Sec. 38a-495-5. Minimum benefit standards

(a) No insurance policy or subscriber contract which provides benefits to any resident of this State may be advertised, solicited or issued for delivery in this State who is eligible for Medicare which does not meet the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

(b) **General Standards.** The following standards apply to Medicare supplement policies and are in addition to all other requirements of Sections 38a-495-1 to 38a-495-17, inclusive.

(1) A Medicare supplement policy may not deny a claim for losses incurred more than six (6) months from the effective date of coverage for a preexisting condition. The policy may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

(2) A Medicare supplement policy may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes only with the prior approval of the Commissioner.

(4) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement policy shall not: (A) provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or (B) be cancelled or nonrenewed by the insurer solely on the grounds of deterioration of health.

(5) (A) Except as authorized by the Commissioner, an insurer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(B) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in paragraph (D) of this subdivision, the insurer shall offer certificateholders an individual Medicare supplement policy. The insurer shall offer the certificateholder at least the following choices:

(i) an individual Medicare supplement policy which provides for continuation of the benefits contained in the group policy; and

(ii) an individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards.

(C) If membership in a group is terminated, the insurer shall:

(i) offer the certificateholder such conversion opportunities as are described in paragraph (B); or

(ii) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(D) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the old group policy on its date of termination.

Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(6) Termination of a Medicare supplement policy shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which 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.

(c) **Minimum Benefit Standards.** The following standards apply to Medigap policies and are in addition to all other requirements of this regulation.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period.

(2) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount.

(3) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days.

(4) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days.

(5) Coverage for the daily copayment amount of Medicare Part A eligible expenses for skilled nursing facility care.

(6) Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B.

(7) Coverage for either all or none of the Medicare Part B deductible amount.

(8) No Medicare supplement policy shall provide coverage for amounts which exceed the co-payment for Medicare eligible expenses under Part B, unless such additional coverage will provide for reimbursement of 100 percent of the usual and prevailing charges for Medical care. This 100 percent reimbursement shall not be made subject to any additional deductibles.

(9) Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible.

(10) Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

(d) **Medicare Eligible Expenses.** Medicare eligible expenses shall mean health care expenses of the kinds covered by Medicare, to the extent recognized as reasonable by Medicare. Payment of benefits by insurers for Medicare eligible expenses may be conditioned upon the same or less restrictive payment conditions, including determinations of medical necessity as are applicable to Medicare claims.

(e) Any Medicare supplement policy which is not a Medigap policy shall be disapproved

by the Commissioner if it contains a provision or provisions which are unfair or deceptive or which encourage misrepresentation of the policy.

(Effective September 25, 1992)