HEALTHY INDIANA PLAN

HIP Link Protocol

5/26/2015

HIP Link is new program offered by the State of Indiana to help low income Hoosiers pay for their employer sponsored health insurance. This optional program is designed to offer assistance to cover a portion of the employee's premium cost and out of pocket costs associated with employer group health insurance.

Contents

HIP Link Description

a. A description of the HIP Link program;

HIP Link is an optional defined contribution insurance program for all HIP eligible individuals age 21 or older who have access to HIP Link qualifying employer sponsored insurance (ESI). HIP Link allows HIP eligible individuals to choose to enroll into their qualifying ESI instead of into HIP. This option increases choice for beneficiaries and also reduces crowd out of private health insurance.

HIP Link maintains HIP's consumer directed framework by providing enrolled individuals with a HIP Link Personal Wellness and Responsibility (POWER) account valued at $4,000. This Health Savings like account holds the state's defined contribution for ESI coverage of $4,000 and will cover the premiums and out of pocket costs associated with enrollment in ESI. Additionally, the account serves as supplemental coverage for medical expenses incurred during the employer's annual coverage period. Like HIP Plus, individuals enrolled in HIP Link will be required to contribute 2 percent of their income towards the cost of their employer sponsored insurance. Premiums will be deducted from the employee's paycheck as usual, and the state will send the employee reimbursement for the difference between the premium amount and their 2 percent POWER account contribution.

The individual who elects to enroll into HIP Link will receive the benefits offered by the HIP Link qualified employer health insurance instead of the HIP Plus, HIP Basic, or HIP State Plan benefits as applicable. HIP Link beneficiaries will access benefits provided through their employer sponsored insurance.

The state will provide HIP participants with support as they contemplate enrolling in HIP or HIP Link. The state's enrollment broker will provide counseling to assist them with their decision. The enrollment broker will have access to information detailing the benefits in each employer sponsored plan and will be able to explain the differences between HIP and HIP Link, as well as answering questions about HIP Link.

HIP Link Cost Sharing

b. Cost sharing requirements for HIP Link participants including examples of the interplay between the employer premium contribution, employee premium contribution, and state premium contributions, and the POWER account;

HIP Link participants will be responsible for paying 2 percent of their income towards the cost of their employer sponsored insurance. The employer will deduct the full cost of the employee premium from the individual's paycheck. Once a month, the HIP Link enrolled ESI policy holder will receive a check prospectively from the state for the difference between their 2 percent required contributions and their required premium payments for the next month.

Once an applicant is found eligible for HIP Link, the HIP Link coverage will begin the first day of month in which they also are enrolled in HIP Link eligible ESI coverage on the first day of the month. The first check received by a new Link enrollee will reimburse the enrollee for any premiums already paid for the current month of enrollment in the ESI. For example, if the applicant

is found eligible in June and ESI coverage begins June 15, HIP Link coverage will start July 1. However, since the member must enroll in ESI to receive HIP Link and ESI coverage rarely starts on the first of the month, the member's reimbursement will account for the ongoing monthly cost of enrollment and the cost for the June 15 to July 1 timeframe.

To ensure that the reimbursement to the individual is accurate, on a monthly basis all HIP Link eligible employers will confirm the HIP Link member's continued eligibility for ESI and the premium amounts that will be deducted for the next month's coverage. A schedule showing reimbursement and verification timelines is included as Enclosure 1.

The 2 percent contribution for enrolled eligible spouses is based on household income and shared between spouses and dependents that reside in the household. Dependents added to ESI that do not reside in the household per the modified adjusted gross income rules will have a separate 2 percent of income contribution. In the commercial market dependents may stay on their parents ESI policy until age 26.

The premium deduction and reimbursement process does not change for enrolled spouses or dependents. If a Link eligible dependent is enrolled in ESI with their Link eligible parents, the Link eligible employee will still be paying the entire premium for the family, so the enrolled employee will receive the reimbursement for the entire individual plus spouse or family premium amount.

The $4,000 HIP Link POWER account is allocated between required premiums for the enrollment year and the cost sharing the individual may owe on the employer plan. The HIP Link enrollee's 2 percent of income premium contribution is in addition to this amount, so a Link enrollee, regardless of the amount of their 2 percent contribution will always have a $4,000 defined contribution from the state to cover the costs of premiums and out-of-pocket costs on the employer plan. When two or more individuals in a family are enrolled together, the HIP Link accounts are combined. For example, enrolled spouses will have a combined $8,000 HIP Link account. Like an account for a single enrolled employee, a portion of the combined account is allocated to the ESI premiums, and the remainder of the account covers the out-of-pocket costs for ESI on a first in-first out basis, regardless of which enrolled Link individual the claim applied to. The following are examples of the Link account allocation for an individual only and with an enrolled spouse.

HIP Link POWER Account Allocation Examples		
	HIP Link Enrolled Employee	**HIP Link Enrolled Employee & Spouse**
Annual Income	$16,000	$22,000
2 percent Annual Contribution	$320	$440
State Contribution to HIP Link Account	$4,000	$8,000
Total Available Funds for Premium and Cost Sharing	$4,000+ $320 = **$4,320**	$8,000+$440 = **$8,440**
Annual Employee Portion of Premium	$470	$1,500
Account funds allocated for premium reimbursement	$470-$320 = **$150**	$1,500-$440=$**1,060**
Monthly Premium	$150/12= **$12.50**	$1,060/12= **$88.33**

Reimbursement		
POWER Account funds available for cost sharing	$4,000-$150= **$3,850**	$8,000-$1,060= **$6,940**

HIP Link enrollees receive a HIP Link card, which serves as proof of their supplemental coverage. Providers will bill the ESI as primary insurance coverage. The portion of cost that is defined as individual responsibility in the form of a deductible, copay, or coinsurance is then submitted to HIP Link by the provider. HIP Link will pay the member's portion of the service, using the primary insurance contracted rate. Provided the individual has HIP Link funds, they will not be responsible for any cost sharing for services covered by their primary insurance. HIP Link will also cover services required by the alternative benefit plan that may not be covered by the primary insurer including family planning, 72 hour emergency supply of pharmaceuticals, FQHC and RHC services, and non-emergency transportation for low-income parents and caretakers. Low-income parents and caretakers, transitional medical assistance, or women that become pregnant and elect to stay in HIP Link at their redetermination period, will have access to non-emergency transportation benefits. These services will be reimbursed at state plan Medicaid reimbursement rates. Provider entities required to be reimbursed on the prospective payment system (PPS) will always be paid at the prospective payment system (PPS) rates, unless the service is covered by the individuals ESI and the ESI payment rate for the service is higher than the PPS rate.

Other than the 2 percent contribution to the employee premium, HIP Link eligible individuals have no cost sharing unless their HIP Link account is exhausted. Once the account is exhausted, HIP Link eligible individuals are responsible for paying up to 5 percent of their quarterly income for services received. The 2 percent monthly premium contribution counts towards this amount, and any medical expenses for which the individual provides proof of payment will be accrued towards the 5 percent cost sharing limit. If individuals received services and paid out of pocket without the provider submitting the claim to HIP Link, then the individual may submit receipts for this service and have these payments count towards their 5 percent of income cost sharing limits.

If the HIP Link account is exhausted and the individual is accruing cost sharing towards their 5 percent limit, the State will do a cost-effectiveness analysis on an individual basis to determine if it is more cost-effective to allow the individual to remain enrolled in HIP Link or for them to move back to HIP. Cost-effectiveness will be determined on the expected cost to enroll the individual in HIP compared to the cost of remaining enrolled in HIP Link. The individuals care utilization and remaining amount before hitting the ESI out-of-pocket maximum will be considered in determining if remaining in HIP Link is more cost-effective. If it is more cost-effective to allow individuals to remain enrolled in HIP Link then the state will continue to pay the individual's out-of-pocket costs and premiums for the ESI coverage. If it is less cost-effective to remain in Link, the state will enroll the individual into HIP Plus and the individual will be disenrolled from HIP Link. The State would prefer to give individuals the option to remain in HIP Link, however, per the requirements of the HIP 2.0 Special Terms and Conditions, if an individual hits the 5 percent limit and it is not cost effective for them to remain in HIP Link, then the individual will be given notice of the transfer from HIP Link to HIP but will not be allowed the choice to remain in HIP Link.

HIP Link members that complete a year of coverage in HIP Link will be eligible for rollover. In the initial coverage year, HIP Link rollover will be based on the amount remaining in the HIP Link POWER account. HIP Link enrollees may reduce their future year's HIP Link contribution amount

by up to 50 percent based on the percentage of HIP Link funds remaining in their HIP Link account. In future years of HIP Link enrollment, HIP Link enrollees may be eligible to increase this rollover to 100 percent if they participate in an employee wellness program or complete recommended preventive services.

HIP Link Health Plan Requirements

c. The benefits and cost sharing requirements for employer sponsored plans in the program

To be eligible as an ESI plan in which a HIP Link eligible individual can enroll, the plan must meet both benefit and affordability requirements.

Benefit Requirements

HIP Link benefits are indexed to the HIP Link alternative benefit plan which is based on the State of Indiana's commercial essential health benefit benchmark. These benefits serve as the benefit floor that must be offered by health plans eligible for employer sponsored insurance. Provided that each essential health benefit category meets the benefit value requirements, employer sponsored insurance may vary benefits within the category. For example Indiana's EHB has 12 chiropractic visits per year in the ambulatory services EHB category. However, the state would not disqualify a plan that offered 10 chiropractic visits a year and also offered 5 massage therapy visits, since the value of these two benefits combined is at least equivalent to the 12 chiropractic visits contained in the State EHB benchmark.

In addition to meeting the state's essential health benefit requirements, health plans also cannot offer elective abortion for which federal funding is prohibited and must meet mental health parity requirements.

Depending on the type of health plan applying for coverage, the Indiana Department of Insurance (IDOI) may already have completed an in depth review of all of these requirements as noted on the chart below.

	Small Group Health Plan that meets the 2014 ACA requirements	Large Group Plan updated to meet the 2014 ACA requirements	Small Group Health Plan NOT updated for 2014 ACA requirements	Large Group Plan NOT updated for 2014 ACA requirements	Self-Funded	Non-Indiana Plan
EHB / MV	Compliant	Verify Compliant	Verify Compliant	Verify Compliant	Verify Compliant	Verify Compliant
Abortion[1]	Compliant	Compliant	Verify Not Offered	Verify Not Offered	Verify Not Offered	Verify Not Offered
MHPAEA [2]	Compliant	Verify	Verify	Verify	Verify	Verify

For example, if the plan applying for Link eligibility is a state licensed small group QHP plan then the state is assured that this plan already meets all of the benefit requirements and no further benefit

[1] §27-8-13.4-2

[2] Mental Health Parity and Equity Addiction Act (MHPAEA) - The parity protections ensure that limits applied to mental health and substance use disorder services are not more restrictive than limits applied to medical and surgical services.

review will be necessary. For large group plans that are reviewed by the IDOI, these plans may have been filed in tandem with a small group plan and be guaranteed to meet all applicable benefit requirements or they may have benefits that vary slightly from the state EHB and require further review.

To assist the state with review when applying, plans must attest to either offering the state EHB *or* meeting the minimum value requirements required by federal law and offering benefits in all applicable essential health benefit categories.[3] Plans that do not meet one of these requirements will not be HIP Link eligible. All plans that apply will be required to provide documentation of the benefits offered along with their application including a summary of benefits and coverage and more detailed schedule of benefits. These documents will be used in the health plan review process as detailed in the following section.

Affordability Requirements

In addition to meeting benefit requirements, an employer plan must meet the HIP Link affordability test. Plan affordability is a function of the premiums the employer applies to employees and eligible dependents enrolled in their plan, the plan deductibles, coinsurance, out-of-pocket maximums and any funds in the form of Health Reimbursement Accounts (HRA) that are provided by the employer to cover the costs of coverage. Since some of these requirements vary by employer, it is possible that a small group plan that is Link eligible with one employer is not Link eligible with another employer due to a higher premium amount or not offering an HRA.

The state's actuary, Milliman Inc., has developed an affordability tool that takes inputs of employee premium contribution amounts, plan deductibles, out of pocket maximums, average coinsurance, and employer HRA contributions. These inputs are compared to the funding available in the HIP Link POWER account ($4,000 for an individual and $8,000 for a couple, etc.) and the claims probability distribution in the commercial market.[4] The $4,000 HIP Link account was designed to be sufficient for 80 percent of enrollees in ESI. If the probability is 80 percent or higher that the HIP Link POWER account funds plus the individuals 2 percent contribution[5] will be sufficient to cover the premiums and out of pocket expenses of the ESI plan, then the plan will be considered affordable. To ensure that employers that offer dental benefits are not penalized for offering additional benefits, their standard of review will be lowered to a probability of 75 percent or higher that the HIP Link POWER account funds plus the individuals contributions will be sufficient to cover the premiums and out of pocket expenses of the ESI plan, then the plan with dental benefits included will be considered affordable. An analysis of the funding for the HIP Link POWER account and the HIP Link affordability tool is attached with the submission.

The HIP Link affordability calculations are subject to change based on actual program experience after implementation.

[3] The state will not make ESI plans ineligible for Link if they do not offer pediatric dental and vision, since all HIP Link enrollees will be age 21 or older.

[4] The claims probability distribution is a compilation of total annual claims amounts observed in the commercial market and the frequency of occurrence of these claims amounts per 100,000 commercial market enrollees.

[5] The average HIP Link household income is projected to be $16,000 per year.

HIP Link Health Plan Review Process

d. The criteria and process by which the state shall review and certify employer plans for the HIP Link program;

Health plans may be received either through employer application or through insurer submission.

Employer Application Process

The state has developed an online HIP Link Portal through which employers may submit their health plans for consideration of HIP Link eligibility. During the application process, employers will be asked to confirm:

- That they have at least one employee that is a resident of Indiana
- That they have a valid FEIN
- That they contribute at least 50 percent of the cost of the premium to the plans

Employers that do not meet these basic requirements will not be eligible to be HIP Link employers. Once they complete the registration process and verify they meet these basic HIP Link employer eligibility criteria, the employer will be asked to submit details of their employer sponsored health insurance. These details will include the type of plan they offer. Each plan type is subject to a different review standard, as detailed in the benefits requirements section above. The types of plans employers may identify include those noted on the below table.

Type of Plan	# Full time Employees	Additional Information
Small Group Health Plan updated to meet the 2014 Affordable Care Act (ACA) requirements	50 or fewer	• Other names: non-grandfathered plan OR qualified health plan (QHP) • QHP plan may have been purchased on the Small Business Health Options (SHOP) online marketplace
Small Group Health Plan NOT updated to meet the 2014 ACA requirements	50 or fewer	• Other names: grandfathered plan OR transitional plan • Plan available in 2013 or earlier • Generally no change in benefits or employee cost • May offer extra benefits on a rider[6]
Large Group Plan updated to meet the 2014 ACA requirements	51 or more	• Other names: non-grandfathered plan
Large Group Plan NOT updated to meet the 2014 ACA requirements	51 or more	• See "Small Group Health Plan NOT updated to meet the 2014 ACA requirements"
Self-Funded Plan	Varies	• Funded by employer o No premium to insurer o Employer funds employee health expenses • Plan design unique to employer • Insurer may act as third party administrator of the plan
Non-Indiana Plan	Varies	• Business located outside of Indiana • Health insurance plan not certified in Indiana • May be Small Group, Large Group, or Self-funded plan

[6] Due to federal requirements, a group policy that offers benefits on a rider cannot be HIP Link eligible.

Based on the plan selected, employers will be asked to verify if their plan covers abortions for which federal funding is prohibited, if their health plan meets the mental health parity requirements and if the health plan meets the benefit requirements.

<table>
<tr><td>1</td><td>Indiana Essential Health Benefits
Indiana's Essential Health Benefits available at http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/indiana-ehb-benchmark-plan.pdf.</td><td><u>OR</u></td><td>Minimum Value plus coverage of specified benefit categories
Minimum value calculator available at http://www.cms.gov/site-search/search-results.html?q=minimum%20value%20calculator.
Benefit coverage for 9 benefit categories:
1) Ambulatory patient services, 2) Emergency services, 3) Hospitalization, 4) Maternity and newborn care, 5) Mental health and substance use disorder services, 6) Prescription drugs, 7) Rehabilitative and habilitative services and devices, 8) Laboratory services and 9) Preventive and wellness services.</td></tr>
<tr><td>2</td><td colspan="3">Mental Health Parity and Addiction Equity Act (MHPAEA)
Provides mental health and substance use disorder benefits at parity with medical benefits available at http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html.</td></tr>
<tr><td>3</td><td colspan="3">Abortion
Does not cover abortion for which federal funding is prohibited reference at http://www.cms.gov/site-search/search-results.html?q=abortion%20for%20which%20federal%20funding%20is%20prohibited.
Does not cover elective abortions reference at https://iga.in.gov/legislative/laws/2014/ic/titles/027/articles/008/chapters/13.4/.</td></tr>
</table>

In addition to these confirmations, employers will upload the summary of benefits and coverage document, their premium rates, a benefit schedule for each plan offered and provide detail on if they also offer vision or dental insurance. Employers will also enter in details of any HRA contributions available to employees including the amount of these contributions. Due to IRS restrictions, contributions to Health Savings Accounts must be suspended if the employee enrolls in HIP Link.

Employer Plan Review Process

The state HIP Link Employer Counseling Team (ECT) will receive the data entered by the employer on the portal, including the employer's benefit verifications, HRA amounts and uploads of premium rates, summary of benefits and coverage documents and schedule of benefits documents. Utilizing this data, the ECT will review the submitted health plans to determine if they are HIP Link eligible plans. Samples of the types of documents that the State expects to be uploaded by the employer are attached with the submission.

Affordability Review

The ECT will confirm that the employer indicated that they cover at least 50 percent of the premium for the ESI and verify this attestation with the upload of the ESI premium rates. Any employer that does not cover at least 50 percent of the premium will not be eligible for Link.

The ECT will review the premium rate document and the summary of benefit and coverage document and identify the below amounts:

- Monthly premium rate for an enrolled employee, monthly premium rate for an employee plus spouse, and monthly premium rate for an employee plus dependents.
- Single employee and family deductible.
- Single employee and family out-of-pocket maximum.
- Plan average coinsurance.

Once these amounts are identified, the ECT will input the amounts into the plan affordability tool along with any HRA contribution the employer provides. When the tool is populated with these inputs, it will return a result that indicates if the plan is affordable or not.

The ECT will need to run the tool separately for a single enrollee, and an enrollee plus spouse or enrollee plus dependents. Since premium rates, deductibles, and out of pocket maximum amounts are different for the employee only and the employee plus spouse and dependents, some health plans may meet the affordability standard for HIP Link when only a single individual is enrolled, but not meet it if a spouse is also enrolled, even when accounting for the availability of a $4,000 POWER account for each Link enrolled individual. Information on which plans are affordable for individuals, spouses and families is provided to the enrollment broker for use in options counseling.

If the tool yields that the plan is affordable, the ECT will note which type of enrollments the plan is affordable for (e.g. employee only, employee plus spouse, employee plus dependents), and proceed to the benefit review phase. If the tool does not find the plan affordable, then the ECT team will communicate this to the employer.

Benefit Review

The level of benefit review conducted by the ECT depends on type of plan that is being reviewed. Only employers that have indicated that their plans meet the benefit requirements will be able to submit plan documentation.

If the plan has already been reviewed for compliance with the state's essential health benefits with the IDOI, then the ECT will not complete additional review and will consider the health plan to meet the HIP Link benefit requirements. This will be the case for all Small Group Plans that comply with the 2014 Affordable Care Act requirements.

When reviewing large group health plans, the ECT will contact the IDOI to verify if the plan submitted by the employer was submitted in concert with a small group plan. In cases where the Large Group and Small Group plan were submitted together, the Large Group plan will have the same benefits as the small group plan, and will be guaranteed to meet the State's EHB requirements.

For large group plans that are submitted separately from small group plans, and for self-insured plans that are not reviewed by the IDOI, the ECT team will leverage the plan documentation submitted by the employer. The ECT team will specifically review the summary of benefits and coverage for items listed as excluded to ensure no Essential Health Benefits are excluded from the plan and will also verify there are no dollar amount limits on any essential health benefits, and that all visit limits

on services like physical therapy, speech therapy, and occupational therapy are at least equivalent to the state EHB or if they are less that there is a comparable increase in benefits within the benefit category. Specific attention will be paid to coverage of (1) preventive services to ensure that all ACA required preventive services are covered by the plan,(2) maternity services, (3) rehabilitative and habilitative services, (4) review of mental health and substance use disorder treatments to assure that that the plan meets the mental health parity requirements and (5) coverage of prescription drugs. The Indiana EHB that will be used as reference for HIP Link plan review is submitted with this protocol.

The ECT may contact the employer, the health insurer or third party administrator if they have questions about the plan benefits. If the plan does not offer benefits that meet the Indiana Essential Health Benefit requirements or offer benefits at least equivalent to the Indiana EHB in every applicable class and category and meet the federal minimum value requirements, then the health plan cannot be a HIP Link eligible plan.

Insurer Application Process

Insurers that sell group products in the Indiana market will be able to submit plans to the ECT team to have them determined HIP Link eligible on the basis of benefits offered. Since premiums and HRA contributions vary by employer, insurer submitted plans cannot be confirmed to be HIP Link eligible, however, if an employer is applying with a plan that has already been determined to offer benefits that meet the HIP Link standards, then the benefit review process described above in the employer section is not needed.

Initially, health insurers offering group health policies or third party administration services will be able to submit detail on their health plans to the ECT. The ECT will conduct outreach to these health plans, provide detail on the benefit requirements of HIP Link, and ask these health insurers to submit the summary of benefits and coverage, schedule of benefits, and proof of either meeting the State EHB standards or offering benefits that are at least equivalent to the state EHB in each applicable benefit category and class. The ECT will review the submitted documentation, verify that the plan has submitted sufficient proof of meeting the benefit requirements, and for plans that qualify the state will issue the plan a HIP Link plan ID. Employers may use this plan ID when applying for HIP Link, and employers that use the HIP Link plan ID are not required to upload benefit documentation as part of their application.

HIP Link Premium Reimbursement Process

e. The process by which the state shall reimburse employees for the state premium contribution and administer the POWER accounts for HIP Link beneficiaries;

As detailed in the cost sharing section, HIP Link participants will be responsible for paying 2 percent of their income towards the cost of their employer sponsored insurance. The employer will deduct the full cost of the premium from the individual's paycheck. Once a month, the individual will receive a check prospectively from the state for the difference between their 2 percent required contributions and their required premium payments for the next month. The first check received by a new Link enrollee will reimburse the enrollee for any premiums already paid for coverage during

their Link enrollment and for the next month's enrollment. To ensure that the reimbursement to the individual is accurate, on a monthly basis all HIP Link eligible employers will confirm the HIP Link member's continued eligibility for ESI and the premium amounts that will be deducted for the next month's coverage. HIP Link employers will complete this confirmation through the Employer Portal. A schedule showing reimbursement and verification timelines is included as Enclosure 1. HIP Link enrollees that receive reimbursement for months in which they were not enrolled in ESI will be subject to benefit recovery.

HIP Link Eligibility and Transition Process

f. A protocol that ensures that those who lose access to ESI or whose plan is no longer Link eligible will be enrolled promptly into HIP Plus without a gap in coverage.(or if they have incomes below the poverty line and do not elect to make POWER account contributions will move to HIP Plus without a gap in coverage), and that sets forth any adjustment to the individual's POWER account (affecting only the unspent value of the POWER account);

Individuals not currently enrolled in HIP may enroll in HIP Link if they select HIP Link on their Indiana Health Coverage Application. Applicants may provide their employer's HIP Link ID. If the applicant does not provide the employer's HIP Link ID, the ECT team will research the employers HIP Link ID through the HIP Link Employer portal, and the applicant will be sent a request to verify the employers HIP Link ID. If the applicant can be matched to HIP Link eligible employer and is verified as eligible for HIP, then the employer will be asked to verify that the individual is employed and enrolled in HIP Link eligible ESI. If enrolled in ESI, then the applicant will be enrolled in HIP or HIP Link per the below schedule:

a. If the applicant is currently enrolled in HIP Link eligible ESI at the time of verification and was eligible for and enrolled in ESI at the beginning of the month, then the applicant will be enrolled in HIP Link effective the 1st of the month of the application date.
b. If the applicant is not currently enrolled in HIP Link eligible ESI or was not enrolled in HIP Link eligible ESI effective on the first of the current month, but is enrolled in ESI effective the first of the following month, then the applicant will be enrolled in HIP Link effective the 1st of the month following eligibility verification.
c. If the applicant is eligible for enrollment in HIP Link at a future date, for example the applicant must wait 60 days for ESI eligibility due to an employer waiting period, they will be enrolled into HIP as a conditionally eligible HIP Plus member. The member will be enrolled into HIP Link on the first day of the month in which they are eligible for a full month of ESI coverage.

Current HIP members who want to enroll in HIP Link, do not have to file an application to enroll. They may use the standard change reporting process to request HIP Link enrollment. The member will need to provide the HIP Link ID of their employer, or the ECT will research the HIP Link ID. If the current HIP member can be matched with a HIP Link employer, the HIP Link employer will be sent a verification request through the employer portal to confirm that the HIP member is enrolled in or eligible for enrollment in ESI. If the member is eligible for or enrolled in the HIP Link qualified ESI, they will be enrolled in HIP Link effective the first of the month in which the employer can confirm concurrent HIP Link enrollment. There will be no break in coverage as they transition from HIP to HIP Link.

In HIP Link, eligible individuals' 12 month redetermination periods will be aligned with the employer benefit period. For example, if the individual enrolls in HIP Link in July and the employer plan year ends on December 31, the individual's first Medicaid redetermination will occur so that their new HIP Link benefit period begins January 1 in concert with the employers new plan year. This allows the individual's $4,000 POWER account contribution to align with the employers benefit year.

If enrolled in HIP, then the applicant will be enrolled in HIP Link per the below schedule:

a. HIP members that are currently enrolled in ESI will be transferred to HIP Link effective the 1st of the month after the enrollment in HIP Link eligible ESI is confirmed by the employer.
b. HIP members that are eligible for immediate enrollment in ESI will be transferred to HIP Link effective the 1st of the month which the employer confirms they have ESI enrollment for the entire month.
c. HIP members that are eligible for future enrollment in ESI will be transferred to ESI effective the 1st of the month where the employer confirms active enrollment in HIP Link eligible ESI for the entire month.

For applicants or enrollees who have ESI eligibility beginning in the month prior to their HIP Link enrollment, reimbursement for their premium payments will consider the entire benefit period of their ESI enrollment. For example, if the individual is eligible for HIP Link eligible ESI effective July 17th and the employer's benefit plan year is through December 31st, then the premium reimbursement for the individual will be calculated on the premium due from July 17th to December 31st. The individual will be eligible for HIP Link effective August 1, but will receive premium reimbursement for their entire enrollment period in ESI (July 17-December 31st).

Employers of individuals that have requested HIP Link enrollment, but who are not HIP Link eligible employers will be targeted for outreach by the HIP Link ECT to promote employer enrollment in HIP Link.

Applicants and HIP enrollees are only eligible for one HIP Link special enrollment per continuous Medicaid or HIP eligibility period. Applicants and enrollees may always elect to enroll in HIP Link during their employer's open enrollment period.

HIP Link Counseling Process

g. The counseling process and related materials used to counsel prospective beneficiaries;

All individuals that select HIP Link will be informed that HIP Link is coverage that provides a defined contribution to help pay for the costs of employer sponsored insurance including premiums, deductibles, copayments and coinsurance. Individuals will also be informed that HIP Link will replace their current HIP coverage and that they may contact the enrollment broker with specific questions about the benefit differences between their ESI coverage option and HIP coverage.

Enrollment counseling for HIP Link is performed by the state's enrollment broker that currently assists HIP eligible individuals with MCE plan selection and with understanding the differences between HIP Plus, HIP Basic and HIP State Plan benefits. HIP Link eligible individuals may seek counseling:

a. Before applying for HIP Link or requesting a transfer from HIP to HIP Link
    - In this counseling the individual could find out if their employer was a HIP Link qualified employer, what types of benefits were on the employer plan, and how this compares to the HIP coverage options.
b. After applying for HIP Link, but prior to the ESI coverage start date
c. When exiting HIP Link

The enrollment broker currently educates HIP members and prospective members on the benefits in HIP Basic, HIP Plus and HIP State Plan. HIP Link will be added to this current education strategy. When an employer applies for HIP Link, they upload their plan documentation including their summary of benefits and coverage and their benefit schedule. The enrollment broker will use their existing knowledge about the HIP benefits combined with the uploaded documents to counsel the beneficiary on the differences between the HIP and HIP Link benefits. Counseling will be tailored to every individual, based on questions and concerns raised by the individual about the benefits that are most important to them. For example, if an individual applying to Link is currently receiving physical therapy on a weekly basis, the enrollment broker will be able to tell the individual how the specific physical therapy benefits will vary between HIP and HIP Link by reviewing the employer documentation. The enrollment broker will provide all individuals requesting counseling with a broad overview of the differences between HIP and HIP Link benefits and be equipped to answer specific questions about the benefits which the specific caller is most interested. The enrollment broker may also utilize the affordability tool or affordability summary documents to provide customized information on the plan affordability for the enrolling individual.

In addition to reference the uploaded employer documents on the benefits provided, the enrollment broker will have access to detailed analysis on the difference between HIP benefits and the State's EHB benefits, which serve as the benefit floor for all HIP Link eligible plans, and notes from the ECT team reviewers which will indicate unique features of the plan benefits. With these resources, the enrollment broker will be equipped to offer all HIP Link eligible members individualized counseling on the differences between HIP and HIP Link benefits.

HIP Link Disenrollment Process

h. Any circumstances that would allow an individual to disenroll from HIP Link and enroll into HIP Plus, including the ongoing process to self-identify as being medically frail and move out of HIP Link and into the ABP that is the state plan benefit package;

Individuals may disenroll from HIP Link if:

a. The HIP Link enrollee becomes medically frail
    - HIP Link will accept individual attestation of medically frail. If an individual becomes medically frail, they will report a change to the Division of Family Resources through the standard change reporting process. The individual will be asked to complete the medically frail questionnaire where they attest to their

medically frail health status. Completion of the questionnaire is required to be considered frail for a HIP Link to HIP transfer, but verification of the condition noted on the questionnaire will take place after the transfer. The individual who requests the transfer and completes the questionnaire will have their coverage changed from HIP Link to HIP State Plan Plus. The individual's Managed Care Entity will be responsible for verifying the frail status as is the case for all other medically frail enrollees in HIP. If the frail status is verified, the individual will remain enrolled in HIP State Plan Plus, if not the individual will transfer to HIP Plus per the standard HIP medically frail process.

b. The HIP Link enrollee becomes pregnant, or at any point during the pregnancy
    - Pregnant women may elect to stay in HIP Link or transfer to HIP or Medicaid for Pregnant Women (HIP Maternity) at any time. Regardless of where they receive benefits once they report their pregnancy, they will be exempt from cost sharing. In HIP Link enrolled pregnant women will receive full reimbursement for their premium payment to the employer. Pregnant women may elect to remain in HIP Link at redetermination.
c. Low-income parents and caretakers and transitional medical assistance
    - These individuals may elect to transfer from HIP Link to HIP at any time.
d. They exhaust their HIP Link POWER account funding for out-of-pocket expenses, spend 5 percent of their quarterly income on health expenses and continued enrollment in HIP Link is determined to not be cost-effective by the state.
e. The employer no longer is HIP Link eligible, or the ESI coverage option is no longer HIP Link qualified.
f. The individual loses access to the employer ESI.
g. The spouse or dependent is no longer eligible for HIP Link.
    - In this case the spouse or dependent may disenroll from HIP Link.

HIP Link Appeals Process

i. The appeals procedure for HIP Link

HIP and HIP Link member eligibility decisions are appealable to the State through the standard appeals process. The process to appeal is detailed on all eligibility notices. These appeals would include but not be limited to an individual's eligibility for HIP Link, an individual's 2% of income contribution amount, and HIP Link coverage start dates.

Appeals relating to payment made by the HIP Link account or benefits that are covered in addition to the ESI, including 72 hour emergency supply of pharmaceuticals, family planning benefits, services provided in FQHCs and non-emergency transportation services for low-income parents and caretakers and individuals eligible for transitional medical assistance may be addressed through the standard appeals process.

Appeals relating to benefits covered on the employer sponsored plan must be addressed to the employer's health insurance carrier. HIP Link will not have an appeals process related to the benefits covered on the employer's health insurance. Appeals related to out of pocket medical expenses as funded from the HIP Link account will be handled by the state.

Provider appeals on payment will be addressed through the standard appeals process.

HIP Link Education

j. The state's strategy for educating beneficiaries and employers on the HIP Link program.

The state will conduct targeted outreach to health insurers and employers about HIP Link. This outreach will include specific information about the HIP Link program including one page program overviews, FAQs, Step-by-Step Application Guides, and program manuals including a specific manual for employers and enrolled HIP Link members. HIP Link member manuals include program specifics including details on premium reimbursement, how to transition in and out of HIP Link, and how to access their HIP Link and wrapped benefits.

Insurers can identify plans that may be HIP Link eligible and submit them to the ECT. Employers may log onto the HIP Link Employer Portal and apply to become a HIP Link employer. Once approved as a HIP Link employer per the process discussed above, employers may market their HIP Link eligibility to their employees.

Current and potential beneficiaries will be informed about HIP Link through the states HIP marketing and outreach campaign.

Enclosure 1: HIP Link Employee Reimbursement Schedule

HIP LINK EMPLOYEE PREMIUM PRIMARY PAYMENT SCHEDULE
2015

May-15						
S	M	T	W	TH	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

Sep-15						
S	M	T	W	TH	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

09/29 payment is for the month of Octobe

Jun-15						
S	M	T	W	TH	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

06/30 payment is for the month of July

Oct-15						
S	M	T	W	TH	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Jul-15						
S	M	T	W	TH	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

Nov-15						
S	M	T	W	TH	F	S
1	2	3	4	5	6	7
7	9	10	11	12	13	14
14	16	17	18	19	20	21
21	23	24	25	26	27	28
28	30					

Aug-15						
S	M	T	W	TH	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

Dec-15						
S	M	T	W	TH	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

12/29 payment is for the month of Januar

Validation Due Primary

Primary Refund Date

HIP LINK OFF-CYCLE EMPLOYEE PREMIUM PRIMARY PAYMENT SCHEDULE

FOR NEWLY ENROLLED MEMBERS

2015

May-15						
S	M	T	W	TH	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

Sep-15						
S	M	T	W	TH	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

New enrollments after 08/18/15

09/29 payment is for the month of October

Jun-15						
S	M	T	W	TH	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

New enrollments after 05/19/15

06/30 payment is for the month of July

Oct-15						
S	M	T	W	TH	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

New enrollments after 09/15/15

Jul-15						
S	M	T	W	TH	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

New enrollments after 06/16/15

Nov-15						
S	M	T	W	TH	F	S
1	2	3	4	5	6	7
7	9	10	11	12	13	14
14	16	17	18	19	20	21
21	23	24	25	26	27	28
28	30					

New enrollments after 10/20/15

Aug-15						
S	M	T	W	TH	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

New enrollments after 07/21/15

Dec-15						
S	M	T	W	TH	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

New enrollments after 11/17/15

12/29 payment is for the month of January

Validation Due Primary Payment Cycle

Primary Refund Date

*Off-Cycle Pro-rated Refund Date **

Jan-16						
S	M	T	W	TH	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

New enrollments after 12/15/15

**** Refund will be prorated based on number of days remaining in month.***
Subsequent payments will be paid on Primary Refund Date

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-877-814-9709

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For in-network and out-of-network providers **$2500** individual/**$5000** family Doesn't apply to preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$4000** individual/**$8000** family network and non-network combined.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **in-network providers**, see www.anthem.com or call 1-877-814-9709. This plan uses the Blue Access PPO.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term **in-network**, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20%	40%	——————none——————
	Specialist visit	20%	40%	——————none——————
	Other practitioner office visit	20%	40%	Coverage is limited to 12 visits per calendar year for chiropractic care. Acupuncture is not covered.
	Preventive care/screening/immunization	No Charge	40%	Not subject to deductible
If you have a test	Diagnostic test (x-ray, blood work)	20%	40%	——————none——————
	Imaging (CT/PET scans, MRIs)	20%	40%	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com or call 1-877-941-5241.	Generic drugs	$10 copay/ retail $20 copay/mail	Not covered	Retail is limited to a 30 day supply Mail order is limited to a 90 day supply Benefit applies deductible and accumulates to out of pocket maximum.
	Preferred brand drugs	Retail: 20%, min $30, max $50 Mail: 20%, min $60, max $100	Not covered	Retail is limited to a 30 day supply Mail order is limited to a 90 day supply Benefit applies deductible and accumulates to out of pocket maximum.
	Non-preferred brand drugs	Retail: 40%, min $50, max $70 Mail: 40%, min $100, max $140	Not covered	Retail is limited to a 30 day supply Mail order is limited to a 90 day supply Benefit applies deductible and accumulates to out of pocket maximum.
	Specialty drugs	40% min $75, max $150	Not covered	Retail and mail order prescription are limited 30-days supply. Benefit applies deductible and accumulates to out of pocket maximum.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	——————none——————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	——————none——————
	Emergency medical transportation	20% coinsurance	20% coinsurance	——————none——————
	Urgent care	20% coinsurance	20% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	——————none——————
	Physician/surgeon fee	20% coinsurance	40% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	40% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Substance use disorder outpatient services	20% coinsurance	40% coinsurance	——————none——————
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	——————none——————
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Private duty nursing limited to 82 visits/year and 164 visits/lifetime. No registered nurse and licensed practical nurse unless billed through a home health care agency.
	Rehabilitation services	20% coinsurance	40% coinsurance	Physical, occupational, and speech therapy are limited to 25 visits each. Manipulation therapy is limited to 12 visits.
	Habilitation services	20% coinsurance	40% coinsurance	All rehabilitation and habilitation visits count toward your rehabilitation visit limit.
	Skilled nursing care	20% coinsurance	40% coinsurance	Coverage is limited to 100 day maximum per calendar year combined network and non-network.
	Durable medical equipment	20% coinsurance	40% coinsurance	——————none——————
	Hospice service	20% coinsurance	20% coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	No Charge	40% coinsurance	Not subject to deductible in-network. Typically this type of exam is performed at your physician's office and only routine vision screening is covered.
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency Care when Traveling Outside the US
- Routine Foot Care
- Weight-Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery
- Chiropractic Care
- Most coverage provided outside the United States

See www.BCBS.com/bluecardworldwide

- Routine Eye Care (screening only)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-814-9709. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Anthem Blue Cross/Blue Shield
Clinical Appeals
P.O. Box 105568
Atlanta, GA 30348-5568

Prescription Drugs:
Express Scripts
1-877-841-5241

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-877-814-9709

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-814-9709

[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-877-814-9709

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-814-9709

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,040
- **Patient pays** $3,500

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,500
Copays	$0
Coinsurance	$1,000
Limits or exclusions	$0
Total	**$3,500**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,340
- **Patient pays** $3,060

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,500
Copays	$0
Coinsurance	$560
Limits or exclusions	$0
Total	**$3,060**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Your Anthem Benefits

Anthem

State of Indiana - Consumer-Driven Health Plan 1
Blue Access℠ for Health Savings Accounts
Summary of Benefits, Effective January 1, 2015

Please note: As we receive additional guidance and clarification on federal health care reform from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits.

Covered Benefits	Network	Non-Network
Deductible *Family coverage requires the family deductible to be met before coinsurance applies.* *The single deductible **does not** apply to family coverage.* *(Deductibles are combined network and non-network)*	Single: $2,500 Family: $5,000	
Out-of-Pocket Limit (OOP) (Single/Family) *Family coverage requires the family OOP to be met before 100% coverage applies.* *The single OOP **does not** apply to family coverage.* Out-of-Pockets are combined network and non-network; includes the deductible	Single: $4,000 Family: $8,000	
Physician Home and Office Services Primary Care Physician (PCP)/Specialty Care Physician (SCP) Including office surgeries and allergy serum: • allergy injections (PCP and SCP) and allergy testing • non-routine mammograms • diabetic education (regardless of outpatient setting) • MRAs, MRIs, PETS, C-scans, nuclear cardiology imaging studies and non-maternity related ultrasounds	20%	40%
Preventive Care Services Services include but are not limited to: Annual physical exams, pelvic exams, pap testing, PSA tests, immunizations, annual diabetic eye exam, routine vision and hearing exams • Physician home and office visits (PCP/SCP) • Other outpatient services @ hospital/alternative care facility • Routine mammograms • Screening colorectal cancer exam/laboratory testing **All preventive services are limited to one of each service per year per covered member; if the office visit is billed separately or if the primary purpose of the office visit is not for the delivery of a preventive service, cost sharing may be imposed for the office visit**	No deductible/coinsurance	40% (not subject to deductible)
Emergency and Urgent Care • **Emergency Room services @ hospital (facility/other covered services)** • **Urgent Care Center services**	20% 20%	20% 20%
Maternity Services	20%	40%
Inpatient and Outpatient Professional Services Include but are not limited to: • Medical care visits, intensive medical care, concurrent care, consultations, surgery and administration of general anesthesia and Newborn exams	20%	40%
Inpatient Facility Services	20%	40%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	20%	40%
Other Outpatient Services *(including but not limited to):* • Non-surgical outpatient services for example: MRIs, C-scans, chemotherapy, ultrasounds and other diagnostic outpatient services. • Home care services (network/non-network combined) Unlimited visits (includes IV therapy) **(No RN/LPN unless billed through a home health care agency)** • Durable medical equipment and orthotics (network/non-network combined) Unlimited benefit maximum (including medical supplies) • Prosthetic devices unlimited benefit maximum for prosthetics received on an outpatient basis. (Surgical prosthetics do not apply) • Physical medicine therapy day rehabilitation programs	20%	40%
• Hospice care • Ambulance services	20%	20%

Covered Benefits	Network	Non-Network
Outpatient Therapy Services **(Combined network and non-network limits apply)** • Physician Home and Office Visits (PCP/SCP) • Other outpatient services @ hospital/alternative care facility • Physical therapy: 25 visits • Occupational therapy: 25 visits • Manipulation therapy: 12 visits • Speech therapy: 25 visits	20%	40%
Behavioral Health Services: **Mental Health and Substance Abuse**[1] • Inpatient facility services • Physician home and office visits (PCP/SCP) • Other outpatient services @ hospital/alternative care facility **Authorization of all inpatient psychiatric and substance abuse services is required. If authorization is not obtained, benefits will not be allowed.**	20%	40%
Human Organ and Tissue Transplants[2] • Acquisition and transplant procedures, harvest and storage	20%	40%

Prescription Drug Coverage – THIS COVERAGE IS ADMINISTERED BY EXPRESS SCRIPTS[3]

Below benefits apply after medical deductible has been met; prescription expenses accumulate to the OOP maximum

	Retail Rx (Up to a 30-day supply)	Mail Order Rx (Up to a 90-day supply)
Preventive (mandated by the ACA)	$0 (no deductible)	$0 (no deductible)
Generic	$10 co-pay	$20 co-pay
Formulary	20% - minimum $30, maximum $50	20% - minimum $60, maximum $100
Brand Non-Formulary	40% - minimum $50, maximum $70	40% - minimum $100, maximum $140
Specialty	40% - minimum $75, maximum $150 (30-day supply only)	

Notes:

- *Non-network human organ and tissue transplants are excluded from the out-of-pocket limits.*
- *Dependent Age: to end of the month which the child attains age 26*
- *No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a non-network provider, the member is responsible for any balance due after the plan payment.*
- *Benefit Period = calendar year.*
- *Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime.*
- *Skilled Nursing Facility – limited to 100 days.*

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[1] *We encourage you to contact our mental health subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.*

[2] *Kidney and cornea are treated the same as any other illness and subject to the medical benefits*

[3] *PRESCRIPTION BENEFITS ADMINISTERED BY EXPRESS SCRIPTS. ANY QUESTIONS RELATED TO RX NEED TO BE DIRECTED TO* ***(877)841-5241***

Precertification:

- *Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.*

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

State of Indiana 2015 Rates

Plan	Coverage	Bi-Weekly Employee Rate	Bi-Weekly Employer Rate	Bi-Weekly Total Rate	Early Retirees (Monthly)	COBRA (Monthly)	Annual Employee Rate	Annual Employer Rate	Annual Employer HSA Contribution	Total Annual Employer Contribution	Annual Total Rate
Wellness	Single	$45.98	$174.30	$220.28	$477.27	$486.82	$1,195.48	$4,531.80	$1,251.12	$5,782.92	$6,978.40
	Family	$70.04	$530.04	$600.08	$1,300.17	$1,326.18	$1,821.04	$13,781.04	$2,502.24	$16,283.28	$18,104.32
Wellness W/ Non-Tobacco Use	Single	$10.98	$174.30	$185.28	$401.44	$409.47	$285.48	$4,531.80	$1,251.12	$5,782.92	$6,068.40
	Family	$35.04	$530.04	$565.08	$1,224.34	$1,248.83	$911.04	$13,781.04	$2,502.24	$16,283.28	$17,194.32
CDHP 1	Single	$53.12	$183.90	$237.02	$513.54	$523.81	$1,381.12	$4,781.40	$1,001.52	$5,782.92	$7,164.04
	Family	$92.84	$549.24	$642.08	$1,391.17	$1,419.00	$2,413.84	$14,280.24	$2,003.04	$16,283.28	$18,697.12
CDHP 1 W/ Non-Tobacco Use	Single	$18.12	$183.90	$202.02	$437.71	$446.46	$471.12	$4,781.40	$1,001.52	$5,782.92	$6,254.04
	Family	$57.84	$549.24	$607.08	$1,315.34	$1,341.65	$1,503.84	$14,280.24	$2,003.04	$16,283.28	$17,787.12
CDHP2	Single	$112.16	$199.38	$311.54	$675.00	$688.50	$2,916.16	$5,183.88	$599.04	$5,782.92	$8,699.08
	Family	$256.58	$580.20	$836.78	$1,813.02	$1,849.28	$6,671.08	$15,085.20	$1,198.08	$16,283.28	$22,954.36
CDHP 2 W/ Non-Tobacco Use	Single	$77.16	$199.38	$276.54	$599.17	$611.15	$2,006.16	$5,183.88	$599.04	$5,782.92	$7,789.08
	Family	$221.58	$580.20	$801.78	$1,737.19	$1,771.93	$5,761.08	$15,085.20	$1,198.08	$16,283.28	$22,044.36
Traditional PPO	Single	$260.78	$222.42	$483.20	$1,046.93	$1,067.87	$6,780.28	$5,782.92	$0.00	$5,782.92	$12,563.20
	Family	$667.88	$626.28	$1,294.16	$2,804.01	$2,860.09	$17,364.88	$16,283.28	$0.00	$16,283.28	$33,648.16
Traditional PPO W/ Non-Tobacco Use	Single	$225.78	$222.42	$448.20	$971.10	$990.52	$5,870.28	$5,782.92	$0.00	$5,782.92	$11,653.20
	Family	$632.88	$626.28	$1,259.16	$2,728.18	$2,782.74	$16,454.88	$16,283.28	$0.00	$16,283.28	$32,738.16
Dental	Single	$1.20	$10.02	$11.22	$24.31	$24.80	$31.20	$260.52	$0.00	$260.52	$291.72
	Family	$3.16	$26.36	$29.52	$63.96	$65.24	$82.16	$685.36	$0.00	$685.36	$767.52
Vision	Single	$0.17	$1.47	$1.64	$3.55	$3.62	$4.42	$38.22	$0.00	$38.22	$42.64
	Family	$2.52	$1.64	$4.16	$9.01	$9.19	$65.52	$42.64	$0.00	$42.64	$108.16

Flexible Spending Accounts										
Medical, Limited Purpose Medical (HSA Holders) and/or Dependent Care Admin Fee	$1.62	$0.00	$1.62	$3.51	$3.51	$42.12	$0.00	$0.00	$0.00	$42.12

HSA Accounts	Coverage	Initial Contribution *	Bi-Weekly Contribution	Monthly Contribution	Maximum Annual ER Contribution
Wellness	Single	$625.56	$24.06	$52.13	$1,251.12
	Family	$1,251.12	$48.12	$104.26	$2,502.24
HSA 1	Single	$500.76	$19.26	$41.73	$1,001.52
	Family	$1,001.52	$38.52	$83.46	$2,003.04
HSA 2	Single	$299.52	$11.52	$24.96	$599.04
	Family	$599.04	$23.04	$49.92	$1,198.08

*Initial contribution as listed above apply to employees with a CDHP effective between 1/1/15 thru 6/1/15 and with an open HSA. CDHPs effective after 6/1/15 but before 12/2/15 and with an open HSA, will receive 1/2 of the initial contribution.

Employees participating in the CDHP plans are reminded that they must open an HSA account in order to receive the State's HSA contribution.

Revised 9/16/14

Milliman

HIP Link Plan Affordability Tool v1.1

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HIP Link Plan Affordability Tool

Background

HIP Link provides eligible individuals with premium and cost sharing assistance for participation in employer sponsored insurance (ESI) coverage. HIP 2.0 eligible individuals may be eligible to participate in HIP Link if they have affordable ESI coverage available through their employer. For an ESI plan to be qualified for HIP Link, HIP Link POWER Account funding must be sufficient to cover the annual cost of care for the majority of eligible individuals. Cost of care is inclusive of the ESI plan's required employee premium contributions and cost sharing.

Instructions

The HIP Link health plan affordability test can be completed through the use of the user inputs required by the "Affordability Test" worksheet of this tool. User inputs are highlighted in yellow, and the results of the test can be found in row 24 of the "Affordability Test" worksheet. Row 24 will be shaded green for plans that pass the test, and will be shaded red for plans that fail.

Required user inputs include the following:

HIP Link Eligible Member Information

> Number of Eligible Adults in Household: This number depends on the employee tier selected on the application (i.e., employee, spouse or dependent). If all three are selected, the input is 2. The Tool is limited to a maximum of two eligible adults.
> Annual Household Income: Enter the HIP Link eligible individual's total household income. When testing an employer's plan, this number should be $16,000. The program is using an average HIP Link member's annual income.

ESI Coverage Information

> Coverage Type: Enter "Single" for employee only coverage or "Two Person" for employee plus spouse or dependent coverage.
> Employee Premium Contributions: Enter the required employee premium contributions for the ESI plan.
> Contribution Frequency: Enter the frequency of the required employee premium contributions. If an annualized figure is known, users may select "annually".

ESI Plan Design Information

> Annual Deductible: Enter the annual deductible for the health plan. If in non-single coverage, enter the total required amount for the family. This is located on the SBC.
> Average Coinsurance: Enter the average coinsurance required by the ESI plan. This is located on the SBC.
> Annual Out-of-Pocket Maximum: Enter the annual out-of-pocket maximum for the health plan. If in non-single coverage, enter the total required amount for the family. This is located on the SBC. *Please note that out-of-pocket maximums entered into the Tool should be inclusive of plan deductibles.*
> Dental Coverage Provided?: Enter "Yes" if dental coverage is provided to employees. The premium associated with this coverage should be included within "Employee Premium Contributions" entered in the "ESI Coverage Information" section; however, member cost sharing should not be in the Deductible, Coinsurance, and Out-of-Pocket Maximum values entered above.

Note: Amounts may vary for employee only vs employee + spouse or dependent. If coverage is for both the user will need to calculate affordability for employee only and employee + spouse or dependent.

ESI HRA Account Information

> HRA Contributions Provided by Employer: Enter "Yes" if the ESI plan includes HRA contributions provided by the employer. This information is located on the employer application or on the uploaded pdf.
> HRA Payout Structure: Applicable if "Yes" entered above. Select "HRA Pays 1st" if the HRA pays prior to member cost sharing. Select "HRA Pays 2nd" if the HRA pays after member cost sharing.
> Annual Employer HRA Contributions: Applicable if "Yes" entered above. Enter the annual amount of HRA contributions provided by the employer. This information is located on the uploaded pdf.

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HIP Link Plan Affordability

HIP Link Eligible Member Information

Number of Eligible Adults in Household	1
Annual Household Income	$ 16,000
State HIP Link POWER Account Funding	$ 4,000
Member HIP Link POWER Account Funding	$ 320
Total Potential POWER Account Funding	**$ 4,320**

ESI Coverage Information

Coverage Type	Single
Potential POWER Account Funding	$ 4,320
Employee Premium Contributions	$ 39.26
Contribution Frequency	Monthly
Net POWER Account Balance	**$ 3,849**

ESI Plan Design Information

Single Annual Deductible	$ 2,500
Average Coinsurance	20%
Single Annual Out-of-Pocket Maximum	$ 4,000
Dental Coverage Provided?	No
Sufficiency Threshold	**80%**

ESI HRA Account Information

HRA Contributions Provided by Employer	No
HRA Payout Structure	HRA Pays 1st
Annual Employer HRA Contributions	$ 1,000

POWER Account Sufficiency Probability: Greater than 80%

INDIANA EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Preferred Provider Organization
Issuer Name	Anthem Ins Companies Inc (Anthem BCBS)
Product Name	PPO
Plan Name	Blue 5 Blue Access PPO Medical Option 6 Rx Option G
Supplemented Categories (Supplementary Plan Type)	• Pediatric Oral (FEDVIP) • Pediatric Vision (FEDVIP)
Habilitative Services Included Benchmark (Yes/No)	Yes

BENEFITS AND LIMITS

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
1	**Primary Care Visit to Treat an Injury or Illness**	Covered	Primary Care Visit to Treat an Injury or Illness	No					Non-interactive telemedicine services; Non-preventive nutritional therapy/counseling.		No
2	**Specialist Visit**	Covered	Specialist Visit	No					Non-interactive telemedicine services; Non-preventive nutritional therapy/counseling.		No
3	**Other Practitioner Office Visit (Nurse, Physician Assistant)**	Covered	Other Practitioner Office Visit	No					Non-interactive telemedicine services; Non-preventive nutritional therapy/counseling.		No
4	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Outpatient Facility Services	No					Oral surgery that is dental in origin; Removal of impacted wisdom teeth; Reversal of voluntary sterilization; radial keratotomy, keratoplasty, Lasik and other surgical procedures to correct refractive defects; surgeries for sexual dysfunction; surgeries or services for sexual transformation; surgical treatment of flat feet, subluxation of the foot, weak, strained, unstable feet, tarsalgia, metatarsalgia, hyperkeratoses; surgical treatment of gynecomastia; treatment of hyperhidrosis; sclerotherapy for treatment of varicose veins of the lower extremity; treatment of telangiectatic dermal veins.		No
5	**Outpatient Surgery Physician/Surgical Services**	Covered	Physician Medical and Surgical Services in an Outpatient Facility	No					Oral surgery that is dental in origin; Removal of impacted wisdom teeth; Reversal of voluntary sterilization; radial keratotomy, keratoplasty, Lasik and other surgical procedures to correct refractive defects; surgeries for sexual dysfunction; surgeries or services for sexual transformation; surgical treatment of flat feet, subluxation of the foot, weak, strained, unstable feet, tarsalgia, metatarsalgia, hyperkeratoses; surgical treatment of gynecomastia; treatment of hyperhidrosis; sclerotherapy for treatment of varicose veins of the lower extremity; treatment of telangiectatic dermal veins.		No
6	**Hospice Services**	Covered	Hospice Services	No					Services provided by volunteers; housekeeping services.		No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
7	**Non-Emergency Care When Traveling Outside the U.S.**	Covered	Non-Emergency care When Traveling Outside the U.S.	No							No
8	**Routine Dental Services (Adult)**	Not Covered	Dental Services						Treatment of natural teeth due to diseases; dental care, treatment, supplies, or dental x-rays; damage to teeth due to chewing or biting is not deemed an accidental injury and is not covered; oral surgeries or periodontal work on the hard and/or soft tissue that supports the teeth meant to help the teeth or their supporting structures; appliances for temporomandibular joint pain dysfunction; or periodontal care, prosthodontal care or orthodontic care; removal of impacted wisdom teeth.		
9	**Infertility Treatment**	Not Covered	Infertility Treatment						Diagnostic testing or treatment related to infertility; Artificial insemination, in vitro fertilization, other types of artificial or surgical means of conception including drugs administered in connection with these procedures.		
10	**Long-Term/ Custodial Nursing Home Care**	Not Covered	Long-Term/Custodial Nursing Home Care								
11	**Private-Duty Nursing**	Covered	Private duty nursing services	Yes	50000	Other other	dollars per benefit period		Private duty nursing services in an inpatient setting.	Home nursing services provided through home health care. Limit applies to private duty nursing in home setting.	Yes
12	**Routine Eye Exam (Adult)**	Not Covered	Routine Eye Exam						Routine eye exam and refraction; Services for vision training and orthoptics; eyeglasses and eyewear.		
13	**Urgent Care Centers or Facilities**	Covered	Urgent Care Services in an Urgent Care Center or Facility	No							No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
14	**Home Health Care Services**	Covered	Home Health Care Services	Yes	90	Visits per year			Food, housing, homemaker services and home delivered meals; home or outpatient hemodialysis services; physician charges; helpful environmental materials; Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider; Services provided by a member of the patient's immediate family; Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities; Manipulation therapy services rendered in the home.	Medical treatment provided in the home on a part time or intermittent basis including visits by a licensed health care professional, including a nurse, therapist, or home health aide; and physical, speech, and occupational therapy. When these therapy services are provided as part of home health they are not subject to separate visit limits for therapy services.	No
15	**Emergency Room Services**	Covered	Emergency Room Services	No					Care received in and emergency room that is not emergency care.		No
16	**Emergency Transportation/ Ambulance**	Covered	Emergency Transportation/Ambulance	No					Non covered services for ambulance include but are not limited to, trips to a physician's office or clinic, a morgue or a funeral home.	Ambulance transportation from home, scene of accident or medical emergency to hospital; between hospitals; between hospital and skilled nursing facility; from hospital or skilled nursing facility to patient's home.	No
17	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Inpatient Hospital Services	No					Oral surgery that is dental in origin; Removal of impacted wisdom teeth; Reversal of voluntary sterilization; radial keratotomy, keratoplasty, Lasik and other surgical procedures to correct refractive defects; surgeries for sexual dysfunction; surgeries or services for sexual transformation; surgical treatment of flat feet, subluxation of the foot, weak, strained, unstable feet, tarsalgia, metatarsalgia, hyperkeratoses; surgical treatment of gynecomastia; treatment of hyperhidrosis; sclerotherapy for treatment of varicose veins of the lower extremity; treatment of telangiectatic dermal veins.	Facility billed services while in an inpatient facility. Includes room and board, nursing services, and ancillary services and supplies.	Yes

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
18	**Inpatient Physician and Surgical Services**	Covered	Inpatient Physician and Surgical Services	No					Oral surgery that is dental in origin; Removal of impacted wisdom teeth; Reversal of voluntary sterilization; radial keratotomy, keratoplasty, Lasik and other surgical procedures to correct refractive defects; surgeries for sexual dysfunction; surgeries or services for sexual transformation; surgical treatment of flat feet, subluxation of the foot, weak, strained, unstable feet, tarsalgia, metatarsalgia, hyperkeratoses; surgical treatment of gynecomastia; treatment of hyperhidrosis; sclerotherapy for treatment of varicose veins of the lower extremity; treatment of telangiectatic dermal veins.	Facility billed services while in an inpatient facility. Includes room and board, nursing services, and ancillary services and supplies.	Yes
19	**Bariatric Surgery**	Not Covered	Bariatric Surgery								
20	**Cosmetic Surgery**	Not Covered	Cosmetic Surgery						For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services treatment or surgeries, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Certificate. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery.		

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
21	**Skilled Nursing Facility**	Covered	Skilled Nursing Facility	Yes	90	Days per year	N & NN Total		Custodial or residential care in a skilled nursing facility or any other facility is not covered except as rendered as part of Hospice care.	Items and services provided as an inpatient in a skilled nursing bed of skilled nursing facility or hospital, including room and board in semi-private accommodations; rehabilitative services; and drugs, biologicals, and supplies furnished for use in the skilled nursing facility and other medically necessary services and supplies.	No
22	**Prenatal and Postnatal Care**	Covered	Prenatal and Postnatal Care	No					Services related to surrogacy is member is not the surrogate.	Maternity care, maternity-related checkups, and delivery of the baby in the hospital are covered.	No
23	**Delivery and All Inpatient Services for Maternity Care**	Covered	Delivery and All Inpatient Facility and Professional Services for Maternity Care	No				48	Services related to surrogacy is member is not the surrogate.	Maternity care, maternity-related checkups, and delivery of the baby in the hospital are covered. 48 hour minimum length of stay for vaginal delivery; 96 hour minimum length of stay for cesarean delivery.	No
24	**Mental/Behavioral Health Outpatient Services**	Covered	Mental/Behavioral Health Outpatient Services	Yes	30	Visits per year			Custodial or Domiciliary Care. Supervised living or halfway houses. Residential treatment centers. Room and board charges unless the treatment provided meets Our Medical Necessity criteria for Inpatient admission patient's condition. Services or care provided or billed by a school, halfway house, Custodial Care center for the developmentally disabled or outward bound programs, even if psychotherapy is included. Services related to non-compliance of care if the Member ends treatment for Substance Abuse against the medical advice of the Provider.	Also includes partial day mental health services and substance abuse services, and intensive outpatient programs. Combined with Substance Abuse Disorder Outpatient Services.	No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
25	**Mental/Behavioral Health Inpatient Services**	Covered	Mental/Behavioral Health Inpatient Services	Yes	30	Days per year			Custodial or Domiciliary Care. Supervised living or halfway houses. Residential treatment centers. Room and board charges unless the treatment provided meets Our Medical Necessity criteria for Inpatient admission patient's condition. Services or care provided or billed by a school, halfway house, Custodial Care center for the developmentally disabled or outward bound programs, even if psychotherapy is included. Services related to non-compliance of care if the Member ends treatment for Substance Abuse against the medical advice of the Provider.	Also includes partial day mental health services and substance abuse services, and intensive outpatient programs. Combined with Substance Abuse Disorder Inpatient Services.	No
26	**Substance Abuse Disorder Outpatient Services**	Covered	Substance Abuse Disorder Outpatient Services	Yes	30	Visits per year			Custodial or Domiciliary Care. Supervised living or halfway houses. Residential treatment centers. Room and board charges unless the treatment provided meets Our Medical Necessity criteria for Inpatient admission patient's condition. Services or care provided or billed by a school, halfway house, Custodial Care center for the developmentally disabled or outward bound programs, even if psychotherapy is included. Services related to non-compliance of care if the Member ends treatment for Substance Abuse against the medical advice of the Provider.	Also includes partial day mental health services and substance abuse services, and intensive outpatient programs. Combined with Mental/Behavioral Health Outpatient Services.	No
27	**Substance Abuse Disorder Inpatient Services**	Covered	Substance Abuse Disorder Inpatient Services	Yes	30	Days per year			Custodial or Domiciliary Care. Supervised living or halfway houses. Residential treatment centers. Room and board charges unless the treatment provided meets Our Medical Necessity criteria for Inpatient admission patient's condition. Services or care provided or billed by a school, halfway house, Custodial Care center for the developmentally disabled or outward bound programs, even if psychotherapy is included. Services related to non-compliance of care if the Member ends treatment for Substance Abuse against the medical advice of the Provider.	Also includes partial day mental health services and substance abuse services, and intensive outpatient programs. Combined with Mental/Behavioral Health Inpatient Services.	No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
28	**Generic Drugs**	Covered	Generic Prescription Drugs	No					Over the counter drugs and drugs with over the counter equivalents; Drugs for weight loss; Stop smoking aids; Nutritional and/or dietary supplements; drugs for the treatment of sexual or erectile dysfunction or inadequacies; fertility drugs; human growth hormone for children born small for gestational age; treatment of onchomycosis.		No
29	**Preferred Brand Drugs**	Covered	Preferred Brand Prescription Drugs	No					Over the counter drugs and drugs with over the counter equivalents; Drugs for weight loss; Stop smoking aids; Nutritional and/or dietary supplements; drugs for the treatment of sexual or erectile dysfunction or inadequacies; fertility drugs; human growth hormone for children born small for gestational age; treatment of onchomycosis.		No
30	**Non-Preferred Brand Drugs**	Covered	Non-Preferred Brand Prescription Drugs	No					Over the counter drugs and drugs with over the counter equivalents; Drugs for weight loss; Stop smoking aids; Nutritional and/or dietary supplements; drugs for the treatment of sexual or erectile dysfunction or inadequacies; fertility drugs; human growth hormone for children born small for gestational age; treatment of onchomycosis.		No
31	**Specialty Drugs**	Covered	Specialty Prescription Drugs	No					Over the counter drugs and drugs with over the counter equivalents; Drugs for weight loss; Stop smoking aids; Nutritional and/or dietary supplements; drugs for the treatment of sexual or erectile dysfunction or inadequacies; fertility drugs; human growth hormone for children born small for gestational age; treatment of onchomycosis.		No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
32	**Outpatient Rehabilitation Services**	Covered	Outpatient Rehabilitation Services	Yes	20	Visits per year			Physical Therapy. Non Covered Services include: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening. Occupational Therapy. Does not include diversional, recreational, vocational therapies (e.g., hobbies and crafts) Non Covered Services include: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptions to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment. Cardiac Rehab. Home programs, on-going conditioning and maintenance are not covered. Pulmonary Rehab. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service. Non-Covered Services for physical medicine and rehabilitation include, but are not limited to: admission to a Hospital mainly for physical therapy; long term rehabilitation in an Inpatient setting.	Includes physical therapy, occupational therapy, speech therapy, pulmonary therapy and cardiac rehabilitation. Separate 20 visit limit for PT, OT, ST, Pulmonary Rehab; 36 visit limit for Cardiac Rehab. Benefit limits are shared between rehabilitation and habilitation services.	Yes

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
33	**Habilitation Services**	Covered	Habilitation Services	Yes	20	Visits per year			Physical Therapy. Non Covered Services include: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening. Occupational Therapy. Does not include diversional, recreational, vocational therapies (e.g., hobbies and crafts) Non Covered Services include: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptions to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment. Cardiac Rehab. Home programs, on-going conditioning and maintenance are not covered. Pulmonary Rehab. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service. Non-Covered Services for physical medicine and rehabilitation include, but are not limited to: admission to a Hospital mainly for physical therapy; long term rehabilitation in an Inpatient setting.	Includes physical therapy, occupational therapy, and speech therapy. Separate 20 visit limit for PT, OT, ST. Benefit limits are shared between rehabilitation and habilitation services.	No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
34	**Chiropractic Care**	Covered	Spinal manipulation and manual medical intervention services	Yes	12	Visits per year			Manipulation therapy services rendered in the home as part of Home Care Services are not covered.	Benefit limit applies for spinal manipulation and manual medical intervention services.	No
35	**Durable Medical Equipment**	Covered	Medical Equipment and Supplies	No					Non covered services include: Items for personal hygiene, environmental control or convenience; Exercise equipment; (Repairs and replacement) Repair and replacement due to misuse, malicious breakage or gross neglect. Replacement of lost or stolen items. (Medical and Surgical Supplies) Adhesive tape, band aids, cotton tipped applicators; Arch supports; Doughnut cushions; Hot packs, ice bags; vitamins; medijectors (Durable Medical Equipment) Air conditioners; Ice bags/cold pack pump; Raised toilet seats; Rental of equipment if the Member is in a Facility that is expected to provide such equipment; Translift chairs; Treadmill exerciser; Tub chair used in shower. (Prosthetics) Dentures, replacing teeth or structures directly supporting teeth; Dental appliances; Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets; Artificial heart implants; Wigs (except following cancer treatment); Penile prosthesis in men suffering impotency resulting from disease or injury (Orthotics) Orthopedic shoes (except therapeutic shoes for diabetics); Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace; Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies); Garter belts or similar devices.	Durable medical equipment, medical devices and supplies, prosthetics and appliances, including cochlear implants.	No
36	**Hearing Aids**	Not Covered	Hearing Aids						Hearing aids, fittings and exams for hearing aids.		
37	**Diagnostic Test (X-Ray and Lab Work)**	Covered	Diagnostic Tests	No							No
38	**Imaging (CT/PET Scans, MRIs)**	Covered	Advanced Diagnostic Imaging Services	No							No

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39	**Preventive Care/ Screening/ Immunization**	Covered	Preventive Care/ Screenings and Immunizations	No						Preventive care that meets the recommendations described in the ACA for plans effective after 9/23/2010 but prior to 8/1/2012.	No
40	**Routine Foot Care**	Not Covered	Routine Foot Care						Routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including: cleaning and soaking the feet; applying skin creams in order to maintain skin tone; other services that are performed when there is not a localized illness, injury or symptom involving the foot.	Palliative or cosmetic foot care.	
41	**Acupuncture**	Not Covered	Acupuncture						Services or supplies related to alternative or complementary medicine. Examples of services in this category include: acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.		
42	**Weight Loss Programs**	Not Covered	Weight Loss Programs						Weight loss programs, whether or not they are pursued under medical or physician supervision.		
43	**Routine Eye Exam for Children**	Covered	Routine eye exam	Yes	1	Visits per year					No
44	**Eye Glasses for Children**	Covered	Eyeglasses for adults and children	Yes	1	Other other	1 pair of glasses (lenses and frames per year				No
45	**Dental Check-Up for Children**	Covered	Dental Exams	Yes	1	Other other	1 every 6 months			Limitations, including dollar limits, may apply.	No

OTHER BENEFITS

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
1	**Other**	Covered	Radiation Therapy	No							No
2	**Other**	Covered	Chemotherapy	No							No
3	**Other**	Covered	Infusion Therapy	No							No
4	**Other**	Covered	Renal Dialysis/ Hemodialysis	No							No
5	**Other**	Covered	Allergy Treatment	No							No
6	**Other**	Covered	Injectable drugs and other drugs administered in a provider's office or other outpatient setting	No							No
7	**Other**	Covered	Biofeedback	No							No
8	**Other**	Covered	Autism Services	No						Coverage is provided for the treatment of pervasive developmental disorders. Coverage for pervasive developmental disorders will not be subject to dollar limits, Deductibles, Copayment or Coinsurance provisions that are less favorable than the dollar limits, Deductibles, Copayments or Coinsurance provisions that apply to physical illness under this Plan.	No
9	**Other**	Covered	Vision Correction After Surgery or Accident	No					Prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service.	Prescription glasses or contact lenses when required as a result of surgery or for the treatment of accidental injury.	No
10	**Other**	Covered	Medical supplies, equipment, and education for diabetes care for all diabetics	No						Palliative foot care, medical supplies, equipment, and education for diabetes care for all diabetics.	No

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11	**Other**	Covered	Dental Services for Accidental Injury and Other Related Medical Services	Yes	3000	Other other	dollars/benefit period		Damage to your teeth due to chewing or biting is not deemed an accidental injury and is not covered.	Dental services resulting from an accidental injury when treatment is performed within 12 months after the injury. The benefit limit will not apply to Outpatient facility charges, anesthesia billed by a Provider other than the Physician performing the service, or to services that we are required by law to cover. Coverage includes oral examinations, x-rays, tests and laboratory examinations, restorations, prosthetic services, oral surgery, mandibular/maxillary reconstruction, anesthesia. Other covered dental services include facility charges for Outpatient services for the removal of teeth or for other dental processes if the patient's medical condition or the dental procedure requires a Hospital setting to ensure the safety of the patient.	No
12	**Other**	Covered	Human Organ and Tissue Transplant Services	No						Medically necessary human organ and tissue transplant services. When a human organ or tissue transplant is provided from a living donor to a covered person, both the recipient and the donor may receive the benefits of the health plan. Additional covered services include unrelated donor searches and transportation and lodging.	No

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13	**Other**	Covered	Human Organ and Tissue Transplant Services - Transportation and Lodging	Yes	10000	Other other	$10000/transplant benefit paid		Non covered transportation and lodging includes child care; mileage within the transplant city; rental cars, buses, taxis or shuttle service, except as specifically approved; frequent flyer miles; coupons, vouchers or travel tickets; prepayments or deposits; services for a condition that is not directly related to, or a direct result of, the transplant; telephone calls; laundry; postage; entertainment; interim visits to a medical facility while waiting for the actual transplant procedure; travel expenses for donor companion/caregiver; return visits for the donor for a treatment of a condition found during evaluation.	The Plan will provide assistance with reasonable and necessary travel expenses when patient is required to travel more than 75 miles from residence to reach the facility where the Covered Transplant Procedure will be performed. Assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions.	No
14	**Other**	Covered	Human Organ and Tissue Transplant Services - Unrelated donor search	Yes	30000	Other other	$30000/transplant benefit paid				No
15	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Rehab Facilities Including Room & Board Charges, Physician Fees, Imaging, Testing, and Supplies	Yes	60	Days per year					Yes
16	**Inpatient Physician and Surgical Services**	Covered	Rehab Facilities Including Room & Board Charges, Physician Fees, Imaging, Testing, and Supplies	Yes	60	Days per year					Yes
17	**Private-Duty Nursing**	Covered	Private-Duty Nursing	Yes	100000	Other other	$100000 Per Lifetime		Private duty nursing services in an inpatient setting.	Home nursing services provided through home health care. Limit applies to Private duty nursing in home setting.	No
18	**Outpatient Rehabilitation Services**	Covered	Cardiac Rehabilitation	Yes	36	Visits per year					No

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19	**Other**	Covered	Basic Dental Care – Child	No						Limitations, including dollar limits, may apply.	No
20	**Other**	Covered	Major Dental Care – Child	No						Limitations, including dollar limits, may apply.	No
21	**Other**	Covered	Orthodontia - Child	No						Limitations, including dollar limits, may apply.	No

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

CATEGORY	CLASS	SUBMISSION COUNT
ANALGESICS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANALGESICS	OPIOID ANALGESICS, LONG-ACTING	11
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	11
ANESTHETICS	LOCAL ANESTHETICS	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	ALCOHOL DETERRENTS/ANTI-CRAVING	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID ANTAGONISTS	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	SMOKING CESSATION AGENTS	0
ANTI-INFLAMMATORY AGENTS	GLUCOCORTICOIDS	1
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANTIBACTERIALS	AMINOGLYCOSIDES	9
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	20
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	18
ANTIBACTERIALS	BETA-LACTAM, OTHER	5
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	11
ANTIBACTERIALS	MACROLIDES	5
ANTIBACTERIALS	QUINOLONES	8
ANTIBACTERIALS	SULFONAMIDES	4
ANTIBACTERIALS	TETRACYCLINES	4
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	2
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	4
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	5
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	7
ANTIDEMENTIA AGENTS	ANTIDEMENTIA AGENTS, OTHER	1
ANTIDEMENTIA AGENTS	CHOLINESTERASE INHIBITORS	3
ANTIDEMENTIA AGENTS	N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST	1
ANTIDEPRESSANTS	ANTIDEPRESSANTS, OTHER	8
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	4
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	9
ANTIDEPRESSANTS	TRICYCLICS	9
ANTIEMETICS	ANTIEMETICS, OTHER	10
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	8
ANTIFUNGALS	NO USP CLASS	25
ANTIGOUT AGENTS	NO USP CLASS	5
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	2
ANTIMIGRAINE AGENTS	PROPHYLACTIC	4

CATEGORY	CLASS	SUBMISSION COUNT
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	7
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	3
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2
ANTIMYCOBACTERIALS	ANTITUBERCULARS	10
ANTINEOPLASTICS	ALKYLATING AGENTS	8
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	3
ANTINEOPLASTICS	ANTIMETABOLITES	2
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	6
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	3
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	12
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	3
ANTINEOPLASTICS	RETINOIDS	3
ANTIPARASITICS	ANTHELMINTICS	4
ANTIPARASITICS	ANTIPROTOZOALS	12
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	5
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	3
ANTIPARKINSON AGENTS	ANTIPARKINSON AGENTS, OTHER	3
ANTIPARKINSON AGENTS	DOPAMINE AGONISTS	4
ANTIPARKINSON AGENTS	DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS	2
ANTIPARKINSON AGENTS	MONOAMINE OXIDASE B (MAO-B) INHIBITORS	2
ANTIPSYCHOTICS	1ST GENERATION/TYPICAL	10
ANTIPSYCHOTICS	2ND GENERATION/ATYPICAL	9
ANTIPSYCHOTICS	TREATMENT-RESISTANT	1
ANTISPASTICITY AGENTS	NO USP CLASS	5
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	4
ANTIVIRALS	ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS	5
ANTIVIRALS	ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS	11
ANTIVIRALS	ANTI-HIV AGENTS, OTHER	3
ANTIVIRALS	ANTI-HIV AGENTS, PROTEASE INHIBITORS	9
ANTIVIRALS	ANTI-INFLUENZA AGENTS	4
ANTIVIRALS	ANTIHEPATITIS AGENTS	12
ANTIVIRALS	ANTIHERPETIC AGENTS	6
ANXIOLYTICS	ANXIOLYTICS, OTHER	4
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	5

CATEGORY	CLASS	SUBMISSION COUNT
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	6
BIPOLAR AGENTS	MOOD STABILIZERS	5
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	21
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	2
BLOOD GLUCOSE REGULATORS	INSULINS	8
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	7
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	8
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	1
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	8
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	5
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC BLOCKING AGENTS	4
CARDIOVASCULAR AGENTS	ANGIOTENSIN II RECEPTOR ANTAGONISTS	8
CARDIOVASCULAR AGENTS	ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS	10
CARDIOVASCULAR AGENTS	ANTIARRHYTHMICS	10
CARDIOVASCULAR AGENTS	BETA-ADRENERGIC BLOCKING AGENTS	13
CARDIOVASCULAR AGENTS	CALCIUM CHANNEL BLOCKING AGENTS	9
CARDIOVASCULAR AGENTS	CARDIOVASCULAR AGENTS, OTHER	4
CARDIOVASCULAR AGENTS	DIURETICS, CARBONIC ANHYDRASE INHIBITORS	2
CARDIOVASCULAR AGENTS	DIURETICS, LOOP	4
CARDIOVASCULAR AGENTS	DIURETICS, POTASSIUM-SPARING	4
CARDIOVASCULAR AGENTS	DIURETICS, THIAZIDE	6
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES	2
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS	7
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, OTHER	6
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL	3
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS	3
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	CENTRAL NERVOUS SYSTEM AGENTS, OTHER	4
CENTRAL NERVOUS SYSTEM AGENTS	FIBROMYALGIA AGENTS	3
CENTRAL NERVOUS SYSTEM AGENTS	MULTIPLE SCLEROSIS AGENTS	7
DENTAL AND ORAL AGENTS	NO USP CLASS	8
DERMATOLOGICAL AGENTS	NO USP CLASS	35
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	16
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	6
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	7
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4

CATEGORY	CLASS	SUBMISSION COUNT
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	2
GASTROINTESTINAL AGENTS	LAXATIVES	3
GASTROINTESTINAL AGENTS	PROTECTANTS	2
GASTROINTESTINAL AGENTS	PROTON PUMP INHIBITORS	6
GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	7
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	9
GENITOURINARY AGENTS	GENITOURINARY AGENTS, OTHER	3
GENITOURINARY AGENTS	PHOSPHATE BINDERS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)	GLUCOCORTICOIDS/MINERALOCORTICOIDS	23
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	NO USP CLASS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)	NO USP CLASS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANABOLIC STEROIDS	2
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANDROGENS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ESTROGENS	6
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	PROGESTINS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)	NO USP CLASS	3
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	NO USP CLASS	9
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	5
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	22
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	0
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	10
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	3
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	5
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1
METABOLIC BONE DISEASE AGENTS	NO USP CLASS	15
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	4

CATEGORY	CLASS	SUBMISSION COUNT
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	9
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	11
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	14
OTIC AGENTS	NO USP CLASS	6
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	6
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	11
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	10
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	6
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	5
SKELETAL MUSCLE RELAXANTS	NO USP CLASS	6
SLEEP DISORDER AGENTS	GABA RECEPTOR MODULATORS	3
SLEEP DISORDER AGENTS	SLEEP DISORDERS, OTHER	5
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL MODIFIERS	7
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	11

HIP Link Analysis

State of Indiana

Family and Social Services Administration

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June 17, 2015

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BACKGROUND

The State of Indiana, Family and Social Services Administration (FSSA) is developing a Medicaid expansion proposal using an updated Healthy Indiana Plan (HIP) as the expansion vehicle. Included within this proposal is an optional defined premium assistance program to enable eligible Indiana residents with access to Employer Sponsored Insurance (ESI) to receive premium and cost sharing support. This program is being referred to as HIP Link. FSSA has requested that Milliman evaluate the HIP Link program, especially focusing on the sufficiency of contributions provided to HIP Link enrollees.

HIP LINK

HIP Link is a proposed optional program which will enable eligible individuals to receive premium and cost sharing assistance when enrolling in healthcare coverage offered by their employer. Individuals who elect to enroll in HIP Link will receive a fixed contribution from the State of Indiana to be used for employee premium contributions and required cost sharing amounts. The first year contribution has been set at $4,000, and is expected to increase annually in order to reflect increases in average cost. Funds available to assist with member cost sharing will be provided through a Personal Wellness and Responsibility Account or “POWER Account”. Depending on an individual’s income level, nominal member POWER Account Contributions may be required.

Eligibility for HIP Link will be limited to adults with income below 138% of the Federal Poverty Level (FPL) who are offered Employer Sponsored Insurance, and are not medically frail or pregnant. Those who become pregnant or medically frail when enrolled in HIP Link will be given the opportunity to switch to receiving standard HIP coverage. Individuals with high cost sharing may run through all available POWER Account funding and be subject out of pocket expenses. As proposed, hardship waivers will not be available for enrollees in this situation. Those concerned about the potential for out of pocket expenses will have the ability to elect standard HIP coverage over HIP Link.

This report analyzes the likelihood that the proposed state contribution of $4,000 will be sufficient to cover premium and cost sharing needs of eligible enrollees.

EXECUTIVE SUMMARY

HIP Link is an optional defined premium assistance program proposed by the State of Indiana. Enrollees will receive contributions from the State of Indiana into a POWER Account to be used for Employer Sponsored Insurance (ESI) healthcare expenses. For individuals enrolled in an employer's health plan, healthcare expenses include a combination of required employee premium contributions and member cost sharing amounts. This report analyzes the cost of ESI coverage in Indiana, including variability in employee contributions and required member cost sharing amounts.

EMPLOYER SPONSORED INSURANCE OVERVIEW

Coverage offered by employers in Indiana varies in the richness of the benefits offered in addition to the amount of plan premium contributed by employers. Employers have flexibility in establishing the amount of a health plan's premium paid by the employer versus the portion of plan premium paid for by the employee. With this flexibility comes a significant amount of variation in the generosity of coverage offered by employers. In addition to establishing premium contributions, employers select one or more plan designs to be offered to employees. Employees of larger employers often have the option of selecting one of several plan designs, with varying levels of required employee premium contributions and employee cost sharing.

Table 1 contains estimates of the annual cost of ESI coverage in the state of Indiana for low income employees for three different benefit levels. This information was developed using 2012 Medical Expenditure Panel Survey data (MEPS), which is further outlined within the Data, Assumptions, and Methodology section of this report.

Table 1
State of Indiana, Family and Social Services Administration
Estimated Average ESI Cost For Low Income Employees

	Lean Plan	Average Plan	Rich Plan
Employee Premium Contribution	$ 1,202	$ 1,526	$ 1,850
Employee Cost Sharing*	$ 2,294	$ 1,724	$ 1,053
Total Employee Cost	**$ 3,495**	**$ 3,250**	**$ 2,902**

** Cost sharing estimates have been adjusted to reflect the removal of medically frail and pregnant individuals*.

As demonstrated in Table 1, the average total employee cost of $3,250 per year is lower than the proposed state contribution of $4,000 per year. This means that on average, the proposed state POWER Account Contribution will be sufficient to cover an enrollee's annual healthcare costs. Due to variability in ESI offerings, individuals may be offered plan designs with an estimated annual cost that is higher than the proposed POWER Account Contribution. Additionally, some individuals may have maximum annual out of pocket expenses lower than the amount provided by the state. The remainder of this report analyzes the potential variation in the sufficiency of state POWER Account Contributions that would be provided to HIP Link enrollees.

ESI Plan Designs

The benefit designs offered by employers can have a significant impact on the sufficiency of state provided POWER Account Contributions. Health plans offered by employers in Indiana have deductibles ranging from $0 to over $6,000 for single coverage. In 2013, the average single deductible of health plans offered by employers was approximately $1,135 nationwide and approximately $1,282 in the Midwest region[1]. There is significant variability in the average single deductible level by plan type, with High Deducible Health Plans {HDHPs) having the highest average deductible level and Health Maintenance Organization (HMO) plans having the lowest average deductible level. In the Indiana employer insurance market, Preferred Provider Organization (PPO) and HDHP plans are more common than traditional HMO products, which is consistent with the average deductible being higher in Indiana relative to the national average. Additionally, deductible levels have historically increased over time and the average deductible in 2016 is likely to be higher than in 2013.

[1] Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2013, Section 7.

Employers who offer HDHP plans to employees often provide Health Savings Account (HSA) or Health Reimbursement Account (HRA) contributions in addition to premium contributions. In 2013, when contributing to an employee HSA account, the average employer contribution nationwide was $950 for single coverage[2]. This contribution can be used to assist in meeting a plan's deductible or other cost sharing requirements.

In addition to plan deductibles, ESI enrollees may be subject to copayments and coinsurance when services are rendered. However, all non-grandfathered plan designs offered in 2015 will be subject to a cost sharing out of pocket maximum of $6,600 per single enrollee or $13,200 per family.

ESI Premium by Firm Size

Prior to the implementation of adjusted community rating as prescribed within the Affordable Care Act (ACA), premiums for small employers were often adjusted based on the size of the group. Under the ACA, group size rating is no longer permitted in the small group market. However, variation in ESI offerings by firm size is likely to continue as the application of employer shared responsibility penalties varies by employer size. Employers with under 50 Full Time Equivalent Employees (FTEs) will not be subject to employer shared responsibility penalties. Whether employers are subject to penalties can influence decisions related to offering healthcare coverage along with the affordability of required employee premium contributions.

Table 2 below contains estimated average ESI Employee Premium Contribution for Low Income Employees by Firm Size, based on 2013 Medical Expenditure Panel Survey (MEPS) data.

Table 2
State of Indiana, Family and Social Services Administration
Estimated Average ESI Premium For Low Income Employees

Firm Size	Total Annual Premium	Employee Premium Contribution
Less than 10	$ 7,374	Not Available
10 to 24	$ 5,440	Not Available
25 to 99	$ 7,092	$ 1,838
100 to 999	$ 6,544	$ 1,472
1,000 or More	$ 6,286	$ 1,491
Composite	**$ 6,446**	**$ 1,526**

As demonstrated in Table 2, larger firms often have lower total premium expenses relative to smaller firms. Larger firms are more likely to have self-funded health plans, which can reduce the amount of administrative expenses paid to insurers. Please note that total employee cost includes the sum of the employee premium contribution and employee cost sharing, and employee cost sharing is not addressed in Table 2.

ESI Premium by Industry

In the pre-ACA small group market, premiums often varied based on the Industry of an employer. Industry rating is no longer permitted in the small group market, and so such variations are likely to decrease over time. However, demographic and regional differences by Industry may still influence the average ESI Cost of these segments. Employer healthcare purchasing decisions are likely to continue to vary by Industry, as the income level of employees and the ability to attract and retain needed employees is often a major influence on these decisions.

Table 3 illustrates the estimated average ESI Cost for Low Income Employees by Industry, based on 2013 MEPS data.

[2] Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2013, Section 8.

Table 3 State of Indiana, Family and Social Services Administration Estimated Average ESI Premium For Low Income Employees		
Industry	**Total Annual Premium**	**Employee Premium Contribution**
Agriculture, Forestry, Construction	$ 6,433	Not Available
Mining, Manufacturing	$ 6,041	$ 1,025
Retail, Services	$ 6,167	$ 1,658
Professional Services	$ 7,749	$ 1,725
All Others	$ 5,816	$ 1,691
Composite	**$ 6,446**	**$ 1,526**

Total Annual Premium by Industry is strongly influenced by the average benefit design of the Industry. Professional Services employers are likely to offer more generous benefit designs, as a means of attracting and retaining needed employees. For employers of non-unionized lower income employees, ESI coverage may not be intended to serve the same purpose. Please note that total employee cost includes the sum of the employee premium contribution and employee cost sharing, and employee cost sharing is not addressed in Table 3.

POWER ACCOUNT SUFFICIENCY

Overview

POWER Account sufficiency measures the probability that funds deposited in a member's POWER account, after reduction for the member's ESI Employee Premium Contributions, will be sufficient to cover all member cost sharing.

The Total POWER Account Balance available for member cost sharing may be calculated as follows:

	State Contribution ($4,000 during the first year of the program)
Plus	Member POWER Account Contributions
Less	Member ESI Employee Premium Contributions
Equals	**Total POWER Account Balance Available for Member Cost Sharing**

Enrollees with smaller ESI Employee Premium Contributions will have higher starting POWER Account balances, making the fund more likely to be sufficient to fully fund employee cost sharing.

In addition to the POWER Account, the member may also have access to an employer HSA/HRA contribution. This does not directly affect the sufficiency of the POWER Account, but may provide the member with an additional source of cost sharing funding.

Several other employer plan design parameters impact the sufficiency of POWER Account funds made available to employees, including the following:

- Deductible
- Coinsurance and/or Copayments
- Out of Pocket (OOP) Maximum (no more than $6,600 for self-only non-grandfathered health plans in 2015)

Examples

In order to make factors that affect POWER account sufficiency more concrete, we have developed two examples based on health plans available to employees of the State of Indiana.

Example 1

For state employees, the plan with the lowest ESI Employee Premium Contribution is CDHP 1, a high deductible plan with the following characteristics:

- Bi-weekly 2014 ESI Employee contribution of $11.94, or $310 per year for non-smokers
- $2,500 deductible
- $4,000 Out of Pocket Limit
- 20% coinsurance for in-network (40% out of network) services
- Employer 2014 HSA contribution of $1,123

For a HIP Link member with a monthly contribution of $10, the initial POWER Account balance may be calculated as follows:

	$4,000	State Contribution
Plus	$120	Member POWER Account Contributions
Less	($310)	Member ESI Employee Premium Contributions
Equals	$3,810	Total POWER Account Balance Available for Member Cost Sharing

In this example, the POWER Account would be sufficient when employee cost sharing is lower than $3,810. This would require total claims (for non-preventive services) of greater than $9,050. Under CDHP 1, the first $2,500 would be paid by the POWER Account to cover the deductible, and after that, the POWER account would pay approximately 20% of the remaining claims ($6,550 = $9,050 - $2,500). Since 20% of $6,550 is $1,310, total cost sharing for an employee with total claims of $9,050 would be approximately $3,810 ($2,500 + $1,310). Based on the claims probability distribution in Appendix 1, annual claims are expected to be below $9,050 approximately 86% of the time. (Please note that the claims distribution in Appendix 1 was adjusted to exclude pregnant women and the medically frail).

Even though the POWER account has a 14% chance of not being sufficient, the employee's total exposure is limited by the $4,000 Out of Pocket limit. With $3,810 in POWER Account funding, this means the maximum additional amount that would need to be paid is $190, which is less than the additional funding of $1,123 available from the employer HSA contribution.

Example 2

On the other side of the spectrum, the state employee plan with the highest ESI Employee Premium Contribution is the Traditional PPO. For non-smokers, this plan has the following characteristics:

- Bi-weekly 2014 ESI Employee contribution of $178.74, or $4,647 per year for non-smokers
- $750 deductible
- $2,500 Out of Pocket Limit
- 30% coinsurance for in-network (50% out of network) services

For a HIP Link member with a monthly contribution of $10, the initial POWER Account balance may be calculated as follows:

•		$4,000	State Contribution
•	Plus	$120	Member POWER Account Contributions
•	Less	($4,647)	Member ESI Employee Premium Contributions
•	Equals	($527)	Total POWER Account Balance Available for Member Cost Sharing

The member would be counseled that the POWER account has a 0% chance of being sufficient to cover all cost sharing for this plan. The member would have to contribute $527 in additional funds just to cover the ESI Employee Premium. In addition, there may be additional cost sharing, up to the Out of Pocket limit of $2,500.

The State intends to provide counseling services to potential HIP Link members, to ensure they understand the cost and risk that may be associated with participation in this optional program. Counseling may help them choose the employer plan option that is the best available fit. It addition, it may help those without access to any favorable employer plan options to understand when it may make sense to enroll in the regular HIP program instead.

Estimated Sufficiency Probabilities

Although there are many factors that determine the probability that available POWER Account funding will be sufficient cover all member cost sharing, the two most important factors we have identified are:

- Available Cost Sharing Funding (developed above)
- Annual Deductible

Table 4 below contains POWER account sufficiency estimates stratified by these two critical factors. The POWER account sufficiency percentage is an estimate for the percentage of members projected to not incur any out of pocket expenses in the HIP Link program beyond their required POWER Account Contribution.

Probabilities were developed using a claims probability distribution appropriate for Indiana residents who are not pregnant or medically frail. This distribution is provided in Appendix 1. These values also assume a 20% coinsurance percentage and an out of pocket maximum above $5,000.

Table 4
State of Indiana, Family and Social Services Administration
Percentage Of HIP Link Members Who are not Expected to Incur Additional Cost Sharing

Available Cost Sharing Funding	Annual Deductible									
	$500	$1,000	$1,500	$2,000	$2,500	$3,000	$3,500	$4,000	$4,500	$5,000
$500	28%	28%	28%	28%	28%	28%	28%	28%	28%	28%
$1,000	65%	41%	41%	41%	41%	41%	41%	41%	41%	41%
$1,500	76%	67%	49%	49%	49%	49%	49%	49%	49%	49%
$2,000	82%	78%	69%	55%	55%	55%	55%	55%	55%	55%
$2,500	86%	83%	79%	73%	60%	60%	60%	60%	60%	60%
$3,000	89%	86%	84%	80%	74%	65%	65%	65%	65%	65%
$3,500	92%	89%	87%	84%	81%	76%	67%	67%	67%	67%
$4,000	93%	92%	89%	87%	85%	82%	78%	69%	69%	69%
$4,500	95%	93%	93%	92%	89%	86%	83%	79%	73%	73%
$5,000	95%	95%	93%	93%	92%	89%	86%	84%	80%	74%

Cells shaded grey in the table above represent employer plan characteristics for which over 20% of HIP Link enrollees would be estimated to incur out of pocket expenses exceeding available POWER Account funding. Individuals subject to higher employee contributions will likely have less funding available for cost sharing. Additionally, as demonstrated in this table enrollees with lower annual deductibles are more likely to have sufficient funding relative to individuals who enroll in leaner plan designs.

We recommend providing the information in Table 4 to counselors who will assist individual members in determining whether to enrollee in HIP Link or the standard HIP program. In addition, the State could provide counselors with a simple tool that would allow them to input key plan characteristics in order to develop a customized POWER Account sufficiency estimate. HIP Link enrollees should be advised on whether the majority of their healthcare costs are likely to be covered by the state POWER Account contribution. This information will assist potential HIP Link enrollees in making an educated enrollment decision.

DATA, ASSUMPTIONS, AND METHODOLOGY

This section provides additional detail on the data, assumptions, and methodology used to develop this analysis.

DATA

Indiana Employer Sponsored Insurance information was obtained through the use of 2012 Medical Expenditure Panel Survey data (MEPS). Additionally, we utilized Milliman Health Cost Guidelines® (HCG) data along with information provided within the Milliman Medical Underwriting Guidelines® (MUG).

ASSUMPTIONS AND METHODOLOGY

Data available in the 2012 MEPS was utilized in order to estimate the average total premium and employee contribution for low income employees in the state of Indiana. Standard error provided within the MEPS dataset was utilized in order to understand the volatility in these results. This information was utilized in order to estimate average employee cost sharing, along with the average annual claims cost associated with ESI. Additionally, MEPS data provided insight into variation in ESI costs by Firm Size and Industry. In developing these estimates, Milliman assumed the following:

- Average actuarial value of plan designs offered to low income employees: 70%
- Average annualized healthcare trend: 6%
- Average administrative expenses as a percentage of premium: 15%
- Average member coinsurance: 20%
- Annual Single Maximum Out-of-Pocket: $6,600

In order to understand the volatility in required enrollee cost sharing and estimate POWER Account sufficiency, Milliman claim probability distribution (CPD) tables were utilized. These claims probability distributions were adjusted in order to remove pregnant women and the medically frail, consistent with HIP Link eligibility requirements. For the purpose of this analysis, it was assumed that the medically frail represents 10% of the total population with the highest healthcare costs. The CPD table developed for the purpose of this analysis is included in the appendix of this report.

LIMITATIONS

The information contained in this report has been prepared for the State of Indiana, Family and Social Services Administration (FSSA) and the Office of Medicaid Policy and Planning (OMPP). The data and information presented may not be appropriate for any other purpose.

This report should not be distributed to any other party without the prior consent of Milliman. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for OMPP by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Milliman has relied upon certain data and information provided by the State of Indiana, Family and Social Services Administration and their vendors. The values presented in this letter are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented in our report will need to be reviewed for consistency and revised to meet any revised data.

The services provided for this project were performed under the signed Consulting Services Agreement between Milliman and OMPP approved May 14, 2010, and last amended December 30, 2013.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and I meet the qualification standards for performing the analyses in this report.

APPENDIX 1

Appendix 1 State of Indiana, Family and Social Services Administration Claims Probability Distribution Table Excludes Medically Frail and Pregnant Population		
Annual Claim	Annual Frequency Per 100,000	Prob. That Annual Claim < or = $X
$ -	8,666	8.7%
16.43	2,320	11.0%
51.53	1,658	12.6%
84.87	2,018	14.7%
118.71	1,925	16.6%
152.77	1,783	18.4%
186.71	1,639	20.0%
220.77	1,512	21.5%
254.79	1,419	22.9%
288.75	1,341	24.3%
322.74	1,279	25.6%
373.22	2,409	28.0%
441.18	2,226	30.2%
509.12	2,084	32.3%
577.12	1,955	34.2%
645.20	1,838	36.1%
712.99	1,737	37.8%
780.93	1,640	39.5%
848.94	1,552	41.0%
917.08	1,479	42.5%
984.86	1,401	43.9%
1,052.89	1,335	45.2%
1,120.75	1,256	46.5%
1,188.71	1,197	47.7%
1,256.62	1,141	48.8%
1,324.45	1,092	49.9%
1,442.41	2,527	52.4%
1,612.07	2,246	54.7%
1,782.11	2,029	56.7%
1,952.24	1,861	58.6%
2,121.81	1,711	60.3%
2,291.53	1,567	61.8%
2,461.75	1,449	63.3%
2,631.89	1,338	64.6%
2,801.89	1,244	65.9%
2,971.76	1,171	67.0%
3,141.36	1,086	68.1%
3,311.31	1,020	69.2%
3,563.62	1,874	71.0%
3,903.33	1,670	72.7%
4,243.25	1,505	74.2%
4,583.04	1,359	75.6%
4,922.98	1,236	76.8%
5,263.53	1,121	77.9%

Appendix 1 State of Indiana, Family and Social Services Administration Claims Probability Distribution Table Excludes Medically Frail and Pregnant Population		
Annual Claim	**Annual Frequency Per 100,000**	**Prob. That Annual Claim < or = $X**
5,602.54	1,020	78.9%
5,942.84	939	79.9%
6,282.06	861	80.7%
6,622.03	798	81.5%
7,125.52	1,422	83.0%
7,805.91	1,216	84.2%
8,484.39	1,068	85.2%
9,166.03	937	86.2%
9,843.03	837	87.0%
11,004.25	1,705	88.7%
12,706.18	1,349	90.1%
11,423.14	1,101	91.2%
12,768.34	901	92.1%
14,113.75	756	92.8%
15,463.24	642	93.5%
17,441.30	1,032	94.5%
19,116.13	790	95.3%
21,672.07	618	95.9%
24,241.11	486	96.4%
26,801.75	395	96.8%
29,359.81	331	97.1%
31,915.45	281	97.4%
34,482.39	238	97.6%
37,040.72	210	97.9%
39,593.87	183	98.0%
43,355.41	300	98.3%
48,470.81	234	98.6%
55,536.13	334	98.9%
65,269.54	226	99.1%
74,811.83	165	99.3%
84,158.13	122	99.4%
93,400.99	95	99.5%
102,455.39	73	99.6%
111,399.06	59	99.6%
123,165.41	78	99.7%
142,380.89	76	99.8%
165,097.06	49	99.8%
187,200.53	33	99.9%
209,137.71	24	99.9%
236,374.14	25	99.9%
276,109.35	23	100.0%
321,763.51	14	100.0%
368,162.14	10	100.0%
412,932.77	7	100.0%

Appendix 1 State of Indiana, Family and Social Services Administration Claims Probability Distribution Table Excludes Medically Frail and Pregnant Population		
Annual Claim	**Annual Frequency Per 100,000**	**Prob. That Annual Claim < or = $X**
494,840.69	10	100.0%
660,787.49	5	100.0%
895,917.00	2	100.0%
1,151,512.22	1	100.0%
1,399,506.72	0	100.0%
1,665,017.45	0	100.0%
1,738,140.87	0	100.0%
2,539,614.76	0	100.0%