Sec. 38a-513-3. Minimum standards for group health insurance benefits

The following minimum standards for benefits are prescribed for the categories of coverage noted in subsections (a) to (g), inclusive, of this section. No such group policy or certificate shall be delivered or issued for delivery in this state that does not meet the required minimum standards for the specified categories unless the Commissioner finds that such policies or contracts are approvable as limited benefit health insurance. Nothing in this section shall preclude the issuance of any policy or contract combining two or more categories of coverage.

(a) General Rules.

(1) A "non-cancellable," "guaranteed renewable," or "non-cancellable and guaranteed renewable" 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 non-payment of premium. The policy shall provide that in the event of the insured's death the spouse of the insured, if covered under the policy, shall become the insured.

(2) The terms "non-cancellable," "guaranteed renewable," or "non-cancellable and guaranteed renewable" shall not be used without further explanation. The terms "non-cancellable" or "non-cancellable and 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 set forth in the policy until the age of sixty-five (65) or to eligibility for Medicare, during which period the insurer has no right to unilaterally make any change in any provision of the policy while the policy is in force. Any accident and health or accident only policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age sixty (60) if, at age sixty (60), the insured has the right to continue the policy in force at least to age sixty-five (65) while actively or regularly employed. Except as provided above, the term "guaranteed renewable" may be used only in a policy that the insured has the right to continue in force by the timely payment of premiums until the age of sixty-five (65) or to eligibility for Medicare, during which period the insurer has no right to unilaterally make any change in any provision of the policy while the policy is in force, except as mandated by statute and except that the insurer may make changes in premium rates by classes. Any accident and health or accident only policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age sixty (60) if at age sixty (60), the insured has the right to continue the policy in force at least to age sixty-five (65) while actively and regularly employed.

(3) 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 such person on a pro rata basis.

(4) In the event an insurer cancels or refuses to renew, policies providing pregnancy benefits shall provide for an extension of benefits as to a pregnancy that commences while the policy is in force and for which benefits would have been payable had the policy remained in force.

(5) Policies providing convalescent or extended care benefit following hospitalization

shall not condition such benefits upon admission to the convalescent or extended care facility within a period of less than fourteen (14) days after discharge from the hospital.

(6) Family coverage shall continue for any dependent child who is incapable of self-sustaining employment due to mental or physical handicap on the date that such child's coverage would otherwise terminate under the policy due to the attainment of a specified age limit for children and is chiefly dependent on the insured for support and maintenance. The policy may require that within thirty-one (31) days of such date the company receive due proof of such incapacity in order for the insured to elect to continue the policy in force with respect to such child, or that a separate converted policy be issued at the option of the insured or policyholder.

(7) Any 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, after benefits for the recipient's own expenses have been paid.

(8) A policy may contain a provision relating to recurrent disabilities, except that no such provision shall specify that a recurrent disability be separated by a period of greater than six (6) months.

(9) Accidental death and dismemberment benefits shall be payable if the loss occurs within ninety (90) days after the date of the accident, irrespective of total disability. Disability income benefits, if provided, shall not require the loss to commence less than thirty (30) days after the date of accident, nor shall any policy that the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the policy was in force.

(10) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.

(11) Any accident only policy providing benefits that vary according to the type of accidental cause shall prominently describe the circumstances under which benefits are payable that are lesser than the maximum amount payable under the policy.

(12) Termination of the policy shall be without prejudice to any continuous loss that commenced while the policy was in force, but the extension of benefits beyond the period the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

(b) "Hospital Confinement Indemnity Coverage" is a policy or certificate that provides daily benefits for hospital confinement on an indemnity basis in an amount not less than thirty dollars ($30) per day and not less than thirty-one (31) days during any one period of confinement for each person insured under the policy.

(c) "Disability Income Protection Coverage" is a policy or certificate that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination thereof that:

(1) Provides that periodic payments that are payable at ages after age sixty-two (62) and reduced solely on the basis of age are at least fifty percent (50%) of amounts payable immediately prior to age sixty-two (62).

(2) Contains an elimination period no greater than:

(A) Ninety (90) days in the case of a coverage providing a benefit period of one (1) year or less;

(B) One hundred and eighty (180) days in the case of coverage providing a benefit of more than one (1) year but not greater than two (2) years, or

(C) Three hundred and sixty-five (365) days in all other cases during the continuance of disability resulting from sickness or injury.

(3) Has a maximum period of time for which it is payable during disability of at least six (6) months except in the case of a policy covering disability arising out of pregnancy, childbirth, or miscarriage in which case the period for such disability may be one (1) month. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period. This section does not apply to those policies providing business buyout coverage.

(d) "Accident Only Coverage" is a policy or certificate that provides coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under such a policy shall be at least one thousand dollars ($1,000) and a single dismemberment amount shall be at least five hundred dollars ($500).

(e) "Specified Accident Coverage" is a policy or certificate 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 one thousand dollars ($1,000) for accidental death; one thousand dollars ($1,000) for double dismemberment and five hundred dollars ($500) for single dismemberment.

(f) "Limited Benefit Health Insurance Coverage" is any policy or certificate that covers all of the minimum standards of a category of the type specified in subdivisions (1), (2), (3), (4), (5), (6), and (8) of section 38a-469 of the Connecticut General Statutes but at a lower level of coverage.

(g) "Specified Disease Coverage" is a policy or certificate delivered or issued for delivery in this state that pays benefits for the diagnosis or treatment of one or more specifically named diseases, conditions or syndromes in accordance with section 38a-513-4(g)(13) of the Regulations of Connecticut State Agencies.

(h) "Accident," "Accidental Injury," or "Accidental Means" shall be defined to employ "result" language and shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization. The definition shall not be more restrictive than the following: Injury or injuries, for which benefits are provided, means accidental bodily injuries sustained by the insured person that are the direct cause, independent of disease or bodily infirmity or any other cause and occur while the insurance is in force. Such definition may provide that injuries shall not include injuries for which benefits are provided under any workers' compensation, employers' liability or similar law, the basic reparations benefits of any motor vehicle no-fault plan or injuries occurring while the insured person is engaged in any activity pertaining to any trade, business, employment, or occupation for wage or profit.

(i) "Condition" includes specifically named diseases, conditions or syndromes unless the context otherwise requires.

(j) "Convalescent Nursing Home," "Extended Care Facility," or "Skilled Nursing Facility" shall be defined in relation to its status, facilities, and available services.

(1) A definition of such home or facility shall not be more restrictive than one requiring that it:

(A) Be operated pursuant to law;

(B) Be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;

(C) Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

(D) Provide continuous twenty-four (24) hours a day nursing service by or under the supervision of a registered nurse;

(E) Maintain a daily medical record of each patient.

(2) The definition of such home or facility may provide that such term shall not be inclusive of:

(A) Any home, facility or part thereof used primarily for rest;

(B) A home or facility for the aged or for the care of drug addicts or alcoholics; or

(C) A home or facility primarily used for the care and treatment of mental diseases or disorders or custodial or educational care.

(k) "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals.

(1) The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

(A) Be an institution operated pursuant to law; and

(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 duly 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 (24) hour nursing service by or under the supervision of registered nurses.

(2) The definition of the term "hospital" may state that such term shall not be inclusive of:

(A) Convalescent homes, convalescent, rest, or nursing facilities; or

(B) Facilities primarily affording custodial, educational or rehabilitative care; or

(C) Facilities for the aged, drug addicts or alcoholics; or

(D) Any military or veterans' hospital or soldiers' home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or former members of the Armed Forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

(*l*) "Medicare" shall be defined in any hospital, surgical or medical expense policy that relates its coverage to eligibility for Medicare or Medicare benefits. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of

America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof" or words of similar import.

(m) "Nurses" may be defined so that the description of nurse is restricted to a type of nurse, such as registered nurse or licensed practical nurse. If the words "nurse," "trained nurse" or "registered nurse" are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualifies under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

(n) "Partial Disability" shall be defined in relation to the individual's inability to perform one or more, but not all, of the "major," "important," or "essential" duties of his employment or occupation or may be related to a "percentage" of time worked or to a "specified number of hours" or to "compensation." Where a policy provides total disability benefits and partial disability benefits, only one (1) elimination period may be required.

(o) "Physician" shall be defined as a person who is licensed by the state in which he or she practices to give treatment for which benefits are provided under the policy and who is acting within the scope of his or her license.

(p) "Pre-existing condition" shall not be defined to be more restrictive than the following: Pre-existing condition means the existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a five (5) year period preceding the effective date of the coverage of the insured person or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a five (5) year period preceding the effective date of the coverage of the insured person. This definition does not prohibit an insurer, using an application form designated to elicit the complete health history of a prospective insured and on the basis of the answers on that application, from underwriting in accordance with that insurer's established standards. It is assumed that an insurer that elicits a complete 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 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 forms containing questions relating to the prospective insured's health. This definition does, however, prohibit an insurer that elects to use a simplified application, with or without a question as to the applicant's health at the time of application, from reducing or denying a claim on the basis of the existence of a pre-existing condition that is defined more restrictively than above.

(q) "Residual Disability" shall be defined in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major," "important," or "essential duties" of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. A policy that provides for residual disability benefits may require a qualification period, during which the insured person 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.

(r) "Sickness" shall not be defined to be more restrictive than the following: Sickness means sickness or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period that shall not exceed thirty (30) days from the effective date of the coverage of the insured person. The definition may be further modified to exclude sickness or disease for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

(s) (1) "Total Disability" shall not be defined more restrictively than to mean an individual who is (A) totally disabled from engaging in any employment or occupation for which such individual is, or becomes, qualified by reason of education, training or experience, and (B) not engaged in any employment or occupation for wage or profit.

(2) "Total disability" may be defined in relation to the inability of an individual 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 such individual's occupation, or (B) engage in any training or rehabilitation program. An insurer may require that an individual be completely unable to perform all of the substantial and material duties of such individual's regular occupation to be totally disabled, and may require that an individual receive care from a physician who is not the insured or a member of the insured's immediate family.

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