

TABLE OF CONTENTS

High Deductible Health Plans for Health Care Centers

Definitions. 38a-192- 1
Method of providing access to health care. 38a-192- 2
Reporting of high deductible plans. 38a-192- 3

High Deductible Health Plans for Health Care Centers

Sec. 38a-192-1. Definitions

As used in Sections 38a-192-1 to 38a-192-3 inclusive:

- (1) “Annual” means any 12 month period as determined by the contract;
- (2) “Commissioner” means the Insurance Commissioner;
- (3) “Copay” means a flat fee that an enrollee or member is required to pay each time a specified service is rendered;
- (4) “Deductible” means the amount of covered expenses which must be accumulated annually before benefits become payable as additional covered expenses incurred;
- (5) “Enrollee” means “enrollee” as defined in section 38a-175(14) of the Connecticut General Statutes;
- (6) “Health Care Center” means “health care center” as defined in section 38a-175(9) of the Connecticut General Statutes;
- (7) “High Deductible Plan” means a contract for health care services that has an annual deductible for individuals of not less than \$1,500 for in-network services and an annual deductible for families of not less than \$3,000;
- (8) “Member” means “member” as defined in section 38a-175(14) of the Connecticut General Statutes; and
- (9) “Provider” means “provider” as defined in section 38a-175(19) of the Connecticut General Statutes.

(Adopted effective September 3, 2008)

Sec. 38a-192-2. Method of providing access to health care

(a) In addition to the methods set forth in section 38a-177 of the Connecticut General Statutes and subject to section 38a-183 of the Connecticut General Statutes, a health care center may provide access to health care through the use of a high deductible plan.

(b) Only expenses for health care services that are generally covered by the non-deductible portion of the contract may be applied against the deductible. This restriction includes limitations on particular providers, including in-network and out-of-network providers, if any, as set forth in the contract.

(c) Deductibles shall not be limited to single benefit services only.

(d) The expense for health care services applied against the deductible shall be the actual amount paid to the provider by the member, enrollee or their designee on behalf of the member or enrollee, excluding any amounts in excess of the negotiated allowable expense and any copay amounts paid by the member, enrollee or their designee on behalf of the member or enrollee.

(e) If a high deductible health plan is intended to be federally tax qualified, there shall be disclosure on the face page of the policy in quarter inch type or contrasting color that states: “This policy is intended to be federally tax qualified. Approval by the Insurance Department does not guarantee tax qualification and members and enrollees are encouraged to seek the counsel of a tax advisor”.

(Adopted effective September 3, 2008)

Sec. 38a-192-3. Reporting of high deductible plans

Each health care center shall report all high deductible plan business pursuant to the financial reporting requirements established by the National Association of Insurance Commissioners and the Insurance Department.

(Adopted effective September 3, 2008)