.~~ Medical supplies, drugs and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent the charges or costs would have been covered if the insured person had remained in the hospital;

~~(i)(ix)~~ Physical, speech, hearing and occupational therapy;

~~(ii)(x)~~ Special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, ~~and disposable absorbent pads~~, oxygen, surgical dressings, rubber shields, colostomy and ~~eleostomy~~ileostomy appliances;

~~(iii)(xi)~~ Prosthetic devices including wigs and artificial breasts;

~~(iv)(xii)~~ Nursing home care for noncustodial services; ~~and~~

~~(v)(xiii)~~ Reconstructive surgery when deemed necessary by the attending physician;

~~(xiv)~~ Hospice services, as defined in paragraph (2)(m) above;

~~(xv)~~ Hospital room and board and any other hospital furnished medical services or supplies; and

~~(xvi)~~ Professional ambulance for service to or from a hospital nearest able to appropriately treat the condition.

~~(c)~~ A policy may include coverage of any other expenses necessarily incurred in the treatment of the disease.

Drafting Note: Policies that offer transportation and lodging benefits for an insured person should not condition those benefits on hospitalization.

- (5) (a) The following minimum benefits standards apply to cancer coverages written on a per diem indemnity basis. These coverages shall offer insured persons:
 - (i) A fixed-sum payment of at least ~~[\$100]~~[\$X] for each day of hospital confinement for at least [365] days;

- (ii) A fixed-sum payment ~~equal to one half of at least [X%]~~ the hospital inpatient benefit for each day of hospital or nonhospital outpatient surgery, chemotherapy and radiation therapy, for at least 365 days of treatment; and
 - (iii) A fixed-sum payment of at least ~~\$50~~[X] per day for blood and plasma, which includes their administration whether received as an inpatient or outpatient for at least 365 days of treatment.
- (b) Benefits tied to ~~confinement~~receipt of care in a skilled nursing home or to receipt of home health care are optional. If a policy offers these benefits, they must equal or exceed the following:
- (i) A fixed-sum payment equal to ~~one fourth~~[X%] the hospital in-patient benefit for each day of skilled nursing home confinement for at least 100 days.
 - (ii) A fixed-sum payment equal to ~~one fourth~~[X%] the hospital in-patient benefit for each day of home health care for at least 100 days.
 - (iii) Benefit payments shall begin with the first day of care or confinement after the effective date of coverage if the care or confinement is for a covered disease even though the diagnosis of a covered disease is made at some later date (but not retroactive more than thirty (30) days from the date of diagnosis) if the initial care or confinement was for diagnosis or treatment of the covered disease.
 - (iv) Notwithstanding any other provision of this regulation, any restriction or limitation applied to the benefits in (b)(i) and (b)(ii) whether by definition or otherwise, shall be no more restrictive than those under Medicare.
- (6) The following minimum benefits standards apply to lump-sum indemnity coverage of any specified disease:
- (a) These coverages must pay indemnity benefits ~~on behalf of insured persons off~~ for a specifically named disease or diseases. The benefits are payable as a fixed, one-time payment made within thirty (30) days of submission to the insurer of proof of diagnosis of the specified disease. Dollar benefits shall be offered for sale only in even increments of ~~\$1,000~~[X].

Drafting Note: Policies that offer extremely high dollar benefits may induce fraud and concealment on the part of applicants for coverage. The commissioner should ~~be sensitive to this possibility in approving policies~~avoid approving these policies in light of the fact that these policies are not intended to be comprehensive coverage and are not intended to be sold as such. Policies offering extremely low dollar amounts, however, may offer illusory coverage that may not be understood by consumers. State insurance regulators can address this issue by requiring that this coverage is not offered, marketed, or sold as a substitute for, or alternative to, comprehensive major medical coverage, and requiring the use of disclosures that this coverage is supplementary coverage.

- (b) Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, the same dollar amounts shall be payable regardless of the particular subtype of the disease ~~with one exception. In the case unless there are~~ of clearly identifiable subtypes with significantly lower treatments costs, in which case lesser amounts may only be payable ~~so long as if~~ the policy clearly differentiates that subtype and its reduced benefits.

Drafting Note: The purpose of requiring equal coverage for all subtypes of a specified disease is to ensure that specified disease policies actually provide what people reasonably expect them to. In approving ~~skin cancer or other~~ exceptions, commissioners should consider whether a specified disease policy might mislead if it treats a subtype of a disease differently from the rest of the specified disease.

~~KF.~~ Specified Accident Coverage

“Specified accident coverage” is a policy that provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment combined, with a benefit amount not less than ~~[\$1,000]~~[\$X] for accidental death, ~~[\$1,000]~~[\$X] for double dismemberment ~~[\$500]~~[\$X] for single dismemberment.

L.G. Limited Benefit Health Coverage

- (1) “Limited benefit health coverage” is a policy or contract, other than a policy or contract covering only a specified disease or diseases, that provides benefits that are less than the minimum standards for benefits required under Subsections B, ~~C~~, D, ~~E~~, and F, ~~G~~, I and K. These policies or contracts may be delivered or issued for delivery in this state only if the outline of coverage required by Section ~~8L~~8H of this regulation is completed and delivered as required by Section 8B of this regulation and the policy or certificate is clearly labeled as a limited benefit policy or certificate as required by Section 8A(17). A policy covering a single specified disease or combination of diseases shall meet the requirements of Section ~~7J~~7E and shall not be offered for sale as a “limited benefit health coverage.”
- (2) This subsection does not apply to policies designed to provide coverage for long-term care or to Medicare supplement insurance, as defined in [insert reference to state law equivalent to the NAIC *Long-Term Care Insurance Model Act* and *Medicare Supplement Insurance Minimum Standards Model Act*].

Drafting Note: The NAIC *Long-Term Care Insurance Model Act* defines long-term care insurance as a policy that provides coverage for not less than twelve months. If a state allows issuance of policies that provide benefits similar to long-term care insurance for a period of less than twelve months, then those policies should be considered limited benefit health~~long-term care insurance plans~~policies, and should be subject to the ~~NAIC Accident and Sickness Insurance Minimum Standards Model Act and implementing regulation~~ Limited Long-Term Care Insurance Model Act (#642) and its implementing regulation, the Limited Long-Term Care Insurance Model Regulation (#643).

Drafting Note: This regulation permits the combining of excepted benefit-type products described in this section with other excepted benefit plans. However, it should be noted that combining excepted benefit coverages described in this section with other coverages, whether or not described in this section, could cause the combined product to fail to meet the requirements for excepted benefits under HIPAA or for similar exemptions under state law. This would mean that major medical insurance requirements under federal and state law may apply, such as guaranteed availability, guaranteed renewability, and premium rating restrictions. State insurance regulators should also require that supplementary coverage is not offered, marketed, or sold as a substitute for, or alternative to, comprehensive major medical coverage, including enforcement of the requirements in this regulation for disclosures that this coverage is supplementary coverage.

H. Short-Term, Limited-Duration Health Insurance Coverage

- (1) “Short-term, limited-duration health insurance” means health insurance coverage offered or provided to residents of the state pursuant to a contract with a health carrier, regardless of the situs of the contract, that has an expiration date specified in the contract that is less than [X] [days or months] after the original effective date and, taking into account any extensions that may be elected by the policyholder with or without the carrier’s consent, has a duration no longer than [X] [days or months] after the original effective date of the contract.
- (2) (a) Short-term, limited-duration health insurance must comply with the benefit and coverage requirements of this state, including, if the state requires, providing benefits and coverage of state-mandated benefits and being subject to the state’s external and internal review requirements.

Drafting Note: States should consider whether mental health and substance use disorder benefits, as described in Section 7D(2) and Section 7D(4) of this regulation, should be permitted exclusions to short-term, limited-duration insurance policies.

(b) A short-term, limited-duration health insurance policy or certificate must have:

(i) An annual or lifetime limit of no less than [\$1,000,000];

- (ii) A coinsurance requirement of no more than fifty percent (50%) of covered charges; and
- (iii) A family maximum out-of-pocket limit of not more than [X] per year.

Drafting Note: The annual and lifetime limit and the out-of-pocket limits should vary depending on the specific state interest. For states that have severely limited coverage time frames with limited renewals or extensions, smaller annual and lifetime limits and out-of-pocket maximums should apply.

- (3) Short-term, limited-duration health insurance cannot be issued if it would result in an individual being covered by a short-term, limited duration health insurance policy or certificate for more than [X] months [in any 12-month period].
- (4) Short-term, limited-duration health insurance, including individual policies and group certificates:
 - (a) May not be marketed as guaranteed renewable;
 - (b) Must be marketed as either nonrenewable, or renewable for a limited time without re-underwriting;
 - (c) Must clearly state the duration of the initial term and the total maximum duration, including any renewal options;
 - (d) May not be modified after the date of issuance, except by signed acceptance of the policyholder or the certificate holder, if the policy holder or the certificate holder contributes to the premium; and
 - (e) If the coverage is renewable, the individual policy or group certificate must:
 - (i) Include a statement that the insured has a right to continue the coverage in force by timely payment of premiums for the number of terms listed;
 - (ii) Include a statement that the carrier will not increase premium rates or make changes in provisions in the policy or certificate on renewal based on individual health status; and
 - (iii) Include a statement that the carrier, at the time of renewal, may not deny renewal based on individual health status.
- (5) A short-term, limited-duration health insurance carrier may not include a waiting period or a probationary period.
- (6) A carrier may not rescind a short-term limited duration health insurance policy or certificate during the coverage period except if the insured intentionally fails to disclose a prior diagnosis of a health condition or if the insured intentionally fails to disclose the insured was previously covered under a short-term limited duration health insurance policy or certificate. If the policy or certificate is rescinded, the carrier must refund all payments to the insured to the extent that they exceed claims paid under the rescinded policy or certificate.

Drafting Note: States should be aware that the language in paragraph (6) concerning an insured's failure to disclose prior coverage under a short-term, limited-duration health insurance policy or certificate will need to be tailored to the state's laws and regulations concerning such disclosures of prior coverage.

- (7) A carrier may not cancel a short-term, limited-duration health insurance policy or certificate during the coverage period except in the following circumstances:
 - (a) Nonpayment of premium;
 - (b) Violation of the carrier's published policies approved by the commissioner;

- (c) An insured's commitment of fraudulent acts as to the carrier;
 - (d) An insured's material breach of the insurance contract; or
 - (e) A change or implementation of a federal or state law or regulation that no longer permits the continuing offering of the coverage.
- (8) In the event of a cancellation or rescission of a short-term, limited-duration health insurance policy or certificate, the carrier must notify the insured in writing [thirty (30) days] prior to the cancellation date or in writing a notice of rescission with an appeal period of [thirty (30) days].

Drafting Note: The timeframe for notifying the insured of a cancellation or rescission is bracketed because states may have different timeframes for such notices.

Drafting Note: States should carefully examine their health insurance markets to determine the appropriate maximum term and duration for such plans and whether additional definitions or standards may be needed. In addition, states should review any relevant federal regulations establishing requirements for short-term, limited duration insurance coverage that could differ from the state's requirements.

Section 89. Required Disclosure Provisions

A. General Rules

- (1) (a) All applications, policies, and certificates for coverages specified in Sections 7B, C, D, E, G, I, J, K and L of supplementary or short-term health insurance shall contain include a prominent disclosure statement, by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows: as required by this section, that reflects the type of coverage being provided.
- (b) The disclosures required by this section may be modified only as needed to improve the accuracy and clarity of the disclosure and only with the approval of the commissioner.

Drafting Note: Because states may have different statutory requirements for short-term, limited duration insurance coverage, states should carefully review the disclosure statement requirements in this section for such coverage to ensure it accurately reflects a state's specific requirements. States also should be aware that proposed federal regulations for short-term, limited duration insurance coverage and hospital indemnity or other fixed indemnity coverage include specific disclosure statement requirements for these coverages and recognize that the disclosure statement requirements in this section may need to contain additional information as required by applicable state law, rules, or guidance. A state also may need to require disclosure language to reflect any additional requirements a state may have, such as requirements regarding minimum essential coverage or special enrollment periods for expiration or loss of eligibility for this coverage.

"The [policy][certificate] provides limited benefits. Review your [policy][certificate] carefully."

- (c) The disclosure statement shall be in a sans serif font, in a font size at least equal to the size type used for headings or captions of sections of the document.
- (d) In the application, the disclosure statement shall be placed in close proximity to the applicant's signature block.
- (e) In the policy and certificate, the disclosure statement shall be placed on the first page.
- (f) In this section, the term "prominent" means one or more methods are used to draw attention to the language, including using a larger font size, leading, underlining, bolding, color, or italics.

Drafting Note: States should review their existing readability laws and regulations to help to ensure the statements above are readable. States should also review their existing laws and regulations to ensure the statements above are accessible to potential applicants, including those with disabilities such as blindness or macular degeneration, deafness or hearing loss, learning disabilities, cognitive limitations, limited movement, speech disabilities, photosensitivity, and combinations of these.

(2) Any disclosures, and the documents to which they refer, shall be delivered in the written medium (digital or heard copy) the applicant requests. These documents shall be provided before the applicant submits a completed application.

(3) For hospital indemnity coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase “fixed dollar benefits” made prominent:

“This [policy] [certificate] pays fixed dollar benefits as a result of a covered hospitalization due to a sickness or injury. The benefit amounts are not based on the cost of your medical expenses. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully.”

Drafting Note: States should review the above notice and disclosure requirements for hospital indemnity coverage for consistency with their state regulations. In addition, states should review any relevant federal regulations establishing notice and disclosure requirements for hospital indemnity coverage that could differ from the state’s requirements.

(4) For other fixed indemnity coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase “fixed dollar benefits” made prominent:

“This [policy] [certificate] pays fixed dollar benefits as a result of covered events due to a sickness or injury. The benefit amounts are not based on the cost of your medical expenses. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully.”

Drafting Note: States should review the above notice and disclosure requirements for other fixed indemnity coverage for consistency with their state regulations. In addition, states should review any relevant federal regulations establishing notice and disclosure requirements for other fixed indemnity coverage that could differ from the state’s requirements.

~~(2) All applications for dental plans shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant’s signature block on the application as follows:~~

~~“The [policy] [certificate] provides dental benefits only. Review your [policy] [certificate] carefully.”~~

~~(3) All applications for vision plans shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant’s signature block on the application as follows:~~

~~“The [policy] [certificate] provides vision benefits only. Review your [policy] [certificate] carefully.”~~

(5) For disability income protection coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase “while you are disabled” made prominent:

“This [policy] [certificate] provides periodic payments [weekly, bi-weekly, or monthly] for a set length of specific period of time while you are disabled from a covered sickness or injury. Read the description of benefits provided along with your [enrollment form/application] carefully.”

- (6) For accident only coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase “from a covered accident” made prominent:

“This [policy] [certificate] pays benefits for covered injuries from a covered accident. It does not provide benefits resulting from sickness. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully.”

- (7) For specified disease coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase “of a covered disease” made prominent:

“This [policy] [certificate] pays limited benefits as a result of the diagnosis or treatment of a covered disease specified in the [policy] [certificate]. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully.”

- (8) For specified accident coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase “for a specifically identified type of accident” made prominent:

“This [policy] [certificate] provides benefits for a specifically identified type of accident as named in the [policy] [certificate]. It does not provide benefits resulting from sickness. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully.”

- (9) For limited benefit coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase “limited benefits and only for the events specified” made prominent:

“The [policy] [certificate] pays limited benefits and only for the events specified in the [policy] [certificate]. These limited benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully.”

- (10) For limited scope dental coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the sentence “It is not intended to cover all dental expenses.” made prominent:

“The [policy] [certificate] provides dental benefits only. It is not intended to cover all dental expenses. Read your [policy] [certificate] carefully to understand what dental services it covers and any cost-sharing that may be your responsibility.”

- (11) For limited scope vision coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the sentence “It is not intended to cover all vision expense.” made prominent:

“The [policy] [certificate] provides vision benefits only. It is not intended to cover all vision expenses. Read your [policy] [certificate] carefully to understand what vision services are covered and any cost-sharing that may be your responsibility.”

- (12) For short-term health insurance, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the word “Important” and the sentence “It is not comprehensive health insurance.” made prominent:

“Important: This is short-term health insurance. This is temporary insurance. It is not comprehensive health insurance. Read your [policy] [certificate] carefully to make sure you understand what is covered and any limitations on coverage.

- This insurance might not cover or might limit coverage for:
 - Preexisting conditions; or
 - Essential health benefits (such as pediatric, hospital, emergency, maternity, mental health, substance use services, prescription drugs, or preventive care).

- You will not qualify for federal financial help to pay for premiums or out-of-pocket costs for this policy.
- You are not protected from surprise medical bills.
- When this policy ends, you might have to wait until an open enrollment period to get comprehensive health insurance.

Visit HealthCare.gov online or call 1-800-318-2596 (TTY: 1-855-889-4325) to review your options for comprehensive health insurance. If you're eligible for coverage through your employer or a family member's employer, contact the employer for more information. Contact the [State] department of insurance if you have questions or complaints about this policy."

- ~~(4)~~(13) Each policy of individual ~~accident and sickness insurance and group supplemental health insurance~~ supplementary or short-term health insurance subject to this regulation, as provided in Section 3A of this regulation, shall include a renewal, continuation or nonrenewal provision. The language or specification of the provision shall be consistent with the type of contract to be issued. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.
- ~~(5)~~(14) ~~Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all~~All riders or endorsements added to a policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder. After date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the policyholder, except if the increased benefits or coverage is required by law. The signature requirements in this paragraph ~~apply~~applies to group supplemental health insurance certificates only where the certificate holder also pays the insurance premium.
- ~~(6)~~(15) Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy or certificate and the combined total premium clearly identified as such.
- ~~(7)~~(16) A policy or certificate that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include a definition of the terms and a clear ~~an~~ explanation of the terms in its accompanying outline of coverage.
- ~~(8)~~(17) If a policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as ~~be~~ clearly explained in a separate paragraph of the policy or certificate ~~and be~~ labeled as "Preexisting Conditions Limitations."
- ~~(9)~~ — ~~All accident only policies and certificates shall contain a prominent statement on the first page of the policy or certificate, in either contrasting color or in boldface type at least equal to the size of type used for headings or captions of sections in the policy or certificate, a prominent statement as follows:~~
- ~~"Notice to Buyer: This is an accident only [policy][certificate] and it does not pay benefits for loss from sickness. Review your [policy][certificate] carefully."~~
- ~~Accident only [policies][certificates] that provide coverage for hospital or medical care shall contain the following statement in addition to the Notice to Buyer above: "This [policy][certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses."~~
- ~~(10)~~(18) All policies and certificates, except single-premium nonrenewable policies and as otherwise provided in this paragraph, shall have a notice prominently printed in sans serif font on the first page of the policy or certificate or attached to it stating in substance ~~clearly~~ that the policyholder or certificate holder shall have the right to return the policy or certificate within thirty [30] days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the policyholder or certificate holder is not satisfied for any reason.

Drafting Note: This ~~section~~paragraph should be included only if ~~the~~it is consistent with applicable state ~~law~~has legislation ~~granting authority.~~

~~(11)~~(19) If age is to be used as a determining factor ~~for reducing to reduce~~ the ~~maximum aggregate~~ benefits made available in the policy or certificate as originally issued, ~~that~~fact ~~clear explanation of how~~ age is used shall be prominently set forth in the outline of coverage.

~~(12)~~(20) If a policy or certificate contains a conversion privilege, it shall comply, in substance, with the following: The caption of the provision shall be “Conversion Privilege” or words of similar import. The provision shall ~~indicate the~~clearly explain which persons are eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person ~~by whom who may exercise~~ the conversion privilege ~~may be exercised~~. The provision shall clearly specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

~~(13)~~(21) (a) Outlines of coverage delivered in connection with policies defined in this regulation as hospital ~~confinement~~ indemnity or other fixed indemnity (Section ~~7E8B~~), specified disease (Section ~~7J8E~~), or limited benefit health coverages (Section ~~7L8G~~) to persons eligible for Medicare by reason of age shall contain, in addition to the requirements of Subsections ~~F~~D and ~~F~~F, the following language, which shall be printed on or attached to the first page of the outline of coverage, with the sentence “This is not a Medicare Supplement policy.” made prominent:

This ~~IS NOT A MEDICARE SUPPLEMENT~~is not a Medicare Supplement policy. If you are eligible for Medicare, ~~review~~ask the company for the Guide to Health Insurance for People ~~With Medicare available from the company.~~

Drafting Note: States may want to review the disclosure language in paragraph (21)(a) above for consistency with the consumer disclosure language in Appendix C of the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651).

(b) An insurer shall deliver to persons eligible for Medicare any notice required under [insert reference to state law equivalent of Section 17D of the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act*].

Drafting Note: States that permit individuals under the age of 65 with Medicare coverage to purchase Medicare supplement policies should review how insurers should provide the notices required under paragraph (21)(a) to these individuals.

~~(14)~~(22) Insurers, ~~except direct response insurers,~~ shall give a person applying for specified disease insurance a Buyer’s Guide approved by the commissioner at the time of application enrollment and shall obtain all recipients’ written acknowledgement of the guide’s delivery. ~~Direct response insurers shall provide the Buyer’s Guide upon request but not later than the time that the policy or certificate is delivered.~~

Drafting Note: Paragraph (22) only applies if a state has such a Buyer’s Guide.

~~(15)~~ — All specified disease policies and certificates shall contain on the first page or attached to it in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate], a prominent statement as follows: Notice to Buyer: This is specified disease [policy] [certificate]. This [policy] [certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your [policy] [certificate] carefully with the outline of coverage and the Buyer’s Guide.

Drafting Note: The second sentence of this caption should only be required in those states where the commissioner exercises discretionary authority and requires the guide.

~~(16)~~ — All hospital confinement indemnity policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached

~~to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:~~

~~“Notice to Buyer: This is a hospital confinement indemnity [policy][certificate]. This [policy][certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.”~~

- ~~(17) All limited benefit health policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:~~

~~“Notice to Buyer: This is a limited benefit health [policy][certificate]. This [policy][certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.”~~

- ~~(18) All basic hospital expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:~~

~~“Notice to Buyer: This is a basic hospital expense [policy][certificate]. This [policy][certificate] provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage.”~~

- ~~(19) All basic medical surgical expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:~~

~~“Notice to Buyer: This is a basic medical surgical expense [policy][certificate]. This [policy][certificate] provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage.”~~

- ~~(20) All basic hospital/medical surgical expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:~~

~~“Notice to Buyer: This is a basic hospital/medical surgical expense [policy][certificate]. This [policy][certificate] provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage.”~~

- ~~(21) All individual basic medical expense policies shall display prominently by type, stamp or other appropriate means on the first page of the policy, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy the following:~~

~~“Notice to Buyer: This is an individual basic medical expense policy. This policy provides benefits that are not as comprehensive as individual major medical expense coverage and should not be considered a substitute for comprehensive health insurance coverage.”~~

- ~~(22) All dental plan policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:~~

~~“Notice to Buyer: This [policy][certificate] provides dental benefits only.”~~

~~(23) All vision plan policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:~~

~~“Notice to Buyer: This [policy] [certificate] provides vision benefits only.”~~

B. Outline of Coverage Requirements

(1) An insurer shall deliver an outline of coverage to an applicant ~~or enrollee in the sale of individual accident and sickness insurance, group supplemental health insurance, dental plans and vision plans~~ all applicable plans as required in Section 6 of the Act.

(2) If an outline of coverage was delivered at the time of application or enrollment and the policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered and contain the following statement in no less than twelve (12) point sans serif type, immediately above the company name, with the sentence “It is different from the outline of coverage you received when you [applied] [enrolled].” made prominent:

~~“NOTICE: Read this outline of coverage carefully. It is not identical to different from the outline of coverage provided upon you received when you [application applied][enrollment enrolled]; and theThe coverage originally you applied for has was not been issued.”~~

~~(3) The appropriate outline of coverage for policies or contracts providing hospital coverage that only meets the standards of Section 7B shall be that statement contained in Section 8C. The appropriate outline of coverage for policies providing coverage that meets the standards of both Sections 7B and C shall be the statement contained in Section 8E. The appropriate outline of coverage for policies providing coverage which meets the standards of both Sections 7B and E or Sections 7C and E or Sections 7B, C, and E shall be the statement contained in Section 8G.~~

~~(4)~~(3) In any case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or certificate, an alternate outline of coverage shall be submitted to the commissioner for prior approval. In such instances, no policies may be sold or renewed until approved by the commissioner.

~~(5)~~(4) Advertisements may fulfill the requirements for outlines of coverage if they satisfy the standards specified for outlines of coverage in Section 6H of the Act as well as this regulation.

~~C. Basic Hospital Expense Coverage (Outline of Coverage)~~

~~An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7B of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:~~

~~[COMPANY NAME]~~

~~BASIC HOSPITAL EXPENSE COVERAGE~~

~~THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE~~

~~OUTLINE OF COVERAGE~~

~~Read Your [Policy][Certificate] Carefully This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations~~

~~of both you and your insurance company. It is, therefore, important that you READ YOUR [POLICY][CERTIFICATE] CAREFULLY!~~

~~(2) — Basic hospital coverage is designed to provide, to persons insured, coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services and hospital outpatient services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for physicians or surgeons fees or unlimited hospital expenses.~~

~~(3) — [A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:~~

- ~~(a) — Daily hospital room and board;~~
- ~~(b) — Miscellaneous hospital services;~~
- ~~(c) — Hospital out-patient services; and~~
- ~~(d) — Other benefits, if any.]~~

~~**Drafting Note:** The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.~~

~~(4) — [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]~~

~~(5) — [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]~~

~~D. — Basic Medical Surgical Expense Coverage (Outline of Coverage)~~

~~An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7C of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:~~

~~[COMPANY NAME]~~

~~BASIC MEDICAL SURGICAL EXPENSE COVERAGE~~

~~THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE~~

~~OUTLINE OF COVERAGE~~

~~(1) — Read Your [Policy][Certificate] Carefully This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control your policy. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR [POLICY][CERTIFICATE] CAREFULLY!~~

~~(2) — Basic medical surgical expense coverage is designed to provide, to persons insured, coverage for medical surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services and in hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for hospital expenses fees or unlimited medical surgical expenses.~~

~~(3) — [A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:~~

- ~~(a) — Surgical services;~~
- ~~(b) — Anesthesia services;~~
- ~~(c) — In hospital medical services; and~~
- ~~(d) — Other benefits, if any]~~

~~**Drafting Note:** The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.~~

- ~~(4) — [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]~~
- ~~(5) — [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]~~

~~E. — Basic Hospital/Medical-Surgical Expense Coverage (Outline of Coverage)~~

~~An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Sections 7B and C of this regulation. The items included in the outline of coverage must appear in the sequence prescribed.~~

~~[COMPANY NAME]~~

~~BASIC HOSPITAL/MEDICAL SURGICAL EXPENSE COVERAGE~~

~~THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE~~

~~OUTLINE OF COVERAGE~~

- ~~(1) — Read Your [Policy][Certificate] Carefully — This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore important that you READ YOUR [POLICY][CERTIFICATE] CAREFULLY!~~
- ~~(2) — Basic hospital/medical surgical expense coverage is designed to provide, to persons insured, coverage for hospital and medical surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital outpatient services, surgical services, anesthesia services, and in hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for unlimited hospital or medical surgical expenses.~~
- ~~(3) — [A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:
 - ~~(a) — Daily hospital room and board;~~
 - ~~(b) — Miscellaneous hospital services;~~
 - ~~(c) — Hospital outpatient services;~~
 - ~~(d) — Surgical services;~~
 - ~~(e) — Anesthesia services;~~~~

- ~~(f) In-hospital medical services; and~~
- ~~(g) Other benefits, if any.]~~

~~**Drafting Note:** The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.~~

- ~~(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]~~
- ~~(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]~~

FC. Hospital ~~Confinement~~ Indemnity or Other Fixed Indemnity Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates meeting the standards of Section ~~7E8B~~ of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

~~HOSPITAL CONFINEMENT INDEMNITY COVERAGE~~

~~THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS~~

~~BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES~~

[Hospital Indemnity] [Other Fixed Indemnity] Coverage

The benefits in this [policy] [certificate] are limited. They are intended to supplement your other health insurance coverage. They are not intended to cover all expenses.

OUTLINE OF COVERAGE

- (1) Read ~~Y~~your ~~[Ppolicy][Ccertificate]~~ ~~C~~carefully.— This outline of coverage ~~provides a very brief description of~~ briefly describes your coverage's the important features ~~of coverage. This~~It is not the insurance contract ~~and only the actual policy provisions will control.~~ The [policy] [certificate] itself ~~sets forth in detail the~~details your rights and obligations ~~of both you and those of your insurance company. It is, therefore, important that you~~ ~~READ YOUR [POLICY] [CERTIFICATE]~~ CAREFULLY read your [policy] [certificate] carefully!
- (2) ~~[Hospital confinement indemnity] [Other fixed indemnity] coverage is designed to provide, to persons insured, coverage in the form of pay a fixed daily dollar benefit as a result of a during periods of covered hospitalization resulting from a [hospital stay] [event] due to a covered accident or sickness or injury, subject to any limitations set forth in the policy. The benefit may be limited in ways described in the [policy] [certificate]. Coverage is not provided for any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below. The fixed dollar benefit may be less than the [hospital stay's] [event's] cost.~~
- (3) [A brief, but clear and specific, description of the benefits in the following order:
 - (a) ~~Daily benefit payable during hospital confinement~~When the benefits are payable; and
 - (b) ~~The d~~Duration of benefits described in (a); and
 - (c) ~~The fixed dollar amount of the benefits.]~~

~~**Drafting Note:** The above description of benefits shall be stated clearly and concisely.~~

- (4) [~~A clear~~ description of any ~~policy~~ provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefit, described in Paragraph (3) above.]
- (5) [A clear description of ~~policy~~ provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]
- (6) [~~Any~~ A clear description of any benefits provided in addition to the ~~daily fixed dollar~~ [hospital] ~~[event]~~ benefit.]

~~G. Individual Major Medical Expense Coverage (Outline of Coverage)~~

~~An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7F of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:~~

~~{COMPANY NAME}~~

~~INDIVIDUAL MAJOR MEDICAL EXPENSE COVERAGE~~

~~OUTLINE OF COVERAGE~~

- ~~(1) Read Your Policy Carefully This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!~~
- ~~(2) Individual major medical expense coverage is designed to provide, to persons insured, comprehensive coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in hospital medical services, and out of hospital care, subject to any deductibles, copayment provisions, or other limitations that may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.~~
- ~~(3) [A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:~~
 - ~~(a) Daily hospital room and board;~~
 - ~~(b) Miscellaneous hospital services;~~
 - ~~(c) Surgical services;~~
 - ~~(d) Anesthesia services;~~
 - ~~(e) In hospital medical services;~~
 - ~~(f) Out of hospital care;~~
 - ~~(g) Maximum dollar amount for covered charges; and~~
 - ~~(h) Other benefits, if any]~~

~~**Drafting Note:** The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.~~

- ~~(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]~~

~~(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]~~

~~H. Individual Basic Medical Expense Coverage~~

~~An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7G of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:~~

~~[COMPANY NAME]~~

~~INDIVIDUAL BASIC MEDICAL EXPENSE COVERAGE~~

~~OUTLINE OF COVERAGE~~

~~(1) Read Your Policy Carefully This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!~~

~~(2) Individual basic medical expense coverage is designed to provide, to persons insured, limited coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations that may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.~~

~~(3) [A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:~~

~~(a) Daily hospital room and board;~~

~~(b) Miscellaneous hospital services;~~

~~(c) Surgical services;~~

~~(d) Anesthesia services;~~

~~(e) In-hospital medical services;~~

~~(f) Out of hospital care;~~

~~(g) Maximum dollar amount for covered charges; and~~

~~(h) Other benefits, if any]~~

~~**Drafting Note:** The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.~~

~~(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]~~

~~(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]~~

~~D. Disability Income Protection Coverage (Outline of Coverage)~~

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates meeting the standards of Section 748C of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

~~DISABILITY INCOME PROTECTION COVERAGE~~
Disability Income Protection Coverage

OUTLINE OF COVERAGE

- (1) Read ~~Y~~your ~~[P~~policy] ~~]~~ ~~[certificate]~~ ~~C~~carefully. ~~—This outline of coverage provides a very brief description of~~ briefly describes your coverage's ~~the~~ important features ~~of your policy. This~~ It is not the insurance contract, ~~and only the actual policy provisions will control.~~ The ~~[policy]~~ ~~[certificate]~~ itself ~~sets forth in detail the~~ details your rights and obligations ~~of both you and those of your insurance company. It is, therefore,~~ important that you ~~READ YOUR POLICY CAREFULLY~~ read your [policy] [certificate] carefully!
- (2) Disability income protection coverage is designed to ~~provide, to persons insured, coverage~~ pay a benefit for disabilities resulting from a covered ~~accident or sickness or injury, subject to any limitations set forth in the policy. The benefit may be limited in the ways described in the [policy] [certificate]. Coverage is not provided for basic hospital, basic medical surgical, or major medical expenses. The benefit might not fully replace your income.~~
- (3) ~~[A brief~~ Brief, but clear and specific, description of the benefits contained in ~~this~~ the ~~[policy] [certificate].]~~

~~Drafting Note: The above description of benefits shall be stated clearly and concisely.~~

- (4) ~~[A clear~~ description of any ~~policy~~ provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]
- (5) ~~[A clear~~ description of ~~policy~~ provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

~~II.~~ E. Accident-Only Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with policies or certificates meeting the standards of Section 748D of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

~~ACCIDENT-ONLY COVERAGE~~

~~THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS~~

~~BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES~~

Accident-Only Coverage

The benefits in this [policy] [certificate] are limited.
They are intended to supplement your other health insurance coverage.

They are not intended to cover all expenses.

OUTLINE OF COVERAGE

- (1) Read ~~Y~~your ~~[Ppolicy]~~~~[Ccertificate]~~ ~~C~~carefully. —This outline of coverage ~~provides a very brief description of the~~~~briefly describes your coverage's~~ important features ~~of the coverage. This~~It is not the insurance contract, ~~and only the actual policy provisions will control.~~ The ~~[policy] [certificate]~~ ~~itself sets forth in detail~~~~details~~ ~~they~~our rights and obligations ~~of both you and those of your insurance company.~~ It is, ~~therefore,~~ important that you ~~—READ YOUR [POLICY][CERTIFICATE]~~ ~~CAREFULLY~~ ~~read your [policy] [certificate] carefully!~~
- (2) Accident-only coverage ~~is designed to provide, to persons insured, coverage~~~~pays benefits~~ for ~~certain losses resulting~~~~covered injuries~~ from a covered accident ~~ONLY, subject to any limitations contained in the policy. It does not provide benefits resulting from sickness. The benefits may be limited in ways described in the [policy] [certificate]. Coverage is not provided for basic hospital, basic medical surgical, or major medical expenses.~~
- (3) ~~[A brief~~~~Brief, but clear and specific,~~ description of the benefits ~~and a description of any deductible or copayment provisions applicable to the benefits described.]~~

~~**Drafting Note:** The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described. Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 7A(13) of this regulation.~~

- (4) ~~[A clear~~ description of any ~~policy~~ provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above. ~~Proper disclosure of benefits that vary according to the type of accidental cause shall be made in accordance with Section 8A(13) of this regulation.]~~
- (5) ~~[A clear~~ description of ~~policy~~ provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

~~**KE.**~~ Specified Disease or Specified Accident Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with policies or certificates meeting the standards of Sections ~~7J8E~~ and ~~KE~~ of this regulation. The coverage shall be identified by the appropriate bracketed title. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

~~[SPECIFIED DISEASE][SPECIFIED ACCIDENT] COVERAGE~~

~~THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS~~

~~BENEFITS PROVIDED ARE SUPPLEMENTAL AND
ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES~~

~~Specified Disease or Specified Accident Coverage (Outline of Coverage)~~

~~The benefits in this [policy] [certificate] are limited. They are intended to supplement your other health insurance coverage. They are not intended to cover all expenses.~~

OUTLINE OF COVERAGE

- (1) ~~This coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. Persons covered under Medicaid should not purchase it.~~ Read the Buyer's Guide to Specified Disease Insurance to review the possible limits on benefits in this type of coverage.

~~**Drafting Note:** States should review whether they have the Buyer's Guide to Specified Disease Insurance referenced above. If they do, the state should determine if it is up to date before requiring such a guide to be provided. If the state does not have such a guide, then the state should revise this outline of coverage accordingly.~~

- (2) Read ~~Y~~your [policy] [certificate] ~~[Outline of Coverage]~~ ~~C~~carefully. —This outline of coverage ~~provides a very brief description of the~~briefly describes your coverage's important features ~~of coverage. This~~It is not the insurance contract ~~and only the actual policy provisions will control.~~ The [policy] [certificate] ~~itself sets forth in detail the~~details the your rights and obligations ~~of both you and those of your insurance company.~~ It is, ~~therefore,~~ important that you ~~READ YOUR [POLICY] [CERTIFICATE] CAREFULLY~~ read your [policy] [certificate] carefully!
- (3) [Specified disease][Specified accident] coverage is designed to ~~provide, to persons insured, restricted coverage paying benefits ONLY pay limited benefits when certain losses occur~~as a result of ~~the diagnosis or treatment [of a [specified diseasescovered disease] or [resulting from a [specified accidentspecifically identified type of accident].~~ Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.
- (4) ~~[A brief~~Brief, but clear and specific, description of the benefits, including dollar amounts ~~and a description of any deductible or copayment provisions applicable to the benefits described.]~~ Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 8A(13) of this regulation.

~~**Drafting Note:** The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 7A(13) of this regulation.~~

~~EG.~~ Limited Benefit Health Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates which do not meet the minimum standards of Sections ~~78B, D and G~~C, D, E, F, G, I and K of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

~~LIMITED BENEFIT HEALTH COVERAGE~~

~~BENEFITS PROVIDED ARE SUPPLEMENTAL AND
ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES~~

~~Limited Benefit Health Coverage~~

~~The benefits in this [policy] [certificate] are limited. They are intended to supplement your other health insurance coverage.
They are not intended to cover all expenses.~~

OUTLINE OF COVERAGE

- (1) Read ~~Y~~your [Ppolicy][Ccertificate] ~~C~~carefully. —This outline of coverage ~~provides a very brief description of the~~briefly describes your coverage's important features ~~of your policy. This~~It is not the insurance contract ~~and only the actual policy provisions will control.~~ The [policy] [certificate] itself ~~sets forth in detail~~details the ~~your~~ your rights and obligations ~~of both you and those of your insurance company.~~ It is, ~~therefore,~~ important that you ~~READ YOUR [POLICY] [CERTIFICATE] CAREFULLY~~ read your [policy] [certificate] carefully!
- (2) Limited benefit health coverage ~~is designed to provide, to persons insured, limited or supplemental coverage pays limited benefits. This [policy] [certificate] is not major medical insurance and does not replace it.~~
- (3) ~~[A brief~~Brief, but clear and specific, description of the benefits, including dollar amounts ~~and a description of any deductible or copayment provisions applicable to the benefits described.]~~

~~**Drafting Note:** The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 7A(13) of this regulation.~~

- (4) [A clear description of any provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]
- (5) [A clear description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

H. Short-Term, Limited Duration Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates meeting the standards of Section 8H of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

Short-Term, Limited Duration Coverage

The benefits in this [policy] [certificate] are limited. They are not intended to cover all expenses.

The [policy] [certificate] may not cover preexisting conditions.

OUTLINE OF COVERAGE

- (1) Read your [policy] [certificate] carefully. This outline of coverage briefly describes your coverage's important features. It is not the insurance contract. The [policy] [certificate] itself details your rights and obligations and those of your insurance company. It is important that you read your [policy] [certificate] carefully!
- (2) This is a short-term, limited duration [policy] [certificate]. This is temporary insurance. It is not comprehensive health insurance. It might not cover or might limit coverage for preexisting conditions. It might not cover essential health benefits such as pediatric, hospital, emergency, maternity, mental health, substance use services, prescription drugs, or preventive care. Read your [policy] [certificate] carefully to make sure you understand what is covered and any limitations on coverage.
- (3) [Brief, but clear and specific, description of the benefits in the following order:
 - (a) Benefits covered by the policy or certificate, including required cost-sharing;
 - (b) Benefits that are not covered by the policy or certificate; and
 - (c) Duration of benefits described above.]
- (4) A clearly worded prominent notice that cost-sharing limitations do not apply to benefits not covered by the policy or certificate.
- (5) [A clear description of provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in paragraph (3) above.]
- (6) [A clear description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

M. Limited Scope Dental Plans Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with dental plancare policies and certificates. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

Limited Scope Dental Coverage

The benefits in this [policy] [certificate] are limited. They are not intended to cover all expenses.

OUTLINE OF COVERAGE

- (1) Read ~~Y~~your [pPolicy][Ccertificate] ~~C~~carefully.— This outline of coverage ~~provides a very brief description of the~~briefly describes your coverage's important features ~~of your policy. This~~It is not the insurance contract ~~and only the actual policy provisions will control.~~ The [policy] [certificate] itself ~~sets forth in detail the~~details your rights and obligations ~~of both you and those of your~~ insurance company. It is, ~~therefore,~~ important that you ~~READ YOUR [POLICY][CERTIFICATE]~~ CAREFULLY read your [policy] [certificate] carefully!
- ~~(2)~~ Limited scope dental coverage pays benefits for dental benefits only. It is not intended to cover all dental expenses. Read your [policy] [certificate] carefully to understand what dental care it covers and any cost-sharing that may be your responsibility.
- ~~(2)~~(3) [~~A brief~~Brief, but clear and specific, description of the benefits.]
- ~~(3)~~(4) [A clear description of any ~~policy~~provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph ~~(4)~~(3) above.]
- ~~(4)~~(5) [A clear descriptiondescription of ~~policy~~provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

NJ. Limited Scope Vision Plans Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with vision ~~plan~~care policies and certificates. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

Limited Scope Vision Coverage

The benefits in this [policy] [certificate] are limited. They are not intended to cover all expenses.

OUTLINE OF COVERAGE

- (1) Read ~~Y~~your [pPolicy][Ccertificate] ~~C~~carefully.— This outline of coverage ~~provides a very brief description of the~~briefly describes your coverage's important features ~~of your policy. This~~It is not the insurance contract ~~and only the actual policy provisions will control.~~ The [policy] [certificate] itself ~~sets forth in detail the~~details your rights and obligations ~~of both you and those of your~~ insurance company. It is, ~~therefore,~~ important that you ~~READ YOUR [POLICY][CERTIFICATE]~~ CAREFULLY read your [policy] [certificate] carefully!
- ~~(2)~~ Limited scope vision coverage pays benefits for vision benefits only. It is not intended to cover all vision expenses. Read your [policy] [certificate] carefully to understand what vision care it covers and any cost-sharing that may be your responsibility.
- ~~(2)~~(3) [~~A brief~~Brief, but clear and specific, description of the benefits.]
- ~~(3)~~(4) [A clear description of any ~~policy~~provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph ~~(4)~~(3) above.]
- ~~(4)~~(5) [A clear description of ~~policy~~provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

Section 910. Requirements for Replacement of Individual ~~Accident and Sickness Insurance~~ Supplementary and Short-Term Health Insurance Coverage

~~Drafting Note: Group supplemental health insurance is not addressed here because it is addressed in the Group Coverage Discontinuance and Replacement Model Regulation, which is applicable. States may also have other statutes or regulations that apply.~~

- A. An application form shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other ~~accident and sickness~~ supplementary or short-term health insurance subject to this regulation, as provided in Section 3A of this regulation, presently in force. A supplementary application or other form to be signed by the applicant containing the question may be used.
- B. Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in Subsection C below. The insurer shall retain a copy of the notice. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in Subsection D below. ~~In no event, h~~ However, will the ~~this~~ notices ~~be is not~~ required in the solicitation of ~~the following types of policies:~~ accident-only policies or the replacement of ~~and~~ single-premium nonrenewable policies.
- C. The notice required by Subsection B above for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT

OF ACCIDENT AND SICKNESS INSURANCE

Notice to Applicant About Replacement of [Supplementary] [Short-Term] Health Insurance

According to [your application] [information you have ~~furnished~~ provided], you intend to lapse or otherwise ~~terminate existing~~ end the ~~accident and sickness~~ supplementary or short-term health insurance you have now and replace it with a policy ~~to be issued by the~~ [insert company name] Insurance Company will issue. For your own ~~information and~~ protection, you should ~~be aware of and seriously consider certain factors that~~ know ~~how replacing your policy with a new one~~ may ~~might~~ affect the insurance protection available to you under the new policy your coverage.

- (1) A new policy might not pay claims that the policy you have now would pay. A new policy might not cover Health ~~health~~ conditions which you may ~~that you might~~ presently have, now (preexisting conditions) ~~or may~~ might ~~not be immediately or fully covered under the new policy~~ cover them right away. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy A new policy might cover some but not all the costs related to treating preexisting conditions.

Drafting Note: This subsection may be modified if preexisting conditions are covered under the new policy.

- (2) ~~You may wish to secure the advice of your present insurer or its agent~~ Talk with your current insurance agent regarding the proposed replacement of your present ~~or company representative about replacing your~~ policy. This is not only your right, but it ~~is also in your best interests to make~~ be ~~sure you understand all the relevant factors involved in replacing your present~~ how replacing your policy could affect your future coverage.
- (3) ~~If, after due consideration, you still wish to terminate your present~~ you decide to buy a new policy, and replace it with new coverage, be certain ~~be sure~~ to truthfully and completely answer all questions on the application ~~concern about~~ your medical/health history. Failure to include all material medical information on an application may provide a basis for ~~If you do not,~~ the company ~~to~~ could ~~deny any future claims and to refund your premium as though your policy had never been in force. After~~ the ~~Check that the information on your application has been completed~~ is complete and correct and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)

D. The notice required by Subsection B of this section for a direct response insurer shall be as follows:

~~NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS INSURANCE~~

Notice to Applicant About Replacement of [Supplementary] [Short-Term] Health Insurance

According to [your application] [information you have ~~furnished~~provided], you intend to lapse or otherwise ~~terminate existing~~end the accident and sickness~~supplementary or short-term health~~ insurance you have now and replace it with the attached policy ~~delivered herewith~~issued by [insert company name] Insurance Company. ~~Your new policy provides~~You have thirty days ~~within which you may~~to decide ~~without~~at no cost ~~whether you desire to~~if you want to keep the new policy. For your own ~~information and~~protection, you should ~~be aware of and seriously consider certain factors that~~know how replacing your policy with a new one may~~might~~ affect ~~the insurance protection available to you under the new policy~~your coverage.

- (1) ~~A new policy might not pay claims that the policy you have now would pay. A new policy might not cover Health~~health conditions ~~that you may presently have, now~~ (preexisting conditions) ~~may not be immediately or fully covered under the new policy or might not cover them right away. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy. A new policy might cover some but not all the costs related to preexisting conditions.~~
- (2) ~~You may wish to secure the advice of your present insurer or its~~Talk with your insurance agent or company representative ~~regarding the proposed replacement of your present~~about replacing your policy. ~~This is not only your right, but it~~is also in your best interests ~~to make~~be sure you understand ~~all the relevant factors involved in replacing~~how replacing your policy could affect your presentfuture coverage.
- (3) [To be included only if the application is attached to the policy]. ~~If, after due consideration,~~ you ~~still wish to terminate your present~~decide to buy a new policy, ~~and replace it with new coverage,~~ read the copy of the attached application ~~attached to your new policy~~ and be sure that all questions are answered fully and correctly. ~~Omissions or misstatements in the application could cause~~If they are not, the company could refuse to pay an otherwise valid claim ~~to be denied~~. Carefully check the application and write to [insert company name and address] within ten days if any information is not correct and complete, or if any past medical history has been left ~~out of~~off the application.

[COMPANY NAME]

Drafting Note: The sentence “You have thirty days to decide at no cost if you want to keep the new policy.” should only be required if the state has adopted Section 9A(18).

Section ~~1011~~. Separability

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

PROJECT HISTORY

MODEL REGULATION TO IMPLEMENT THE ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS MODEL ACT (#171)

1. Description of the Project, Issues Addressed, etc.

Amendments to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171)*—Amendments to Model #171 are required for consistency with the federal Affordable Care Act (ACA) and the revisions to its companion model act, the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170)*. Therefore, they did not require approval of a Request for NAIC Model Law Development by the Executive (EX) Committee.

In 2013, the Regulatory Framework (B) Task Force was charged with reviewing existing NAIC models related to health insurance to determine whether they needed to be amended, considering all the changes made by the ACA. During that review process, Model #170 and its companion model regulation, Model #171, were added to the list of NAIC models to be considered for revision, given the model's provisions for certain types of health insurance plans that would not be permitted under the ACA.

Beginning at the 2014 Fall National Meeting, the Task Force began discussing revisions to Model #170 and Model #171. At the 2015 Spring National Meeting, the Task Force decided, given its other priorities for 2015, specifically with respect to revising the formerly titled *Managed Care Network Adequacy Model Act (#74)*, now the *Health Benefit Plan Network Access and Adequacy Model Act (#74)*, to defer discussing additional revisions to the models until it finished its work on Model #74. The Task Force finished that work in late 2015.

In February 2016, the Task Force established the Accident and Sickness Insurance Minimum Standards (B) Subgroup, with Wisconsin as chair, to begin working on revising Model #170 and Model #171. At the 2017 Spring National Meeting, concerned with the uncertainty of the ACA's future, given congressional proposals to repeal, replace, and/or repair it, the Task Force decided to halt Subgroup meetings until there was more certainty about actions at the congressional level.

At the 2017 Fall National Meeting, the Task Force decided to move forward with discussing revisions to Model #170 and Model #171, and it directed the Subgroup to resume its work in early 2018. The Subgroup completed the revisions to Model #170 in late 2018, which the Executive (EX) Committee and Plenary adopted in February 2019.

The Model #170 revisions removed provisions for certain types of health insurance products that would not be permitted because of the requirements of the ACA leaving only those products considered excepted benefits, and therefore, not subject to the ACA's requirements. The Model #170 revisions also added short-term, limited-duration plans to the model because there was no other vehicle available to add those products and the Subgroup did not want to create a whole new model for them. Soon after completing its work on Model #170, the Subgroup began considering revisions to Model #171. The Subgroup met every two weeks until it lost one of its co-chairs in December 2019. After a long hiatus since late 2019 due to the loss of a co-chair, the COVID-19 pandemic, and other resource issues, the Subgroup resumed its meetings in June 2021. The Subgroup has been meeting on a regular basis to discuss the comments received on Model #171. The Subgroup completed its review of all the comments received on Model #171 in September. The Subgroup adopted the revisions to Model #171 during a meeting Oct. 17, 2024. The Regulatory Framework (B) Task Force adopted the revisions on Nov. 4 and the Health Insurance and Managed Care (B) Committee adopted the revisions during a meeting on Nov. 19.

The revisions to Model #171 revise the model for consistency with the revisions to Model #170. The revisions also add standards for short-term, limited-duration (STLD) plans. Because the Subgroup did not want to dictate what benefits and coverages these plans must include, the standards specify that short-term, limited-duration plans must provide the benefits and coverages required by the state. The revisions also clarify provisions on consumer disclosure and outline of coverage requirements making them much more understandable for consumers, including requiring specific language stating that these plans are supplemental and are not intended to be major medical coverage.

2. Name of Group Responsible for Drafting the Model and States Participating

The Accident and Sickness Insurance Minimum Standards (B) Subgroup drafted the revisions to Model #171. At the time of adoption on Oct. 17, 2024, the Subgroup members were: Oklahoma, Co-Chair; Texas, Co-Chair; District of Columbia; Florida; Louisiana; Maine; Missouri; Nebraska; South Carolina; Utah; Vermont; and Washington.

3. Project Authorized by What Charge and Date First Given to the Group

In February 2016, the Task Force established the Accident and Sickness Insurance Minimum Standards (B) Subgroup, with Wisconsin as chair, to begin working on revising Model #170 and Model #171. The Subgroup adopted the revisions to Model #170 in July 2018. Soon after completing its work on Model #170, with Oklahoma and Minnesota as co-chairs, the Subgroup began discussing revisions to Model #171. The Subgroup met every two weeks until it lost one of its co-chairs in December 2019. After a long hiatus starting in late 2019 due to the loss of a co-chair, the COVID-19 pandemic, and other resource issues, the Subgroup, with Oklahoma and Nebraska as co-chairs, resumed its meetings in June 2021. In late 2022, the Subgroup lost Nebraska as co-chair but resumed its meetings in early 2023, with Texas replacing Nebraska as co-chair. The Subgroup continued meeting on a regular basis to discuss the comments received on Model #171. The Subgroup completed its review of all the comments received on Model #171 in September 2024. The Subgroup adopted the revisions to Model #171 during a meeting Oct. 17, 2024.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

Soon after completing its work on Model #170, the Subgroup began considering revisions to Model #171. The Subgroup met every two weeks until it lost one of its co-chairs in December 2019. After a long hiatus since late 2019 due to the loss of a co-chair, the COVID-19 pandemic, and other resource issues, the Subgroup resumed its meetings and discussions of the comments received in June 2021. The Subgroup met on a regular basis to discuss the comments received on Model #171 until it adopted the model revisions Oct. 17, 2024.

During the last few months of 2022, the Subgroup's discussions focused on Section 8—Supplementary and Short-Term Health Minimum Standards for Benefits. This section establishes minimum standards for benefits for the products subject to the model, including accident-only coverage, hospital indemnity or other fixed indemnity coverage, and disability income protection coverage. The revisions also include a new section establishing minimum benefits for STLD plans. The Subgroup completed its discussions of Section 8 in December 2022, including developing a new subsection establishing minimum benefit standards for STLD plans.

The Subgroup resumed its meetings in February 2023, reviewing and discussing comments received on the following Model #171 sections in this order: 1) the remainder of Section 8, including revisiting the proposed new subsection on STLD plans to discuss the Feb. 24, 2023, comments received on that section; 2) Section 7—Prohibited Policy Provisions; 3) revisit Section 5—Definitions and Section 6—Policy Definitions to reconcile any inconsistencies that may have arisen after the Subgroup's review of the substantive provisions of Model #171; and 4) Section 9—Required Disclosure Provisions. The Subgroup is completing work on Section 9—Required Disclosure Provisions. In October 2023, the Subgroup completed its review of all the comments received on Model #171. The Subgroup set a public comment deadline of Dec. 1, 2023, to receive comments on the initial draft reflecting its discussions and preliminary revisions to Model #171.

The Subgroup resumed its meetings in January 2024 to discuss the comments received. The Subgroup completed that review in April 2024 and distributed a final draft, dated May 3, to stakeholders in anticipation of adopting the proposed revisions in June. The Subgroup received additional comments on that draft, and as a result, it resumed its meetings in June 2024 to discuss the comments. The Subgroup completed its review of those comments in September 2024 and distributed another final draft in anticipation of adopting the revisions to Model #171 during a meeting in October. The Subgroup adopted the revisions to Model #171 during a meeting Oct. 17, 2024.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers, and legislators was solicited)

Throughout the drafting process the Subgroup solicited comments from stakeholders, which included consumer and industry representatives, as well as state insurance regulators. The Subgroup discussed and reviewed those comments during public meetings. All the comments received were posted on the Subgroup's webpage. Each proposed revision draft was also posted on the Subgroup's web page.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

Among the issues debated during the drafting process concerned the purpose of excepted benefit products and the fact that they are not intended to be comprehensive major medical coverage. In addressing this issue, the Subgroup enhanced the consumer disclosure provisions and outline of coverage provisions to ensure consumers will be aware that excepted benefit products are

not meant to be comprehensive health insurance coverage. The Subgroup also included additional language in the draft highlighting that insurers should not offer, market, or sell excepted benefit products as a substitute for, or alternative to, comprehensive major medical coverage.

In addition, during the drafting process, the Subgroup and stakeholders involved had to keep in mind that the model sets minimum standards, which means the states and insurance carriers can go above them. In addressing another issue that arose during the process concerning potential and recurring federal changes related to hospital indemnity or other fixed indemnity plans and STLD plans, the Subgroup included in the revisions suggestions that, prior to adopting the model revisions, states review any relevant federal regulations, establishing that requirements for these products that could differ from the state's requirements.

One significant issue discussed and addressed during the drafting process related to the provisions establishing standards for STLD plans, including what benefits should be included. In resolving this issue, the STLD plan provisions rely on a state's requirements for benefits and coverage under such plans.

Another significant issue discussed concerned a provision in the model that allows plans to exclude mental health and substance use coverage from excepted benefit plans. During this discussion, it was highlighted that these are excepted benefit products, not major medical coverage subject to the ACA's guarantee issue and preexisting condition exclusion requirements. Excepted benefit plans are medically underwritten and subject to preexisting condition exclusions. It was also noted that this provision is optional, which means states can require such coverage if they feel it is appropriate. In addition, as already noted, for short-term, limited-duration plans, the benefits and coverages for these plans are tied to a state's requirements. If a state requires these plans to include mental health and substance use benefits, then they must include the coverage. As a compromise to address these concerns, before its adoption of the Model #171 revisions, the Health Insurance and Managed Care (B) Committee added language to a drafting note in Section 7D—Prohibited Policy Provisions making it clear that states should carefully consider whether to permit mental health and substance use coverage exclusions for STLD plans and disability income protection policies given the importance of such coverage. The Committee added similar language to a drafting note in Section 8H—Short-Term, Limited-Duration Health Insurance Coverage.

7. List the key provisions of the model (sections considered most essential to state adoption)

This is not applicable. All the sections are essential to state adoption.

8. Any Other Important Information (e.g., amending an accreditation standard)

This is not an accreditation model.



Summary of Findings and Determination

**Canada Office of the
Superintendent of Financial Institutions (OSFI)**

***Evaluation as a Jurisdiction that
Recognizes and Accepts the
U.S. Group Capital Calculation***

Issued for Public Comment By:

Mutual Recognition of Jurisdictions (E) Working Group

October 24, 2024

I. Executive Summary & Recommendation

The Mutual Recognition of Jurisdictions (E) Working Group of the National Association of Insurance Commissioners (NAIC) has completed this Summary of Findings and Determination with respect to the evaluation of the Canada Office of the Superintendent of Financial Institutions (OSFI) as a jurisdiction that Recognizes and Accepts the U.S. Group Capital Calculation (“Recognize and Accept Jurisdiction”). It is the recommendation of the Working Group that the NAIC approve the OSFI as a Recognize and Accept Jurisdiction and place it on the *NAIC List of Jurisdictions that Recognize and Accept the Group Capital Calculation*, to be effective immediately. Finally, the Working Group recommends that the Department of Insurance and Financial Services for the State of Michigan (DIFS) be the Lead State for purposes of regulatory cooperation and information sharing with the OSFI. These recommendations are based on the following analysis:

II. Procedural History

The Working Group is responsible for overseeing the process for evaluating jurisdictions and maintaining a listing of jurisdictions that meet the NAIC requirements for recognizing and accepting the US approach to the Group Capital Calculation (GCC). As background, on December 9, 2020, the NAIC adopted revisions to the NAIC *Insurance Holding Company System Regulatory Act* (#440) and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450). These revisions implement the GCC filing requirements for insurance groups at the level of the ultimate controlling person for the purpose of evaluating solvency at the group level. The revisions specifically provide that the requirement to file the NAIC’s GCC applies to U.S.-based groups, while a group headquartered outside the U.S. is exempt from the GCC (subject to limited exceptions) if its groupwide supervisor “recognizes and accepts” the GCC for U.S. groups doing business in that jurisdiction. Likewise, a U.S. group subject to a group capital calculation specified by the Federal Reserve Board is exempt from the GCC. This process codifies the concepts of mutual recognition and one group/one group-wide supervisor. To further implement the GCC provisions of Model #440 and Model #450, the Working Group adopted the *Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation* (Recognize and Accept Process) on December 15, 2021.

Section 4L(2) of Model #440 provides two ways a non-U.S. jurisdiction may meet the standards for its insurance groups to be exempt from the GCC:

- (a) If the jurisdiction has been determined to be a Reciprocal Jurisdiction for purposes of credit for reinsurance, which includes a requirement that the jurisdiction “recognizes the U.S. state regulatory approach to group supervision and group capital” or
- (b) If the jurisdiction has otherwise been determined to recognize and accept the GCC by procedures specified in regulation.

As of this date, the only jurisdictions that have been deemed to meet the standards are the current Reciprocal Jurisdictions (European Union member states, United Kingdom, Bermuda, Japan, and Switzerland).

On November 9, 2023, the DIFS requested that the Working Group perform a review of the OSFI under the NAIC Recognize and Accept Process, and further that the DIFS agreed to act as the Lead State. The relevant provisions with respect to the review procedure are summarized, as follows:

- The Working Group will follow the Procedure for Evaluation of Non-U.S. Jurisdictions as set forth in paragraph 8 of the Recognize and Accept Process. This will include public notice on the NAIC website, and consideration of public comments from state regulators, U.S. insurance groups, and any other interested parties. Relevant U.S. state and federal authorities will be notified of the Working Group's decision to evaluate the OSFI.
- Following these public actions, the Working Group will prepare a Preliminary Evaluation Report and Final Evaluation Report in regulator-to-regulator session, followed by a public Summary of Findings and Determination recommending that the OSFI be included on the list of Recognize and Accept Jurisdictions.
- The Working Group may rely on written confirmation by the OSFI that insurers and insurance groups whose lead state is accredited by the NAIC under the NAIC Accreditation Program shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the lead state and will not be subject to group supervision, including worldwide group governance, solvency and capital, and reporting, at the level of the worldwide parent undertaking of the insurance or reinsurance group by the non-U.S. jurisdiction. This may be done by signature to the letter template found in the Appendix of the Process. The Working Group will perform a due diligence review of available public and confidential documents to confirm that to the best of its determination the representations in the written confirmation are true and accurate.
- Finally, the OSFI and Michigan must have a memorandum of understanding to share applicable information with each other, which Michigan as the lead state would share with other NAIC states. Both the OSFI and DIFS are signatories to the IAIS Multilateral Memorandum of Understanding, which we have concluded to be satisfactory for these purposes.
- Upon the NAIC's adoption of an affirmative recommendation with respect to the Summary of Findings and Determination, the OSFI will be added to the NAIC List of Recognize and Accept Jurisdictions. Once approved, a Recognize and Accept Jurisdiction is subject to periodic annual review under an abbreviated process.

To conduct the review, NAIC staff reviewed any public information that was available, focusing on the *June 2019 International Monetary Fund (IMF) Financial System Stability Assessment (FSAP)* and the *January 2020 IMF FSAP Technical Note—Insurance Sector: Regulation and Supervision*. During the review, it was noted that the domestic financial regulator for insurance companies that are domiciled in Quebec is the Quebec Autorité des marchés financiers (AMF), while any companies domiciled in any of the other nine Canadian provinces are regulated by OSFI. The scope of this review only covers OSFI.

The review that was conducted only focused on any issues that would cause the jurisdiction to not meet the standards in Model #440 and Model #450 pertaining to the ability to recognize and accept the U.S. approach to the group capital calculation. During review of the IMF reports, there were no issues noted that would cause any concerns for the OSFI. In addition to the review performed by NAIC staff, the Working Group received a letter from OSFI dated April 9, 2024, confirming the following requirements in the Recognize and Accept Process:

- OSFI recognizes the U.S. state regulatory approach to group supervision and group capital, and confirms that that insurers and insurance groups whose lead state is accredited by the NAIC under the NAIC Accreditation Program shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the lead state and will not be subject to group supervision, including worldwide group governance, solvency and capital, and reporting, at the level of the worldwide parent undertaking of the insurance or reinsurance group by the non-U.S. jurisdiction.
- Information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to a lead state commissioner in accordance with a memorandum of understanding or similar document between the commissioner and OSFI, including but not limited to the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC.
- OSFI will immediately notify the NAIC upon any changes to the assurances provided in this letter.

III. Summary of Findings and Recommendation

Therefore, it is the recommendation of the Mutual Recognition of Jurisdictions (E) Working Group that the NAIC recognize the OSFI as a Recognize and Accept Jurisdiction and place it on the *NAIC List of Jurisdictions that Recognize and Accept the Group Capital Calculation*, to be effective immediately. Finally, the Working Group recommends that the Department of Insurance and Financial Services for the State of Michigan (DIFS) be the Lead State for purposes of regulatory cooperation and information sharing with the OSFI.