Agency

Insurance Department

Subject

Group Specified Disease Health Insurance Minimum Standards

Section

§ 38a-513-1

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Sec. 38a-513-1. Group specified disease policies

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Sec. 38a-513-1. Group specified disease policies

(a) A "group specified disease policy" means a group health insurance policy or certificate 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 38-513-1(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 group 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 group specified disease policies in addition to all other requirements applicable to group accident and sickness policies.

(1) Group policies covering a single specified disease, condition, or syndrome or combination of specified diseases, conditions, or syndromes may not be sold or offered for sale other than as group specified disease policies.

(2) Any group specified disease policy issued pursuant to this section which conditions payment upon pathological diagnosis of a covered disease, condition or syndrome, 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, group specified disease policies described in section 38a-513-1(c) (1) and section 38a-513-1(c) (2) of the Regulations of Connecticut State Agencies shall provide benefits to any covered certificate holder not only for a specified disease, condition or syndrome but also for any other disease, condition or syndrome, directly caused or aggravated by the specified disease, condition or syndrome or its treatment.

(4) All group specified disease policies shall include a provision which allows the certificate holder to continue coverage or convert to an individual specified disease policy in the event of termination of the eligibility of the certificate holder or in the event of the cancellation, nonrenewal or termination of the group specified disease policy. Conversion is to be made without evidence of insurability and without pre-existing conditions limitations or waiting periods, with an effective date that coincides with the date coverage ceased under the group plan.

(5) No group specified disease policy issued pursuant to this section shall contain a waiting or probationary period greater than thirty (30) days. Premiums paid for a certificate holder shall be refunded if the certificate holder is diagnosed with a covered disease, condition or syndrome during the waiting or probationary period. Alternatively, the certificate may provide for an additional option for the certificate holder to continue the certificate in force, but in no event shall benefits for that disease, condition or syndrome be withheld beyond the time period specified in the pre-existing condition provision.

(6) Payment of benefits may be conditioned upon a covered certificate holder receiving

medically necessary care or treatment.

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

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

(9) Benefit payments under group specified disease policies described in section 38a-513-1(c) (1) and section 38a-513-1(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 disease, condition or syndrome even though the diagnosis of a covered disease, condition or syndrome 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 disease, condition or syndrome.

(10) Group 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 and certificate in bold face equal to at least fourteen (14) point type.

(11) Group specified disease policies and certificates shall contain a prominent statement on the first page of the policy and certificate in bold face type at least equal to fourteen (14) point type as follows: "CAUTION! This policy (or certificate) PROVIDES LIMITED COVERAGE. IT IS NOT A MAJOR MEDICAL POLICY (OR CERTIFICATE). Read it carefully. It only pays benefits for treatment (or diagnosis) of (specified disease, condition or syndrome)."

(12) The premiums for a group specified disease policy shall be reasonable in relation to benefits and shall not be excessive or inadequate. The insurer shall establish premiums for group specified disease policies in accordance with generally accepted actuarial principles and practices so as to return to certificate holders in the form of aggregate benefits provided under the policy during the period for which rates are computed at least sixty five percent (65%) of the aggregate premiums earned. Each insurer shall annually report by June 30 earned premiums and incurred claims for the prior calendar year for each approved group 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 certificate holder. No policy shall exclude for a loss due to a preexisting condition for a period greater than twelve (12) months following the certificate holder's effective date of coverage.

(c) Each group specified disease policy shall meet the minimum benefit standards provided in subdivision (1), (2) or (3) of this subsection. In addition, a group 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 group specified disease policy, except that group specified disease 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 certificate holder 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 certificate holder, 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-520(d) of the 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 certificate holder insured under the policy for a specifically named disease, condition or syndrome 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) for each day of hospital confinement;

(B) A fixed-sum payment equal to at least one hundred dollars ($100) 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 disease, condition, or syndrome of not less than one thousand dollars ($1,000). In addition, payment amounts may be limited to not less than two hundred and fifty dollars ($250) for one or more specified diseases, conditions, or syndromes where coverage is provided under such policy for two or more specified diseases, conditions, or syndromes, provided that the aggregate amount payable under the policy for all specified diseases, conditions, or syndromes is at least one thousand dollars ($1,000). Also, coverage for a fixed-sum payment for a spouse or dependent may be included under the policy, provided the benefit amount included is at least twenty-five per cent (25%) of the benefit amount for the certificate holder. Where coverage is advertised or otherwise represented to offer generic coverage of a specified disease, condition, or syndrome, the same dollar amounts shall be payable, regardless of the particular subtype of the disease, condition, or syndrome unless such subtype is clearly identifiable and the policy clearly differentiates that subtype and its benefits.

(d) No group 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 certificate. The items included in the outline of coverage shall appear in the sequence prescribed below:

CAUTION!

(COMPANY NAME)

(SPECIFIED DISEASE, CONDITION OR SYNDROME) COVERAGE

OUTLINE OF COVERAGE

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

(2) (Specified disease, condition or syndrome) Coverage — This certificate is designed to provide, to certificate holders, restricted coverage paying benefits ONLY when certain losses occur as a result of treatment (or diagnosis) of the specified disease, condition, or

syndrome. This certificate does NOT provide general health insurance.

(3) This certificate is NOT A MEDICARE SUPPLEMENT certificate. 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 certificate.)

(5) (A description of any certificate 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 certificate provisions respecting continuation or conversion of coverage in the event of group policy termination.)

(Adopted effective November 30, 2009)