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Coordination of Benefits

Sec. 38a-480-1. Purpose and scope

(a) **Purpose.** The purpose of this regulation is to adopt a group coordination of benefits regulation. This regulation is intended to establish uniformity in the permissive use of overinsurance provisions and to avoid claim delays and misunderstandings that could otherwise result from the use of inconsistent or incompatible provisions among plans.

(b) **Coordination of Benefits.** A Coordination of Benefits (COB) provision is one that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more Plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which Plans pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It avoids duplication of benefits by permitting a reduction of the benefits of a Plan when, by the rules established by this regulation, it does not have to pay its benefits first.

(Effective September 25, 1992)

Sec. 38a-480-2. Applicability

(a) **Coordination Permissive.** This regulation permits, but does not require, Plans to include COB provisions.

(b) **Consistency with this Regulation.** If a group contract includes a COB provision, it must be consistent with this regulation. A Plan that does not include such a provision may not take the benefits of another Plan as defined in Section 38a-480-3 Definitions into account when it determines its benefits. There is one exception: a contract holder's coverage that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder.

(Effective September 25, 1992)

Sec. 38a-480-3. Definitions

(a) **Plan.**

(1) A "Plan" is a form of coverage with which coordination is allowed. The definition of Plan in the group contract must state the types of coverage which will be considered in applying the COB provision of that contract. The right to include a type of coverage is limited by the rest of this subsection 38a-480-3 (a).

(2) The definition shown in the COB Provision in Section 38a-480-4 is an example of what may be used. Any definition that satisfies this subsection 38a-480-3 (a) may be used.

(3) This regulation uses the term "Plan." However, a group contract may, instead, use "Program" or some other term.

(4) "Plan" shall not include individual or family:

(A) insurance contracts;

(B) subscriber contracts;

(C) coverage through Health Maintenance Organizations (HMOs); or

(D) coverage under other prepayment, group practice and individual practice plan; except as provided in (5) and (6) below.

(5) "Plan" may include:

(A) group insurance and group subscriber contracts;

(B) uninsured arrangements of group or group-type coverage;

(C) group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans; and

(D) group-type contracts.

Group type contracts are contracts which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group. Group-type contracts answering this description may be included in the definition of Plan, at the option of the insurer or the service provider and its contract-client, whether or not uninsured arrangements or individual contract forms are used and regardless of how the group-type coverage is designated (for example, ''franchise'' or ''blanket''). The use of payroll deductions by the employee, subscriber or member to pay for the coverage is not sufficient, of itself, to make an individual contract part of a group-type plan.

(6) ''Plan'' may include the medical benefits coverage in group, group-type, and individual automobile ''no-fault'' and traditional automobile ''fault'' type contracts.

(7) ''Plan'' may include Medicare or other governmental benefits. That part of the definition of ''Plan'' may be limited to the hospital, medical and surgical benefits of the governmental program. However, ''Plan'' shall not include a state plan under Medicaid, and shall not include a law or plan when, by law, its benefits are excess to those of any private insurance plan or other non-governmental plan.

(8) ''Plan'':

(A) shall not be construed to include group or group-type hospital indemnity benefits of $30 per day or less; but

(B) may be construed to include the amount by which group or group-type hospital indemnity benefits exceed $30 per day.

''Hospital indemnity benefits'' are those not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

(9) ''Plan'' shall not include student accident or student accident and health coverages for which the student or parent pays the entire premium.

(10) ''Plan'' shall not include:

(A) group contracts issued by or reinsured through the Health Reinsurance Association; or

(B) subscriber contracts issued by a residual market mechanism established by hospital and medical service corporations and providing comprehensive health care coverage as provided in Chapter 700a of Connecticut General Statutes.

(b) **This Plan.** In a COB provision, this term refers to the part of the group contract providing the health care benefits to which the COB provision applies and which may be reduced on account of the benefits of other Plans. Any other part of the group contract providing health care benefits is separate from This Plan. A group contract may apply one COB provision to certain of its benefits (such as dental benefits), coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

(c) **Primary Plan.** A Primary Plan is one whose benefits for a person's health care coverage must be determined without taking the existence of any other Plan into consideration. A Plan is a Primary Plan if either (1) or (2) below is true:

(1) The Plan either has no order of benefit determination rules, or it has rules which differ from those permitted by this regulation.

(2) All plans which cover the person use the order of benefit determination rules required by this regulation and under those rules the Plan determines its benefits

first. There may be more than one Primary Plan (for example, two Plans which have no order of benefit determination rules).

(d) **Secondary Plan.** A Secondary Plan is one which is not a Primary Plan. If a person is covered by more than one Secondary Plan, the order of benefit determination rules of this regulation decide the order in which their benefits are determined in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under the rules of this regulation, has its benefits determined before those of that Secondary Plan.

(e) **Allowable Expense.**

(1) "Allowable Expense" is the necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part under any of the Plans involved, except where a statute requires a different definition. However, items of expense under coverages such as dental care, vision care, prescription drug or hearing aid programs may be excluded from the definition of Allowable Expense. A plan which provides benefits only for any such items of expense may limit its definition of Allowable Expenses to like items of expense.

(2) When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an Allowable Expense and a benefit paid.

(3) The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.

(4) When COB is restricted in its use to a specific coverage in a contract (for example, major medical or dental), the definition of "Allowable Expense" must include the corresponding expenses or services to which COB applies.

(f) **Claim.** A request that benefits of a Plan be provided or paid. The benefits claimed may be in the form of:

(1) services (including supplies);

(2) payment for all or a portion of the expenses incurred;

(3) a combination of (1) and (2) above; or

(4) an indemnification.

(g) **Claim Determination Period.**

(1) This is the period of time, which must be not less than twelve consecutive months, over which Allowable Expenses are compared with total benefits payable in the absence of COB, to determine:

(A) whether overinsurance exists; and

(B) how much each Plan will pay or provide.

It usually is a calendar year, but a Plan may use some other period of time that fits the coverage of the group contract. A person may be covered by a Plan during a portion of a Claim Determination Period if that person's coverage starts or ends during that Claim Determination Period.

(2) As each claim is submitted, each Plan is to determine its liability and pay or provide benefits based upon Allowable Expenses incurred to that point in the Claim Determination Period; but that determination is subject to adjustment as later Allowable Expenses are incurred in the same Claim Determination Period.

(Effective September 25, 1992)

Sec. 38a-480-4. COB contract provision

(a) **General.** Subsection 38a-480-4 (d) contains a COB Provision for use in group contracts. That use is subject to the provision of subsections 38a-480-4 (b) and 38a-480-4 (c) and to the provisions of Section 38a-480-3, Definitions, and Section 38a-480-5, Rules for Coordination of Benefits. The bracketed references in the COB Provision to those rules are not to be included in a group contract.

(b) **Flexibility.** A group contract's COB provision does not have to use the words and format shown in this regulation. Changes may be made to fit the language and style of the rest of the group contract or to reflect the difference among Plans:

(1) which provides services;

(2) which pay benefits for expenses incurred; and

(3) which indemnify.

Substantive changes are allowed only as set forth in this regulation.

(c) **Prohibited Coordination and Benefit Design.** A group contract may not reduce benefits on the basis that:

(1) another plan exists;

(2) except with respect to Part B of Medicare, a person is or could have been covered under another Plan; or

(3) a person has elected an option under another Plan providing a lower level of benefits than another option which could have been elected.

No contract may contain a provision that its benefits are "excess" or "always secondary" to any Plan defined in subsection 38a-480-3 (a), except in accord with the rules permitted by this regulation.

(Reference: Rules in subsection 38a-480-5 (a) (1) below.)

(d) **Text of the COB Provision.**

COORDINATION OF THE GROUP CONTRACT'S BENEFITS WITH OTHER BENEFITS

(1) Applicability.

(A) This Coordination of Benefits ("COB") provision applies to This Plan when an employee or the employee's covered dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

(B) If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

(i) shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but

(ii) may be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. The above reduction is described in subdivision (4) Effect on the Benefits of This Plan.

(2) Definitions.

(A) A "Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment.

(i) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage, but not student accident or student accident & health coverage, for which the student or parent pays the entire premium.

(ii) Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical

Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program. It also does not include group contracts issued by or reinsured through the Health Reinsurance Association, or subscriber contracts issued by a residual market mechanism established by hospital and medical service corporations and providing comprehensive health care coverage as provided in the Connecticut Health Care Act as now constituted or later amended.

Each contract or other arrangement for coverage under (i) or (ii) is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

(B) ''This Plan'' is the part of the group contract that provides benefits for health care expenses.

(C) ''Primary Plan''/''Secondary Plan.'' The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be Secondary Plan as to a different Plan or Plans.

(Reference: Rules in subsection 38a-480-5 (a) (1) below.)

(D) ''Allowable Expense'' means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

(Reference: Rule in subsection 38a-480-5 (d) below.)

(E) ''Claim Determination Period'' means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

(3) Order of benefit determination rules.

(A) General. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

(i) the other Plan has rules coordinating its benefits with those of This Plan; and

(ii) both those rules and This Plan's rules, in subparagraph (B) below, require that This Plan's benefits be determined before those of the other Plan.

(B) Rules. This Plan determines its order of benefits using the first of the following rules which applies:

(i) Non-dependent/Dependent. The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent.

(ii) Dependent Child/Parents Not Separated or Divorced. Except as stated in subparagraph (B) (iii) below, when This Plan and another Plan cover the same child as a dependent of different persons called "parents":

(a) the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

(b) if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in (a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

(Reference: Rules in subsection 38a-480-5 (a) (2) below.)

(iii) Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) first, the Plan of the parent with custody of the child;

(b) then, the Plan of the spouse of the parent with the custody of the child; and

(c) finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(iv) Active/Inactive Employee: The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule (iv) is ignored.

(v) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

(Reference: Rules in subsection 38a-480-5 (a) (3) below.)

(4) Effect on the benefits of this plan.

(A) When this Section applies. This subdivision (4) applies when, in accordance with subdivision (3) Order of Benefit Determination Rules, This Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plan" in (B) immediately below.

(B) Reduction in This Plan's Benefits. The benefits of This Plan will be reduced when the sum of:

(i) the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

(ii) the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a

Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

(5) Right to Receive and Release Needed Information.

Certain facts are needed to apply these COB rules. (The XYZ Company) has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. (The XYZ Company) need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give (The XYZ Company) any facts it needs to pay the claim.

(Reference: Rules in subsections 38a-480-5 (e) below.)

(6) Facility of Payment.

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, (The XYZ Company) may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. (The XYZ Company) will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

(Reference: Rules in subsections 38a-480-5 (e) below.)

(7) Right of Recovery

If the amount of the payments made by (The XYZ Company) is more than it should have paid under this COB provision, it may recover the excess from one or more of:

(A) the persons it has paid or for whom it has paid;

(B) insurance companies; or

(C) other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

(Reference: Rules in subsection 38a-480-5 (e) below.)

(Effective September 25, 1992)

Sec. 38a-480-5. Rules for coordination of benefits

(a) **Order of Benefits.**

(1) General.

(A) The Primary Plan must pay or provide its benefits as if the Secondary Plan or Plans did not exist.

(B) A Secondary Plan may take the benefits of another Plan into account only when, under these rules, it is Secondary to that other Plan.

(Reference: subsections 38a-480-4 (c) and 38a-480-4 (d) (2) (C) above.)

(2) Dependent Child/Parents Not Separated or Divorced.

(A) The word "birthday" in the wording shown in subsection 38a-480-4 (d) (3) (B) (ii) of this regulation refers only to month and day in a calendar year, not the year in which the person was born.

(Reference: subsections 38a-480-4 (d) (3) (B) (ii) above.)

(3) Longer/Shorter Length of Coverage.

(A) To determine the length of time a person has been covered under a Plan, two Plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended. Thus, the start of a new Plan does not include:

(i) a change in the amount or scope of a Plan's benefits;

(ii) a change in the entity which pays, provides or administers the Plan's benefits; or

(iii) a change from one type of Plan to another (such as, from a single employer plan to that of a multiple employer plan).

(B) The claimant's length of time covered under a Plan is measured from the claimant's first date of coverage under that Plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present Plan has been in force.

(Reference: subsection 38a-480-4 (d) (3) (B) (v) above.)

(b) **Reasonable Cash Value of Services.** A Secondary Plan which provides benefits in the form of services may recover the reasonable cash value of providing the services from the Primary Plan, to the extent that benefits for the services are covered by the Primary Plan and have not already been paid or provided by the Primary Plan. Nothing in this provision shall be interpreted to require a Plan to reimburse a covered person in cash for the value of services provided by a Plan which provides benefits in the form of services.

(c) **Excess and Other Nonconforming Provisions.**

(1) Some Plans have order of benefit determination rules not consistent with this regulation which declare that the Plan's coverage is "excess" to all others, or "always secondary." This occurs because: (A) certain Plans may not be subject to insurance regulation; or (B) some group contracts have not yet been conformed with this regulation pursuant to Section 38a-480-7, Effective Date Existing Contract.

(2) A Plan with order of benefit determination rules which comply with this regulation (herein called a Complying Plan) may coordinate its benefits with a Plan which is "excess" or "always secondary" or which uses order of benefit determination rules which are inconsistent with those contained in this regulation (herein called a Noncomplying Plan) on the following basis:

(A) If the Complying Plan is the Primary Plan, it shall pay or provide its benefits on a primary basis.

(B) If the Complying Plan in the Secondary Plan, it shall, nevertheless, pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the Complying Plan were the Secondary Plan. In such a situation, such payment shall be the limit of the Complying Plan's liability.

(C) If the Noncomplying Plan does not provide the information needed by the Complying Plan to determine its benefits within a reasonable time after it is requested to do so, the Complying Plan shall assume that the benefits of the Noncomlying Plan are identical to its own, and shall pay its benefits accordingly. However, the Complying Plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the Noncomplying Plan.

(D) If:

(i) the Noncomplying Plan reduces its benefits so that the employee, subscriber, or member receives less in benefits that he or she would have received had the Complying Plan paid or provided its benefits as the Secondary Plan and the Noncomplying Plan paid or provided its benefits as the Primary Plan; and (ii) governing state law allows the right of subrogation set forth below; then the Complying Plan shall advance to or on behalf of the employee, subscriber, or member an amount equal to such difference. However, in no event shall the Complying Plan advance more than the Complying Plan would have paid had it been the Primary Plan less

any amount it previously paid. In consideration of such advance, the Complying Plan shall be subrogated to all rights of the employee, subscriber, or member against the Noncomplying Plan. Such advance by the Complying Plan shall also be without prejudice to any claim it may have against the Noncomplying Plan in the absence of such subrogation.

(Reference: subsections 38a-480-4 (d) (4), (5), (6) and (7) above.)

(d) **Allowable Expense.** A term such as "usual and customary," "usual and prevailing" or "reasonable and customary," may be substituted for the term "necessary, reasonable and customary." Terms such as "medical care" or "dental care" may be substituted for "health care" to describe the coverages to which the COB provisions apply.

(Reference: subsection 38a-480-4 (d) (2) (D) above.)

(e) **Subrogation.** The COB concept clearly differs from that of subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

(Reference: subsections 38a-480-4 (d) (4), (5), (6) and (7) above.)

(Effective September 25, 1992)

Sec. 38a-480-6. Effect on mandated benefits; spouse coverage

(a) **Mandated Benefits.** Nothing in this regulation may be used so as to diminish the benefits due under a Primary Plan or Secondary Plan with regard to benefits that are mandated by any statute or public act of the State of Connecticut.

(b) **Spouse Coverage.** Nothing in this regulation may be used to negate the provisions of Connecticut General Statutes Section 38a-541.

(Effective September 25, 1992)

Sec. 38a-480-7. Effective date; existing contracts

This regulation takes effect on April 1, 1988.

It applies to every group contract which provides health care benefits and is issued on or after that date.

A group contract which provides health care benefits and was issued before that date shall be brought into compliance with this regulation by the later of: (a) the next anniversary date or renewal date of the group contract; or (b) the expiration of any applicable collectively bargained contract pursuant to which it was written.

(Effective September 25, 1992)

Approval of Group Accident, Group Health, and Group Accident and Health Policy Forms

Sec. 38a-480-8. Definitions

As used in Sections 38a-480-8 through 38a-480-10, inclusive:

(a) "Commissioner" means the Insurance Commissioner of this state.

(b) "Form" means a policy of insurance against loss or expense from sickness, or from bodily injury or death by accident, issued upon a group plan, or application, certificate, rider or endorsement used in connection therewith.

(c) "Insurer" means an insurance company licensed by the Commissioner to write accident and health insurance.

(Effective September 25, 1992)

Sec. 38a-480-9. Filing procedure

Any insurer required pursuant to Section 38a-480 (a) (2) of the General Statutes to file a copy of a form with the Commissioner for approval, shall comply with the following standards:

(a) **Filing Transmittal Letter.**

(1) The filing transmittal letter should be sent to the attention of the Life and Health Division of the Insurance Department.

(2) If one or more elements within a filing vary by member company within a group of companies, the filer shall send a separate filing transmittal letter for each insurer within the group.

(3) The filer shall enclose a return copy of the transmittal letter(s) along with a stamped self-addressed return envelope of a size sufficient to return the duplicate copies of the filing to the insurer, and one letter size self-addressed stamped envelope to provide the notice required by Section 38a-480-10 (a).

(4) The filing transmittal letter shall contain a descriptive caption. The caption shall identify the insurer when the insurer is a member of an affiliated group of insurers using generic letterhead. The caption shall also include a brief description of the type of filing, and any applicable form identification number. All subsequent correspondence to the Insurance Department on the filing shall include the caption in the identical format as it was displayed in the original filing transmittal letter, in addition to the date of the original filing transmittal letter (and the Department's file number, if known).

(5) The body of the filing transmittal letter shall list the documents submitted therewith, briefly outline proposed changes, the approval sought, and specify the proposed effective date. When the form(s) sought to be approved by the Commissioner are not subject to the requirements of the Insurance Plain Language Act, Chapter 699a of the General Statutes, the filing transmittal letter shall so state such fact.

(6) The insurer shall provide in the filing transmittal letter a telephone number for readily contacting the person responsible for submitting the filing.

(b) All forms filed with the Insurance Department in accordance with this section shall be filed in duplicate. All such filings must be submitted in a clearly legible condition.

(c) All form filings shall include a separate document for the disclosure of the intended use of the form and the method it will be marketed. Such disclosure document, which will delimit the scope of the Commissioner's approval of the form, shall contain in numerical sequence the following:

(1) Information on exactly how the form will be marketed (i.e. individual basis, mass merchandised, association membership, union membership etc.);

(2) The market for which the form is intended (especially note markets such as over age 65, key men, professionals, etc.);

(3) The underwriting basis used, note especially any deviation from standard underwriting rules (medical, non-medical, guaranteed issue, simplified application, etc.);

(4) Any limitation of the use of the form by certain agents or brokers;

(5) An explanation of any change in benefits which occur while the contract is in force with a reference to the contract provisions which relate to the benefit change;

(6) A notation and explanation of any deviation from the insurer's usual retention; and

(7) Any additional information which may be necessary to completely understand the form and its use in this state.

(d) Every form filing shall be completed in "John Doe" fashion.

(e) (1) Every form filing subject to the requirements of the Insurance Plain Language Act, Chapter 699a of the General Statutes, shall be accompanied with a

certificate signed by an officer of the insurer, that the form complies with the Insurance Plain Language Act.

(2) The certificate required by subdivision (1) of this subsection shall be in the following form:

(NAME OF COMPANY)
(COMPANY ADDRESS)

This is to certify that the forms listed below are in compliance with Chapter 699a of the Connecticut General Statutes.

A. Option Selected

_____ 1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is _____.

_____ 2. Policy and its related forms are scored separately for the Flesch reading ease test. Scores for the policy and each form are indicated below:

Form	Form Number	Flesch Score

B. Test Option Selected

_____ 1. Test was applied to entire policy form(s)

_____ 2. Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of form(s) enclosed indicating word samples tested.

C. Standards for Certification

A checked block indicates the standard has been achieved.

_____ 1. The policy text achieves a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above.

_____ 2. It is printed in not less than ten point type, one point leaded. (This does not apply to specification pages, schedules and tables.)

_____ 3. The layout and spacing of the policy separate the paragraphs from each other and from the border of the paper.

_____ 4. The section titles are captioned in bold face type or otherwise stand out significantly from the text.

_____ 5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the policy.

_____ 6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsement or riders.

_____ 7. A table of contents or an index of the principal sections is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages.)

(COMPANY NAME)

_____ By: _____
(Date) (Title)

(f) When an insurer makes reference to another document in its filing, it must include a copy and fully disclose the referenced document.

(g) The Insurance Department is obligated to collect, pursuant to Section 12-211 of the General Statutes, form filing fees from foreign or alien insurers, if the state or foreign country in which they are domiciled imposes such (and larger) fees upon Connecticut's domestic insurers. Accordingly, each insurer domiciled in any other state or jurisdiction which requires such fees shall remit the equivalent filing fee (in the form of a check made payable to the Treasurer, State of Connecticut) together

with each such filing submitted. The insurer shall also represent and certify that the fee payment remitted is the same amount required by its domiciliary state or jurisdiction.

(Effective September 25, 1992)

Sec. 38a-480-10. Policy form approval

(a) Within fifteen (15) days of receipt of a form filed with the Commissioner for approval pursuant to Section 38a-480 (a) (2) of the General Statutes, the Insurance Department shall determine a filing to be complete or deficient for purposes of submission for review and shall issue written notice to the insurer regarding the status of the form.

(1) The written notice for a complete filing shall state that the form filing is complete and accepted for filing for review as of the date of its receipt. For purposes of this section, a form filing is complete upon agency determination that it is in compliance with Section 38a-480-9.

(2) The written notice for a deficient filing shall state that the form filing is deficient and not accepted for filing and shall set out the specific items that must be corrected to make the form complete. In addition to this notice, the Insurance Department may notify the insurer, in any manner, of problems with the form.

(b) Unless otherwise provided by law, the Insurance Department shall review all forms filed with the Insurance Commissioner for approval pursuant to Section 38a-480 (a) (2) of the General Statutes in the order in which they are received by the Department; provided, however, that in appropriate circumstances the Commissioner may waive this requirement and direct the immediate review of a form filing. The Department shall employ a chronological logging system to facilitate the chronological review of such forms.

(c) Within seventy-five (75) days after a form is accepted for review, the Insurance Department shall review the form and either approve it or disapprove it. If, upon such review of the form, the Insurance Department determines that additional information from the insurer is necessary in order to ascertain whether the form is contrary to law or is unfair, deceptive or may encourage misrepresentation of the policy, the Department shall make such request to the insurer. The insurer will then have thirty (30) days from the date of the request to provide the Department with the additional information; provided that during such time, the insurer may request in writing that the period for responding to the request for information be extended for an additional period of time, not to exceed sixty (60) days. The request for extension shall be considered granted upon its receipt by the Insurance Department. During the pendency of the Insurance Department's request for information, the seventy-five (75) day period for Department action shall be tolled. If the insurer fails to comply with such request within the allotted time, the insurer shall be deemed to have voluntarily withdrawn its filing and the Department shall close its file without further action.

(d) The Commissioner shall issue an order disapproving the use of any such form if it does not comply with the requirements of law, or if it contains a provision or provisions which are unfair or deceptive or which encourage misrepresentation of the policy. Any such order shall specify the reason for disapproval of the form.

(e) Forms that are approved by the Commissioner shall have the form and the extra copy of the filing transmittal letter stamped "Approved," together with the name and signature of the staff member who acted upon the filing and the date of the approval.

(Effective September 25, 1992)

Sec. 38a-480-10a. Electronic filing

(a) Any insurer filing a copy of a form with the commissioner in accordance with section 38a-480-9 of the Regulations of Connecticut State Agencies may submit such form electronically using software known as the System for Electronic Rate and Form Filing (SERFF), Version 2.0 or higher, or any subsequent corresponding system, adopted by the National Association of Insurance Commissioners. All such filings shall include the information required in section 38a-480-9 of the Regulations of Connecticut State Agencies.

(b) Filings made electronically shall be considered received by the commissioner when received at the Insurance Department. Filings received on a weekend or legal holiday shall be deemed received on the next business day. An electronic communication from the Insurance Department concerning a filing shall be deemed received by the person to whom the communication is addressed when the communication is sent.

(Adopted effective January 2, 2002)

Approval of Form of Life Insurance, Endowment and Annuity Policies and Contracts Providing Additional Benefits for Accidental Death and Waiver of Premium Benefits

Sec. 38a-480-11. Definitions

As used in Section 38a-480-11 through 38a-480-14, inclusive:

(a) "Commissioner" means the Insurance Commissioner of this state.

(b) "Form" means a life insurance, endowment or annuity contract or contracts supplemental thereto which contain only such provisions relating to accident and health insurance as (1) provide additional benefits in case of death by accidental means and (2) operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant become totally and permanently disabled as defined by the contract or supplemental contract.

(c) "Insurer" means an insurance company licensed by the Commissioner to write life insurance.

(Effective September 25, 1992)

Sec. 38a-480-12. Filing procedure

Any insurer required pursuant to Section 38a-480 (a) (3) of the General Statutes to file a copy of a form with the Commissioner for approval, shall comply with the following standards:

(a) **Filing Transmittal Letter.**

(1) The filing transmittal letter should be sent to the attention of the Life and Health Division of the Insurance Department.

(2) If one or more elements within a filing vary by member company within a group of companies, the filer shall send a separate filing transmittal letter for each insurer within the group.

(3) The filer shall enclose a return copy of the transmittal letter(s) along with a stamped self-addressed return envelope of a size sufficient to return the duplicate copies of the filing to the insurer, and one letter size self-addressed stamped envelope to provide the notice required by Section 38a-480-13 (a).

(4) The filing transmittal letter shall contain a descriptive caption. The caption shall identify the insurer when the insurer is a member of an affiliated group of insurers using generic letterhead. The caption shall also include a brief description

of the type of filing, and any applicable form identification number. All subsequent correspondence to the Insurance Department on the filing shall include the caption in the identical form as it was displayed in the original filing transmittal letter, in addition to the date of the original filing transmittal letter (and the Department's file number, if known).

(5) The body of the filing transmittal letter shall list the documents submitted therewith, briefly outline proposed changes, the approval sought, and specify the proposed effective date. When the form(s) sought to be approved by the Commissioner are not subject to the requirements of the Insurance Plain Language Act, Chapter 699a of the General Statutes, the filing transmittal letter shall so state such fact.

(6) The insurer shall provide in the filing transmittal letter a telephone number for readily contacting the person responsible for submitting the filing.

(b) All forms filed with the Insurance Department in accordance with this section shall be filed in duplicate. All such filings must be submitted in a clearly legible condition.

(c) All form filings shall include a separate document for the disclosure of the intended use of the form and the method it will be marketed. Such disclosure document, which will delimit the scope of the Commissioner's approval of the form, shall contain in numerical sequence the following:

(1) Information on exactly how the form will be marketed (i.e. individual basis, mass merchandised, association membership, union membership etc.);

(2) The market for which the form is intended (especially note markets such as over age 65, key men, professionals, etc.);

(3) The underwriting basis used, note especially any deviation from standard underwriting rules (medical, non-medical, guaranteed issue, simplified application, etc.);

(4) Any limitation of the use of the form by certain agents or brokers;

(5) An explanation of any change in benefits which occur while the contract is in force with a reference to the contract provisions which relate to the benefit change;

(6) For individual forms, disclosure of whether the commissions and gross premium rates are consistent with those of the company's individual policies. If the assumptions underlying the premium rates differ from the insurer's regular individual policies, an explanation shall be given of the difference, and the reason that use of the form does not result in unfair discrimination;

(7) A notation and explanation of any deviation from the insurer's usual retention; and

(8) Any additional information which may be necessary to completely understand the form and its use in this state.

(d) Every form filing shall be completed in ''John Doe'' fashion.

(e) (1) Every form filing subject to the requirements of the Insurance Plain Language Act, Chapter 699a of the General Statutes, shall be accompanied with a certificate signed by an officer of the insurer that the form complies with the Insurance Plain Language Act.

(2) The certificate required by subdivision (1) of this subsection shall be in the following form:

(NAME OF COMPANY)

(COMPANY ADDRESS)

This is to certify that the forms listed below are in compliance with Chapter 699a of the Connecticut General Statutes.

A. Option Selected

_____ 1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is _____.

_____ 2. Policy and its related forms are scored separately for the Flesch reading ease test. Scores for the policy and each form are indicated below:

Form	Form Number	Flesch Score

B. Test Option Selected

_____ 1. Test was applied to entire form(s)

_____ 2. Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of form(s) enclosed indicating word samples tested.

C. Standards for Certification

A checked block indicates the standard has been achieved.

_____ 1. The policy text achieves a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above.

_____ 2. It is printed in not less than ten point type, one point leaded. (This does not apply to specification pages, schedules and tables.)

_____ 3. The layout and spacing of the policy separate the paragraphs from each other and from the border of the paper.

_____ 4. The section titles are captioned in bold face type or otherwise stand out significantly from the text.

_____ 5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the policy.

_____ 6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsement or riders.

_____ 7. A table of contents or an index of the principal sections is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages.)

(COMPANY NAME)

_____ By: _____

(Date) (Title)

(f) Each form filing other than those involving group life, group annuities and group accident and health insurance, shall be accompanied with the rates that will be used in connection with such form.

(g) When an insurer makes reference to another document in its filing, it must include a copy and fully disclose the referenced document.

(h) The Insurance Department is obligated to collect, pursuant to Section 12-211 of the General Statutes, form filing fees from foreign or alien insurers, if the state or foreign country in which they are domiciled imposes such (and larger) fees upon Connecticut's domestic insurers. Accordingly, each insurer domiciled in any other state or jurisdiction which requires such fees shall remit the equivalent filing fee (in the form of a check made payable to the Treasurer, State of Connecticut) together

with each such filing submitted. The insurer shall also represent and certify that the fee payment remitted is the same amount required by its domiciliary state or jurisdiction.

(Effective September 25, 1992)

Sec. 38a-480-13. Policy form approval

(a) Within fifteen (15) days of receipt of a form filed with the Commissioner for approval pursuant to Section 38a-480 (a) (3) of the General Statutes, the Insurance Department shall determine a filing to be complete or deficient for purposes of submission for review and shall issue written notice to the insurer regarding the status of the form.

(1) The written notice for a complete filing shall state that the form filing is complete and accepted for filing for review as of the date of its receipt. For purposes of this section, a form filing is complete upon agency determination that it is in compliance with Section 38a-480-12.

(2) The written notice for a deficient filing shall state that the form filing is deficient and not accepted for filing and shall set out the specific items that must be corrected to make the form complete. In addition to this notice, the Insurance Department may notify the insurer, in any manner, of problems with the form.

(b) Unless otherwise provided by law, the Insurance Department shall review all forms filed with the Insurance Commissioner for approval pursuant to Section 38a-480 (a) (3) of the General Statutes in the order in which they are received by the Department; provided, however, that in appropriate circumstances the Commissioner may waive this requirement and direct the immediate review of a form filing. The Department shall employ a chronological logging system to facilitate the chronological review of such forms.

(c) Within seventy-five (75) days after a form is accepted for review, the Insurance Department shall review the form and either approve it or disapprove it. If, upon such review of the form, the Insurance Department determines that additional information from the insurer is necessary in order to ascertain whether the form is contrary to law or is unfair, deceptive or may encourage misrepresentation of the policy, the Department shall make such request to the insurer. The insurer will then have thirty (30) days from the date of the request to provide the Department with the additional information; provided that during such time, the insurer may request in writing that the period for responding to the request for information be extended for an additional period of time, not to exceed sixty (60) days. The request for extension shall be considered granted upon its receipt by the Insurance Department. During the pendency of the Insurance Department's request for information, the seventy-five (75) day period for Department action shall be tolled. If the insurer fails to comply with such request within the allotted time, the insurer shall be deemed to have voluntarily withdrawn its filing and the Department shall close its file without further action.

(d) The Commissioner shall issue an order disapproving the use of any such form if it does not comply with the requirements of law, or if it contains a provision or provisions which are unfair or deceptive or which encourage misrepresentation of the policy. Any such order shall specify the reason for disapproval of the form.

(e) Forms that are approved by the Commissioner shall have the form and the extra copy of the filing transmittal letter stamped "Approved," together with the name and signature of the staff member who acted upon the filing and the date of the approval.

(Effective September 25, 1992)

Sec. 38a-480-13a. Electronic filing

(a) Any insurer filing a copy of a form with the commissioner in accordance with section 38a-480-12 of the Regulations of Connecticut State Agencies may submit such form electronically using software known as the System for Electronic Rate and Form Filing (SERFF), Version 2.0 or higher, or any subsequent corresponding system, adopted by the National Association of Insurance Commissioners. All such filings shall include the information required in section 38a-480-12 of the Regulations of Connecticut State Agencies.

(b) Filings made electronically shall be considered received by the commissioner when received at the Insurance Department. Filings received on a weekend or legal holiday shall be deemed received on the next business day. An electronic communication from the Insurance Department concerning a filing shall be deemed received by the person to whom the communication is addressed when the communication is sent to that person.

(Adopted effective January 2, 2002)

Sec. 38a-480-14. Severability

If any provision of this regulation or application thereof to any person or circumstance 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)