Agency

Insurance Department

Subject

Individual Accident and Sickness Insurance Minimum Standards

Inclusive Sections

§§ 38a-505-1—38a-505-13

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Individual Accident and Sickness Insurance Minimum Standards

Sec. 38a-505-1. Purpose

The purpose of this regulation is to implement Section 38a-505 of the Connecticut General Statutes so as to provide reasonable standardization and simplification of terms and coverages of individual accident and sickness insurance policies and fraternal benefit society certificates in order to facilitate public understanding and comparison and to eliminate provisions contained in individual accident and sickness insurance policies which may be misleading or confusing in connection either with the purchase of such coverages or with the settlement of claims and to provide for full disclosure in the sale of such coverages.

(Effective September 25, 1992)

Sec. 38a-505-2. Authority

This regulation is issued pursuant to the authority vested in the Commissioner under Section 38a-505 of the Connecticut General Statutes.

(Effective September 25, 1992)

Sec. 38a-505-3. Applicability and scope

This regulation shall apply to all individual accident and sickness insurance policies and fraternal benefit society certificates delivered or issued for delivery in this State on and after the effective date hereof; except, it shall not apply to individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when such group or individual policy or contract includes provisions which are inconsistent with the requirements of this regulation, nor to policies being issued to employees or members as additions to franchise plans in existence on the effective date of this regulation. The requirements contained in this regulation shall be in addition to any other applicable regulations or bulletins previously adopted and not inconsistent therewith.

(Effective September 25, 1992)

Sec. 38a-505-4. Effective date

This regulation shall be effective on January 1, 1979 or 180 days after the date of adoption of the regulation, whichever is later, and shall be applicable to all individual accident and sickness insurance policies and fraternal benefit society certificates delivered or issued for delivery in this State on and after such date which are not specifically exempt from this regulation.

(Effective September 25, 1992)

Sec. 38a-505-5. Policy definitions

Except as provided hereafter, no individual accident or sickness insurance policy or fraternal benefit society certificate delivered or issued for delivery to any person in this

State shall contain definitions respecting the matters set forth below unless such definitions comply with the requirements of this section.

(A) "One Period of Confinement" means consecutive days of in-hospital service received as an in-patient, or successive confinements when discharged from and readmission to the hospital occurs within a period of time not more than 90 days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of 180 days.

(B) "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 24 hour nursing service by or under the supervision of registered graduate professional nurses (R.N.'s).

(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 rehabilitory 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 ex-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.

(C) "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 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.);

(e) Maintains a daily medical record of each patient.

(2) The definition of such home of 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.

(D) "Accident," "Accidental Injury," "Accidental Means" shall be defined to employ "result" language and shall not include words which 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 which 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.

(E) "Sickness" shall not be defined to be more restrictive than the following: Sickness means sickness or disease of an insured person which 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 which will 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.

(F) "Pre-existing condition shall not be defined to be more restrictive than the following: Pre-existing condition means the existence of symptoms which 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 which 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.

(G) "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.

(H) "Nurses" may be defined so that the description of nurse is restricted to a type of nurse, such as registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the words "nurse," "trained nurse" or "registered nurse" are used without specific intruction, 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.

(I) "Total Disability."

(1) A general definition of total disability cannot be more restrictive than one requiring the individual to be totally disabled from engaging in any employment or occupation for which he is or becomes qualified by reason of education, training or experience and 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 any training or rehabilitation program.

(3) An insurer may specify the requirement of the complete inability of the person to perform all of the substantial and material duties of his 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).

(J) "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 elimination period may be required.

(K) "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 which 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 which in the opinion of the commissioner adequately and fairly describes the benefit.

(L) "Medicare" shall be defined in any hospital, surgical or medical expense policy which 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) "Mental or Nervous Disorders" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

(Effective September 25, 1992; Amended September 9, 2013)

Sec. 38a-505-6. Separability

If any provision of this regulation (Secs. 38a-505-1—38a-505-5) or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

(Effective September 25, 1992)

Sec. 38a-505-7. Prohibited policy provisions

(A) Except as provided in Section 38a-505-5(E), no policy shall contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy subject to the further exception that a policy may specify a probationary or waiting period not to exceed six (6) months for specified diseases or conditions and losses resulting therefrom for hernia, disorder of reproductive organs, varicose veins, adenoids, appendix and tonsils. However, the permissible six (6) months exception shall not be applicable where such specified diseases or conditions are treated on an emergency basis. Accident policies shall not contain probationary or waiting periods.

(B) No policy or rider for additional coverage may be issued as a dividend unless an equivalent cash payment is offered to the policyholder as an alternative to such dividend policy or rider. No such dividend policy or rider shall be issued for an initial term of less than six (6) months. The initial renewal subsequent to the issuance of any policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that such renewal is optional with the policyholder.

(C) No policy shall exclude coverage for a loss due to a pre-existing condition for a period greater than twelve (12) months following policy issue where the application for such insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and such pre-existing condition is not specifically excluded by the terms of the policy.

(D) A disability income policy may contain a "return of premium" or "cash value benefit" so long as:

(1) The insurance policy is non-cancellable or, if the benefit is added by rider, it is attached to a non-cancellable policy.

(2) The forms provide for the payment of surrender value upon (a) the written request of the insured, and surrender of the policy, (b) lapse of the policy, (c) death of the insured, or (d) on the termination date of the contract.

(3) the surrender value is based on policy duration, premiums paid by the insured and benefits paid by the company. A refund is available after a policy has been in force a minimum of three years (two years on policies issued on ages 46-50).

(4) The form is not issued beyond age 50.

(5) The insurer includes a detailed statement of the method of computing the premium rates, the tables of cash value, and the estimated loss ratio.

(6) The insurer includes a demonstration of the fiscal integrity of the product and the company.

(7) The form is not on the basis of the 10 year roll-over concept.

(E) No other policy shall provide a return of premium or cash value benefit, except returned or 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.

(F) Policies providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the Federal Government.

(G) No policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition except as follows:

(1) Pre-existing conditions or diseases, except for congenital anomalies of a covered dependent child;

(2) Mental or emotional disorders, alcoholism and drug addiction except as set forth in section 38a-488a of the Connecticut General Statutes;

(3) Pregnancy, except for complications of pregnancy, other than for policies defined in section 38a-505-9(F) of the Regulations of Connecticut State Agencies;

(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 thereto;

(b) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury except with respect to individual health insurance policies providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the Connecticut General Statutes;

(c) Aviation;

(d) With respect to short-term renewable policies, inter-scholastic sports;

(5) Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such 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 of a covered dependent child which has resulted in a functional defect;

(6) Treatment provided in a government hospital, benefits provided under Medicare or

other governmental program (except Medicaid), any state or federal workers' compensation, employers liability or occupational disease law, or the basic reparations benefits of any 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.

(7) Dental care or treatment except as set forth in sections 38a-491, 38a-491a, and 38a-491b, inclusive, of the Connecticut General Statutes;

(8) Eye glasses, hearing aids and examination for the prescription or fitting thereof except as set forth in section 38a-490b of the Connecticut General Statutes;

(9) Rest cures, custodial care, transportation and routine physical examinations; and

(10) Territorial limitations.

(H) Other provisions of this regulation shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described pre-existing 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 of the policy or unless notice of the waiver appears on the first page or specification page.

(I) Policy provisions precluded in this Section shall not be construed as a limitation on the authority of the Commissioner to disapprove other policy provisions in accordance with Section 38a-481 of the Connecticut General Statutes which, in the opinion of the Commissioner, are unjust, unfair, or deceptive, or unfairly discriminatory to the policyholder, beneficiary, or any person insured under the policy or which encourage misrepresentation of the policy.

(Effective September 25, 1992; Amended August 30, 2004)

Sec. 38a-505-8. Separability

If any provision of this regulation (Sec. 38a-505-7) or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

(Effective September 25, 1992)

Sec. 38a-505-9. Accident and sickness minimum standards for benefits

The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. No individual policy of accident and sickness insurance or fraternal benefit society certificate shall be delivered or issued for delivery in this State which 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 and the outline of coverage complies with the appropriate outline in Section 38a-505-10 (K). Nothing in this section shall preclude the issuance of any policy

or contract combining two or more categories of coverage such as hospital expense coverage and medical-surgical expense 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 explanatory language in accordance with the disclosure requirements of Section 38a-505-10 (A) (1). The terms "non-cancellable" or "non-cancellable and guaranteed renewable" may be used only in a policy which 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 make unilaterally any change in any provision of the policy while the policy is in force; provided, however, any accident and health or accident only policy which 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 which 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 make unilaterally 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; provided, however, any accident and health or accident only policy which 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) In a family policy covering both husband and wife, the age of the younger spouse must be used as the basis for meeting the age and durational requirements of the definitions of "non-cancellable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age limit (e.g., age 65) 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 said definition.

(4) When accidental death and dismemberment coverage is part of the insurance coverage offered under the contract, the insured shall have the option to include all insureds under such coverage and not just the principal insured.

(5) If a policy contains a status type military service exclusion or a provision which

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.

(6) In the event the insurer cancels or refuses to renew, policies providing pregnancy benefits shall provide for an extension of benefits 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 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.

(8) Family coverage shall continue for any dependent child who is incapable of self-sustaining employment due to mental retardation 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 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.

(9) 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.

(10) A policy may contain a provision relating to recurrent disabilities, provided, however, that no such provision shall 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 benefits, if provided, shall not require the loss to commence less than thirty (30) days after the date of accident, nor shall any policy which 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.

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

(13) Any accident only policy providing benefits which vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits are payable which are lesser than the maximum amount payable under the policy.

(14) All Medicare supplement policies providing in-hospital benefits only shall include in their provided benefits the initial Part A Medicare deductible as established from time to time by the Social Security Administration.

(15) Termination of the 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

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) **Basic Hospital Expense Coverage—**"Basic Hospital Expense Coverage" is a policy of accident and sickness insurance which provides coverage for a period of not less than thirty-one (31) days during any one period of confinement for each person insured under the policy for expense incurred for necessary treatment and services rendered as a result of accident or sickness for at least the following:

(1) Daily hospital room and board in an amount not less than the lesser of (a) 80% of the charges for semi-private room accommodations, or (b) $30.00 per day;

(2) Miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than either 80% of the charges incurred up to at least $1,000.00 or ten times the daily hospital room and board benefits; and

(3) Hospital outpatient services consisting of (a) hospital services on the day surgery is performed, and (b) hospital services rendered within seventy-two (72) hours after accidental injury, in an amount not less than $50.00, and (c) X-ray laboratory tests to the extent that benefits for such services would have been provided to an extent not less than $100.00 if rendered to an in-patient of the hospital.

(4) Benefits provided under (1) and (2) above may be provided subject to a combined deductible amount not in excess of $100.00.

(C) **Basic Medical-Surgical Expense Coverage—**"Basic Medical-Surgical Expense Coverage" is a policy of accident and sickness insurance which provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for at least the following:

(1) Surgical services:

(a) In amounts not less than those provided on a fee schedule based on an acceptable relative value scale of surgical procedures, such as the 1964 California Relative Value Schedule, up to a maximum of at least $500.00 for any one procedure; or

(b) Not less than 80% of the reasonable charges.

(2) Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician (or his assistant) performing the surgical service:

(a) In an amount not less than 80% of the reasonable charges; or

(b) 15% of the surgical service benefit.

(3) In-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than 80% of the reasonable charges; or $5.00 per day for not less than twenty-one (21) days during one period of confinement.

(D) **Hospital Confinement Indemnity Coverage—**"Hospital Confinement Indemnity

Coverage" is a policy of accident and sickness insurance which provides daily benefits for hospital confinement on an indemnity basis in an amount not less than $30.00 per day and not less than thirty-one (31) days during any one period of confinement for each person insured under the policy.

(E) **Major Medical Expense Coverage—**"Major medical expense coverage" is an accident and sickness insurance policy which provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than $10,000.00; copayment by the covered person not to exceed 25% of covered charges; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of such bases not to exceed 5% of the aggregate maximum limit under the policy, unless the policy is written to complement underlying hospital and medical insurance in which case such deductible may be increased by the amount of the benefits provided by such underlying insurance, for each covered person for at least:

(1) Daily hospital room and board expenses, prior to application of the copayment percentage, for not less than $50.00 daily (or in lieu thereof the average daily cost of semi-private room rate in the area where the insured resides) for a period of not less than 31 days during continuous hospital confinement;

(2) Miscellaneous hospital services, prior to application of the copayment percentage, for an aggregate maximum of not less than $1,500 or 15 times the daily room and board rate if specified in dollar amounts;

(3) Surgical services, prior to application of the copayment percentage, to a maximum of not less than $600 for the most severe operations with the amounts provided for other operations reasonably related to such maximum amount;

(4) Anesthesia services, prior to application of the copayment percentage, for a maximum of not less than 15 percent of the covered surgical fees or alternatively, if the surgical schedule is based on relative values, not less than the amount provided therein for anesthesia services at the same unit value as used for the surgical schedule;

(5) In-hospital medical services, prior to the application of the copayment percentage, as defined in subdivision (C) (3) of Section 38a-505-9;

(6) Out-of-hospital care, prior to application of the copayment percentage, consisting of physician's services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury; and diagnostic X-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician; and

(7) Not fewer than three of the following additional benefits, prior to application of the copayment percentage, for an aggregate maximum of such covered charges of not less than $1,000;

(a) In-hospital private duty graduate registered nurse services;

(b) Convalescent nursing home care;

(c) Diagnosis and treatment by a radiologist or physiotherapist;

(d) Rental of special medical equipment, as defined by the insurer in the policy;

(e) Artificial limbs or eyes, casts, splints, trusses or braces;

(f) Treatment for functional nervous disorders, and mental and emotional disorders;

(g) Out-of-hospital prescription drugs and medications.

(F) **Disability Income Protection Coverage—**"Disability income protection coverage" is a policy which 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 which:

(1) Provides that periodic payments which are payable at ages after 62 and reduced solely on the basis of age are at least 50% of amounts payable immediately prior to 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 year but not greater than two 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. Section 38a-505-9 (F) does not apply to those policies providing business buyout coverage.

(G) **Accident Only Coverage—**"Accident only coverage" is a policy of accident insurance which 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 $1,000.00 and a single demberment amount shall be at least $500.00.

(H) **"Specified Accident Coverage"** is an accident insurance policy which 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 $1,000.00 for accidental death; $1,000.00 for double dismemberment and $500.00 for single dismemberment.

(I) **"Limited Benefit Health Insurance Coverage"** is any policy or contract which provides benefits that are less than the minimum standards for benefits required under Sections 38a-505-7 (B), (C), (D), (E), (F), (G) and (H). Such policies or contracts may be delivered or issued for delivery in this state only if the outline of coverage required by Section 38a-505-10 (K) is completed and delivered as required by Section 38a-505-10 (B).

(Effective September 25, 1992)

Sec. 38a-505-10. Required disclosure provisions

(A) **General Rules.**

(1) Each individual policy of accident and sickness insurance or fraternal benefit society

certificate shall include a renewal, continuation, or non-renewal provision. The language or specifications of such provision must be consistent with the type of contract to be issued. Such 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.

(2) Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all riders or endorsements added to a policy after date of issue or at reinstatement or renewal which 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 which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increase benefit or coverage is required by law.

(3) Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

(4) A policy which 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 such terms and an explanation of such terms in its accompanying outline of coverage.

(5) If a policy contains any limitations with respect to pre-existing conditions, such limitations must appear as a separate paragraph of the policy and be labeled as "Pre-existing Conditions Limitations."

(6) All accident only policies shall contain a prominent statement on the first page of the policy or attached thereto in either contrasting color or in boldface type at least equal to the size of type used for policy captions, a prominent statement as follows: "This is an accident only policy and it does not pay benefits for loss from sickness."

(7) All policies, except single premium non-renewable policies, shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy within ten (10) days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.

(8) If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy as originally issued, such fact must be prominently set forth in the outline of coverage.

(9) If a policy 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 indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised. The provision shall 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.

(B) **Outline of Coverage Requirements for Individual Coverages—**No individual accident and sickness insurance policy or fraternal benefit society certificate subject to this regulation shall be delivered or issued for delivery in this State unless an appropriate outline of coverage as prescribed in Sections 38a-505-10 (C) through 38a-505-10 (K) is completed as to such policy or contract; and

(1) Is either delivered with the policy; or

(2) Delivered to the applicant at the time application is made and acknowledgement of receipt or certification of delivery of such outline of coverage is provided to the insurer.

If an outline of coverage was delivered at the time of application and the policy or contract is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or contract must accompany the policy or contract when it is delivered and contain the following statement, in no less than twelve (12) point type, immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is *not* identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

The appropriate outline of coverage for policies or contracts providing hospital coverage which only meets the standards of Section 38a-505-9 (B) shall be that statement contained in Section 38a-505-10 (C). The appropriate outline of coverage for policies providing coverage which meets the standards of both Sections 38a-505-9 (B) and 38a-505-10 (C) shall be the statement contained in Section 38a-505-9 (E). The appropriate outline of coverage for policies providing coverage which meets the standards of both Sections 38a-505-9 (B) and 38a-505-9 (E) or Sections 38a-505-9 (C) and 38a-505-9 (E) or Sections 38a-505-9 (B), 38a-505-9 (C) and 38a-505-9 (E) shall be the statement contained in Section 38a-505-10 (C).

In any other case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or contract, an alternate outline of coverage may be submitted to the Commissioner for prior approval.

(C) **Basic Hospital Expense Coverage** (Outline of Coverage)—An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 38a-505-9 (B). The items included in the outline of coverage *must appear in the sequence prescribed.*

(Company Name)

Basic Hospital Expense Coverage

Outline of Coverage

(1) **Read Your Policy Carefully—**This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) **Basic Hospital Expense Coverage—**Policies of this category are designed to provide to persons insured coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, and hospital outpatient services, subject to any limitations, deductibles and co-payment requirements set forth in the policy. Coverage is not provided for physician's or surgeon's fees or *unlimited* hospital expenses.

(3) (A brief *specific* description of the benefits, including dollar amounts and number of days duration where applicable, contained in *this policy,* in the following order:

(a) Daily hospital room and board;

(b) Miscellaneous hospital services;

(c) Hospital outpatient services; and

(d) Other benefits, if any.

*NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(D) **Basic Medical-Surgical Expense Coverage** (Outline of Coverage)—An outline of coverage in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 38a-505-9 (C). The items included in the outline of coverage *must appear in the sequence prescribed.*

(Company Name)

Basic Medical-Surgical Expense Coverage

Outline of Coverage

(1) **Read Your Policy Carefully—**This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) **Basic Medical-Surgical Expense Coverage—**Policies of this category are designed to provide to persons insured coverage for medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and co-payment requirements set forth in the policy. Coverage is not provided for hospital expenses or *unlimited* medical-surgical expenses.

(3) (A brief *specific* description of the benefits, including dollar amounts and number of

days duration where applicable, contained in *this policy,* in the following order:

(a) Surgical services;

(b) Anesthesia services;

(c) In-hospital medical services; and

(d) Other benefits, if any.

*NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.)

(4) (A descripton of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(E) **Basic Hospital and Medical Surgical Expense Coverage (Outline of Coverage)—** An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Sections 38a-505-9 (B) and 38a-505-9 (C). The items included in the outline of coverage *must appear in the sequence prescribed.*

(Company Name)

Basic Hospital and Medical Surgical Expense Coverage

Outline of Coverage

(1) **Read Your Policy Carefully—**This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) **Basic Hospital and Medical Surgical Expense Coverage—**Policies of this category are designed to provide, to persons insured, coverage for hospital and medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital out-patient services, surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and co-payment requirements set forth in the policy. Coverage is not provided for *unlimited* hospital or medical-surgical expenses.

(3) (A brief *specific* descripton of the benefits, including dollar amounts and number of days duration where applicable, contained in *this policy,* in the following order:

(a) Daily hospital room and board;

(b) Miscellaneous hospital services;

(c) Hospital outpatient services;

(d) Surgical services;

(e) Anesthesia services;

(f) In-hospital medical services; and

(g) Other benefits, if any.

*NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability of continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(F) **Hospital Confinement Indemnity Coverage** (Outline of Coverage)—An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 38a-505-9 (D). The items included in the outline of coverage *must appear in the sequence prescribed.*

(Company Name)

Hospital Confinement Indemnity Coverage

Outline of Coverage

(1) **Read Your Policy Carefully—**This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) **Hospital Confinement Indemnity Coverage—**Policies of this category are designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Such policies do not provide any benefits other than the fixed daily indemnity for hospital confinement and any additional benefits described below.

(3) (A brief *specific* description of the benefits contained in *this policy,* in the following order:

(a) Daily benefit payable during hospital confinement; and

(b) Duration of benefit described in (a).

*NOTE: The above description of benefits shall be stated clearly and concisely.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(6) Any benefits provided in addition to the daily hospital benefit.

(G) **Major Medical Expense Coverage** (Outline of Coverage)—An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the

standards of Section 38a-505-9 (E). The items included in the outline of coverage *must appear in the sequence prescribed.*

(Company Name)

Major Medical Expense Coverage

Outline of Coverage

(1) **Read Your Policy Carefully—**This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) **Major Medical Expense Coverage—**Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, co-payment provisions, or other limitations which may be set forth in the policy. *Basic* hospital or *basic* medical insurance coverage is not provided.

(3) (A brief *specific* description of the benefits, including dollar amounts, contained in *this policy,* in the following order:

(a) Daily hospital room and board;

(b) Miscellaneous hospital services;

(c) Surgical services;

(d) Anesthesia services;

(e) In-hospital medical services;

(f) Out-of-hospital care;

(g) Maximum dollar amount for covered charges; and

(h) Other benefits, if any.

*NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

(H) **Disability Income Protection Coverage** (Outline of Coverage)—An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 38a-505-9 (F). The items included in the outine of coverage *must appear in the sequence prescribed.*

(Company Name)

Disability Income Protection Coverage

Outline of Coverage

(1) **Read Your Policy Carefully—**This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) **Disability Income Protection Coverage—**Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major-medical expenses.

(3) (A brief *specific* description of the benefits contained in *this policy*: *NOTE: The above description of benefits shall be stated clearly and concisely.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(I) **Accident Only Coverage** (Outline of Coverage)—An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 38a-505-9 (G). The items included in the outline of coverage *must appear in the sequence prescribed.*

(Company Name)

Accident Only Coverage

Outline of Coverage

(1) **Read Your Policy Carefully—**This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) **Accident Only Coverage—**Policies of this category are designed to provide, to persons insured, coverage for certain losses resulting from a covered accident *ONLY,* subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major-medical expenses.

(3) (A brief *specific* description of the benefits contained in *this policy*: *NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a

description of any deductible or co-payment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with subsection (A) (13) of Section 38a-505-9.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(J) **Specified Accident Coverage** (Outline of Coverage)—An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 38a-505-9 (H). The items included in the outline of coverage *must appear in the sequence prescribed.*

(Company Name)

Specified Accident Coverage

Outline of Coverage

(1) **Read Your Policy Carefully—**This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) **Specified Accident Coverage—**Policies of this category are designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of specified accidents. Coverage is not provided for basic hospital, basic medical-surgical, or major-medical expense.

(3) (A brief *specific* description of the benefits, including dollar amounts, contained in *this policy*:

*NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with subsection (A) (13) of Section 38a-505-9.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(K) **Limited Benefit Health Coverage** (Outline of Coverage)—An outline of coverage, in the form prescribed below, shall be issued in connection with policies which do not meet the minimum standards of Section 38a-505-9 (B), (C), (D), (E), (F), (G) and (H). The items included in the outline of coverage *must appear in the sequence prescribed.*

(Company Name)

Limited Benefit Health Coverage

Outline of Coverage

(1) **Read Your Policy Carefully—**This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) **Limited Benefit Health Coverage—**Policies of this category are designed to provide, to persons insured, limited or supplemental coverage.

(3) (A brief *specific* description of the benefits, including dollar amounts, contained in *this policy:*

*NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with subsection (A) (13) of Section 38a-505-9.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(Effective September 25, 1992)

Sec. 38a-505-11. Requirements for replacement

(A) Application forms shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and sickness insurance presently in force. A supplementary application or other form to be signed by the applicant containing such a 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 (C) below. One (1) copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in (D) below. In no event, however, will such a notice be required in the solicitation of the following types of policies: accident only and single premium nonrenewable policies.

(C) The notice required by (B) above for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

Notice to Applicant Regarding Replacement

of Accident and Sickness Insurance

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by (Company Name) Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____

(date)

_____

(applicant's signature)

(D) The notice required by (B) above for a direct response insurer shall be as follows:

Notice to Applicant Regarding Replacement
of Accident and Sickness Insurance

According to (your application) (information you have furnished) you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with the policy delivered herewith issued by (Company Name) Insurance Company. Your new policy provides 10 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay

of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) (To be included only if the application is attached to the policy.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (Company Name and Address) within 10 days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)

_____

(Effective September 25, 1992)

Sec. 38a-505-12. Separability

If any provision of this regulation (Secs. 38a-505-9—38a-505-11) or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

(Effective September 25, 1992)

Sec. 38a-505-13. Specified disease policies

(a) A "specified disease policy" means an individual health insurance policy delivered or issued for delivery in this state which pays benefits for the diagnosis or treatment of one or more specifically named diseases, conditions or syndromes in accordance with section 38a-505-13 (c) of the Regulations of Connecticut State Agencies. As used in this section, "condition" includes specifically named diseases, conditions or syndromes unless the context otherwise requires. Any specified disease policy shall meet the general requirements in subsection (b) of this section and the minimum benefit standards pursuant to subsection (c) of this section.

(b) **General Requirements**:

The following requirements shall apply to specified disease policies in addition to all other requirements applicable to individual accident and sickness policies.

(1) Policies covering a single specified condition or combination of specified conditions may not be sold or offered for sale other than as specified disease policies.

(2) Any policy issued pursuant to this section which conditions payment upon

pathological diagnosis of a covered condition, shall also provide that if such a pathological diagnosis is medically inappropriate, a clinical diagnosis shall be accepted in lieu thereof.

(3) Notwithstanding any other provision of this section, specified disease policies described in Section 38a-505-13 (c)(1) and Section 38a-505-13 (c)(2) of the Regulations of Connecticut State Agencies shall provide benefits to any covered person not only for a specified condition but also for any other condition directly caused or aggravated by the specified condition or its treatment.

(4) Specified disease policies shall be at least guaranteed renewable.

(5) No policy issued pursuant to this section shall contain a waiting or probationary period greater than thirty (30) days. Premiums paid shall be refunded if the insured is diagnosed with a covered condition during the waiting or probationary period.

(6) Payment of benefits may be conditioned upon a covered person receiving medically necessary care or treatment.

(7) Any application for a specified disease policy shall contain a prominent statement above the signature of the applicant that a person who is already covered by Medicaid should not purchase this coverage. Such statement shall be in bold face type or contrasting color.

(8) The benefits of a specified disease policy shall be paid regardless of other coverage.

(9) Benefit payments under specified disease policies described in Section 38a-505-13 (c)(1) and Section 38a-505-13 (c)(2) of the Regulations of Connecticut State Agencies shall begin with the first day of care or confinement after the effective date of the policy if such care or confinement is for a covered condition even though the diagnosis of a covered condition is made at some later date (but not retroactive more than ninety (90) days from the date of diagnosis) if the initial care or confinement was for diagnosis or treatment of such covered condition.

(10) Specified disease policies shall provide a thirty (30) day free look. Notice of the thirty (30) day free look shall appear on the face page of the policy in bold face equal to at least fourteen (14) point type.

(11) Specified disease policies shall contain a prominent statement on the first page of the policy in bold face type at least equal to fourteen (14) point type as follows: "CAUTION" This policy provides limited coverage. It is not a major medical policy. Read it carefully. It only pays benefits for treatment (or diagnosis) of (specified disease).

(12) The premiums for a policy shall be reasonable in relation to benefits and shall not be excessive or inadequate. The insurer shall establish premiums for specified disease policies in accordance with generally accepted actuarial principles and practices so as to return to policyholders in the form of aggregate benefits provided under the policy during the period for which rates are computed at least sixty-five per cent (65%) of the aggregate premiums earned. The insurer may also charge an annual policy fee of up to thirty dollars ($30.00), which fee shall be excluded from premium for the purposes of the sixty-five per cent (65%) calculation. Each insurer shall annually report by June 30 earned premiums and incurred claims for the prior calendar year for each approved specified disease policy form in a format acceptable to the insurance commissioner.

(13) "Preexisting condition" shall not be defined to be more restrictive than the following: Preexisting condition means a condition for which medical advice or treatment was recommended by a physician or received from a physician within a twelve (12) month period preceding the effective date of the coverage of the insured person. No policy shall exclude for a loss due to a preexisting condition for a period greater than twelve (12) months following policy issue.

(c) Each specified disease policy shall meet the minimum benefit standards provided in subdivision (1), (2) or (3) of this subsection. In addition, a specified disease policy may combine coverages of the types described in subdivisions (1), (2), and (3) of this subsection. A policy that combines coverages and meets the minimum benefit standard requirements set forth in subdivision (1), (2), or (3) of this subsection may be approved for sale in the state if it includes some, but not all, of the benefits otherwise permitted by another type of specified disease policy, except that policies combining coverage of the types described in subdivisions (1) and (2) of this subsection shall meet the minimum requirements for each type of coverage.

(1) Coverage for medical expenses incurred by each person insured under the policy for one or more specifically named diseases, conditions or syndromes, with a deductible amount not in excess of one thousand dollars ($1,000), co-insurance by the insured not to exceed twenty five per cent (25%), and an overall aggregate lifetime benefit limit, per person, of not less than two hundred and fifty thousand dollars ($250,000). Any inside limits shall be reasonable. Policy benefits shall include:

(A) Hospital room and board and hospital furnished medical services or supplies;

(B) Treatment by, or under the direction of, a physician or surgeon;

(C) Private duty services of a registered nurse (R.N.) or a Licensed Practical Nurse (L.P.N.);

(D) X-ray, radium, cobalt, nuclear medicine, chemotherapy, and other therapeutic procedures used in diagnosis and treatment;

(E) Licensed ambulance for local service to or from a local hospital;

(F) Blood transfusions, and plasma, and the administration thereof;

(G) Drugs and medicines prescribed by a physician;

(H) The rental of any respirator or other mechanical apparatus;

(I) Braces, crutches, wheelchairs and other adaptive devices deemed necessary by the attending physician because of the incapacitating nature of the covered condition;

(J) Transportation beyond the local area for medically necessary treatment;

(K) Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical services rendered by a physician other than the physician (or his assistant) performing the surgical service, in an amount not less than (i) eighty per cent (80%) of the reasonable charges, or (ii) fifteen percent (15%) of the surgical service benefit;

(L) Home health care as described in Section 38a-493(d) of the Connecticut General Statutes;

(M) Physical, speech, hearing and occupational therapy for symptoms related to the covered condition;

(N) Special equipment and supplies, including, but not limited to hospital bed, bedpans, pulleys, wheelchairs, aspirator, disposable diapers, oxygen, surgical dressings, rubber shields, colostomy and eleostomy appliances;

(O) Reconstructive surgery when medically necessary;

(P) Prosthetic devices including wigs and artificial breasts;

(Q) Nursing home care;

(R) Hospice care; and

(S) any other expenses necessarily incurred in the care and treatment of the covered condition.

(2) Per diem indemnification for each person insured under the policy for a specifically named condition with no deductible amount, and an overall aggregate benefit limit of not less than two hundred and fifty thousand dollars ($250,000) while medically confined, subject to the following minimum benefit standards:

(A) A fixed-sum payment of at least one hundred and fifty dollars ($150.00) for each day of hospital confinement;

(B) A fixed-sum payment equal to at least one hundred dollars ($100.00) for each day of hospital or non-hospital out-patient surgery, chemotherapy and radiation therapy; and

(C) A fixed-sum payment equal to one-half of the hospital in-patient benefit for each day of nursing home care, hospice care, and home health care for at least one hundred (100) days.

(3) A fixed-sum one-time payment made not more than thirty (30) days after submission to the insurer of proof of diagnosis of the specified condition, of not less than one thousand dollars ($1,000). In addition, payment amounts may be limited to not less than two hundred fifty dollars ($250) for one or more specified conditions where coverage is provided under such policy for two or more specified conditions, provided that the aggregate amount payable under the policy for all specified conditions is at least one thousand dollars ($1,000). Also, coverage for a fixed-sum payment for a spouse or dependent may be offered to the insured, provided the benefit amount offered is at least twenty-five per cent (25%) of the benefit amount for the insured. Where coverage is advertised or otherwise represented to offer generic coverage of a specified condition, the same dollar amounts shall be payable, regardless of the particular subtype of the condition, unless such subtype is clearly identifiable and the policy clearly differentiates that subtype and its benefits.

(d) No specified disease policy shall be delivered or issued for delivery in this State unless an outline of coverage in the form prescribed below is completed and is delivered with the policy or at the time of application for the policy. The items included in the outline of coverage shall appear in the sequence prescribed below:

CAUTION!

(COMPANY NAME)

(SPECIFIED CONDITION) COVERAGE
OUTLINE OF COVERAGE

(1) Read Your Policy Carefully — This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions shall control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) (Specified condition) Coverage — This policy is designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of (specified condition) treatment (or diagnosis). This policy does NOT provide general health insurance.

(3) This policy is NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from (the company).

(4) (A brief specific description of the benefits, including dollar amounts, contained in this policy.)

(5) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (4) above.)

(6) (A description of policy provisions respecting renewability, including age restrictions and any reservation of right to change premiums.)

(Adopted effective May 31, 1997; Amended June 7, 2010)