**SECTION 8E(4) SUGGESTED REVISIONS FROM JULY 15 MEETING**

(4) A policy that provides coverage on an expense-incurred basis for cancer-only coverage, or for cancer in combination with one or more other specified diseases, 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 $[X], an overall aggregate benefit limit of not less than $[X], and a benefit period of not less than three (3) years.

 (b) A policy must include at least the minimum benefits specified in this subparagraph. Coverage under clauses (i) - (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 out-patient basis:

(i) Treatment by, or under the direction of, a licensed physician, 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.”

 (ii) Tests, procedures, and other medical services and supplies used in diagnosis and treatment;

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

 (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;

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

 (vi) Durable medical equipment deemed necessary by the attending physician for the treatment of the disease;

 (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

 (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. 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 licensed 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) Home health includes, but is not limited to:

(I) Part-time or intermittent skilled nursing services provided by a registered nurse or a licensed practical nurse;

(II) 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) Physical, occupational or speech and hearing therapy; and

(IV) 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.

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

 (x) Special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, chux, oxygen, surgical dressings, rubber shields, colostomy and eleostomy appliances;

 (xi) Prosthetic devices including wigs and artificial breasts;

 (xii) Nursing home care for noncustodial services;

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

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

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(d) 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.