

(7) Credit-only insurance (for example, mortgage insurance).

(8) Coverage for on-site medical clinics.

(9) Travel insurance, within the meaning of §144.103 of this subchapter.

(b) *Other excepted benefits.* The requirements of this part do not apply to individual health insurance coverage described in paragraphs (b)(1) through (b)(6) of this section if the benefits are provided under a separate policy, certificate, or contract of insurance. These benefits include the following:

(1) Limited scope dental or vision benefits. These benefits are dental or vision benefits that are limited in scope to a narrow range or type of benefits that are generally excluded from benefit packages that combine hospital, medical, and surgical benefits.

(2) Long-term care benefits. These benefits are benefits that are either—

(i) Subject to State long-term care insurance laws;

(ii) For qualified long-term care insurance services, as defined in section 7702B(c)(1) of the Code, or provided under a qualified long-term care insurance contract, as defined in section 7702B(b) of the Code; or

(iii) Based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(3) Coverage only for a specified disease or illness (for example, cancer policies) if the policies meet the requirements of §146.145(b)(4)(ii)(B) and (C) of this subchapter regarding non-coordination of benefits.

(4) Hospital indemnity or other fixed indemnity insurance only if—

(i) The benefits are provided only to individuals who attest, in their fixed indemnity insurance application, that they have other health coverage that is minimum essential coverage within the meaning of section 5000A(f) of the Internal Revenue Code, or that they are treated as having minimum essential coverage due to their status as a bona fide resident of any possession of the United States pursuant to Code section 5000A(f)(4)(B).

(ii) There is no coordination between the provision of benefits and an exclusion of benefits under any other health coverage.

(iii) The benefits are paid in a fixed dollar amount per period of hospitalization or illness and/or per service (for example, \$100/day or \$50/visit) regardless of the amount of expenses incurred and without regard to the amount of benefits provided with respect to the event or service under any other health coverage.

(iv) A notice is displayed prominently in the application materials in at least 14 point type that has the following language: “THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.”

(v) The requirement of paragraph (b)(4)(iv) of this section applies to all hospital or other fixed indemnity insurance policy years beginning on or after January 1, 2015, and the requirement of paragraph (b)(4)(i) of this section applies to hospital or other fixed indemnity insurance policies issued on or after January 1, 2015, and to hospital or other fixed indemnity policies issued before that date, upon their first renewal occurring on or after October 1, 2016.

(5) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act, 42 U.S.C. 1395ss, also known as Medigap or MedSupp insurance). The requirements of this part 148 (including genetic non-discrimination requirements), do not apply to Medicare supplemental health insurance policies. However, Medicare supplemental health insurance policies are subject to similar genetic non-discrimination requirements under section 104 of the Genetic Information Nondiscrimination Act of 2008 (Pub. L. 110-233), as incorporated into the NAIC Model Regulation relating to sections 1882(s)(2)(e) and (x) of the Act (The NAIC Model Regulation can be accessed at <http://www.naic.org>).

(6) Coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code (also known as CHAMPUS supplemental programs).