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

(8) Coverage for on-site medical clinics.

(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), or hospital indemnity or other fixed indemnity insurance (for example, $100/day) if the policies meet the requirements of §146.145(b)(4)(ii)(B) and (b)(4)(ii)(C) of this subchapter regarding noncoordination of benefits.

(4) 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).

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

(6) Similar supplemental coverage provided to coverage under a group health plan.

[62 FR 16995, Apr. 8, 1997; 62 FR 31696, June 10, 1997]

Subpart E—Grants to States for Operation of Qualified High Risk Pools

SOURCE: 68 FR 23414, May 2, 2003, unless otherwise noted.

§148.306 Basis and scope.

This subpart implements section 2745 of the Public Health Service Act (the PHS Act). It provides for grants to States that have qualified high risk pools that meet the specific requirements described in §148.310. It also provides specific instructions on how to apply for the grants and outlines the grant review and grant award processes.

§148.308 Definitions.

For the purposes of this subpart, the following definitions apply:

CMS stands for Centers for Medicare & Medicaid Services.

Loss means the difference between expenses incurred by a qualified high risk pool, including payment of claims and administrative expenses, and the premiums collected by the pool.

Qualified high risk pool means a high risk pool that meets the conditions described in §148.128(a)(2)(ii):

(1) It provides to all eligible individuals, as defined in §148.103, health insurance coverage (or comparable coverage) that does not impose any preexisting condition exclusion or affiliation periods for coverage of an eligible individual; and

(2) Provides for premium rates and covered benefits for the coverage consistent with the standards included in the National Association of Insurance Commissioners (NAIC) Model Health Plan for Uninsurable Individuals Act (as in effect as of August 21, 1996) but only if the model has been revised in State regulations to meet all of the requirements of this part and title 27 of the PHS Act.

Standard risk rate means a rate developed by a State using reasonable actuarial techniques and taking into account the premium rates charged by other insurers offering health insurance coverage to individuals in the same geographical service area to which the rate applies. The standard