

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

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### **Section 1. Purpose**

The purpose of this regulation is to implement [insert reference to state law equivalent to the NAIC *Supplementary and Short-Term Health Insurance Minimum Standards Model Act*] (the Act) to standardize and simplify the terms and coverages, to facilitate public understanding and comparison of coverage, to eliminate provisions that may be misleading or confusing in connection with the purchase and renewal of the coverages or with the settlement of claims and to provide for full disclosure in the marketing and sale of supplementary and short-term health insurance, as defined in the Act. This regulation is also intended to assert the commissioner’s jurisdiction over limited scope dental coverage and limited scope vision coverage, and to provide for disclosure in the sale of those coverages.

### **Section 2. Authority**

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

### **Section 3. Applicability and Scope**

- A. This regulation applies to all individual and group insurance policies and certificates providing hospital indemnity or other fixed indemnity, accident only, specified accident, specified disease, limited benefit health and disability income protection, referred to collectively in Section 1 of the Act and hereafter, as “supplementary health insurance,” delivered or issued for delivery in this state on and after [insert effective date] that are not specifically exempted from this regulation. This regulation applies to short-term, limited-duration insurance coverage offered, delivered or issued for delivery to residents of this state regardless of the situs of the delivery of the contract on and after [insert effective date].
- B. This regulation applies to limited scope dental coverage and limited scope vision coverage only as specified.
- C. This regulation shall not apply to:

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Minimum Standards Model Act

- (1) Medicare supplement policies subject to [insert reference to state law equivalent to the Model Regulation to Implement the NAIC *Medicare Supplement Insurance Minimum Standards Model Act*];
- (2) Long-term care insurance policies subject to [insert reference to state law equivalent to the NAIC *Long-Term Care Insurance Model Act*];
- (3) TRICARE (Chapter 55, Title 10 of the United States Code) supplement insurance policies;  
or
- (4) Limited long-term care insurance policies subject to [insert reference to state law equivalent to the NAIC *Limited Long-Term Care Insurance Model Act*].

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

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

#### **Section 4. Effective Date**

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

#### **Section 5. Definitions**

For purposes of this regulation:

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

#### **Section 6. Policy Definitions**

- A.
  - (1) Except as provided in this regulation, a supplementary health insurance or a short-term limited duration insurance policy delivered or issued for delivery to any person in this state and to which this regulation applies shall contain definitions respecting the matters set forth below that comply with the requirements of this section.
  - (2) Except as provided in this regulation, to the extent these definitions are used in a policy [or certificate], definitions used in a policy [or certificate] may vary from the definitions in this section, but not in a manner that restricts coverage.

- B. “Convalescent nursing home,” “extended care facility,” “skilled nursing facility,” “assisted living facility” or “continued care retirement community” means in relation to its status, facility and available services.
- (1) A definition of the home or facility shall not be more restrictive than one requiring that it:
    - (a) Be operated pursuant to law;
    - (b) Be approved for payment of Medicare and/or Medicaid benefits or be qualified to receive approval for payment of Medicare and/or Medicaid benefits, if so requested;
    - (c) Be engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;
    - (d) Except for an “assisted living facility” or a “continued care retirement community,” 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 is permitted but is not required to exclude:
    - (a) A home, facility or part of a home or facility used primarily for rest;
    - (b) A home or facility for the aged and/or for the care of individuals with a substance use disorder; or
    - (c) A home or facility primarily used for the care and treatment of mental diseases or disorders, or for custodial or educational care.

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

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

- (d) It maintains clinical records on all patients; and
- (e) It has a full-time administrator.

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

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

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

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

- E.
  - (1) “Injury” means a bodily injury resulting from an accident, independent of disease, which occurs while the coverage is in force.
  - (2) The definition shall not use words such as “external, violent, visible wounds” or similar words of characterization or description.
  - (3) The definition may state that the disability shall have occurred within a specified period of time (not less than thirty (30) days) of the injury, otherwise the condition shall be considered a sickness.

- (4) The definition may provide that “injury” shall not include an injury for which benefits are provided under workers’ compensation, employers’ liability or similar law; or under a motor vehicle no-fault plan, unless prohibited by law; or injuries occurring while the insured person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit.
- F. “Mental or nervous disorder” means any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or its successor.
- G. “Nurse” may be defined so that the description of nurse is restricted to a type of nurse, such as an advance practice nurse, a registered nurse, a licensed practical nurse, or a licensed vocational nurse. If the words “nurse,” “advance practice nurse,” “trained nurse” or “registered nurse” are used without specific instruction, then the use of these terms requires the insurer to recognize the services of any individual who qualifies under the terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

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

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

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

- K. “Preexisting condition” means 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.

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

## Section 7. Prohibited Policy Provisions

- A.
  - (1) Except as provided in this subsection, a policy shall not contain provisions establishing a probationary or waiting period during which coverage under the policy is excluded or restricted.
  - (2) A policy, other than an accident only policy, may exclude coverage for a loss due to a preexisting condition, as defined in Section 6J, for a period not to exceed twelve (12) months following the issuance of the policy or certificate. The twelve-month limitation is not required if the condition was disclosed during the application or enrollment process and specifically excluded by the terms of the policy or certificate, or when the insured knowingly made a material misrepresentation during the application or enrollment process.
  - (3) A policy, other than an accident only policy or a short-term, limited duration health insurance policy, may specify a probationary or waiting period not to exceed six (6) months for specified diseases or conditions and losses resulting from disease or condition related to hernia, disorder of the reproductive organs, varicose veins, adenoids, and tonsils, except when the specified diseases or conditions are treated on an emergency basis.
- B. A disability income protection policy may contain a “return of premium” or “cash value benefit” option so long as the return of premium or cash value benefit is not reduced by an amount greater than the aggregate of claims paid under the policy; and the insurer demonstrates that the reserve basis for the policies is adequate. No other policy subject to the Act and this regulation shall provide a return of premium or cash value benefit, except return of unearned premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds.

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

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

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

- (1) Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;
- (2) Mental or emotional disorders, alcoholism and drug addiction;

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

- (3) Pregnancy, except for complications of pregnancy, other than for policies defined in Section 8C of this regulation;
- (4) Illness, treatment or medical condition arising out of:
  - (a) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary to it;
  - (b) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;
  - (c) Non-commercial or recreational aviation;
  - (d) With respect to short-term nonrenewable policies, interscholastic sports; and
  - (e) With respect to disability income protection policies, incarceration.

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

- (5) Cosmetic surgery, except for reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly that has resulted in a functional defect;
- (6) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or asymptomatic complaints of the feet;
- (7) Chiropractic care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects of it, where the interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;

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

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



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

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

- E. Notwithstanding Subsection D of this section, 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.
- F. The enumeration in this section of specific precluded policy provisions shall not be construed as a limitation on the authority of the commissioner to disapprove other policy provisions in accordance with [cite Section 4B of the *Supplementary and Short-Term Health Insurance Minimum Standards Act*] that in the opinion of the commissioner are unjust, unfair or unfairly discriminatory to the policyholder, beneficiary or a person insured under the policy.
- G. A policy providing a type of supplementary health insurance that is not defined as a “plan” under the *Coordination of Benefits Model Regulation* (#120) shall not include a coordination of benefits provision or any other provision that allows it to reduce its benefits based on the existence of other coverage its insured may have.
- H. A policy shall not limit an insured’s choice of health care provider if the provider is licensed or otherwise qualified under state law and the services to be provided are within the health care provider’s scope of practice.

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

## **Section 8.      Supplementary and Short-Term Health Insurance Minimum Standards for Benefits**

The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. A supplementary or short-term health insurance policy or certificate shall not be delivered or issued for delivery in this state unless it meets the required minimum standards for the specified categories or the commissioner finds that the policies or contracts are approvable as limited benefit health insurance and the outline of coverage complies with the outline of coverage in Section 9H of this regulation.

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

A. General Rules

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

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

- (2)
  - (a) The terms “noncancellable,” “guaranteed renewable,” or “noncancellable and guaranteed renewable” shall not be used without further explanatory language in accordance with the disclosure requirements of Section 9A.
  - (b) The terms “noncancellable” or “noncancellable and guaranteed renewable” may be used only in an individual supplementary policy that the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.
  - (c) Except as provided in Subparagraph (d) of this paragraph, the term “guaranteed renewable” may be used only in a policy that the insured has the right to continue in force by the timely payment of premiums until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.
  - (d) An individual supplementary policy or individual accident-only policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may be designated as “guaranteed renewable” if it provides that the insured has the right to continue the policy, while actively and regularly employed, at least until the insured has reached full retirement and, as defined under the federal Social Security Act.
- (3) In an individual supplementary policy covering a married couple or civil union couple, the age of the younger spouse shall be used as the basis for meeting the age and durational requirements of the definitions of “noncancellable” or “guaranteed renewable.” However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age so long as the policy may be continued in force as to the younger spouse to the age or for the durational period as specified in the policy.

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

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

- (4) When accidental death and dismemberment coverage is part of the individual supplementary insurance coverage offered under the contract, the insured shall have the option to include all insureds under the coverage and not just the principal insured.
- (5) If a policy contains a status-type military service exclusion or a provision that suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to the person on a pro rata basis.
- (6) Policies providing pregnancy benefits shall provide for an extension of benefits, in the event the insurer cancels or refuses to renew for reasons other than non-payment of premium, as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.
- (7) Policies providing convalescent or extended care benefits following hospitalization may condition the benefits upon admission to the convalescent or extended care facility within a specified time after discharge from the hospital, as long as the required admission date is not less than thirty (30) days after discharge from the hospital.
- (8) In individual supplementary or short-term health insurance policies, coverage shall continue for a dependent child who is incapable of self-sustaining employment due to intellectual or physical disability on the date that the child's coverage would otherwise terminate under the policy due to the attainment of a specified age for children and who is chiefly dependent on the insured for support and maintenance. The policy may require that within thirty-one (31) days after the date the insurer receives due proof of the disability in order for the insured to elect to continue the policy in force with respect to the child, or that a separate converted policy be issued at the option of the insured or policyholder.
- (9) A policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy or certificate, after benefits for the recipient's own expenses have been paid.
- (10) A policy may contain a provision relating to recurrent disabilities; but a provision relating to recurrent disabilities shall not specify that a recurrent disability be separated by a period greater than six (6) months.
- (11) Accidental death and dismemberment benefits shall be payable if the loss occurs within ninety (90) days from the date of the accident, irrespective of total disability. Disability income protection benefits, if provided, shall not require the loss to commence less than thirty (30) days after the date of accident, nor shall any policy that the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the coverage was in force.
- (12) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.

- (13) An accident-only policy providing benefits that vary according to the type of accidental cause shall prominently set forth in the outline of coverage and the disclosure materials required under Section 9 of this regulation the circumstances under which benefits are payable that are lesser than the maximum amount payable under the policy.
- (14) Termination of the policy shall be without prejudice to the right to receive benefits for a continuous loss that commenced while the policy or certificate was in force. The continuous total disability of the insured may be a condition for the extension of benefits beyond the period the policy was in force, limited to the duration of the benefit period, if any, or payment of the maximum benefits.
- (15) A policy providing coverage for certain illnesses and injuries may not define covered illnesses and injuries in a way that is misleading or includes unfair exclusions. For example, a policy providing coverage for fractures or dislocations may not provide benefits only for “full or complete” fractures or dislocations.

B. Hospital Indemnity or Other Fixed Indemnity Coverage

- (1) “Hospital indemnity or other fixed indemnity coverage” provides benefits as a result of hospital confinement or other health-related events and based on a fixed dollar amount, regardless of the amount of expenses incurred, without coordination with any other health coverage.
- (2) “Hospital indemnity coverage” may provide a single lump sum benefit for hospital confinement of not less than \$[X], and/or daily benefit for hospital confinement on an indemnity basis in an amount not less than \$[X] per day and not less than [X] days during each period of confinement for each person insured under the policy.

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

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

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

**Drafting Note:** For indemnity products that are triggered by a variety of health events and provide a variety of daily benefit dollar amounts, state insurance regulators should examine the amount payable per day and the total amount payable per year or lifetime to determine whether an indemnity product’s benefits could be mistaken for comprehensive major medical coverage. Indemnity products should not be offered, marketed, or sold as an alternative to, or substitute for, or replacement for major medical coverage. It is the marketing of supplementary coverage as an alternative, substitute or replacement for comprehensive major medical coverage that presents the unfair trade practice, and not the supplementary coverage itself when it is offered and marketed as supplementary excepted benefits coverage and accurately described to the consumer.

C. Disability Income Protection Coverage

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

- (1) Provides that a plan is prohibited from reducing periodic payments based on age, except that a plan may reduce periodic payments provided that such reductions do not take place until the individual has reached full retirement age, as defined under the federal Social Security Act, to receive Social Security benefits;

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

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

D. Accident Only Coverage

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

E. Specified Disease Coverage

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

- (b) Insurance covering specified diseases other than cancer must meet the standards of Paragraphs (3) and (6) of this subsection.

(2) General Rules

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

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

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

- (g) Payments may be conditioned upon an insured person's receiving medically necessary care, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment.

- (h) Benefits for specified disease coverage shall be paid regardless of other coverage, except as permitted by [insert reference to state law equivalent to Section 3B(3) of the *Uniform Individual Accident and Sickness Policy Provision Law* (UPPL) (#180), regarding multiple policies with the same insurer].

**Drafting Note:** Specified disease coverage is recognized as supplementary coverage. Any specified disease coverage, therefore, must be payable in addition to and regardless of other coverage. The same general rule should apply so that group insurance cannot reduce its benefits because of the existence of specified disease coverage. Section 3H(4) of the *Coordination of Benefits Model Regulation* (#120) states that the definition of a “plan” (for the purpose of coordination of benefits) “shall not include individual or family insurance contracts.” States should consider using this language to prevent benefit reductions that could otherwise occur because of the existence of specified disease coverage purchased by the insured.

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

- (I) Eligibility for payment of benefits when the attending physician of the insured provides a written statement that the insured person has a life expectancy of six (6) months or less;
    - (II) A fixed-sum payment of at least \$[X] per day; and
    - (III) A lifetime maximum benefit limit of at least \$[X].
  - (iii) Hospice care does not cover non-terminally ill patients who may be confined in a:
    - (I) Convalescent home;
    - (II) Rest or nursing facility;
    - (III) Skilled nursing facility;
    - (IV) Rehabilitation unit; or
    - (V) Facility providing care or treatment for persons suffering from mental disorders , who are aged, or who have a substance use-related disorder.
- (3) The following minimum benefits standards apply to non-cancer coverages:
- (a) Coverage for each insured person for a specifically named disease (or diseases) with a deductible amount not in excess of \$[X] and an overall aggregate benefit limit of no less than \$[X] and a benefit period of not less than [two (2) years] for at least the following incurred expenses:
    - (i) Hospital room and board and any other hospital furnished medical services or supplies;
    - (ii) Treatment by a licensed physician, surgeon, or other health care professional acting within the scope of their license;

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

- (iii) Private duty services of a licensed nurse;
  - (iv) Tests, procedures, and other medical services and supplies used in diagnosis and treatment;
  - (v) Professional ambulance for service to or from a hospital nearest able to appropriately treat the condition;
  - (vi) Blood transfusions, including expense incurred for blood donors;



- (vii) Drugs and medicines prescribed by a physician;
  - (viii) Durable medical equipment deemed necessary by the attending physician for the treatment of the disease;
  - (ix) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and
  - (x) May include coverage of any other expenses necessarily incurred in the treatment of the disease.
- (b) Coverage for each insured person for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than \$[X] payable at the rate of not less than \$[X] a day while confined in a hospital and a benefit period of not less than 500 days.
- (4) A policy that provides coverage on an expense-incurred basis for cancer-only coverage, or for cancer in combination with one or more other specified diseases shall provide coverage for each insured person for services, supplies, care and treatment of cancer, consistent with the requirements in this paragraph.
  - (a) Coverage may be limited to amounts not in excess of the usual and customary charges, with a deductible amount not in excess of \$[X], an overall aggregate benefit limit of not less than \$[X], and a benefit period of not less than three (3) years.
  - (b) A policy shall include at least the minimum benefits specified in this subparagraph. Coverages under items (i) through (xiv) of this subparagraph may be subject to cost-sharing by the insured person not to exceed twenty percent (20%) of covered charges when rendered on an outpatient basis:
    - (i) Treatment by, or under the direction of, a licensed physician, surgeon, or other health care professional acting within the scope of their license;

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

- (ii) Tests, procedures, and other medical services and supplies used in diagnosis and treatment;
- (iii) Blood transfusions and their administration, including expense incurred for blood donors;
- (iv) Drugs and medicines prescribed by a physician, including but not limited to, chemotherapy, including both oral and IV administered, immunotherapy, targeted therapies, and chemotherapy supportive drugs;

- (v) Private duty services of a licensed nurse provided in a hospital;
- (vi) Durable medical equipment deemed necessary by the attending physician for the treatment of the disease;
- (vii) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease;
- (viii) (I) Home health care that is necessary care and treatment provided at the insured person's residence by a home health care agency or by others under arrangements made with a home health care agency. The program of treatment shall be prescribed in writing by the insured person's attending physician, who shall approve the program prior to its start.

**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 care includes, but is not limited to:
  - a. Part-time or intermittent skilled nursing services provided by a registered nurse or a licensed practical nurse;
  - b. Part-time or intermittent home health aide services that provide supportive services in the home under the supervision of a registered nurse or a physical, speech or hearing occupational therapists;
  - c. Physical, occupational or speech and hearing therapy; and
  - d. Medical supplies, drugs and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent the charges or costs would have been covered if the insured person had remained in the hospital;
- (ix) Physical, speech, hearing and occupational therapy;
- (x) Special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, disposable absorbent pads, oxygen, surgical dressings, rubber shields, colostomy and ileostomy appliances;
- (xi) Prosthetic devices including wigs and artificial breasts;
- (xii) Nursing home care for noncustodial services;

- (xiii) Reconstructive surgery when deemed necessary by the attending physician;
  - (xiv) Hospice services, as defined in Paragraph (2)(m) above;
  - (xv) Hospital room and board and any other hospital furnished medical services or supplies; and
  - (xvi) Professional ambulance for service to or from a hospital nearest able to appropriately treat the condition.
- (c) A policy may include coverage of any other expenses necessarily incurred in the treatment of the disease.

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

- (5) (a) The following minimum benefits standards apply to cancer coverages written on a per diem indemnity basis. These coverages shall offer insured persons:
- (i) A fixed-sum payment of at least \$[X] for each day of hospital confinement for at least [365] days;
  - (ii) A fixed-sum payment of at least [X%] the hospital inpatient benefit for each day of hospital or nonhospital outpatient surgery, chemotherapy and radiation therapy, for at least 365 days of treatment; and
  - (iii) A fixed-sum payment of at least \$[X] per day for blood and plasma, which includes their administration whether received as an inpatient or outpatient for at least 365 days of treatment.
- (b) Benefits tied to receipt of care in a skilled nursing home or to receipt of home health care are optional. If a policy offers these benefits, they must equal or exceed the following:
- (i) A fixed-sum payment equal to [X%] the hospital in-patient benefit for each day of skilled nursing home confinement for at least 100 days.
  - (ii) A fixed-sum payment equal to [X%] the hospital in-patient benefit for each day of home health care for at least 100 days.
  - (iii) Benefit payments shall begin with the first day of care or confinement after the effective date of coverage if the care or confinement is for a covered disease even though the diagnosis of a covered disease is made at some later date (but not retroactive more than thirty (30) days from the date of diagnosis) if the initial care or confinement was for diagnosis or treatment of the covered disease.

- (iv) Notwithstanding any other provision of this regulation, any restriction or limitation applied to the benefits in (b)(i) and (b)(ii) whether by definition or otherwise, shall be no more restrictive than those under Medicare.
- (6) The following minimum benefits standards apply to lump-sum indemnity coverage of any specified disease:
  - (a) These coverages must pay indemnity benefits for a specifically named disease or diseases. The benefits are payable as a fixed, one-time payment made within thirty (30) days of submission to the insurer of proof of diagnosis of the specified disease. Dollar benefits shall be offered for sale only in even increments of \$[X].

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

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

**Drafting Note:** The purpose of requiring equal coverage for all subtypes of a specified disease is to ensure that specified disease policies actually provide what people reasonably expect them to. In approving 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.

#### F. Specified Accident Coverage

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

#### G. Limited Benefit Health Coverage

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

equivalent to the NAIC *Long-Term Care Insurance Model Act* and *Medicare Supplement Insurance Minimum Standards Model Act*].

**Drafting Note:** The NAIC *Long-Term Care Insurance Model Act* (#640) defines long-term care insurance as a policy that provides coverage for not less than twelve months. If a state allows issuance of policies that provide benefits similar to long-term care insurance for a period of less than twelve months, then those policies should be considered limited long-term care insurance policies and should be subject to the *Limited Long-Term Care Insurance Model Act* (#642) and its implementing regulation, the *Limited Long-Term Care Insurance Model Regulation* (#643).

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

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

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

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

- (b) A short-term, limited-duration health insurance policy or certificate must have:
  - (i) An annual or lifetime limit of no less than [\$1,000,000];
  - (ii) A coinsurance requirement of no more than fifty percent (50%) of covered charges; and
  - (iii) A family maximum out-of-pocket limit of not more than [X] per year.

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

- (3) Short-term, limited-duration health insurance cannot be issued if it would result in an individual being covered by a short-term, limited duration health insurance policy or certificate for more than [X] months [in any 12-month period].

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

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

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

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

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

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

## Section 9. Required Disclosure Provisions

### A. General Rules

- (1) (a) All applications, policies, and certificates for coverage of supplementary or short-term health insurance shall include a prominent disclosure statement, as required by this section, that reflects the type of coverage being provided.
- (b) The disclosures required by this section may be modified only as needed to improve the accuracy and clarity of the disclosure and only with the approval of the commissioner.

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

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

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

- (2) Any disclosures, and the documents to which they refer, shall be delivered in the written medium (digital or heard copy) the applicant requests. These documents shall be provided before the applicant submits a completed application.
- (3) For hospital indemnity coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase “fixed dollar benefits” made prominent:

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

This insurance might not cover or might limit coverage for:

- Preexisting conditions; or
- Essential health benefits (such as pediatric, hospital, emergency, maternity, mental health, substance use services, prescription drugs, or preventive care).
- You will not qualify for federal financial help to pay for premiums or out-of-pocket costs for this policy.
- You are not protected from surprise medical bills.
- When this policy ends, you might have to wait until an open enrollment period to get comprehensive health insurance.

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

- (13) Each policy of individual supplementary or short-term health insurance subject to this regulation, as provided in Section 3A of this regulation, shall include a renewal, continuation or nonrenewal provision. The language or specification of the provision shall be consistent with the type of contract to be issued. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.
- (14) 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 requirement in this paragraph applies to group supplemental health insurance certificates only where the certificate holder also pays the insurance premium.
- (15) Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy or certificate and the combined total premium clearly identified as such.
- (16) A policy or certificate that provides for the payment of benefits based on standards described as “usual and customary,” “reasonable and customary,” or words of similar import shall include a definition of the terms and a clear explanation of the terms in its accompanying outline of coverage.

- (17) If a policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall be clearly explained in a separate paragraph of the policy or certificate labeled “Preexisting Conditions Limitations.”
- (18) All policies and certificates, except single-premium nonrenewable policies and as otherwise provided in this paragraph, shall have a notice prominently printed in sans serif font on the first page of the policy or certificate or attached to it stating clearly that the policy or certificate holder shall have the right to return the policy or certificate within thirty [30] days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the policyholder or certificate holder is not satisfied for any reason.

**Drafting Note:** This paragraph should be included only if it is consistent with applicable state law.

- (19) If age is to be used as a determining factor to reduce the benefits made available in the policy or certificate as originally issued, a clear explanation of how age is used shall be prominently set forth in the outline of coverage.
- (20) If a policy or certificate contains a conversion privilege, it shall comply, in substance, with the following: The caption of the provision shall be “Conversion Privilege” or words of similar import. The provision shall clearly explain which persons are eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person who may exercise the conversion privilege. The provision shall clearly specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.
- (21) (a) Outlines of coverage delivered in connection with policies defined in this regulation as hospital indemnity or other fixed indemnity (Section 8B), specified disease (Section 8E), or limited benefit health coverages (Section 8G) to persons eligible for Medicare by reason of age shall contain, in addition to the requirements of Subsections D and F, the following language, which shall be printed on or attached to the first page of the outline of coverage, with the sentence “This is not a Medicare Supplement policy.” made prominent:

This is not a Medicare Supplement policy. If you are eligible for Medicare, ask the company for the Guide to Health Insurance for People with Medicare.

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

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

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

- (22) 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.

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

B. Outline of Coverage Requirements

- (1) An insurer shall deliver an outline of coverage to an applicant of all applicable plans as required in Section 6 of the Act.
- (2) If an outline of coverage was delivered at the time of application or enrollment and the policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered and contain the following statement in no less than twelve (12) point sans serif type, immediately above the company name, with the sentence "It is different from the outline of coverage you received when you [applied] [enrolled]." made prominent:
- "NOTICE: Read this outline of coverage carefully. It is different from the outline of coverage you received when you [applied][enrolled]. The coverage you applied for was not issued."
- (3) In any case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or certificate, an alternate outline of coverage shall be submitted to the commissioner for prior approval. In such instances, no policies may be sold or renewed until approved by the commissioner.
- (4) Advertisements may fulfill the requirements for outlines of coverage if they satisfy the standards specified for outlines of coverage in Section 6H of the Act as well as this regulation.

C. Hospital Indemnity or Other Fixed Indemnity Coverage (Outline of Coverage)

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

[COMPANY NAME]

[Hospital Indemnity] [Other Fixed Indemnity] Coverage

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

They are not intended to cover all expenses.

OUTLINE OF COVERAGE

- (1) Read your [policy][certificate] carefully. This outline of coverage briefly describes your coverage's important features. It is not the insurance contract. The [policy] [certificate] itself details your rights and obligations and those of your insurance company. It is important that you read your [policy] [certificate] carefully!
- (2) [Hospital indemnity] [Other fixed indemnity] coverage is designed to pay a fixed dollar benefit as a result of a covered [hospital stay] [event] due to a sickness or injury. The benefit may be limited in ways described in the [policy] [certificate]. The fixed dollar benefit may be less than the [hospital stay's] [event's] cost.
- (3) [A brief, but clear and specific, description of the benefits in the following order:
  - (a) When the benefits are payable;
  - (b) The duration of benefits described in (a); and
  - (c) The fixed dollar amount of the benefits.]
- (4) [A clear description of any provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefit, described in Paragraph (3) above.]
- (5) [A clear description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]
- (6) [A clear description of any benefits provided in addition to the fixed dollar [hospital] [event] benefit.]

D. Disability Income Protection Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates meeting the standards of Section 8C 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] [certificate] carefully. This outline of coverage briefly describes your coverage's important features. It is not the insurance contract. The [policy] [certificate] itself details your rights and obligations and those of your insurance company. It is important that you read your [policy] [certificate] carefully!
- (2) Disability income protection coverage is designed to pay a benefit for disabilities resulting from a covered sickness or injury. The benefit may be limited in the ways described in the [policy] [certificate]. The benefit might not fully replace your income.

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

E. Accident-Only Coverage (Outline of Coverage)

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

[COMPANY NAME]

Accident-Only Coverage

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

They are not intended to cover all expenses.

OUTLINE OF COVERAGE

- (1) Read your [policy][certificate] carefully. This outline of coverage briefly describes your coverage's important features. It is not the insurance contract. The [policy] [certificate] details your rights and obligations and those of your insurance company. It is important that you read your [policy] [certificate] carefully!
- (2) Accident-only coverage pays benefits for covered injuries from a covered accident. It does not provide benefits resulting from sickness. The benefits may be limited in ways described in the [policy] [certificate].
- (3) [Brief, but clear and specific, description of the benefits and a description of any deductible or copayment provisions applicable to the benefits described.]
- (4) [A clear description of any provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above. Proper disclosure of benefits that vary according to the type of accidental cause shall be made in accordance with Section 8A(13) of this regulation.]
- (5) [A clear description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

F. 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 8E and F of this regulation. The coverage shall be identified by the appropriate bracketed title. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

Specified Disease or Specified Accident Coverage (Outline of Coverage)

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

They are not intended to cover all expenses.

OUTLINE OF COVERAGE

- (1) Read the Buyer's Guide to Specified Disease Insurance to review the possible limits on benefits in this type of coverage.

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

- (2) Read your [policy] [certificate] carefully. This outline of coverage briefly describes your coverage's important features. It is not the insurance contract. The [policy] [certificate] details your rights and obligations and those of your insurance company. It is important that you read your [policy] [certificate] carefully!
- (3) [Specified disease] [Specified accident] coverage is designed to pay limited benefits as a result of the diagnosis or treatment [of a covered disease] or [resulting from a specifically identified type of accident]. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.
- (4) [Brief, but clear and specific, description of the benefits, including dollar amounts and a description of any deductible or copayment provisions applicable to the benefits described.] Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 8A(13) of this regulation.

G. 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 8B, D and G of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

Limited Benefit Health Coverage

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

They are not intended to cover all expenses.

OUTLINE OF COVERAGE

- (1) Read your [policy][certificate] carefully. This outline of coverage briefly describes your coverage's important features. It is not the insurance contract. The [policy] [certificate] itself details your rights and obligations and those of your insurance company. It is important that you read your [policy] [certificate] carefully!
- (2) Limited benefit health coverage pays limited benefits. This [policy] [certificate] is not major medical insurance and does not replace it.
- (3) [Brief, but clear and specific, description of the benefits, including dollar amounts and a description of any deductible or copayment provisions applicable to the benefits described.]
- (4) [A clear description of any provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]
- (5) [A clear description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

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

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

[COMPANY NAME]

Short-Term, Limited Duration Coverage

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

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

OUTLINE OF COVERAGE

- (1) Read your [policy] [certificate] carefully. This outline of coverage briefly describes your coverage's important features. It is not the insurance contract. The [policy] [certificate] itself details your rights and obligations and those of your insurance company. It is important that you read your [policy] [certificate] carefully!
- (2) This is a short-term, limited duration [policy] [certificate]. This is temporary insurance. It is not comprehensive health insurance. It might not cover or might limit coverage for preexisting conditions. It might not cover essential health benefits such as pediatric, hospital, emergency, maternity, mental health, substance use services, prescription drugs, or preventive care. Read your [policy] [certificate] carefully to make sure you understand what is covered and any limitations on coverage.
- (3) [Brief, but clear and specific, description of the benefits in the following order:



- (a) Benefits covered by the policy or certificate, including required cost-sharing;
  - (b) Benefits that are not covered by the policy or certificate; and
  - (c) Duration of benefits described above.]
- (4) A clearly worded prominent notice that cost-sharing limitations do not apply to benefits not covered by the policy or certificate.
  - (5) [A clear description of provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]
  - (6) [A clear description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

I. Limited Scope Dental Coverage (Outline of Coverage)

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

[COMPANY NAME]

Limited Scope Dental Coverage

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

OUTLINE OF COVERAGE

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

J. Limited Scope Vision Coverage (Outline of Coverage)

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

[COMPANY NAME]

#### Limited Scope Vision Coverage

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

#### OUTLINE OF COVERAGE

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

#### **Section 10. Requirements for Replacement of Individual Supplementary and Short-Term Health Insurance Coverage**

- A. An application form shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other supplementary or short-term health insurance subject to this regulation, as provided in Section 3A of this regulation, presently in force. A supplementary application or other form to be signed by the applicant containing the question may be used.
- B. Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in Subsection C below. The insurer shall retain a copy of the notice. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in Subsection D below. However, this notice is not required in the solicitation of accident-only policies or the replacement of 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 About Replacement of [Supplementary] [Short-Term] Health Insurance

According to [your application] [information you have provided], you intend to lapse or otherwise end the supplementary or short-term health insurance you have now and replace it with a policy the [insert company name] Insurance Company will issue. For your own protection, you should know how replacing your policy with a new one might affect your coverage.

- (1) A new policy might not pay claims that the policy you have now would pay. A new policy might not cover health conditions that you might have now (preexisting conditions) or might not cover them right away. A new policy might cover some but not all the costs related to treating preexisting conditions.

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

- (2) Talk with your current insurance agent or company representative about replacing your policy. It is in your best interest to be sure you understand how replacing your policy could affect your future coverage.
- (3) If you decide to buy a new policy, be sure to truthfully and completely answer all questions on the application about your medical/health history. If you do not, the company could deny any future claims and refund your premium as though your policy had never been in force. Check that the information on your application is complete and correct before you sign it.

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 About Replacement of [Supplementary] [Short-Term] Health Insurance

According to [your application] [information you have provided], you intend to lapse or otherwise end the supplementary or short-term health insurance you have now and replace it with the attached policy issued by [insert company name] Insurance Company. You have thirty days to decide at no cost if you want to keep the new policy. For your own protection, you should know how replacing your policy with a new one might affect your coverage.

- (1) A new policy might not pay claims that the policy you have now would pay. A new policy might not cover health conditions you have now (preexisting conditions) or might not cover them right away. A new policy might cover some but not all the costs related to preexisting conditions.
- (2) Talk with your insurance agent or company representative about replacing your policy. It is in your best interest to be sure you understand how replacing your policy could affect your future coverage.

- (3) [To be included only if the application is attached to the policy]. If you decide to buy a new policy, read the copy of the attached application and be sure that all questions are answered fully and correctly. If they are not, the company could refuse to pay an otherwise valid claim. 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 off the application.

[COMPANY NAME]

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

## **Section 11. Separability**

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

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*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. 4<sup>th</sup> Quarter 16, 17, 652, 654, 660-687 (amended and reprinted).

Fall 2024 (amended).