

**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS  
FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**

Draft: 5/28/21  
Model#171

The revisions to this draft reflect changes made from the existing model.

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

**Table of Contents**

|             |  |
|-------------|--|
| Section 1.  | Purpose  |
| Section 2.  | Authority  |
| Section 3.  | Applicability and Scope  |
| Section 4.  | Effective Date   |
| Section 5.  | Policy Definitions   |
| Section 6.  | Prohibited Policy Provisions   |
| Section 7.  | Supplementary and Short-Term Health Minimum Standards for Benefits                       |
| Section 8.  | Required Disclosure Provisions   |
| Section 9.  | Requirements for Replacement of Individual Supplementary and Short-Term Health Insurance |
| Section 10. | Separability   |

**Section 1. Purpose**

The purpose of this regulation is to implement [insert reference to state law equivalent to the NAIC *Supplementary and Short-Term Health Insurance Minimum Standards Model Act*] (the Act) to standardize and simplify the terms and coverages, to facilitate public understanding and comparison of coverage, to eliminate provisions that may be misleading or confusing in connection with the purchase, *renewal and continuation* of the coverages or with the settlement of claims and to provide for full disclosure in the marketing and sale of 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 coverage, and to provide for disclosure in the sale of those coverages.

**Section 2. Authority**



This regulation is issued pursuant to the authority vested in the commissioner under [insert reference to state law equivalent to NAIC *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 and group 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 *regardless of the situs of the delivery of the contract* on and after [insert effective date] that are not specifically exempted from this regulation. This regulation applies to short-term, limited-duration health insurance coverage delivered or issued for delivery in this state on and after [insert effective date], which, unless otherwise specified, is included in the definition of “short-term health insurance” under the Act.
- B. This regulation *applies* to limited scope dental coverage and limited scope vision coverage only as specified.

**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS  
FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**

C. This regulation shall not apply to:



- (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*];
- (2) Long-term care insurance policies subject to [insert reference to state law equivalent to the NAIC *Long-Term Care Insurance Model Act*]; or
- (3) TRICARE formerly known as Civilian Health and Medical Program of the Uniformed Services (Chapter 55, title 10 of the United States Code) (CHAMPUS) supplement insurance policies.

**Drafting Note:** TRICARE supplement insurance is not subject to federal regulation. TRICARE supplement policies are sold only to eligible individuals as determined by the Department of Defense and are tied to TRICARE benefits. In general, states regulate 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].

**Section 5. Policy Definitions**

A. Except as provided in this regulation, a supplementary or short-term health 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.

B. “Convalescent nursing home,” “extended care facility,” “skilled nursing facility,” “*assisted living facility*” or “*continued care retirement community*” shall be defined 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;



**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS  
FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**

- (d) 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 *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 *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.

D. “Hospital” may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission.

- (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” *is permitted but is not required to exclude*:
- (a) Convalescent homes or, convalescent, rest or nursing facilities;
  - (b) Facilities affording primarily custodial, educational or rehabilitary care;
  - (c) Facilities for the aged *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.

**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS  
FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**

- E. (1) “Injury” shall be defined as bodily injury resulting from an accident, independent of disease , which occurs while the coverage is in force.
- (3) The definition shall not use words such as “external, violent, visible wounds” or similar words of characterization or description.
- (4) 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.
- (5) 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.
- F. “Medicare” means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended.
- G. *“Mental health condition or substance use disorder” means any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of the Mental Disorders.*
- H. “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.

**NOTE: SECTION 5I BELOW IS TO BE MOVED TO SECTION 7.**

- I. “One period of confinement” *may be defined* 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.
- J. “Partial disability” shall be defined to mean that, due to a disability, an individual:
- (1) 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.
- K. (1) “Physician” may be defined by including words such as “qualified physician” or “licensed physician.” 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.

**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS**  
**FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**

- (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.

- L. "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.

- M. "Residual disability" shall be defined 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.
- N. "Sickness" shall not be defined to be more restrictive than the following: "Sickness means sickness 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." The definition may be further modified to exclude sickness or disease for which benefits are provided under a worker's compensation, occupational disease, employers' liability or similar law.
- O. "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.

**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS  
FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**

- (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. Prohibited Policy Provisions**

- A. Except as provided in Section 5K, a policy shall not contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy, subject to the further exception that a 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 reproduction organs, varicose veins, adenoids, appendix and tonsils. 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 *Supplementary and Short-Term Health 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.

- D. A disability income protection policy may contain a "return of premium" or "cash value benefit" 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.

**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS  
FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**

- E. Policies providing hospital indemnity or other fixed indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.
- F. A policy shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:
  - (1) Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;
  - (2) Mental or emotional disorders, alcoholism and drug addiction;
  - (3) Pregnancy, except for complications of pregnancy, other than for policies defined in Section 7C 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) Aviation;
    - (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 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 symptomatic complaints of the feet;
- (7) 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; benefits provided under Medicare or other governmental program (except Medicaid), a state or federal workmen’s 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

**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS  
FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**

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;
- (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.

**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.

- G. 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.
- H. 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 4B of the *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.

**Section 7. 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. 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 8H of this regulation.

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

A. General Rules

- (1) A “noncancellable,” “guaranteed renewable,” or “noncancellable and guaranteed renewable” individual supplementary or short-term health 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.
- (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 8A(1).
- (b) The terms “noncancellable” or “noncancellable and guaranteed renewable” may be used only in an individual supplementary or short-term health policy that the

**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS  
FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**

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 supplementary or short-term health 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 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) Except as provided above, 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.
- (3) In an individual supplementary or short-term health policy covering both husband and wife, 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:** For Paragraphs (2) and (3) above, coverage as defined under HIPAA or applicable state law must be guaranteed renewable except for reasons stated in Part B Section 2742 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, the ACA or applicable state law.

- (4) When accidental death and dismemberment coverage is part of the individual supplementary or short-term health 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 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 condition the benefits upon admission to the convalescent or extended care facility within a period of less than fourteen (14) days after discharge from the hospital.
- (8) In individual 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 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 the date the company receives due proof of the

**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS  
FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**

incapacity 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 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 to 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 fractures or dislocations may not provide benefits only for “full or complete” fractures or dislocations.

**B. Hospital Indemnity or Other Fixed Indemnity Coverage**

- (1) “Hospital indemnity or other fixed indemnity coverage” is a policy of supplementary health insurance that provides daily benefits for hospital confinement 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.

**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS  
FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**

- (2) 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 indemnity or other fixed indemnity coverage is recognized as supplemental coverage. Any hospital 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 indemnity or other fixed indemnity coverage. Section 3H(4) of the *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 indemnity or other fixed indemnity coverage purchased by the insured.

C. Disability Income Protection Coverage

“Disability income protection coverage” is a policy that provides for periodic payments, weekly or 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);
- (2) Contains an elimination period no greater than:
  - (a) Ninety (90) days in the case of a coverage providing a benefit of one year or less;
  - (b) 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
  - (c) Three hundred 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 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;
- (4) Where a policy provides total disability benefits and partial disability benefits, only one elimination period may be required.

D. Accident Only Coverage

**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS  
FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**

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

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 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 diseases but also for any other conditions or diseases, directly caused or aggravated by the specified diseases or the treatment of the specified disease.
- (d) Individual supplementary or short-term health insurance 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.

**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS  
FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**

- (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 for specified disease coverage shall be paid regardless of other coverage.

**Drafting Note:** Specified disease coverage is recognized as supplemental 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 *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" or substantially similar language should be used that does not have the misleading or deceptive effect of the phrase "actual charges."
- (k) "Preexisting condition" shall not be defined to be more restrictive than the following: "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 preexisting condition is specifically excluded.
- (m) Hospice Care.
  - (i) "Hospice" means a facility 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:

**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS  
FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**

- (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 per day; and
  - (III) A lifetime maximum benefit limit of at least \$10,000.
- (iii) Hospice care does not cover nonterminally 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 treatment for persons suffering from mental diseases or disorders or care for the aged or substance abusers.
- (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] and an overall aggregate benefit limit of no less than [\$10,000] 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 physician or surgeon;
  - (iii) Private duty services of a registered nurse (R.N.);
  - (iv) X-ray, radium and other therapy procedures used in diagnosis and treatment;
  - (v) Professional ambulance for local service to or from a local hospital;
  - (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) Braces, crutches and wheel chairs as are deemed necessary by the attending physician for the treatment of the disease;
  - (x) 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

**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS  
FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**

- (xi) 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] payable at the rate of not less than [\$50] a day while confined in a hospital and a benefit period of not less than 500 days.
- (4) A policy that provides coverage for each insured person for cancer-only coverage or in combination with one or more other specified diseases on an expense incurred basis for services, supplies, care and treatment of cancer, in amounts not in excess of the usual and customary charges, with a deductible amount not in excess of [\$250], and an overall aggregate benefit limit of not less than [\$10,000] and a benefit period of not less than three (3) years shall provide at least the following minimum provisions:
  - (a) Treatment by, or under the direction of, a legally qualified physician or surgeon;
  - (b) X-ray, radium chemotherapy and other therapy procedures used in diagnosis and treatment;
  - (c) Hospital room and board and any other hospital furnished medical services or supplies;
  - (d) Blood transfusions and their administration, including expense incurred for blood donors;
  - (e) Drugs and medicines prescribed by a physician;
  - (f) Professional ambulance for local service to or from a local hospital;
  - (g) Private duty services of a registered 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) Braces, crutches and wheelchairs deemed necessary by the attending physician for the treatment of the disease;
  - (j) 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) (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:

**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS  
FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**

- (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) 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.

- (l) Physical, speech, hearing and occupational therapy;
- (m) Special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, chux, oxygen, surgical dressings, rubber shields, colostomy and eleostomy appliances;
- (n) Prosthetic devices including wigs and artificial breasts;
- (o) Nursing home care for noncustodial services; and
- (p) Reconstructive surgery when deemed necessary by the attending physician.

**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] for each day of hospital confinement for at least [365] days;

**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS  
FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**

- (ii) A fixed-sum payment equal to one half 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 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 in a skilled nursing home or to receipt of home health care are optional. If a policy offers these benefits, they must equal the following:
  - (i) A fixed-sum payment equal to one-fourth 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 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 of 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.

**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.

- (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 of clearly identifiable subtypes with significantly lower treatments costs, lesser amounts may be payable so long as the policy clearly differentiates that subtype and its 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.

**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS  
FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**

F. 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] for accidental death, [\$1,000] for double dismemberment [\$500] for single dismemberment.

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, D, E, and F. These policies or contracts may be delivered or issued for delivery in this state only if the outline of coverage required by Section 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 7E and shall not be offered for sale as a “limited 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 long-term care insurance plans, and should be subject to the *Limited Long-Term Care Insurance Model Act* (#642) and its implementing regulation, the *Limited Long-Term Care Insurance Model Regulation* (#643).

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

**Section 8. Required Disclosure Provisions**

A. General Rules

- (1) All applications for coverages specified in Section 7B, C, D, E, F, G and H 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 limited benefits. Review your [policy][certificate] carefully.”

- (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.”

**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS  
FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**

- (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.”
- (4) Each policy of individual 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) 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 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 to group supplemental health insurance certificates only where the certificateholder also pays the insurance premium.
- (6) 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.
- (7) 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 an explanation of the terms in its accompanying outline of coverage.
- (8) If a policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and be labeled as “Preexisting Condition 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) All policies and certificates, except single-premium nonrenewable policies and as otherwise provided in this paragraph, shall have a notice prominently printed on the first

**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS  
FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**

page of the policy or certificate or attached to it stating in substance that the policyholder or certificateholder 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 certificateholder is not satisfied for any reason.

**Drafting Note:** This section should be included only if the state has legislation granting authority.

- (11) If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy or certificate as originally issued, that fact shall be prominently set forth in the outline of coverage.
- (12) 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 persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised. The provision shall 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) (a) Outlines of coverage delivered in connection with policies defined in this regulation as hospital indemnity or other fixed indemnity (Section 7B), specified disease (Section 7E), or limited benefit health coverages (Section 7G) to persons eligible for Medicare by reason of age shall contain, in addition to the requirements of Subsections D and F, the following language, which shall be printed on or attached to the first page of the outline of coverage:

This IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from the company.
- (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*].
- (14) 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.
- (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.

**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS  
FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**

- (16) (a) All hospital indemnity or other fixed 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 policythe following:

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

- (b) For all “hospital indemnity or other fixed indemnity” products sold in the individual market, a notice must be displayed prominently in the application materials in at least 14 point type that has the following language: “THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE.”

- (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 limited scope dental coverage 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.”

- (19) All limited scope vision coverage 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 supplementary and short-term health insurance, limited scope dental coverage and limited scope vision coverage 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 type, immediately above the company name:

**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS  
FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**

“NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon [application][enrollment], and the coverage originally applied for has not been issued.”

- (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.
- (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.

D. Hospital 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 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]

HOSPITAL INDEMNITY [OR OTHER FIXED INDEMNITY] COVERAGE

THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS

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

OUTLINE OF COVERAGE

- (1) Read Your [Policy][Certificate] Carefully—This outline of coverage provides a very brief description of the important feature of coverage. 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) Hospital indemnity or other fixed indemnity coverage is designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for any benefits other than the fixed daily indemnity for hospital services and any additional benefit described below.
- (3) [A brief specific description of the benefits in the following order:

**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS  
FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**

- (a) Daily benefit payable during hospital confinement; and
- (b) Duration of benefit described in (a).]

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

- (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 benefit, 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.]
- (6) [Any benefits provided in addition to the daily hospital benefit.]

E. Disability Income Protection 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]

DISABILITY INCOME PROTECTION 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) Disability income protection coverage is designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.
- (3) [A brief specific description of the benefits contained in this policy.]

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

**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS  
FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**

- (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.]

F. Accident-Only 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 7D 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

OUTLINE OF COVERAGE

- (1) Read Your [Policy][Certificate] Carefully—This outline of coverage provides a very brief description of the important features of the coverage. 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) Accident-only coverage is designed to provide, to persons insured, coverage for certain losses resulting from a covered accident ONLY, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.
- (3) [A brief specific description of the benefits.]

**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 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 reservations of right to change premiums.]

G. 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 7E and F 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:

**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS  
FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**

[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

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.
- (2) Read Your [policy] [certificate] [Outline of Coverage] Carefully—This outline of coverage provides a very brief description of the important features of coverage. 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!
- (3) [Specified disease][Specified accident] coverage is designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of [specified diseases] or [specified accidents]. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.
- (4) [A brief specific description of the benefits, including dollar amounts.]

**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.

H. 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 7B, D and G 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

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!

**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS  
FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**

- (2) Limited benefit health coverage is designed to provide, to persons insured, limited or supplemental coverage.
- (3) [A brief specific description of the benefits, including dollar amounts.]

**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 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 description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

**I. Limited Scope Dental Coverage (Outline of Coverage)**

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

- (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) [A brief specific description of the benefits.]
- (3) [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 (1) above.]
- (4) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

**J. Limited Scope Vision Coverage (Outline of Coverage)**

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

- (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) [A brief specific description of the benefits.]

**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS  
FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**

- (3) [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 (1) above.]
- (4) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

**Section 9. Requirements for Replacement of Individual Supplementary and Short-Term Health Insurance Coverage**

- 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 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, however, will the notices be required in the solicitation of the following types of policies: accident-only 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 SUPPLEMENTARY OR SHORT-TERM HEALTH INSURANCE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing supplementary or short-term health insurance and replace it with a policy to be issued by [insert company name] Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

- (1) Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. 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.

**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 regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
- (3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concern your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After

**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS  
FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**

the application has been completed 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 SUPPLEMENTARY OR SHORT-TERM HEALTH INSURANCE

According to [your application] [information you have furnished] you intend to lapse or otherwise terminate existing supplementary or short-term health insurance and replace it with the policy delivered herewith issued by [insert company name] Insurance Company. Your new policy provides thirty days within which you may decide without cost whether you desire to keep the policy. For your own information and protection you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

- (1) Health conditions that you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. 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.
- (2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present 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 policy and replace it with new coverage, read the copy of the 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 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 the application.

[COMPANY NAME]

**Section 10. 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.

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**WORKING DRAFT REFLECTING SUBGROUP DISCUSSIONS  
FROM ITS SEPT. 16, OCT. 7, OCT 28., NOV. 4, NOV. 19 AND DEC. 16, 2019, MEETINGS**