STATE OF CONNECTICUT

INSURANCE DEPARTMENT

BULLETIN HC-97
JUNE 9, 2014

TO: ALL INSURANCE COMPANIES, FRATERNAL BENEFIT SOCIETIES, HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS AND HEALTH CARE CENTERS THAT DELIVER OR ISSUE SMALL GROUP HEALTH INSURANCE POLICIES IN CONNECTICUT

RE: REVISED STATUTORY PLANS REQUIRED BY CONN. GEN. STAT. §38a-568

Conn. Gen. Stat. §38a-568 requires health insurance carriers, including health care centers that transact small employer group health insurance business in this state, to offer plans established by the Board of the Connecticut Small Employer Health Reinsurance Pool (CSEHRP). The CSEHRP Board filed revised major medical and health care center plans that were approved by the Insurance Department on May 30, 2014. The approved schedules of benefits are attached as Exhibits I and II. Carriers must include the appropriate version of the revised plans as part of their small employer form and rate filings for January 1, 2015.

Questions

Please contact the Insurance Department Life and Health Division at cid.lh@ct.gov with any questions.

Anne Melissa Dowling
Deputy Insurance Commissioner

EXHIBIT I

CSEHRP

Indemnity Gold Plan

Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Medical Deductible *Individual* *Family* *(copays are not applied to deductible)*	$1,000 $2,000	$3,000 $6,000
Prescription Drug Deductible *Individual* *Family* *(copays are not applied to deductible)*	$0 $0	$350 $700
Out-of-Pocket Maximum *Individual* *Family*	$3,000 $6,000	$6,000 $12,000
Physician Office Visits		
Preventive Care/Screenings/Immunizations	$0	30% coinsurance
Primary Care (injury or illness)	$20 copay	30% coinsurance**
Specialist	$45 copay	30% coinsurance**
Emergency/Urgent Care		
Urgent Care Center or Facility	$75 copay	30% coinsurance**
Emergency Room	$150 copay	$150 copay
Ambulance	$0	$0
Hospital Services		
Inpatient	$500 copay per day to a maximum of $1,000 per admission*	30% coinsurance**
Outpatient (performed at hospital or ambulatory facility)	$500 copay*	30% coinsurance**
Skilled Nursing Facility 90 day calendar year maximum	$500 copay per day to a maximum of $1,000 per admission*	30% coinsurance**
Mental Health, Substance Abuse & Behavioral Health Care		
Mental Health, Substance Abuse & Behavioral Health Services	Covered same as any other illness	Covered same as any other illness
Hospice Care		
Hospice Services	$0	30% coinsurance**
Outpatient Services		
Home Health Care 100 visit calendar year maximum	$0	25% coinsurance subject to a $50 deductible
Advanced Radiology (CT/PET Scan, MRI)	$75 copay per service up to a combined calendar year maximum of $375 for MRI and CT scans; $400 for PET scans	30% coinsurance**

*After in-network medical deductible is met **After out-of-network deductible is met

Indemnity Gold Plan

Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Outpatient Services		
Non-Advanced Radiology (X-ray, Diagnostic)	$45 copay	30% coinsurance**
Laboratory Services	$30 copay	30% coinsurance**
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) *combined 40 visit calendar year maximum*	$30 copay	30% coinsurance**
Chiropractic Care *20 visit calendar maximum*	$45 copay	30% coinsurance**
Other Services		
Durable Medical Equipment	30% coinsurance	30% coinsurance**
Prosthetics	30% coinsurance	30% coinsurance**
Diabetic Supplies & Equipment	30% coinsurance	30% coinsurance**
Prescription Drugs		
Generic Drugs	$5 copay	30% coinsurance****
Preferred Brand Drugs	$25 copay	30% coinsurance****
Non–Preferred Brand Drugs	$50 copay	30% coinsurance****
Specialty Drugs	$60 copay	30% coinsurance****

Pediatric-Only Services (for children under age 19)

Pediatric Dental Care		
Diagnostic & Preventive (Oral Exam, Cleaning, X-ray)	$0	50% coinsurance**
Basic Restorative (Filling, Simple Extraction)	20% coinsurance	50% coinsurance**
Major Restorative (Endodontic, Crown)	40% coinsurance	50% coinsurance**
Orthodontia Services *medically necessary only*	50% coinsurance	50% coinsurance**
Pediatric Vision Care		
Routine Eye Exam	$45 copay	30% coinsurance
Prescription Eye Glasses *one pair of frames & lenses per calendar year*	lenses: $0 collection frames: $0 non-collection frames: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit equal to the cost of the collection frame and will be entitled to a negotiated discount	100% coinsurance

*After in-network medical deductible is met

**After out-of-network medical deductible is met

***After in-network prescription drug deductible is met

****After out-of-network prescription drug deductible is met.

EXHIBIT II

CSEHRP

HMO Gold Plan

Plan Overview	In-Network Member Pays
Medical Deductible ***Individual*** ***Family*** ***(copays are not applied to deductible)***	**$1,000** **$2,000**
Prescription Drug Deductible ***Individual*** ***Family*** ***(copays are not applied to deductible)***	**$0** **$0**
Out-of-Pocket Maximum ***Individual*** ***Family***	**$3,000** **$6,000**
Physician Office Visits	
Preventive Care/Screenings/Immunizations	**$0**
Primary Care (injury or illness)	**$20 copay**
Specialist	**$45 copay**
Emergency/Urgent Care	
Urgent Care Center or Facility	**$75 copay**
Emergency Room	**$150 copay**
Ambulance	**$0**
Hospital Services	
Inpatient	**$500 copay per day to a maximum of $1,000 per admission***
Outpatient (performed at hospital or ambulatory facility)	**$500 copay***
Skilled Nursing Facility **90 day calendar year maximum**	**$500 copay per day to a maximum of $1,000 per admission***
Mental Health, Substance Abuse & Behavioral Health Care	
Mental Health, Substance Abuse & Behavioral Health Services	**Covered same as any other illness**
Hospice Care	
Hospice Services	**$0**
Outpatient Services	
Home Health Care **100 visit calendar year maximum**	**$0**
Advanced Radiology (CT/PET Scan, MRI)	**$75 copay per service up to a combined calendar year maximum of $375 for MRI and CT scans; $400 for PET scans**

***After in-network medical deductible is met**

HMO Gold Plan

Plan Overview	In-Network Member Pays
Outpatient Services	
Non-Advanced Radiology (X-ray, Diagnostic)	$45 copay
Laboratory Services	$30 copay
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) *combined 40 visit calendar year maximum*	$30 copay
Chiropractic Care *20 visit calendar maximum*	$45 copay
Other Services	
Durable Medical Equipment	30% coinsurance
Prosthetics	30% coinsurance
Diabetic Supplies & Equipment	30% coinsurance
Prescription Drugs	
Generic Drugs	$5 copay
Preferred Brand Drugs	$25 copay
Non–Preferred Brand Drugs	$50 copay
Specialty Drugs	$60 copay

Pediatric-Only Services (for children under age 19)

Pediatric Dental Care	
Diagnostic & Preventive (Oral Exam, Cleaning, X-ray)	$0
Basic Restorative (Filling, Simple Extraction)	$45 copay
Major Restorative (Endodontic, Crown)	$45 copay
Orthodontia Services *medically necessary only*	$45 copay
Pediatric Vision Care	
Routine Eye Exam	$45 copay
Prescription Eye Glasses *one pair of frames & lenses per calendar year*	lenses: $0 collection frames: $0 non-collection frames: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit equal to the cost of the collection frame and will be entitled to a negotiated discount

*After in-network medical deductible is met