

MODEL REGULATION TO IMPLEMENT THE ACCIDENT AND SICKNESS 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 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 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. This regulation is also intended to assert the commissioner’s jurisdiction over dental and vision plans, and to provide for disclosure in the sale of those plans.

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 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 policies and certificates, delivered or issued for delivery in this state on and after [insert effective date] that are not specifically exempted from this regulation.
- B. This Act shall apply to dental plans and vision plans 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) 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) Long-term care insurance policies subject to [insert reference to state law equivalent to the NAIC Long-Term Care Insurance Model Act]; or
- (5) Civilian Health and Medical Program of the Uniformed Services (Chapter 55, title 10 of the United States Code) (CHAMPUS) supplement insurance policies.

Drafting Note: CHAMPUS supplement insurance is not subject to federal regulation. CHAMPUS supplement policies are sold only to eligible individuals as determined by the Department of Defense and are tied to CHAMPUS benefits. In general, states regulate CHAMPUS 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, an individual accident and sickness insurance policy or group supplemental 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.
 - (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.
- C. “Convalescent nursing home,” “extended care facility,” or “skilled nursing facility” 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 benefits or be qualified to receive approval for payment of Medicare 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 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:
 - (a) A home, facility or part of a home or facility used primarily for rest;
 - (b) A home or facility for the aged or for the care of drug addicts or alcoholics; 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 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 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:
 - (a) Convalescent homes or, convalescent, rest or nursing facilities;
 - (b) Facilities affording primarily custodial, educational or rehabilitary care;
 - (c) Facilities for the aged, drug addicts or alcoholics; 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. “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.
- G. “Nurse” may be defined so that the description of nurse is restricted to a type of nurse, such as registered nurse, a licensed practical nurse, or a licensed vocational nurse. If the words “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.

- 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 the individual’s inability to perform one or more but not all of the “major,” “important” or “essential” duties of employment or occupation, or may be related to a percentage of time worked or to a specified number of hours or to compensation.
- J. “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.

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 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 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.
- 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. 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 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.

- D. A disability income 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.

- E. Policies providing hospital confinement 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 7H 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 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 effect 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 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.

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

- 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 3B of the Accident and Sickness 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. Accident and Sickness 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 health insurance policy 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 8L 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 5A and B of the NAIC Accident and Sickness Insurance Minimum Standards Model Act].

A. General Rules

- (1) A “noncancellable,” “guaranteed renewable,” or “noncancellable and guaranteed renewable” individual accident and sickness 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 accident and sickness 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) 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 accident and sickness 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 or applicable state law.

- (4) When accidental death and dismemberment coverage is part of the individual accident and sickness 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 accident and sickness 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 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 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 ~~of~~ 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. 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.

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.

D. Hospital Confinement Indemnity Coverage

- (1) “Hospital confinement indemnity coverage” is a policy of accident and sickness 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.
- (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 confinement indemnity coverage is recognized as supplemental coverage. Any hospital confinement 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 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 coverage purchased by the insured.

E. 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.

F. 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.

G. 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. Section 7F does not apply to those policies providing business buy-out coverage;
- (4) Where a policy provides total disability benefits and partial disability benefits, only one elimination period may be required.

H. Accident Only Coverage

“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].

I. 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 accident and sickness 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.

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.

- (f) 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.
- (g) 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 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.

- (h) 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.
- (i) 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."
- (j) "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."
- (k) 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.
- (l) 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:
 - (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
 - (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:
 - (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 ileostomy 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;
 - (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.

J. 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.

K. 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, 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 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 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 benefit health plans, and should be subject to the NAIC Accident and Sickness Insurance Minimum Standards Model Act and implementing regulation.

Section 8. Required Disclosure Provisions

A. General Rules

- (1) All applications for coverages specified in Sections 7B, C, D, E, G, I, J, K and L 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."
- (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 accident and sickness insurance and group supplemental health insurance 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 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 confinement indemnity (Section 7E), specified disease (Section 7J), or limited benefit health coverages (Section 7L) to persons eligible for Medicare by reason of age shall contain, in addition to the requirements of Subsections F and J, 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 a 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 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:

“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) 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) 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.
- (5) 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

- (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 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.]

F. Hospital Confinement 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 7E 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

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 confinement 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 confinement and any additional benefit described below.
- (3) [A brief specific description of the benefits in the following order:
 - (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.]

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.]

I. 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 7H 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.

- (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.]

J. 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 7I 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.]

K. 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 7J and K 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**

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.

L. 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, 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

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) 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.]

M. Dental Plans (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.]

N. Vision Plans (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.]
- (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 Accident and Sickness Insurance

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 insurance 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 ACCIDENT AND SICKNESS INSURANCE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness 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 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 ACCIDENT AND SICKNESS INSURANCE**

According to [your application] [information you have furnished] you intend to lapse or otherwise terminate existing accident and sickness 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.

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

1975 Proc. I 2, 6, 573, 575, 590-605 (adopted).

1977 Proc. I 26, 28, 54-77, 317, 325 (amended).

1979 Proc. II 31, 34, 327, 333, 339-344 (amended regarding Medicare supplement insurance).

1980 Proc. II 22, 26, 588, 591, 594, 622, 634-636 (amended).

1989 Proc. II 13, 23-24, 467-468, 518-519, 548-570 (amended to remove reference to Medicare supplement insurance).

1998 Proc. 4th Quarter 16, 17, 652, 654, 660-687 (amended and reprinted).

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**MODEL REGULATION TO IMPLEMENT THE ACCIDENT AND SICKNESS
INSURANCE MINIMUM STANDARDS MODEL ACT**

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state’s activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column or Related State Activity column based on the definitions listed below. The NAIC’s interpretation may or may not be shared by the individual states or by interested readers.

This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.

**MODEL REGULATION TO IMPLEMENT THE ACCIDENT AND SICKNESS
INSURANCE MINIMUM STANDARDS MODEL ACT**

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**MODEL REGULATION TO IMPLEMENT THE ACCIDENT AND SICKNESS
INSURANCE MINIMUM STANDARDS MODEL ACT**

KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

RELATED STATE ACTIVITY: Examples of Related State Activity include but are not limited to: older versions of the NAIC model, statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column **only** (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner**.

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

| NAIC MEMBER | MODEL ADOPTION | RELATED STATE ACTIVITY |
|----------------------|--|---|
| Alabama | NO CURRENT ACTIVITY | |
| Alaska | NO CURRENT ACTIVITY | |
| American Samoa | NO CURRENT ACTIVITY | |
| Arizona | NO CURRENT ACTIVITY | |
| Arkansas | ARK. CODE R. 18 (1981/2003). | |
| California | CAL. CODE REGS. tit. 10, §§ 2540 to 2540.7 (1976) (portions of model). | CAL. CODE REGS. tit. 10, §§ 2219 to 2220.31 (1972). |
| Colorado | NO CURRENT ACTIVITY | |
| Connecticut | CONN. AGENCIES REGS §§ 38a-505-1 to 38a-505-12 (1979/2013). | |
| Delaware | NO CURRENT ACTIVITY | |
| District of Columbia | NO CURRENT ACTIVITY | |
| Florida | FLA. ADMIN. CODE ANN. r. 69O-154.102 to 69O-154.107 (1975/2003). | |

**MODEL REGULATION TO IMPLEMENT THE ACCIDENT AND SICKNESS
INSURANCE MINIMUM STANDARDS MODEL ACT**

| NAIC MEMBER | MODEL ADOPTION | RELATED STATE ACTIVITY |
|--------------------|--|--|
| Georgia | NO CURRENT ACTIVITY | |
| Guam | NO CURRENT ACTIVITY | |
| Hawaii | NO CURRENT ACTIVITY | |
| Idaho | IDAHO ADMIN. CODE r. 30.18.01.30 (1981/2001). | |
| Illinois | ILL. ADMIN. CODE tit. 50, §§ 2007.10 to 2007.100 (1978/2014). | |
| Indiana | NO CURRENT ACTIVITY | |
| Iowa | IOWA ADMIN. CODE r. 191-36.1 to 191-36.12 (1981/2007). | |
| Kansas | NO CURRENT ACTIVITY | KAN. ADMIN. REGS. §§ 40-4-22 to 40-4-33 (1975/1986). |
| Kentucky | | 806 K.Y. ADMIN. REGS. 17:500 (2005/2008). |
| Louisiana | NO CURRENT ACTIVITY | |
| Maine | 755 ME. CODE R. (2004). | |
| Maryland | NO CURRENT ACTIVITY | |
| Massachusetts | 211 MASS. CODE REGS. 42.01 to 42.99 (1974/2003) (portions of model). | |
| Michigan | NO CURRENT ACTIVITY | |
| Minnesota | NO CURRENT ACTIVITY | |
| Mississippi | NO CURRENT ACTIVITY | |
| Missouri | NO CURRENT ACTIVITY | |
| Montana | NO CURRENT ACTIVITY | |

**MODEL REGULATION TO IMPLEMENT THE ACCIDENT AND SICKNESS
INSURANCE MINIMUM STANDARDS MODEL ACT**

| NAIC MEMBER | MODEL ADOPTION | RELATED STATE ACTIVITY |
|--------------------|---|--|
| Nebraska | NO CURRENT ACTIVITY | |
| Nevada | NO CURRENT ACTIVITY | |
| New Hampshire | | N.H. CODE ADMIN. R. ANN. INS. 1902.07 (2006) |
| New Jersey | N.J. ADMIN. CODE §§ 11:4-16.1 to 11:4-16.11 (1981/2012). | |
| New Mexico | NO CURRENT ACTIVITY | |
| New York | N.Y. COMP. CODES R. & REGS. tit. 11, §§ 52.1 to 52.17; §§ 52.54. to 52.63 (Regulation 62) (1983/2008). | |
| North Carolina | NO CURRENT ACTIVITY | |
| North Dakota | NO CURRENT ACTIVITY | |
| Northern Marianas | NO CURRENT ACTIVITY | |
| Ohio | NO CURRENT ACTIVITY | |
| Oklahoma | OKLA. ADMIN. CODE §§ 365:10-5-1 to 365:10-5-8 (1981/2005) (Does not contain outline of coverage forms). | |
| Oregon | NO CURRENT ACTIVITY | |
| Pennsylvania | PA. CODE §§ 88.131 to 88.195 (1982/1989). | |
| Puerto Rico | NO CURRENT ACTIVITY | |
| Rhode Island | R.I. CODE R. 27-23-701 to 27-23-708 (1978). | |
| South Carolina | S.C. CODE ANN. REGS. 69-34 (1981/1989). | |
| South Dakota | NO CURRENT ACTIVITY | |

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| NAIC MEMBER | MODEL ADOPTION | RELATED STATE ACTIVITY |
|----------------|---|---|
| Tennessee | NO CURRENT ACTIVITY | |
| Texas | TEX. ADMIN. CODE §§ 3.3001 to 3.3111 (1977/1997). | |
| Utah | UTAH ADMIN. CODE r. 590-126 (1989/2009). (Also applies to long-term care and Medicare supplement policies). | |
| Vermont | 80 VT. CODE R. § 1 (1980/1989). | |
| Virgin Islands | NO CURRENT ACTIVITY | |
| Virginia | 14 VA. ADMIN. CODE §§ 5-140-10 to 5-140-100 (1989). | |
| Washington | WASH. ADMIN. CODE 284-50-300 to 284-50-435 (1977/1987). | |
| West Virginia | W. VA. CODE R. §§ 114-12-1 to 114-12-8 (1974/1999). | W. VA. CODE R. §§ 114-39-1 to 114-39-7 (1994/2003). |
| Wisconsin | | WIS. ADMIN. CODE INS. § 3.13 (1982/2009); § 3.28 (1974/1999); § 3.29 (1974/2009). |
| Wyoming | NO CURRENT ACTIVITY | |

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The first model adopted contained provisions only applicable to individual policies. An interested party commented in support of this decision because there were already procedures and practices in place to adequately inform an employer or member of a group as to the scope and extent of group coverage. **1974 Proc. I 424.**

When the first draft of the regulation was distributed for comments, interested parties expressed concern about regulatory authority to require or prohibit certain provisions or benefits. **1974 Proc. II 485.**

When a group was appointed in 1997 to review the model, the members proposed amendments in several areas. They discussed the addition of group insurance provisions to the NAIC Individual Accident and Sickness Insurance Model Act and Regulation, extension of disclosure requirements, addition of clarifying drafting notes, adjustment to the models necessitated by the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and modernization of model language. In addition, the group discussed updating minimum benefit standards. **1997 Proc. 3rd Quarter 1278.**

Section 1. Purpose

The provisions of Section 1 were included in the original model adopted in 1973. **1975 Proc. I 590.**

The drafting group reviewing the model act and regulation in 1998 sought to standardize the use of the word “group.” The goal was to clarify that the model act and regulation covered individual major medical and supplemental policies and group supplemental policies. The model act and regulation were not intended to govern group major medical products. A regulator had expressed concern that basic hospital and surgical coverages were being sold through associations in a way that misled consumers into thinking the products provided more benefits than they actually covered. This issue was addressed in the draft model regulation through required disclosures in the outline of coverage for group basic hospital and surgical products. **1998 Proc. 1st Quarter 807.**

Section 2. Authority

This provision was included in the original model adopted in 1973, with only technical amendments since. **1975 Proc. I 590.**

Section 3. Applicability and Scope

A. Some of the language from this section was included in the original model adopted in 1974, including most of Subsection A. **1975 Proc. I 590.**

B. The issue of whether dental plans should be excluded from the models was considered by the drafting group. Staff said that there were no other model acts that addressed minimum standards for dental plans. A regulator said that dental plans were gaining in importance and, short of setting up a new dental plan working group, he recommended including them in these models. Another regulator observed that dental plans had not caused much concern. She felt that they fit here and they might as well be left in. **1998 Proc. 1st Quarter 807.**

The issue was discussed again prior to the next meeting, and the drafters agreed that dental and vision plans were not susceptible to the same kinds of problems as other limited benefit health plans; that is, consumers were generally aware of the scope of their coverage and did not suffer from the misconception that they had comprehensive health coverage. However, since these forms of coverage were not regulated elsewhere, the group decided to keep dental and vision plans within the scope of this model act. The group agreed that the disclosure requirements for limited benefit health plans were not appropriate for dental or vision plans and, therefore, decided to exempt these plans from the specific notice requirements of the act and regulation. However, these plans would still be required to provide outlines of coverage. **1998 Proc. 2nd Quarter II 756.**

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Section 3 (cont.)

C. A regulator suggested that the working group should consider specifically excluding long-term care insurance and credit insurance from the model. **1997 Proc. 4th Quarter II 836.**

At the next meeting, the group reported that the Minimum Standards Act and Regulation specifically excluded products that were regulated under the NAIC Long-Term Care Insurance Model Act and Regulation. This raised the question as to whether the Long-Term Care Insurance Model Act and Regulation included policies that covered home health care (including stand-alone home health policies) or policies that covered less than one year of benefits. Staff reported that stand-alone home health coverage was included under the Long-Term Care Insurance Model Act and Regulation as long as the duration of the coverage was at least 12 months. With respect to coverage with a duration of less than 12 months, the drafting group agreed that it would be considered limited benefit health coverage under the Minimum Standards Act and Regulation. Some members of the group indicated that a stand-alone home health benefit (or any “long-term care type coverage”) of less than 12 months would not be allowed because it did not meet the definition of long-term care insurance; others indicated that it would be regulated as limited benefit health coverage. The group agreed to include a drafting note in the Minimum Standards Act and Regulation indicating that if a state allowed a long-term care product of less than one year, then it should be considered a limited benefit health plan. **1998 Proc. 2nd Quarter II 756.**

An interested party asked that Civilian Health and Medical Plan for the Uniformed Services (CHAMPUS) plans be excluded from applicability from the models. He stated that these products were similar in structure to Medicare supplement insurance, and they should be treated as such. The working group recommended that the exclusion be placed in the next draft. **1997 Proc. 4th Quarter II 836.**

At its prior meeting, the drafting group had decided to exclude CHAMPUS supplement insurance from the models. However, the regulators wanted to confirm that these products were subject to some regulation. They researched the issue and discovered that CHAMPUS supplement insurance was not regulated on the federal level. In many instances, states regulated them as group products through filing requirements. An interested party stated that members of his association were of the opinion that CHAMPUS supplement plans were regulated as group plans, the products were filed with state insurance departments, and the products were primarily sold through associations of CHAMPUS-eligible individuals. Because there had been few reports of problems with CHAMPUS supplement plans, the drafters recommended excluding these products from the drafts and suggested that states be alerted to this issue through a drafting note. There were no objections to the drafting note from the working group or interested parties. **1998 Proc. 1st Quarter 807.**

Section 4. Effective Date

The original model contained language regarding the model’s applicability that was deleted in the 1998 amendments. **1998 Proc. 4th Quarter II 661.**

Section 5. Policy Definitions

- A. Subsection A was included in the original model in nearly the same form as it currently appears. **1975 Proc. I 590.**
- B. Subsection B was included in the original model in nearly the same form as it currently appears. **1975 Proc. I 590.**
- C. Subsection C was included in the original model in nearly the same form as it currently appears. **1975 Proc. I 590.**
- D. Subsection D was included in the original model in nearly the same form as it currently appears. **1975 Proc. I 590.**

A consumer advocate raised the issue of how a hospital is defined. She stated that in some cases, a hospital is able to change the designation of a bed, known as a “swing bed.” This could occur when the hospital is designated as both an acute care and long-term care facility. She gave an example about a bed in which an insured was confined. The bed was redesignated as a long-term care bed during the insured’s hospital stay. The newly designated bed was not covered by the insured’s medical policy, resulting in a situation where the insured now owed money, but never left the hospital bed. A regulator suggested that

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this might be a nursing home issue. The consumer advocate responded that the policy of designating beds as swing beds was resulting in insureds becoming discharged sooner. She stated that this was particularly evident when an insured moved from acute care to subacute care. She also said that in hospital indemnity policies, there was often an exclusion for skilled nursing care. When beds that were designated as acute care were subsequently designated as skilled nursing beds, but the insured never moves from the bed, the result may be that the care would not be paid for by the insurance policy. **1997 Proc. 3rd Quarter 1278.**

E. In 1978 a task force working on issues related to senior citizens recommended including provisions in regard to Medicare and Medicare supplements in the model regulation. Extensive provisions were adopted in regard to the standards for Medicare supplement policies. **1979 Proc. II 339-344.**

In 1989 technical amendments were made to the model to delete obsolete references to Medicare supplement. A separate model on Medicare coverage had been adopted. **1989 Proc. II 518-519.**

G. Subsection G was included in the original model in nearly the same form as it currently appears. **1975 Proc. I 590.**

H. This definition was added in 1976 without recorded discussion. It replaced a definition of continuous hospital confinement that had been included in the original model regulation. **1977 Proc. I 55.**

I. Subsection I was included in the original model in nearly the same form as it currently appears. **1975 Proc. I 590.**

J. Subsection J was included in the original model in nearly the same form as it currently appears. **1975 Proc. I 590.**

K. In the context of “updating” the models, the working group agreed to conform the look-back period for preexisting conditions for all plans to two years. At the prior meeting, industry representatives indicated that this change raised many complex issues with respect to disability income coverage. The drafting group received reports from an industry trade association with respect to the issues raised by changing the look-back period from five years to two years for disability income products. Based on the information provided, the group was not convinced that disability income should be treated any differently than other products covered by the regulation and recommended the conformed look-back period. **1998 Proc. 2nd Quarter II 756.**

L. This definition was added in 1976 without recorded discussion. **1977 Proc. I 58.**

M. Subsection M was included in the original model in nearly the same form as it currently appears. **1975 Proc. I 590.**

N. Subsection N was included in the original model in nearly the same form as it currently appears. **1975 Proc. I 590.**

Section 6. Prohibited Policy Provisions

A. The language of Subsection A has seen only technical changes from that included in the very first model regulation. **1975 Proc. I 593.**

B. The language originally adopted included only the first sentence of Paragraph (1). The additional language of that paragraph and the provisions of Paragraph (2) were added in 1976 without recorded discussion. **1977 Proc. I 58.**

The drafting group reviewed the section of the model regulation that addressed return of premium riders. The chair said that the model disallowed the use of return of premium riders with all products, with the exception that return of premium riders were allowable with disability income products. **1997 Proc. 4th Quarter II 836.**

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C. The text of Subsection C was included in the original model in much the same form as it currently appears. **1975 Proc. I 593.**

D. The text of Subsection D was included in the original model in much the same form as it currently appears. **1975 Proc. I 593.**

The drafting group reviewed the section of the model regulation that addressed return of premium riders. The chair said that the model disallowed the use of return of premium riders with all products, with the exception that return of premium riders were allowable with disability income products. **1997 Proc. 4th Quarter II 836.**

E. This subsection has not changed since its original adoption. **1975 Proc. I 593.**

F. This subsection first appeared in the 1976 version of the model. **1977 Proc. I 59-60.**

A regulator asked about the exception to pre-existing conditions exclusions. Specifically, he asked about the reference to carpal tunnel and chronic fatigue syndrome. The chair of the drafting group said that these exclusions were common in product filings. A regulator asked if it was because these conditions lend themselves to faking of injuries. An interested party stated that these conditions were difficult to deal with at claim time. He said that the insurance company should have some control or limit benefits for those conditions. **1997 Proc. 4th Quarter II 837.**

The drafting group discussed the exclusion for carpal tunnel and chronic fatigue syndromes. It was agreed that there currently was not sufficient information to address the issue. While there was consensus that these conditions were subject to fraud, there was also concern that some claims were legitimate. Disability insurance or workers' compensation may cover some of the claims, but insufficient data was available. **1998 Proc. 1st Quarter 812.**

The next draft included language to allow limitations or exclusions for disability income products for incarceration, carpal tunnel and chronic fatigue syndrome. The drafting group agreed that it was reasonable to allow incarceration as an exclusion from disability income insurance, but were not persuaded, despite information from industry representatives, to allow exclusions or limitations for chronic fatigue and carpal tunnel syndromes. While industry representatives emphasized that the cost of these claims was significant and subject to fraud, the consensus of the regulators was that if industry investigated claims adequately, the risk of fraud was limited. A regulator questioned why these conditions should be treated differently than other disabling conditions, based only upon the perception of the insurer that such claims were more subject to fraud and were costly. There was not consensus among the drafting group members with respect to this issue. **1998 Proc. 2nd Quarter II 757.**

At the next meeting, the working group again discussed the appropriate treatment for carpal tunnel and chronic fatigue syndromes under a disability income policy. An interested party noted that experts do not agree on when a person is disabled by chronic fatigue syndrome or when a person can return to work. The working group decided to add carpal tunnel and chronic fatigue syndromes as allowable exclusions or limitations under a disability income policy. A regulator questioned whether the group should allow these exclusions simply because they might not be fully understood. Another responded that chronic fatigue syndrome in particular is susceptible to fraud. Another member of the drafting group expressed the concern that companies could label something as chronic fatigue syndrome and exclude it. An interested party stated that medical professionals believe the syndromes exist and that insurance companies have many resources to deal with malingerers. Two separate motions to allow carpal tunnel and chronic fatigue syndromes as allowable exclusions or limitations under a disability income policy passed. Neither motion passed unanimously. **1998 Proc. 3rd Quarter 578-579.**

When the parent committee was considering adoption of the model, one commissioner questioned why carpal tunnel and chronic fatigue syndromes were allowed as exclusions in disability income insurance policies under the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act. He said it was best left to the states to determine exclusions of particular diseases under specific policies. The working group chair stated that this issue had been the subject of lengthy discussions at the working group level and there had been testimony by company representatives that

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the percentage of cases with these two syndromes was increasing. It was a concern of the majority of the working group members that consumers would take advantage of these diseases to make claims under a policy; that the potential for fraud with these two syndromes was high. The commissioner reflected that there was a transitory value to that type of thinking and that there may be new diseases that crop up next year that could be subject to fraud or abuse. He believed it should be left at the state level. Another commissioner wondered whether company representatives were arguing that these syndromes are not legitimate diseases. The working group chair replied affirmatively; the difficulty of diagnosis is an issue for the companies. An interested party stated that these diseases were legitimate, but with chronic fatigue syndrome in particular, medical experts disagree on what it is. She stated that not every company will choose to have those exclusions in its policies. She also noted that carpal tunnel syndrome was often work-related, and more often than not the consumer might have other coverage, such as workers' compensation coverage. One commissioner stated that he was quite concerned about the message it would send if these exclusions were in an NAIC model act, and that it could be perceived that the NAIC was saying these were not legitimate diseases. The parent committee voted amend the model to take out those specific exclusions and substitute a drafting note about conditions that are difficult to diagnose and subject to frequent claims. **1998 Proc. 4th Quarter II 651.**

G. This subsection first appeared in 1976 without recorded discussion. **1977 Proc. I 60.**

H. This provision first appeared in the original model in nearly the same form as the current version. **1975 Proc. I 593.**

Section 7. Accident and Sickness Minimum Standards for Benefits

The drafting group discussed updating minimum benefit limits for hospital indemnity policies and other limited benefit insurance plans. One regulator expressed concern about the minimum benefits of some plans being too small to be of any value to the policyholder. He suggested that the drafting group look at significant changes to major medical policy minimums. The group looked at the example of the lifetime maximum of only \$10,000 for a major medical policy as one that might be too small to be of consequence. A regulator asked why, in the context of limited benefit insurance, major medical health insurance was mentioned. The chair explained that if a policy's benefits were below those of a major medical or basic hospital insurance policy, then those plans were considered limited benefit plans by definition. In the NAIC model, the benefits or major medical, basic hospital or basic surgical policies were integrated, so if one of the pieces was removed, the policy then became a limited benefit plan. A consumer advocate expressed concern about raising minimum benefit levels. She said that by raising these levels, more plans would be considered limited benefit plans, and thus expose more policies and policyholders to those issues that concern the working group. The chair pointed out that plans could be required to have additional disclosure statements attached, so that consumers would be alerted to the status of the policy. She also pointed out that insurance departments have the ability to disapprove policies if they believe the product to be unfair to the consumer. **1997 Proc. 3rd Quarter 1278.**

At the next meeting a regulator said that the threshold seemed very low for some of the products. The chair of the drafting group stated that one of the goals of the drafting group was to recommend modernized minimum benefit levels. A regulator pointed out that if the working group considers raising the minimum benefit levels, more plans would become limited benefit plans. Another regulator suggested that the working group consider eliminating the internal limits on major medical coverage and also suggested that a hospice benefit be added in the minimum benefit requirements. **1997 Proc. 4th Quarter II 837.**

A. When interested parties reviewed the first draft of the model regulation, they expressed concern about the way "non-cancelable" and "guaranteed renewable" were used. They opined that the use of the terms contradicted the definitions enacted into law in a number of states. **1974 Proc. II 470, 485.**

The provisions adopted did not contain the language that had been found so objectionable. **1975 Proc. I 593-594.**

When the model was revised in 1976, the language now found in Paragraph (2) was added. Much of the language in Subparagraphs (a), (b) and (c) was included in that version. **1977 Proc. I 60-61.**

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Section 7A (cont.)

In 1998 a drafting note was added following the description of the renewability provisions in Paragraph (3) to indicate that coverage that was subject to the guaranteed renewability provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) must include the HIPAA guaranteed renewability provisions applicable to individual health insurance coverage. The drafting group decided to refine the drafting note to make it clear that the HIPAA guaranteed renewability provisions did not apply to coverage that was an excepted benefit under HIPAA and to make a reference to applicable state law or NAIC model that referenced the individual guaranteed renewability provisions of HIPAA. **1998 Proc. 2nd Quarter II 756.**

Paragraph (10) was added in 1976. **1977 Proc. I 62.**

Paragraph (15) was added in 1998. **1998 Proc. 4th Quarter II 669.**

- B. The drafting note under Paragraph (1) was added in 1976. **1977 Proc. I 62.**
- C. The basic provisions were included in the original model. **1975 Proc. I 595.**
- D. This new category was added in 1998. **1998 Proc. 4th Quarter II 670.**
- E. The basic provisions of Subsection E were found in the first version of the model. **1975 Proc. I 596.**

The drafting group reported on its progress in updating the minimum benefit levels in the model regulation. The regulation defined limited benefit health coverage as coverage that did not meet the minimum standards for any of the specified categories of coverage. Therefore, a critical piece of this proposed legislation was the definition of the minimum benefit levels for those categories, in particular major medical coverage. The chair identified three primary issues: restricting limited benefit plans to excepted benefits under HIPAA; identifying appropriate limits of coverage; and, of lesser significance, addressing the relative value scale in establishing limits. The drafting group recognized the far-reaching implications of the changes it was proposed to the major medical category. **1998 Proc. 2nd Quarter II 757.**

- F. The listing for the elements of major medical expense was replaced with a new list in 1976. **1977 Proc. I 64.**

Numerous changes were included in the 1998 redraft. **1998 Proc. 4th Quarter II 670-671.**

G. A regulator suggested a new category, Individual Basic Medical Expense Coverage, that contained the same type of standards as Individual Major Medical Expense Coverage, but at lesser levels. He further explained that with this new category, as with Individual Major Medical Expense Coverage, internal limits were eliminated except as specifically allowed. Staff pointed out there would still be Basic Hospital/Medical-Surgical Expense Coverage, which was a combination of two limited benefit categories. The chair of the drafting group pointed out that ultimately the group would be making a recommendation that Basic Hospital Expense Coverage, Basic Medical-Surgical Expense Coverage, and Basic Hospital/Medical-Surgical Expense Coverage should be excepted benefits under federal law and, therefore, not creditable coverage under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Conversely, she thought that the new category, Individual Basic Medical Expense Coverage, which contained a minimum \$250,000 lifetime maximum benefit, should be creditable coverage under HIPAA. Any product that had benefits less than those in Individual Basic Medical Expense Coverage would not be creditable coverage. The members of the working group agreed. **1998 Proc. 3rd Quarter 578.**

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An interested party said some plans have expressed concern about the rise in the minimum lifetime maximum benefit in Individual Major Medical Expense Coverage. A consumer advocate expressed concern about the high \$25,000 deductible in the new category of Individual Basic Medical Expense Coverage. The drafter pointed out that it was a maximum deductible, and carriers were free to offer plans with lower deductibles. The higher deductible would result in a lower premium. The working group agreed that the new category, Individual Basic Medical Expense Coverage, should have a disclosure provision to the effect that the benefits provided were not as comprehensive as those in Individual Major Medical Expense Coverage.

1998 Proc. 3rd Quarter 578.

H. The provisions regarding disability income protection coverage were modified in 1976. **1977 Proc. I 65.**

I. This language was found in the original model adopted in 1974. **1975 Proc. I 596.**

J. In 1980 a group was formed to look at specified disease policies. Several philosophies had been expressed by various commissioners. One concept was to ban the sale of dread disease policies while another was some form of regulation, probably through minimum standards for benefits and broad disclosure. The concerns of regulators centered around the belief that there may be market abuses that were compounded by the lack of consumer understanding. **1980 Proc. II 612.**

The model regulation was modified by adding new language with standards for cancer coverage. **1980 Proc. II 634.**

The issue of whether hospice care should be a required minimum standard for major medical coverage and for specified disease coverage was raised and the drafting group members agreed the hospice care should not be a mandated benefit for major medical coverage and that benefit mandates should be left to the individual states. However, with respect to specified disease coverage, the group decided that since there were already mandates within this category, it should consider whether hospice should be mandated as well. The group decided to recommend that a hospice benefit should not be mandated for specified disease products, but that, if it is offered, it should be subject to minimum standards. The standards recommended were six months or less life expectancy, at least \$50 per day benefit payment, and a maximum cap of no less than \$10,000. **1998 Proc. 2nd Quarter II 757.**

L. Limited benefit coverage was first described in the 1976 version. **1977 Proc. I 66.**

The provisions of this subsection were modified in 1998. **1998 Proc. 4th Quarter II 676-677.**

Section 8. Required Disclosure Provisions

Most of the language of the forms has changed little over the years. **1975 Proc. I 599-605.**

The chair suggested that enhanced disclosure could be the solution to many of the problems with limited benefit plans. She stated that in the current adopted model only accident and sickness policies required disclosure statements. The drafting group suggested that the requirement be expanded to all other supplemental health insurance policies. In addition, a disclosure statement should be placed near the signature box on those plans that are intended to supplement insurance plans, along with the statement that the benefits are intended to be supplemental. The outline of coverage for those products should also have the same language and the information should be extended to group coverage as well as individual products. **1997 Proc. 3rd Quarter 1279.**

The chair of the drafting group said that the group suggested that additional notices be added to policies, certificates and applications. She said that these were appropriate in light of the group's concern about sufficient disclosure to consumers. She said that the subgroup believed it was important to put the notice into the application so that the disclosure statement would be emphasized to the purchaser. She said that this notice is similar to the notice on long-term care insurance policy applications. A regulator asked if the outline of coverage was delivered at the time of application or at the time of delivery of the policy and the drafting group chair replied that the regulation allowed for either method of distribution. An interested

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party said that if applications had to contain the notice it would become a significant issue because this would prevent the use of a combination application. Requiring separate application forms for each product would create additional expense for the carriers due to new filing of forms. He stated that he had not seen any problems in this area. A regulator asked if the application and outline of coverage could contain boxes which the agent could check. The interested party responded that the provision stating that the notice would have to be in the proximity to the signature block would be unworkable, as the form would have to have several notices, some of which would not be in proximity to the signature block. **1997 Proc. 4th Quarter II 837.**

A. A consumer advocate suggested that the free-look term be standardized for all coverages in the model. After discussion, the working group concurred on suggesting that a 30-day free-look period be uniform for all coverages under the model. **1998 Proc. 1st Quarter 812.**

The language of Paragraphs (1) through (3) and (16) through (23) was added with the 1998 redraft. **1998 Proc. 4th Quarter II 677-679.**

B. A regulator asked if the outline of coverage was delivered at the time of application or at the time of delivery of the policy and the drafting group chair replied that the regulation allowed for either method of distribution. An interested party said that created a problem for direct marketers. Another interested party emphasized to the working group that her association supported adequate disclosure to consumers. She stated that the disclosure of information was in the outline of coverage and in the text of the cover page of the policy and she opined that it would not be a good idea to place the notice in the application. A regulator suggested that a sentence be placed in close proximity to the signature block referring the purchaser to the outline of coverage for more information on the policy coverage. **1997 Proc. 4th Quarter II 837-838.**

Since the model regulation was changed to require delivery of the outline of coverage at policy application for coverage issued through an agent, the issue was raised as to whether advertising material that contained the same information as the outline of coverage could fulfill this requirement. The drafting group agreed that if the advertisement contained exactly the same information in the same format (order, prominence, etc.) as required in the outline of coverage, then it could be used in place of the outline of coverage. Industry representatives pointed out that this was already allowed under the current model. The model was revised to include a new Paragraph (5) clarifying that point. **1998 Proc. 2nd Quarter II 757.**

C. Interested parties spoke against the required disclosure forms. They felt strongly that an outline of coverage was preferable to the formats included in the draft, which were extremely rigid. **1974 Proc. II 488.**

Section 9. Requirements for Replacement of Individual Accident and Sickness Insurance

Most of the text of the section appears in nearly identical format to the original model adopted in 1974. **1975 Proc. I 604-605.**

Section 10. Separability

The section was included in the original model adopted in 1974. **1975 Proc. I 605.**

Chronological Summary of Action

December 1974: Model adopted.

December 1976: Some amendments were made.

June 1979: Added standards for Medicare supplement insurance.

June 1980: Revised to set standards for dread disease policies.

June 1989: Removed provisions related to Medicare supplement insurance in recognition of the extensive model specific to that topic.

March 1999: Model extensively revised. Includes group supplemental health insurance.