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Connecticut's Official Health Insurance Marketplace

Connecticut Health Insurance Exchange

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Access Health CT

Solicitation to Health Plan Issuers for Participation in the Individual and/or Small Business Health Options Programs (SHOP) Marketplaces

Plan Year 2016

Release Date: April 2, 2015

**04/08/2015 V2 2016 Plan Year Key Deliverables Calendar Updated*

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I. General Information and Background

The Connecticut Health Insurance Exchange dba Access Health CT (AHCT) is soliciting applications from health insurance Issuers ("Issuers") to market and sell Qualified Health Plans ("QHPs") through the AHCT Marketplace for the 2016 plan year. The Solicitation defines the requirements an Issuer must comply with to participate in the AHCT Individual Marketplace and/or the Small Business Health Options Programs (SHOP) Marketplaces.

This Solicitation may be amended by addenda as may be necessary to assure compliance with state and federal laws. AHCT will post any amendments to this Solicitation on its website.

Issuers participating in the AHCT Individual Marketplace must agree to offer QHPs to any eligible consumer seeking to purchase such coverage for a term of twelve (12) months for coverage beginning on January 1st of a given plan year, or a term that shall last for the remainder of the plan year when coverage starts on February 1st or later in a given plan year. The open enrollment period for the 2016 plan year will begin on November 1, 2015 and end on January 31, 2016. The Issuer will also agree to offer its QHPs during special enrollment periods to eligible enrollees, and their currently enrolled eligible co-beneficiaries, where applicable, who may experience a valid change in circumstances as defined in 45 C.F.R. §155.420 or 45 C.F.R. §155.420(d)(9).

Issuers participating in the SHOP Marketplace must permit a qualified employer to begin to offer coverage for its small group at any point during the year. The employer's plan year must consist of the 12-month period beginning with the qualified employer's effective date of coverage (45 C.F.R. §155.725(b)) and last for the following12 months after the effective date. Issuers offering QHPs through the SHOP Marketplace must also charge the same contract rate for each month of the applicable small employer's policy year in accordance with 45 C.F.R. §156.285(3).

Only health plans certified as a QHP by AHCT for the 2016 plan year can be sold through the AHCT Marketplace. AHCT offers Issuers a state-wide Marketplace to make it easier for individuals and small employers and their employees to compare plans and buy health insurance.

AHCT is the only distribution channel in Connecticut through which individuals and small employers are able to purchase coverage that may provide for certain affordability subsidies, including:

- Premium tax credits and/or reduced cost-sharing plan variants for Individuals and families purchasing health insurance through the individual Marketplace whose household income is between 100 percent and 400 percent of the Federal poverty level;
- An Alaska Native/American Indian (as defined in 45 C.F.R. §155.300) plan and a limited cost sharing plan variant for each plan offered by a QHP through the Individual Marketplace in accordance with 45 C.F.R. §155.350; and
- Small Business tax credits available to eligible employers offering coverage in the SHOP Marketplace.

To receive certification, an Issuer and its health plans must meet all federal and state statutory requirements, as well as the standards set by AHCT. AHCT is responsible for certifying health plans and ensuring that plans remain compliant with AHCT's QHP certification requirements.

The QHP certification process and requirements for the 2016 plan year maintain many aspects of the processes and requirements carried out for previous plan years, including close coordination and collaboration with the Connecticut Insurance Department (CID).

In setting the certification requirements outlined in this Solicitation, AHCT was guided by its mission to increase the number of insured residents, improve health care quality, lower costs and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.

Through this Solicitation, AHCT looks specifically to the Issuers to be a cooperative partner with AHCT in reaching our common goal of providing quality health care coverage to Connecticut residents.

A. Regulatory Filings

In accordance with Connecticut state law, all fully insured products must have forms and rates filed with and approved by, where applicable by the CID in advance of an Issuer presenting the product to the market for sale.

Any determinations by AHCT to certify a health plan as "qualified" will be conditional upon the CID approving rate and form filings. AHCT will require Issuers to use the AHCT's "Schedule of Benefits Template" for form filings. The template is included in the exhibits section of this document.

B. Segregation of Funds for Abortion Services

In accordance with 45 C.F.R. §156.280, an Issuer offering coverage for non-excepted abortion services should, as a condition of participating in the AHCT Marketplace, submit a plan to the State Insurance Commissioner that details its process and methodology for complying with the segregation of funds requirements. For additional information, please refer to the CID Bulletin No. MC-21.

C. Solicitation Process and Timetable

The following schedule includes dates pertinent to Issuer and QHP certification. Please note that the target dates are subject to change. Any subsequent updates will be communicated, within a reasonable time, directly to the individual identified in the Issuer Notice of Intent and posted on the AHCT website at www.ct.gov/hix .

Deliverable/Milestone	**Target Dates** *(dates are subject to change)*
Proposed HHS Notice of Benefit and Payment Parameters and AV Calculator Released by CMS	November 21, 2014
Assess Proposed Regulations/Run Draft Model 2016 AV Calculator	December 1 – December 22, 2014
Evaluate 2015 Standard Plan Designs for 2016 Plan Year	December 23, 2014 – February 13, 2015
Final 2016 AV Calculator Released	January 16, 2015
Review Proposed 2016 Standard Plans with Advisory Committees (Individual and Small Group)	February 5, 2015
Review Proposed 2016 Standard Plans with Advisory Committees (Individual and Small Group)	February 10 2015
CID Bulletin Release	February 18 2015
Present Proposed 2016 AHCT Standard Plan Designs and Actuarial Value (AV) of EHB Components at the Board of Directors (BOD) Meeting	February 19, 2015
Publish 2016 AHCT Standard Plan Designs	February 20, 2015
Final HHS Notice of Benefit and Payment Parameters for 2016 released	February 20, 2015
Final 2016 Letter to Issuers in the Federally-Facilitated Marketplaces Released	February 20, 2015
2016 AHCT Schedule of Benefits (SOB) Template Released to Issuers	March 17, 2015
AHCT Assess and Finalize 2016 CT Issuer SERFF Data Submission Requirements	March 17 – April 17, 2015
Release 2016 AHCT Issuer Solicitation and Non-Binding Notice of Intent	April 2, 2015
Issuer Non-Binding Notice of Intent Submission Deadline	April 10, 2015
Publish 2016 AHCT Issuer Application (for New and Existing Issuers), Instructions & Checklist	April 20, 2015
Inquiries Submitted to AHCT on QHP Application from Issuer	April 21 – April 23, 2015
AHCT Responds to Issuer Application Questions	April 29, 2015
2016 Form Filings [Evidence of Coverage (EOC), Schedule of Benefits (SOB)] and Rates Due to Connecticut Insurance Department (CID)	April 30, 2015
Issuer Prepares 2016 Federal QHP Data Templates and Supporting Documents	May 1 – May 15, 2015
Issuer Data Submission Inquiry Period	May 1 – May 15, 2015
QHP Applications, Template Data, Select Supporting Documents Submission Deadline	May 18, 2015

Deliverable/Milestone	Target Dates *(dates are subject to change)*
AHCT Review of 2016 Issuer Data Submissions/Resubmissions	May 19 – August 14, 2015
AHCT/ Issuer Calls to Address/Resolve Federal QHP Data Submission	June 17 – August 14, 2015
CID Deadline to Approve 2016 Issuer Submitted Form & Rate Filings	July 30 – August 7, 2015
Certification of 2016 AHCT Issuer Plan Submissions	July 30 – September 12, 2015
Upload 2016 QHP Plan Data into AHCT Plan Management Staging System	August 17 – August 20, 2015
AHCT/Issuer Plan Preview Sessions	August 24 – September 4, 2015
Refine/Approve Pre-Published 2016 AHCT QHP Plan Data	September 8 – September 15, 2015
Certified 2016 AHCT QHP Plan Data Made Available to CMS	September 16, 2015
Activate Approved 2016 AHCT QHP Plan Data within Plan Management System	October 31, 2015
2016 QHP Plan Data Published in AHCT Consumer Portal	November 1, 2015
Plan Year 2016 Open Enrollment Period	November 1, 2015 – January 31, 2016

Note: Calendar revised to reflect 2016 Open Enrollment Date on April 8, 2015

D. Non-Binding Notice of Intent (Pre-Requisite)

All Issuers seeking participation in the Individual Marketplace and/or SHOP Marketplace must submit the **Non-Binding Notice of Intent (NBNOI) to Submit Qualified Health Plans.** An Issuer cannot apply without first submitting the NBNOI, unless pre-approved by AHCT. Only those Issuers acknowledging interest in this Solicitation by submitting the NBNOI will continue to receive Solicitation related correspondence from AHCT.

Submission Instructions and Deadlines for NBNOI:

1. Please complete the form titled "**Non-Binding Notice of Intent (NBNOI) to Submit Qualified Health Plan"**. The NBNOI is available at http://www.ct.gov/hix/.
2. Issuers should submit this form via email to the AHCT's contact person identified in Section E no later than April 10, 2015.
3. Please make sure the email subject line reads: "Non-Binding Notice of Intent to Submit Qualified Health Plans".
4. The Issuer will receive a response confirming the submission.

E. Authorized AHCT Contact for Solicitation

AHCT's authorized Contact Person for all matters concerning this Solicitation:

Name: Michele Barnett

E-Mail: CTHIX-Issuers@ct.gov

Mailing Address:

Access Health CT
Attn: Michele Barnett, 15th Floor
280 Trumbull Street
Hartford, CT 06103

Phone: 860-757-6802

All questions to, and requests for information from AHCT concerning this Solicitation by a Prospective Issuer or a representative or agent of a Prospective Issuer, should be directed to the Authorized Contact Person. Please include "Access Health CT QHP Solicitation" in all correspondence. Questions should be in writing, and submitted by email. All answers to questions, and any Addenda to this Solicitation, will be made available to all Prospective Issuers.

F. Eligibility and Enrollment

a. Individual Marketplace

AHCT is responsible for the enrollment process and all eligibility determinations of individuals and families. In addition, all eligibility changes must be made through AHCT.

AHCT will perform primary verifications through the Federal Data Services Hub (FDSH).

Please refer to Chapter 45, Section 155 the US Code of Federal Regulations for eligibility requirements. All eligibility determinations, re-determinations and changes will be made in accordance with federal and state law and in accordance with the terms of the Issuer Agreement and any related transactions between the Issuer and AHCT which serve to amend or clarify such documents or applications of law. AHCT will distribute an 834 Companion Guide to all participating Issuers, which will include the specifics with regard to transactions and the coding of transactions.

b. Small Business Health Options Programs (SHOP) Marketplace

AHCT and licensed certified brokers assist small employers as defined in 45 C.F.R. §155.20, and the employees of those groups, with QHP selection and enrollment assistance.

AHCT's SHOP vendor transfers data electronically between the SHOP vendor and Issuers. The SHOP vendor produces a single premium invoice to the small employer for the total premium dollars due. The small employer remits the premium due (both employee and employer contributions) to the

SHOP vendor. The SHOP vendor processes the small employer premium payments by disbursing the applicable amount to the appropriate Issuer. The SHOP vendor is also is responsible for sending an aggregated broker commission payment to the individual brokers for all enrollees the broker has assisted.

G. Qualifying Events and Special Enrollment

AHCT grants a special enrollment period for qualifying events in accordance with 45 C.F.R. §155.420(d) for the Individual Marketplace and 45 C.F.R. §155.725(j) for the SHOP Marketplace.

Additionally, pursuant to 45 C.F.R. §155.420(d)(2)(i) and C.G.S.§38a-564, special enrollment is available when a court has ordered coverage be provided to a spouse or minor child.

All special enrollment periods begin as of the date of the qualifying event, not as of the date reported to AHCT.

H. Grace Periods

a. Individual Marketplace

i. Enrollees Receiving Advance Premium Tax Credit

Issuers must adhere to the requirements in 45 C.F.R. §156.270 in determining grace period and termination procedures due to non-payment of the premium for enrollees receiving Advanced Premium Tax Credit (APTC). Currently, the grace period for those receiving APTCs is as follows:

1) During the first month where premium is in arrears, coverage shall remain as if the account was not in arrears,

2) During the second and third months, the Issuer may pend claim payments on any claims received but may not limit an enrollee's access to coverage. Issuers may notify a requesting provider of the status of an enrollee's account,

3) The account may be cancelled at the end of the ninety (90) day grace period back to the end of the first month of the current grace period. The APTC payments received by the Issuer may be kept for the first month only and the Issuer may seek payment of any remaining premium due through any lawful collection action. The Issuer shall remit back to the federal government, upon cancellation, any APTCs received by the Issuer on behalf of the enrollee for the second and third months of the grace period.

ii. Enrollees Not Receiving Advance Premium Tax Credit

AHCT will require Issuers to comply with a 30 day grace period for the enrollees not receiving APTCs. If no payment is received during this one month grace period, the enrollment may be cancelled effective at the end of that one month grace period, not back to the end of the last month in which payment in full was received by the Issuer.

b. SHOP Marketplace

AHCT has established a 30 day grace period for small employers that do not pay the premium on time. To account for months without 30 days, the grace period extends to the end of the month.

I. OPM Certification of Multi-State Plan (MSP) Options

The U.S. Office of Personnel Management (OPM) is responsible for implementing the Multi-State Plan Program (MSP Program) as required under section 1334 of the Affordable Care Act. In accordance with §1334(d) of the Affordable Care Act, MSP Options offered by MSP Issuer under contract with OPM are deemed to be certified by AHCT.

AHCT requires MSP Issuers to comply with all of the standards and requirements set forth in AHCT's Issuer Application for Participation and all applicable Federal and Connecticut State laws that may apply to either health insurance, in total, or Exchanges. Additionally, Issuers offering an MSP Option on the AHCT Marketplace must be distinguished from any other Issuer participating on the AHCT Marketplace by Issuer HIOS ID number and plan marketing names.

J. Amendments to Solicitation

AHCT reserves the right to amend this Solicitation as may be necessary to assure compliance with state and federal laws AHCT will post any amendments to this Solicitation on its website (www.ct.gov/hix).

II. Application Components and Certification Requirements

This section outlines the various components that AHCT will require in the QHP Application for this Solicitation. The QHP Application and any associated guidance related to its submission, including the submission of any supporting documentation, will be provided to the primary point of contact identified by the Issuer in the NBNOI.

The QHP Application will collect Issuer information, benefit information and rate data, largely through standardized Federal QHP data templates and supporting documentation. Additionally, Issuers will be required to attest to adherence to the regulations set forth in 45 C.F.R. parts 155 and 156 and AHCT requirements. AHCT has adopted the requirements in 45 C.F.R. 156.340, therefore the Issuers maintain responsibility for the compliance of any delegated entities. Attestations will clearly state that any vendors and/or contractors of the Issuer will comply with all state and federal laws.

AHCT will grant Issuer and QHP certification for one year, providing Issuer meets all requirements. Issuers interested in offering QHPs through AHCT Marketplace in subsequent plan years must seek recertification on an annual basis.

A. Issuer General Information

The QHP Application will request the name and address of the legal entity that has obtained the Certificate of Authority to offer health insurance policies in the State of Connecticut. This information must match the information on file with the CID. Issuers will be required to provide AHCT with the following information:

- Company information;
- Primary contact for each Marketplace the Issuer applies to participate in;
- Market coverage (Individual, SHOP, or both);
- List of vendors directly involved in service delivery.

B. Issuer Compliance and Performance Oversight

AHCT will request Issuers submit a compliance plan as part of the QHP Application. Issuers will be required to submit any subsequent changes made by the Issuer to its compliance plan during the plan year. The compliance plan is intended to document the Issuer's efforts to ensure that appropriate policies and procedures are in place to maintain adherence with Federal and State law as well as to prevent fraud, waste and abuse. AHCT expects an Issuer's compliance program to include the following elements:

- Designation of a compliance officer and compliance committee
- Written policies and procedures and documentation of proven adherence

- Effective communication among all levels of the company ensuring a shared responsibility to compliance
- A record retention policy, not less than 10 years for any information related to CSR or APTC
- Compliance education and an effective training program
- Compliance metrics as part of an employee performance appraisal process and compliance standards enforced through well-publicized disciplinary guidelines
- An internal audit process and the monitoring of such
- Corrective action plan initiatives to monitor and respond to detected offenses
- A statement of corporate philosophy and codes of conduct

Further, the Issuer will be required to attest that its compliance plan adheres to all applicable laws, regulations, and guidance and that the compliance plan is implemented or ready to be implemented.

AHCT intends to monitor and evaluate an Issuer's performance using information received directly by AHCT as well as from other sources, including the CID, Office of Healthcare Advocate, consumers and providers. AHCT will utilize complaint data, Issuer self-reported problems, information related to consumer service and satisfaction, health care quality and outcomes, Issuer operations, and network adequacy in its assessment of Issuer's performance in the Marketplace.

AHCT expects Issuers to thoroughly investigate and resolve consumer complaints received directly from members or forwarded to the Issuer by AHCT or any other individual or organization through the Issuer's internal customer service process and as required by state law. As part of compliance and performance monitoring, AHCT reserves the right to require the Issuers to provide complaints reports at a frequency established by AHCT.

C. Licensure and Financial Condition

Consistent with 45 C.F.R. §156.200(b)(4), AHCT requires participating Issuers to be licensed by the CID as well as have a designation of good standing. The licensing and monitoring functions are the responsibility of the CID. The following are some examples of a designation of good standing:

- the CID has not restricted an Issuer's ability to underwrite new health plans
- the Issuer is not in hazardous financial condition
- the Issuer is not under administrative supervision
- the Issuer is not in receivership

AHCT will require Issuers to submit a State Certification Form that will be provided at a later date. Issuers applying for QHP certification must be able to demonstrate State licensure prior to the beginning of the annual open enrollment period.

D. Market Participation

- An Issuer may elect to participate in either the Individual Marketplace or SHOP Marketplace, or both.
- If a certified Issuer ceases participation in AHCT's Marketplace for the plan year 2016, the Issuer may be denied re-entry onto the marketplace until the next Solicitation which will take place in 2016 for the 2017 plan year.
- If participating in the SHOP, the Issuer must agree to fully participate in each of the AHCT's purchasing options. The three options are Issuer Bundle, Metal Tier Bundle, and Single Plan option. Each choice model is defined below:
    - **Issuer Bundle (Vertical Choice)**: Allows an eligible employer to offer their eligible employees plan options from all available "metal tiers" from any one selected Issuer (i.e. any 'Issuer A' plan in any metal tier);
    - **Metal Tier Bundle (Horizontal Choice)**: Allows an eligible employer to offer their eligible employees plan options from all of participating Issuers, across any one selected "metal tier" (i.e. any Silver plan from any of the Issuers);
    - **Single Plan**: Allows an eligible employer to offer their eligible employees one plan design in any one metal tier from any one Issuer for group offering.

AHCT will only calculate and display premiums based on the total of the individual premiums of covered participants and beneficiaries as described in 45 C.F.R. 147.102(c)(3)(i).

E. Marketing Guidelines

All marketing materials for any QHP offered through AHCT must be reviewed and approved in advance by AHCT . Issuers must allow up to five business days for AHCT's review and approval prior to the materials being published and/or released.

AHCT will not permit Issuers to display or make reference, verbally or otherwise, to a calculator for the purpose of estimating a consumer's eligibility for APTCs or other affordability programs. Affordability program eligibility assessment and enrollment is the sole responsibility of AHCT.

Currently AHCT does not permit co-branding of an Issuer's brand or logos with those of AHCT without AHCT's express written prior approval. Specifically, Issuers are not permitted to use AHCT's name or logo in any of their marketing materials. In addition, Issuers' marketing material cannot include a reference to the "Exchange" "Marketplace" or "Connecticut Exchange" or any other word or sequence of words used with the intent to express a connection with AHCT or which may lead a consumer to reasonably assume a connection between AHCT and the issuer without express prior approval from AHCT.

AHCT requires the Issuer's Plan Marketing Names to be consumer friendly and in plain language; specifically, AHCT prohibits inclusion of an Issuer's internal coding, numeric values, and/or special characters (e.g., "%", "#", "$", etc.) in the Plan Marketing Names. Issuers must include appropriate commonly known product abbreviations in the plan name, e.g., "PPO", "HMO", "POS", "HSA", the

metal level, e.g., Platinum, Gold, Silver, Bronze, as well as, the term "Standard" for those plans required by AHCT. AHCT's character limit on the Plan Marketing Names is 75 characters.

F. Consumer Information

a. Enrollee Materials

Issuers will be required to submit to AHCT in English and Spanish:

• Evidence of Coverage (EOC): the document(s) for each QHP product the Issuer intends to offer on the Exchange for sale (PPO, HMO, POS); and,

• Schedule of Benefits (SOB): the documents for each unique offering that depicts the cost-sharing for each metal tier.

The Issuer must utilize the specific AHCT SOB template for all plan designs (standard and non-standard plan designs) intended to be offered through AHCT.

The EOC and SOB should be combined in a portable document format (PDF) and submitted through the System for Electronic Rate and Form Filing ("SERFF") Plan Management System. The SOB should appear as the first document in the combined PDF. The purpose for this formatted approach is to enhance a consumer's shopping experience by permitting the consumer to easily review the cost sharing and contract by company and plan design.

• Summary of Benefits and Coverage (SBC): provide the SBC for each plan design and plan variation including each of the coverage examples defined by HHS for each QHP offered through the AHCT Marketplace. AHCT expects to display this information to consumers via a link or URL provided by the Issuer.

In accordance with 45 C.F.R. §147.200 and 45 C.F.R. §147.136(e) Issuers must provide the SBC in a culturally and linguistically appropriate manner. In addition, the Issuer must conform with 45 C.F.R. §155.205(c)(2)(i)(A) which requires all issuers to provide telephonic interpreter services in at least 150 unique languages.

b. Company Logo

Issuers will be required to provide an electronic image of the Issuer's logo.

c. Provider Directory

Pursuant to 45 C.F.R. 156.230, AHCT will require Issuers to make available provider directories to AHCT by providing the URL to the Issuer's network directory in the Network Template.

The URL provided must link directly to the provider directory, so that consumers do not have to log on, enter a policy number, or otherwise navigate the Issuer's website before locating the directory. If an Issuer maintains multiple provider networks, the consumer must be able to easily discern which providers participate in which plans and which provider networks apply to which QHP(s). AHCT will not certify any QHP unless the URL is direct to the provider directory search tool for the

specific QHP. The directory must include location, contact information, specialty, and medical group, any institutional affiliations for each provider, and whether the provider is accepting new patients. AHCT will require Issuers to include an option for consumers to search the directories by filtering those providers that are accepting new patients versus those that are not. Additionally, the provider directory must include an indicator for each provider, regardless of provider's specialty, that clearly states whether the provider is accepting new patients or not. Such information must be kept up-to-date. The Issuer is expected to update its provider network directory at least once a month. AHCT reserves the right to modify this frequency during the plan year.

AHCT encourages Issuers to include languages spoken, provider credentials, and whether the provider is an Indian health provider. Directory information for Indian health providers should describe the service population served by each provider, as some Indian health providers may limit services to Indian beneficiaries, while others may choose to serve the general public.

AHCT also requires Issuers to submit in-network provider directories to AHCT for each QHP in a searchable PDF or in an unprotected excel format. Additionally, Issuers will be required to provide updates of provider directories to AHCT electronically no less often than quarterly in a format specified by AHCT.

d. Prescription Drug Formulary

Issuers must publish, in a document with a searchable format and with a direct URL, an up-to-date, accurate, and complete list of all covered drugs on its formulary drug list, including any tiering structure that it has adopted and any restrictions on the manner in which a drug can be obtained, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, AHCT, HHS, the U.S. Office of Personnel Management, and the general public pursuant to 45 C.F.R. 156.122(d). The URL provided as part of the QHP Application should link directly to the formulary, so that consumers do not have to log on, enter a policy number or otherwise navigate the Issuer's website before locating it. If an Issuer has multiple formularies, it should be clear to consumers which formulary applies for the specific QHP in which the consumer has elected to search under.

AHCT requires Issuers to submit drug formularies for each QHP to AHCT electronically and in a searchable document format as specified by AHCT. Additionally, AHCT reserves the right to require Issuers to provide formulary updates to AHCT no less than quarterly throughout the year.

G. QHP Requirements

- Each QHP must comply with the benefit standards required by the ACA, including:
  - Cost sharing limits
  - Actuarial value ("AV") requirements
  - Federally approved State-specific essential health benefits (EHB)
    - In the Standard Plan designs Issuers are required to embed pediatric dental benefits
    - In the Non-Standard plan designs, inclusion of pediatric dental benefits is at the option of the Issuer
- The Issuer must set premium rates for its QHPs for the entire benefit year.

- An Issuer must submit a justification for a rate increase prior to the implementation of the increase. An Issuer must prominently post the justification on its website. AHCT will request a URL to the Issuer's website where the rate increase justification has been posted. To ensure consumer transparency, AHCT will provide access to such justification on the Marketplace website.
- Except for cost sharing reduction variants, each plan in a metal tier must meet the specified Actuarial Value (AV) requirements based on the cost-sharing features of the plan:
    - Bronze plan – AV of 60 percent
    - Silver plan – AV of 70 percent
    - Gold plan – AV of 80 percent
    - Platinum plan – AV of 90 percent

  A *de minimis* variation of +/- 2 percentage points in AV is allowable for any QHP offered at any plan level. A de minimis variation of +/- 1 percentage point in AV is allowable for the silver plan cost-sharing reduction variants available in the Individual Marketplace.

All QHPs offered must include the Connecticut specific EHBs. No substitution of actuarially equivalent benefits will be allowed. Please refer to the Exhibit titled "Connecticut's Essential Health Benefits".

Issuers must not employ market practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs (see 45 C.F.R. 156.225). To ensure non-discrimination in QHP benefit design, AHCT will perform an outlier analysis on QHP cost sharing (e.g., co-payments and co-insurance) for Issuer's plans as part of the QHP certification application process. QHPs identified as having potentially discriminatory benefit/cost-sharing structures may be given the opportunity to modify such cost sharing.

45 C.F.R. 156.420 requires Issuers to submit three plan variations for each silver level QHP Issuer as well as the zero and limited cost-sharing plan variations for all QHPs, except catastrophic plans, an Issuer offers through the AHCT Individual Marketplace.

The AHCT Standard Plan designs are not "gatekeeper" plans and were designed to provide enrollees with direct access to specialists. Accordingly, AHCT will not certify the Standard Plan design's offered by an Issuer at any coverage level if the Issuer requires a referral from a Primary Care Provider (PCP) in order for an enrollee to be able to access a specialist. Should an Issuer impose the "gatekeeper" requirement in its non-Standard Plans, such requirement must be described explicitly in the Issuer's Evidence of Coverage. AHCT will require an Issuer to identify "gatekeeper" requirement in the Schedule of Benefits and/or the Issuer's Plan Marketing Name(s).

An Issuer will be required to provide a prescription drug formulary in accordance with the greater of either the requirements expressed in 45 C.F.R. 156.122 or equal in number and type to the formulary used in the plan with the highest enrollment (representing a similar product) which the Issuer or its parent companies (if applicable) offers outside of the AHCT Marketplace.

H. Plan Options

Standardized plan designs promote transparency, ease, and simplicity for comparison shopping by consumers. AHCT has developed a standard plan design for each metal tier for the 2016 benefit year which defined deductible, co-payment and/or co-insurance cost sharing on an in-network and out-of-network basis. The 2016 Standard Plan Designs can be found on AHCT's website (http://www.ct.gov/hix/cwp/view.asp?a=4295&q=562272).

a. Individual Marketplace

To participate in the AHCT Individual Marketplace the following criteria must be met:

- An Issuer **must** submit at least one Standard Gold Plan, one Standard Silver Plan, and two Standard Bronze Plans (one Standard Bronze Plan and one Standard HSA compatible Bronze Plan).
- The Standard Silver Plan offered **must** be the lowest cost Silver Plan offered by the Issuer in the AHCT individual Marketplace
- An Issuer **must** submit three cost-sharing reduction (CSR)variants for each Silver Plan offered by the Issuer to households with attested income between 100% and 250% of Federal Poverty Level (FPL) applicable at the start of the plan year. The CSR variants are
    - a 73% AV CSR silver plan variant which must be separated from the silver design on which it is based by a minimum AV difference of 2%,
    - an 87% CSR silver plan variant, and
    - a 94% CSR silver plan variant.

The variants must conform to the requirements of 45 C.F.R. §156.420 and any other applicable federal guidance or regulations.

- An Issuer **must** submit two cost-sharing alternatives for each QHP in accordance with 45 C.F.R. §156.420 which shall be made available to members of federally-recognized American Indian tribes or Alaskan-Natives. There must be:
    1. one alternative that offers zero cost-sharing for American Indians under 300% of the FPL applicable at the start of the plan year; and
    2. one alternative that offers limited cost-sharing for American Indians, regardless of income, for any item or service that is an EHB furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services.
- An Issuer **must** offer a child-only QHP option at the same level of coverage(s) as any QHP offered through the AHCT Marketplace in accordance with 45 C.F.R. §156.200(c). A consumer seeking child-only coverage may obtain that coverage through the purchase of a single QHP with applicable rating for child-only coverage. In other words, any QHP can be sold as a child-only plan.

Issuers are also encouraged to submit also offer any of the following:

- The Issuer may opt to offer a catastrophic coverage plan. Any Issuer offering the catastrophic coverage plan option must comply with Federal law including Section 1302 (e) of the ACA and 45 C.F.R. §156.155; and any applicable State law.
- One Standard Platinum Plan and up to two Non-Standard Platinum Plans

- Up to three Non-Standard Gold Plans
- Up to three Non-Standard Silver Plans with the corresponding cost-sharing reduction plans
- Up to three Non-Standard Bronze Plans

b. SHOP Marketplace

Please note that the Standard Plan Designs for the SHOP Marketplace may differ from the Standard Plan Designs offered in the Individual Marketplace. To participate in the SHOP, an Issuer must offer the following combination of Standard plans:

- One Standard Platinum Plan
- One Standard Gold Plan
- Two Standard Silver Plans (one Standard Silver Plan and one Standard HSA compatible Silver Plan).
- Two Standard Bronze Plans (one Standard Bronze Plan and one Standard HSA compatible Bronze Plan).

In addition, Issuers are encouraged to submit any combination of the following plans:

- Up to two Non-Standard Platinum Plans
- Up to three Non-Standard Gold Plans
- Up to three Non-Standard Silver Plans
- Up to three Non-Standard Bronze Plans

I. Federal QHP Data Templates

The Federal QHP data templates must be completed and submitted via the System for Electronic Rate and Form Filing (SERFF). The templates listed below illustrate the data requirements for an Issuer to obtain QHP Certification for each plan design intended for sale on the AHCT Marketplace. The templates are located on the SERFF website and contain Issuer and Plan information required to effectively evaluate the Issuers QHP submissions.

The data templates can be found on the SERFF website http://www.serff.com/plan_management_data_templates.htm. AHCT intends to extract information from these Templates to optimize the consumer shopping experience screens.

AHCT anticipates requiring Issuers to provide the following templates, as part of QHP Application:

- Administrative Data - General Company Contact Information.
- Plans and Benefits Template– Plan and Benefit Data.
- Prescription Drug Formulary Template - Prescription drug benefit information and formulary information, including formulary URL.
- Network Template - Provider network information.
- Service Area Template - Geographic service area information.
- Rates Table Template – Premium information by Plan for each age band.
- Business Rules Template - Supporting business rules.
- Network Adequacy Template –Provider information.
- NCQA / URAC / AAAHC Template - Accreditation Information.

- Uniform Rate Review- Data for market-wide rate review – the template includes Issuer information to support rating development.

AHCT does not intend to require Issuers to submit the Federal ECP Template. Issuers will be required to submit ECP data in the AHCT ECP Template.

J. Rating Factors

Issuers should refer to the CID Bulletin HC-91 for information regarding rating factors in Individual and SHOP markets.

- *Single Risk Pool*. An Issuer must consider all of its enrollees in all health plans offered by the Issuer both inside and outside of the AHCT Marketplace to be members of a single risk pool encompassing either the individual market or small group market.
- *Tobacco Use*. Issuers are prohibited from using tobacco use as a rating factor in the Small Group market in accordance with CGA§38a -567. ACHT also does not permit tobacco rating in the individual market for 2016.
- *Family Composition*. Federal regulations require Issuers to add up the premium rate of each family member to arrive at a family rate. However, the rates applicable to no more than the three oldest child dependents who are under the age of 21 will be used in computing the family premium.
- *Age.* Federal regulations require a uniform age rating curve that specifies the distribution of relative rates across all age bands and is applicable to the entire market. The federal government's proposed age curve anchors the premium amount to age 21, and is expressed as a ratio, for all ages between ages 0 and 64, inclusive, subject to the following:
    - Children: single age band covering children 0 to 20 years of age, where all premium rates are the same
    - Adults: one-year age bands starting at age 21 and ending at age 63
    - Older adults: a single age band covering individuals 64 years of age and older, where all premium rates are the same
    - Rates for adults age 21 and older may vary within a ratio of 3:1
- AHCT has adopted the CMS recommendation referenced in "Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review, 78 Federal Register page 13411, (February 27, 2013)" regarding alignment of Connecticut's rating and service areas. The rating area factor is required to be actuarially justified for each area. AHCT currently requires the Issuers to offer QHPs in all counties identified below.

RATING AREA	**SERVICE AREA**	**COUNTY**
Rating Area 1	Service Area 1	Fairfield
Rating Area 2	Service Area 2	Hartford
Rating Area 3	Service Area 3	Litchfield
Rating Area 4	Service Area 4	Middlesex
Rating Area 5	Service Area 5	New Haven
Rating Area 6	Service Area 6	New London
Rating Area 7	Service Area 7	Tolland
Rating Area 8	Service Area 8	Windham

Statewide coverage is not a prerequisite to certification, but a QHP will need to cover an entire rating area.

K. Wellness Incentives

AHCT encourages Issuers to offer wellness programs as described in 45 C.F.R. §146 and 147. Issuers planning to offer a wellness program(s) in the SHOP Marketplace will be required to describe wellness programs they currently offer outside of the AHCT Marketplace and provide information on how success of such programs is monitored as well as the program(s) outcomes. AHCT may require Issuers intending to offer a wellness program(s) to provide a detailed proposal of such programs. AHCT reserves the right to decide whether a wellness program(s) as described by an Issuer should be offered in the SHOP.

L. Accreditation

1. Issuers Certified by AHCT as of January 1, 2014:

a) That were fully accredited as of January 1, 2014: will need to maintain accreditation and provide evidence of accreditation for QHPs offered through AHCT;

b) That were not accredited as of January 1, 2015: will need to demonstrate full accreditation by January 1, 2016.

2. Issuers Applying for Initial Certification as of January 1, 2016:

a) That are currently fully accredited: will need to maintain accreditation and seek accreditation for QHPs offered through AHCT upon Issuer and QHP certification and obtain such accreditation by May 1, 2017;

b) That are not currently accredited: will need to seek accreditation and obtain full accreditation by January 1, 2018.

The accreditation must be granted by a recognized accrediting entity for the same state in which the Issuer is applying to offer coverage. The Issuer must schedule or plan to schedule with a recognized accrediting entity a review of its QHP policies and procedures.

Issuers will be asked to provide information about their accreditation status to determine if the standard in §155.1045(b) is met. This information will be verified with the indicated accrediting entity. For certification in the 2016 benefit year, the National Committee for Quality Assurance (NCQA), URAC, and the Accreditation Association for Ambulatory Health Care (AAAHC) have been recognized by CMS as accrediting entities for the purpose of QHP certification.

Issuers will be considered accredited if the Issuer is accredited with the following status: by AAAHC with “Accredited,” status; by NCQA with “Excellent,” “Commendable,” “Accredited,” and /or “Interim” status; or by URAC with “Full,” “Provisional,” and/ or “Conditional,” status. An Issuer will not be considered accredited if the accreditation review is scheduled or in process.

Issuers will be required to authorize the accrediting entity to release to AHCT and HHS a copy of its most recent accreditation survey, together with any survey-related information that HHS may require, such as corrective action plans and summaries of findings.

M. Reporting Requirements

Quality Rating System (QRS)

Issuers are required to comply with standards and requirements related to data collection of quality rating information pursuant to 45 C.F.R. 156.1120, and the QHP Enrollee Survey pursuant to 45 C.F.R. 156.1125. Issuers must collect and report validated data annually, on a timeline and in a standardized form and manner specified by HHS, to support the calculation of the QRS scores and ratings for each QHP that has been offered in a Marketplace for at least one year.

Issuers are also required to contract with and authorize an HHS-approved vendor to annually collect and submit QHP Enrollee Survey data on their behalf for each QHP. Issuers that had more than 500 enrollees in QHPs in the previous plan year are required to submit this data. Issuers are expected to follow the specific requirements related to data collection, validation and submission, as well as minimum enrollment criteria, for the QRS and QHP Enrollee Survey as detailed in technical guidance issued by CMS.

Consistent with 45 C.F.R. 156.200(b)(5), in order to demonstrate compliance with the quality reporting standards as part of the certification process for the 2016 coverage year, Issuers will be required to attest that they comply with the specific quality reporting and implementation requirements related to the QRS and QHP Enrollee Survey.

AHCT reserves the right to require Issuers to submit the following:

- CAHPS data for product most comparable to submitted QHP;
- NCQA star rating in the five core areas (i.e. “Access and Service,” “Qualified Providers,” “Staying Healthy,” “Getting Better” and “Living with Illness”) for NCQA-accredited product most comparable to submitted QHP;
- Medical Loss Ratio (“MLR”) for the most recent year and projected MLR for 2016, for non-group/small-group.
- Quality Improvement Strategy (QIS): a narrative outlining how they will attempt to better coordinate care and control costs, improve chronic illness management, reduce medical error, or otherwise promote health care delivery and payment reform for the benefit of the consumer and metrics Issuers intend to use to demonstrate program success.
- Reports demonstrating success of their Quality Improvement Strategy to AHCT on ongoing basis throughout the benefit year.

Additionally, AHCT anticipates following CMS guidance expected to be released in the fall of 2015 providing Issuers with the necessary information to comply with QIS requirements. Upon release of the guidance, AHCT will require Issuers to abide with implementing a payment structure that provides increased reimbursement or other provider incentives to improve quality of patient care.

Additionally, the QHP Application will require the following or similar attestation language:

- The Applicant attests that the company currently has in place, a quality improvement strategy consistent with the standards of Section 1311(g) of the ACA.
- The Applicant attests that the information on health care quality and outcomes as described in Section 399JJ of the Public Health Service Act will be disclosed to the Exchange.
- The Applicant will report to HHS and the Exchange at least annually, the pediatric quality reporting measures described in Section 1139A of the Social Security Act.
- The Applicant attests that an enrollee will require satisfaction surveys consistent with the requirements of section 1311(c) of the ACA.

N. Patient Safety Standards

Beginning on January 1, 2015 Issuers are required to comply with patient safety standards and may only contract with hospitals and health care providers that meet specified quality improvement criteria. Proposed regulatory requirements at §156.1110 in the CMS 2015 Payment Notice outline how Issuers can demonstrate compliance with these standards, on a transitional basis, for 2 years beginning January 1, 2015 or until further regulations are issued, whichever is later.

Specifically, the proposal requires Issuers that contract with a hospital with greater than 50 beds to verify that the hospital, as defined in section 1861(e) of the SSA, is Medicare-certified or has been issued a Medicaid-only CMS Certification Number (CCN) and is subject to the Medicare Hospital Condition of Participation requirements for:

(1) A quality assessment and performance improvement program as specified in 42 C.F.R. §482.21; and
(2) Discharge planning as specified in 42 C.F.R. §482.43.
In addition, Issuers would be required to collect and maintain documentation of the CCNs from their applicable network hospitals.

As part of the certification for the 2016 benefit year, AHCT anticipates requiring Issuers to demonstrate compliance with these patient safety standards as part of the QHP Application with an attestation that they have collected and are maintaining the required documentation from their network hospitals.

O. Network Adequacy

Pursuant to 45 C.F.R. §156.230(a)(2), an Issuer of a QHP that has a provider network must maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible to enrollees without unreasonable delay. Issuers will need to attest that they meet this standard as part of the certification/recertification process.

In addition to the attestation, AHCT requires that an Issuer's provider network for the Standard plan designs offered for sale in the Marketplace must include at least 85% of those unique providers and unique entities that are in the Issuer's network for its largest plan (representing a similar product) that is marketed, sold and has active enrollees outside of the Marketplace ("the benchmark plan").

If an Issuer has an affiliated company that is active outside of the Marketplace, but in the State of Connecticut, AHCT will look to the larger of the Issuer's network for its largest plan or the network of the Issuer's affiliated company's largest plan (representing a similar product) that is marketed, sold and has active enrollees outside of the Marketplace, but in the State of Connecticut, as the "benchmark plan" for the purposes of such network adequacy calculation.

In order to determine whether the Issuer's provider network(s) meet the 85% requirement, AHCT will periodically require an Issuer to provide current network information for both its Standard Plan designs' network and for the benchmark plan network. A quarterly submission of this information is currently required, but AHCT reserves the right to modify the frequency of reporting as needed.

Issuers' networks for all QHPs will need to adhere to AHCT's reasonable access standards. AHCT is currently evaluating the requirements for the 2016 benefit year. AHCT's intention is to develop reasonable access standards based on membership distribution by Issuer throughout the State and implement specific geographical access standards by provider type. Issuers will be required to submit provider network information in a format specified by AHCT.

Issuers will be required to submit a report on consumer complaints pertaining to access to network providers in a format and at a frequency specified by AHCT.

Issuers are also required to meet specific standards for the inclusion of Essential Community Providers (ECPs) within their QHP provider networks. The definition of an ECP is included in 45 C.F.R. §156.235. The ECP must provide services that are considered covered health services under the currently adopted definition of Essential Health Benefits to individuals at disparate risk for inadequate access to healthcare.

ECP Network Adequacy standards:

- Issuers must contract with 90% of the Federally Qualified Health Centers (FQHCs) in Connecticut.
- Issuers must contract with 75% of the non-FQHC providers on the AHCT ECP list. This list is subject to periodic updates by CMS and AHCT.

To determine whether an Issuer is meeting the ECP standards, AHCT will require the Issuer to complete "ECP List" on a quarterly basis. AHCT will provide Issuers that submit the Non-Binding Notice of Intent with the ECP list/template for ECP data submission. If an Issuer does not meet the standard(s) at the time of quarterly submission of ECP data to AHCT, the Issuer will be required to provide AHCT with a narrative outlining demonstration of a good faith effort in contracting as described in the exhibit titled "Supplementary Response: Inclusion of ECPs".

P. Attestations

Consistent with the ACA, the Issuer must agree to comply with the minimum certification standards with respect to each QHP on an ongoing basis.

- Attestations will be required as part of the QHP application submission.
- The attestation language will cover the minimum certification standards required by CMS, AHCT and/or the CID.

- Attestations will cover Issuer's existing operations as well as any contractual commitments needed to meet AHCT requirements on an ongoing basis.
- Issuer will attest that it has in place an effective internal claims and appeals process and agrees to comply with all requirements for an external review process with respect to QHP enrollees, consistent with state and federal law. (45 C.F.R. §147 and 45 C.F.R. §800.503 for Multi-State Plan options).

Q. User Fees/Market Assessment

Attestation language will be included in the QHP application that commits the Issuer to pay user fee and /or Issuer assessments, as applicable.

R. Issuer Accountability

To ensure timely certification, AHCT will require Issuers to submit an attestation that the Issuer's business leaders have collectively performed a comprehensive preview of all required 2016 Federal QHP Data templates and supporting documents prior to submission via SERFF for the express purpose of presenting said data to AHCT for Issuer and QHP certification.

Issuers will also be required to utilize specific QHP Application Review Tools developed by CMS and provide AHCT with an output of such Tools to demonstrate that all errors have been corrected prior to submission of data to AHCT.

[COMPANY NAME]
Individual
[PLAN NAME]
SCHEDULE OF BENEFITS

Deductible and Out-of-Pocket Maximum	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Deductible –		
Plan Deductible *Individual* *Family*		
Out-of-Pocket Maximum *Individual* *Family* (Includes deductible, copayments and coinsurance)		
Benefits	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Provider Office Visits		
Adult Preventive Visit		
Infant / Pediatric Preventive Visit		
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)		
Specialist Office Visits		
Mental Health and Substance Abuse Office Visit		
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)		
Laboratory Services		
Non-Advanced Radiology (X-ray, Diagnostic)		
Prescription Drugs - Retail Pharmacy ***up to 30 day supply per prescription***		

[COMPANY NAME]
Individual
[PLAN NAME]
SCHEDULE OF BENEFITS

Deductible and Out-of-Pocket Maximum	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Tier 1		
Tier 2		
Tier 3		
Tier 4		
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per calendar year limit combined for physical, speech, and occupational therapy)		
Physical and Occupational Therapy (40 visits per calendar year limit combined for physical, speech, and occupational therapy)		
Other Services		
Chiropractic Services (up to 20 visits per calendar year)		
Diabetic Equipment and Supplies		
Durable Medical Equipment (DME)		
Home Health Care Services (up to 100 visits per calendar year)		
Outpatient Services (in a hospital or ambulatory facility)		
Inpatient Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) *(skilled nursing facility stay is limited to 90 days per calendar year)		
Emergency and Urgent Care		
Ambulance Services		
Emergency Room		
Urgent Care Centers		

[COMPANY NAME]
Individual
[PLAN NAME]
SCHEDULE OF BENEFITS

Deductible and Out-of-Pocket Maximum	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive		
Basic Services		
Major Services		
Orthodontia Services (medically necessary only)		
Pediatric Vision Care (for children under age 19)		
Prescription Eye Glasses (one pair of frames and lenses or contact lens per calendar year)	Lenses: $0; Collection frame: $0; Non–collection frame: members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the Issuer with the retailer.	
Routine Eye Exam by Specialist (one exam per calendar year)		

[COMPANY NAME]
Small Business Health Options Programs (SHOP)
[PLAN NAME]
SCHEDULE OF BENEFITS

Deductible and Out-of-Pocket Maximum	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Deductible –		
Plan Deductible *Individual* *Family*		
Out-of-Pocket Maximum *Individual* *Family* (Includes deductible, copayments and coinsurance)		
Benefits	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Provider Office Visits		
Adult Preventive Visit		
Infant / Pediatric Preventive Visit		
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)		
Specialist Office Visits		
Mental Health and Substance Abuse Office Visit		
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)		
Laboratory Services		
Non-Advanced Radiology (X-ray, Diagnostic)		
Prescription Drugs - Retail Pharmacy ***up to 30 day supply per prescription***		

[COMPANY NAME]
Small Business Health Options Programs (SHOP)
[PLAN NAME]
SCHEDULE OF BENEFITS

Deductible and Out-of-Pocket Maximum	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Tier 1		
Tier 2		
Tier 3		
Tier 4		
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per plan year limit combined for physical, speech, and occupational therapy)		
Physical and Occupational Therapy (40 visits per plan year limit combined for physical, speech, and occupational therapy)		
Other Services		
Chiropractic Services (up to 20 visits per plan year)		
Diabetic Equipment and Supplies		
Durable Medical Equipment (DME)		
Home Health Care Services (up to 100 visits per plan year)		
Outpatient Services (in a hospital or ambulatory facility)		
Inpatient Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) *(skilled nursing facility stay is limited to 90 days per plan year)		
Emergency and Urgent Care		
Ambulance Services		
Emergency Room		
Urgent Care Centers		
Pediatric Dental Care (for children under age 19)		

[COMPANY NAME]
Small Business Health Options Programs (SHOP)
[PLAN NAME]
SCHEDULE OF BENEFITS

Deductible and Out-of-Pocket Maximum	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Diagnostic & Preventive		
Basic Services		
Major Services		
Orthodontia Services (medically necessary only)		
Pediatric Vision Care (for children under age 19)		
Prescription Eye Glasses (one pair of frames and lenses or contact lens per plan year)	Lenses: $0; Collection frame: $0; Non–collection frame: members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	
Routine Eye Exam by Specialist (one exam per plan year)		

Instructions for Completing the Schedule of Benefits Template

1. Include out-of-network category unless HMO without POS. If HMO without POS, remove this column.
2. If a plan offers a tiered network, rename the "In-Network (INET) Member Pays" column to "Tier 1 In-Network (INET) Member Pays" and add a "Tier 2 In-Network (INET) Member Pays" column. The Issuer should include a comprehensive narrative including label/title that is used in the Issuer's marketing, member communication materials and the Issuer's online provider directory to denote the tiered network.
3. All office visits must have the same cost share as the PCP or Specialist with the exception of items in statute such as mammography ultrasound and PT/occupational therapy.
4. Include the "Separate Prescription Drug Deductible" section immediately below the "Plan Deductible" section if a plan features separate deductibles.
5. Include the following language in American Indian Limited Cost-sharing plan variations: "No Member cost when services are rendered by an Indian Health Service provider" in each benefit category immediately below the cost-sharing for services provided by a non-Indian Health Service provider.
6. Include the appropriate deductible definition that applies to the plan: "The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage,
   - **For non-aggregate use:**
     [each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.]
   - **For Aggregate use:**
     [the entire Family Annual Deductible must be met before any member of the family can receive benefits that are subject to the deductible.**]**
7. Include "Prescription Drugs – Mail Order" for plans that feature this benefit. Display immediately under the "Prescription Drugs – Retail Pharmacy" if the plan offers "Mail Order".
8. Remove "Pediatric Dental Care" section for any non-standard plans that do not offer embedded pediatric dental benefits.
9. Include "calendar year" for QHPs offered in the Individual market.
10. Include "plan year" for QHPs offered in the SHOP market.
11. "Mammography Ultrasound" benefit must be listed separately if copayment for non-advanced radiology exceeds $20. Insert below "Non-Advanced Radiology (X-ray, Diagnostic)".
12. Include narrative for "Outpatient Services" facility designation if one or both applies:
    - in a hospital based facility including an ambulatory facility
    - in a free-standing facility, not associated with a hospital

    Facility text must appear in the same section under Outpatient Services text.

    Note: providers must be identified as hospital based or free standing in the provider directory if any cost differential

Instructions for Completing the Schedule of Benefits Template

13. Free text field to be completed by the Issuers to provide contact information, any disclaimers regarding prior authorization requirements, etc.

Insert a footer displaying FORM # and Product Type: HMO/POS/PPO/HSA] for each plan.

Connecticut's Essential Health Benefits

All plans in the individual and small employer group markets both inside and outside of the exchange are required to provide at minimum coverage for the essential health benefits. A QHP's essential health benefits will form the basis for calculating the actuarial value of the QHP.

SERVICE	LIMIT
Outpatient Services	
PCP Office Visits (non-preventive)	
Specialist Office Visits	
Outpatient Surgery Physician/Surgical Services	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	
Home Health Care Services	100 visits/year
Emergency Services	
Emergency Room	
Emergency Transportation/Ambulance	per state mandate*
Walk-in/Urgent Care Centers	
Hospitalization	
Inpatient Hospital (Facility & Provider Services)	
Skilled Nursing/Rehabilitation Facility	90 days/year
Hospice	life expectancy of 6 months or less
Residential Treatment Facilities	
Mental Health and Substance Use Disorder Services	
Mental/Nervous and Substance Abuse Services	same as any other illness
Rehabilitative and Habilitatlve Services and Devices	
Outpatient Rehabilitation Services (PT/OT/ST)	40 visits (combined)/year
Cardiac Rehabilitation	
Chiropractic Visits	20 visits/year
Durable Medical Equipment	
Prosthetics	
Ostomy Appliances and Supplies	per state mandate*
Diabetic Equipment and Supplies	
Wound care supplies	per state mandate*
Disposable Medical Supplies	
Hearing Aids	for children under 12; 1/every 24 months
Surgically Implanted Hearing Devices	
Wigs	per state mandate*
Birth to Three	per state mandate*
Prescription Drugs	
Laboratory and Imaging Services	
Laboratory Services	
Non-advanced Radiology	
Advanced Imaging (includes MRI, PET, CAT, Nuclear Cardiology)	
Preventive and Wellness Services and Chronic Disease	
Adult Physical Exam	every 1-3 years for ages 22-49; 1/year for age 50+ as recommended by physician
Preventive Services	based on USPSTF A and B recommendation
Prenatal and Postnatal Care	
Infant/Pediatric Physical Exam	in accordance with national guidelines
Routine Immunizations	in accordance with national guidelines
Routine Gynecological Exam	1/year
Screening for Gestational Diabetes	for pregnant women between 24 and 28 weeks of gestation and at first prenatal visit for high risk of diabetes
Human Papillomavirus Testing	for women aged 30+; 1/every 3 years
Counseling for Sexually Transmitted Infections	for women 1/year
Counseling and Screening for HIV	for women 1/year
Contraceptive Methods and Counseling	for women
Breastfeeding Support, Supplies and Counseling	for women
Screening and Counseling for Interpersonal and Domestic Violence	for women 1/year
Preventive Lab Services	complete blood count & urinalysis, 1/year
Baseline Routine Mammography	1 between ages 35-39 ; 1/year for age 40+
Routine Cancer Screenings	in accordance with national guidelines
Blood Lead Screening and Risk Assessment	per state mandate*

*Since PPACA prohibits annual dollar limits, any dollar limits in state mandates no longer apply

Connecticut's Essential Health Benefits

SERVICE	LIMIT
Bone Density	1/every 23 months
Pediatric Hearing Screening	under age 19 as part of physical
Other Services	
Craniofacial Disorders	per state mandate*
Oral Surgery for Treatment of Tumors, Cysts, Injuries, Treatments of Fractures Including TMJ and TMD	TMJ for demonstrable joint disease only
Dental Anesthesia	per state mandate*
Reconstructive Surgery	to correct serious disfigurement or deformity resulting from illness or injury, surgical removal of tumor, or treatment of leukemia; for correction of congenital anomaly restoring physical or mechanical function
Maternity Coverage	
Mastectomy	per state mandate*
Breast Reconstructive Surgery after Mastectomy Including on Non-diseased Breast to Produce a Symmetrical Appearance	per state mandate*
Breast prosthetics	per state mandate*
Breast Implant Removal	per state mandate*
Autism Coverage	per state mandate*
Clinical Trials	per state mandate*
Solid Organ and Bone Marrow Transplants	
Medically Necessary Donor Expenses and Tests	
Transportation, Lodging and Meal Expense for Transplants	up to $10,000 per episode (initial evaluation until sooner of discharge or cleared to return home)
Lyme Disease Treatment	per state mandate*
Allergy Testing	up to $315 every 2 years
Diabetes Education	per state mandate*
Sterilization	
Casts and Dressings	
Renal Dialysis	
Sleep Studies	1 complete study/lifetime
Pain Management	per state mandate*
Neuropsychological Testing	per state mandate*
Accidental Ingestion of a Controlled Drug	per state mandate*
Diseases and Abnormalities of the Eye	annual retina exams for members with glaucoma or diabetic retinopathy
Corneal Pachymetry	1 complete test/lifetime
Infertility	per state mandate*
Genetic Testing	for members who have or are suspected of having a clinical genetic disorder
Specialized Formula	per state mandate*
Nutritional Counseling	2 visits/year
Enteral or Intravenous Nutritional Therapy	
Modified Food Products for Inherited Metabolic Disease	per state mandate*
Pediatric Vision Care	
Routine Eye Exam	1 exam/year
Lenses	1 pair/year
Frames	1 frame/year
Contact lenses	1 fitting and set of lenses/year
Pediatric Oral Care	
Exams	1 every 6 months
Bitewings	1 time/year
Other X-rays	
Sealants	on premolar and molar teeth
Fluoride treatments including topical therapeutic fluoride varnish application	for clients with moderate to high risk of dental decay
Access for Baby Care Early Dental Examination and Fluoride Varnish where an oral health screen, oral health education and fluoride varnish are applied to children's teeth during well child examinations	up to 4 years of age
Medically Necessary Orthodontia (under age of 19)	
Replacement Retainer	limited to 1 replacement/lifetime
Amalgam and Composite Restorations (Fillings)	
Fixed Prosthodontics: Crowns, In lays and Onlays	
Re-cementing Bridges, Crowns Inlays & Space Maintainers	

*Since PPACA prohibits annual dollar limits, any dollar limits in state mandates no longer apply

Connecticut's Essential Health Benefits

SERVICE	LIMIT
Removable Prosthodontics: Full or Partial Dentures	
Repair, Relining and Rebasing Dentures	
Intermediate Endodontic Services	
Major Endodontic Services: Root Canal Treatment, Retreatment of root canal therapy; apicoectomy; apexification	
Oral Surgery: Surgical Extraction, including Impacted Teeth	
Non-surgical Extraction	
Periodontal Surgery and Services	
Space Maintainers	
General Anesthesia and Sedation	
Miscellaneous Adjunctive Procedures	

*Since PPACA prohibits annual dollar limits, any dollar limits in state mandates no longer apply

“Supplementary Response: Inclusion of ECPs”

Demonstration of Good Faith Effort in Meeting ECP Contracting Standards

If an Issuer cannot meet the Essential Community Provider (ECP) contracting standards required by Access Health CT, the Issuer will provide a separate narrative describing the reason(s) why the standards cannot be achieved. The response should address the Issuer’s current and planned efforts to contract with additional ECPs and shall reference the provider information and contract offer dates, as well as why those efforts have been unsuccessful.

Issuers should be as specific as possible in responding. For example, an indication of the number of contracts offered to ECPs for the upcoming plan year, the names of the ECPs for which 1) contract negotiations are still in progress or 2) agreement on contract terms with the ECP could not be reached, and information on the terms that could not be agreed upon should be included.
The Issuer shall include in the narrative, a description of its strategy as to how it will increase ECP participation in its provider networks in the future to comply with the contracting requirements, including the planned timeframe to accomplish the minimum contracting standards. For example, the Issuer shall describe plans to offer contracts to additional ECPs or to modify current contract terms.

Issuers shall specifically address the following questions in their responses:
• How does the Issuer’s current network provide an adequate access to care for individuals with HIV/AIDS (including those with co-morbid behavioral health conditions)?
• How does the Issuer’s current network provide an adequate access to care for American Indians and Alaska Natives?
• How does the Issuer’s current network provide an adequate access to care for low-income and underserved individuals seeking women’s health and reproductive health services?
• How does the Issuer’s current mental health network meet the State and federal requirement for mental health parity, specifically addressing the full continuum of care? If the current network does not meet the parity requirements, what is the Issuer’s corrective action plan?
• What steps has the Issuer taken to contract with School-Based Health Centers (SBHCs)?
• The Issuer may provide additional information that demonstrates good faith effort to meet the Connecticut standards for ECP contracting.
• The Issuer shall provide additional documentation as requested by Access Health CT to demonstrate its contracting efforts to meet Connecticut’s ECP standards, by the earlier of the date requested by AHCT or within 5 business days of a written request.