

Appendix 6.1.

HUSKY Plan Benefit Package

<u>Benefit Features</u>	<u>HUSKY Coverage</u>	<u>State Employee Source Plan</u>
Deductible		
Individual	None	N.A.
Family	None	N.A.
Copayment and Premium Maximums		
Families with household incomes between 185% and 235% FPL	\$650	MD modified
Families with household incomes between 235% and 300% FPL	\$1,250	
Coinsurance	None	All but Blue Cross Out of Network
Lifetime Benefit Maximum	None	N.A.
Outpatient Physician Visits	\$5 copay	All but Blue Cross Out of Network

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Preventive Care	Periodic and well child visits, immunizations, WIC evaluations, and prenatal care covered in full with \$5 copay on other visits. Periodicity schedule and reporting based on the American Academy of Pediatrics (see below).	Blue Cross	
	<u>Age Category</u>		<u>No. Exams</u>
	Birth to Age 1		6 exams
	Ages 1-5		6 exams
	Ages 6-10		1 exam every 2 years
	Ages 11-21		1 exam every year
Family Planning			
Preventive Family Planning Services	Covered in full for preventive services		
Oral Contraceptives	\$5 copay included in prescription drugs		Kaiser
Abortions	Covered only if necessary to save the life of the mother or if the pregnancy is the result of rape or incest.	Kaiser	
Inpatient physician	100%		Kaiser
Inpatient Hospital	100%		Kaiser
Outpatient Surgical Facility	100%		Kaiser

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Ambulance	100% if determined to be an emergency in accordance with state law.		All
Pre-Admission/ Continued Stay	Arranged through Provider	All but Kaiser (uses PCP)	
Prescription Drug	\$3 copay on generics		Various

\$6 copay on brand names.
Formularies.

Mental Health

Inpatient	100%. 60 day maximum	Blue Cross
	exchangeable with alternate levels of care. Supplemental coverage available under HUSKY Plus for medically eligible children.	
Outpatient	30 visits	Kaiser
	1-10: 100%	
	11-20: \$25 copay	
	21-30: Lesser of a \$50 copay or 50%.	
	Separate limit for substance abuse. Supplemental coverage available under HUSKY Plus for medically eligible children.	

Substance Abuse

Detoxification	100%	Various
Inpatient	100%	Blue Cross
	Drug: 60 days	
	Alcohol: 45 days	
	Supplemental coverage available under HUSKY Plus for medically eligible children.	

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Outpatient	100%, 60 visits per calendar year. Supplemental coverage available under HUSKY Plus for medically eligible children.	Kaiser
Skilled Nursing	100% with P.A.	Various
Home Health	100%	Kaiser
Hospice	100%	Kaiser
Short Term Rehab and Physical Therapy	100%	All but Kaiser
Long Term Rehab and Physical Therapy	Supplemental coverage available under HUSKY Plus for medically eligible children.	N.A.

Lab and X-Ray	100%	All
Pre-Admission Testing	100%	All
Emergency Care	100% if determined to be an emergency in accordance with state law. \$25 copay waived if the patient is admitted.	Kaiser
DME	100% with P.A. Supplemental coverage available under HUSKY Plus for medically eligible children.	Various

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Eye Care	\$5 copay on exams. Optical hardware partially covered: Lenses and up to \$50 for frames, once every two years. Maximum of \$100 for lenses and frames per prescription.	Kaiser
Hearing Exam	\$5 copay	Kaiser
Nurse Midwives	\$5 copay	Blue Cross
Nurse Practitioners	\$5 copay	Blue Cross
Podiatrists	\$5 copay	Blue Cross
Chiropractors	\$5 copay	Blue Cross
Naturopaths	\$5 copay	Blue Cross
Hearing Aids	Covered under HUSKY Plus for medically eligible children.	
Therapies (OT,Speech)	Short term coverage with P.A. Supplemental coverage available under HUSKY Plus for medically eligible children.	

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Dental		
Exams, 1 every 6 months	100%	Cigna
X-Rays	100%	Cigna
Fillings	100%	Cigna
Fluoride Treatments	100%	Cigna
Oral Surgery	100%	Cigna
Sealants	100%	Cigna
Bridge and Crown	Copay	Cigna
Root Canals	Copay	Cigna
Dentures (full and partial)	Copay	Cigna
Extractions	Copay	Cigna
Orthodontia	Covered; patient pays up to the applicable maximum copay. (\$1,785 for state employees)	Cigna
	Supplemental coverage available under HUSKY Plus for medically eligible children.	

**SUMMARY OF CONNECTICUT'S PUBLIC ACT NO 97-99
"AN ACT CONCERNING MANAGED CARE"**

Each year each MCO (which includes HMOs) shall submit:

A **report on its QAP**, which includes:

- Ratio of number of complaints received to number of enrollees
- Summary complaints received related to providers and delivery of care or services and the action taken on the complaint
- Ratio of the number of prior authorizations (PAs) denied to the number of the PAs requested
- Number of utilization review (UR) determinations not to certify an admission, service, procedure or extension of stay, and the denials upheld and reversed on appeal
- All data required by NCQA for HEDIS (or such equivalent data as the insurance commissioner may require by regulation)
- The commissioner shall find that these requirements are met if the plan that has received a one-year or higher level of NCQA accreditation and has submitted HEDIS

A model provider contract

A written statement of the types of financial arrangements or contractual provisions that the MCO has with hospitals, UR companies, physicians, and any other health care providers

Such information as the insurance commissioner deems necessary to complete the consumer report card, which may include at least:

- The organization's characteristics (model, profit or nonprofit, address, number of enrollees, whether accredited, etc.)
- A summary of financial arrangements with providers, including any change in rates over the prior three years, its medical loss ratio or percentage of the total premium revenues spent on medical care compared to administrative costs and plan marketing
- A description of services, the number of PCPs and specialists, and distribution and the number of hospitals, by county
- Utilization review information, including the name or sources of any established medical protocols and the UR standards
- Medical management information, including the provider-to-patient ratio by PCP and specialty care provider, the percentage of

primary and specialty care providers who are board certified, and how the medical protocols incorporate input from physicians actively practicing in Connecticut in the relevant speciality areas.

- The quality assurance information required above
- The status of the organization's compliance with reporting requirements
- Whether the organization markets to individuals and Medicare beneficiaries
- The number of hospital days per thousand enrollees
- The average length of hospital stays for specific procedures, as may be requested by the insurance commissioner

A summary of the procedures used to credential providers

Each MCO shall:

Provide annually to each enrollee a **provider list** and notify an enrollee as soon as possible of the termination or withdrawal of the enrollee's PCP

Prior to implementing new **medical protocols** or substantially or materially altering existing protocols, obtain input from physicians actively practicing in Connecticut and practicing in the relevant speciality areas.

Make available, upon request of a participating provider, its medical protocols and if a MCO denies treatment, service, or procedure, the organization shall furnish, upon request, a copy of the relevant medical protocol, along with an explanation of the denial at the time the denial is made.

Provide every enrollee with a **plan description**, including a statement of the number of MCO's UR determinations not to certify an admission, service, procedure or extension of stay, and the denials upheld and reversed on appeal; a description of emergency services; use of drug formularies; number, types and specialities, and geographic distribution of direct health care providers; PA and UR requirements and procedures, internal grievance procedures, and internal and external complaint procedures; medical loss ratio; telephone number for obtaining further information; how notification is provided when the plan is no longer contracting with an enrollee's PCP; procedures for obtaining referrals; NCQA accreditation; enrollee satisfaction information; and procedures for

protecting the confidentiality of medical records and other patient information.

Establish and maintain an internal **grievance procedure** to assure that enrollees may seek a review of any grievance that may arise from a MCO's action or inaction, other than action or inaction based on UR, and obtain a timely resolution of any such grievance. Enrollees shall be informed of the grievance procedure at the time of enrollment and at least annually thereafter. Notices describing the procedure shall include the process for filing a grievance and the time periods. (There is a separate notice and appeals procedure for UR decisions, including an expedited appeals process for emergency or life threatening situations and an external review by a physician who is a specialist in a related field.) Any enrollee who has exhausted the internal mechanisms provided by an MCO or UR not to certify an admission, services, procedure, or extension of stay may appeal such determination to the insurance commissioner.

No contract between an MCO and a provider:

Shall prohibit the provider from discussing with an enrollee any treatment options and services available in or out of network, including experimental treatments

Shall prohibit the provider from disclosing, to an enrollee who inquires, the method the MCO uses to compensate the provider