MHCC | MARYLAND HEALTH CARE COMMISSION

Report on the Limited Health Benefit Plan Required Under Chapter 287 of the Acts of 2004

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Introduction

Chapter 287 of the Acts of 2004 requires that the Maryland Health Care Commission (MHCC or "Commission") submit a report to the Maryland General Assembly by January 1, 2008 on participation in the Limited Health Benefit Plan (LHBP) and its impact on the small group health insurance market and the population of uninsured individuals in Maryland. Additionally, the report is to include recommendations on continuing or expanding the availability of the LHBP in the small group market. Further, with the enactment of HB 800 during the 2007 legislative session, the Commission is required to develop alternative insurance options for individuals enrolled in the LHBP.

The report is to include the following enrollment data for the periods July 1, 2005 through June 30, 2007:

- the number of carriers offering the Limited Health Benefit Plan;
- the number of policies sold;
- the number of eligible employees covered under LHBP policies; and
- the average age, geographic area, and average wage of each employer group covered under the LHBP policies.

In addition, the report must include:

- the impact of the LHBP on the small group health insurance market and the population of uninsured individuals in Maryland;
- recommendations on continuing or expanding the availability of the LHBP in the small group market; and
- alternative insurance options for individuals enrolled in the LHBP.

Background

In 2004, the Maryland General Assembly enacted SB 570, *"Health Insurance – Small Group Market – Limited Health Benefit Plan."* This Act required the Commission to adopt regulations specifying the Limited Health Benefit Plan. In specifying the LBP regulations, the Commission was required to:

- ensure that the actuarial value of the LBP did not exceed 70% of the actuarial value of the CSHBP as of January 1, 2004; and
- consider including in the LBP the benefits required to be included in a limited benefit plan authorized by Chapter 434 of the Acts of 1991.[1]

The Act also required prominent carriers participating in Maryland's small group market to offer the Limited Benefit Plan. A prominent carrier is defined in statute as a carrier that insures at

[1] A table of the benefits required to be included in a limited benefit plan of the early 1990s is included in Appendix A.

least 10% of the total lives insured in the small group market. Other small group carriers could offer the LBP voluntarily, but were not obligated to offer it. Carriers could offer the LBP only to small employers that met the following two qualifications:

- The small employer did not provide the Comprehensive Standard Health Benefit Plan (CSHBP) during the preceding 12 months; or, if the small employer existed for less than 12 months, had not provided insurance coverage from the date the business commenced; and
- The average annual wage of the employees of the small employer did not exceed 75% of the average annual wage in Maryland.[2, 3]

Once the small employer qualified for and chose to purchase the LBP, the carrier was then obligated to offer coverage to all eligible employees and their dependents under the LBP and could not offer the CSHBP to any employees of that small employer. Moreover, a carrier could not offer a benefit in addition to the LBP, except for a rider to lower the cost-sharing arrangements. These riders were subject to all the provisions of the small group market including guaranteed issuance, guaranteed renewal, adjusted community rating, and the prohibition on pre-existing condition limitations. Finally, carriers also were prohibited from offering riders deemed by the Insurance Commissioner to promote risk selection.

Like the CSHBP, the LBP had to contain a uniform set of benefits. Once chosen, small employers were required to offer it to all eligible employees and their dependents but were not required to contribute toward premiums.

Development of the Limited Health Benefit Plan

Throughout the Summer and Fall of 2004, the Commission engaged the relevant stakeholders in a series of meetings and public hearings to help develop the LBP. These stakeholders included small business owners, carriers, brokers, agents, advocates, representatives of various interest groups such as the Maryland Retailers Association, etc. The group considered limited benefit plans available in other states. After three meetings and one public hearing, where numerous options were considered, the LBP was developed to include the same breadth of benefits included in the CSHBP. However, coverage for each service was limited or capped annually, at either a specified dollar amount per covered person or up to a certain credit fund limit.[4] The LHBP regulations (COMAR 31.11.12) were implemented effective April 2005 so that plans could begin offering it by July 1, 2005.

[2] At the time of renewal, if the average wage of the employees exceeded 75% of the State's average annual wage, the employer was allowed to renew the policy.
[3] In a letter dated April 20, 2007 to Commission staff, the Department of Labor, Licensing and Regulation (DLLR) indicated that the estimated annual average wage in Maryland for 2006 was $46,165.
[4] Tables illustrating the Capped Benefit Plan and the Credit Fund Plan are included in Appendix B.

Enrollment in the Limited Health Benefit Plan

As required in statute, the Commission contacted participating carriers in Maryland's small group market requesting their enrollment data in the LHBP for the periods:

- July 1, 2005 through December 31, 2005
- January 1, 2006 through December 31, 2006
- January 1, 2007 through June 30, 2007.

The only carriers to offer the LHBP throughout the existence of the program were CareFirst and MAMSI Life and Health Insurance Company (a subsidiary of United HealthCare). CareFirst and United are the two prominent carriers in the small group market that were required to participate in the program.

One prominent carrier reported to have sold one (1) policy, with enrollment from November 2005 through March 2006. For that five-month enrollment period, the number of eligible employees who were covered averaged 10.4 employees. The average age of this group, located in the Baltimore metropolitan area, was 35 years. This carrier claimed that they did not have average wage data for the group.

The other prominent carrier reported that they sold one (1) LHBP policy in 2005 and that group, located in Anne Arundel County, remained continuously enrolled through June 30, 2007. The policy covers two (2) eligible employees, with an average age between 30 and 34 years. This carrier also claimed that they did not have average wage data for the group.

Impact of the Limited Health Benefit Plan on the Small Group Market and Uninsured Individuals in Maryland

Based on these reported data, it is evident that the LBP has had a minimalist impact on both the small group market and the uninsured population in the State. Moreover, in a letter to Chairman Hammen dated March 10, 2006, the Office of the Attorney General indicated that the current LHBP is in violation of federal law because HIPAA requires that any benefit plan offered in any part of the small group market must be offered to all groups within that market.

In bill hearings on various small group reform legislation in 2007, the prominent carriers testified that, since they were required to include the same covered services under the LHBP as the CSHBP, there was not a significant difference in premium (about $25) between the two products. They indicated that for the LBP to be attractive to low wage workers, which was the intent of the legislation, monthly premiums for the LBP would have to be about $100 or less. With the rich benefit structure of the LBP, this was not feasible. In addition, the prominent carriers indicated that the requirement that the value of the LBP could not exceed 70% of the value of the CSHBP hindered them from offering an attractive, yet affordable product. Therefore, it would not be prudent or effective to continue offering the LBP without making changes to the eligibility

criteria and, more importantly, creating a benefit design that would significantly reduce the premium. Absent the ability to generate a desirable benefit package at a market responsive premium, the LBP should be discontinued.

Alternative Insurance Options for Individuals Enrolled in the Limited Health Benefit Plan

Appendix B shows the required benefits for LBPs offered in Maryland. As noted earlier in the report, carriers could offer two plan options: a Credit Fund Plan and a Capped Benefit Plan. Both options provided very rich benefits, by LBP standards. The annual maximum for the Credit Fund was $10,000 for all services (except for prescription drugs) and provided first dollar coverage up to $250 per individual and $500 per family for preventive care and outpatient services. Inpatient and outpatient services were covered as well, but subject to a deductible. The prescription drug benefit was a $500 annual maximum benefit, with a $15 copay for generic drugs and a discount for brand name drugs. The Capped Benefit Plan had separate limits for different types of services. For example, facility charges for an inpatient hospital stay were covered in-network at $1,000 per day up to 30 days per covered person per year - which implies a $30,000 annual maximum just for inpatient facility charges. (See Appendix B for more detail on these options).

Mercer, the Commission's consulting actuary, conducted the following analysis on alternative options for the Limited Benefit Plan:

As of March 2007, there were approximately 162 million individuals with employer sponsored insurance.[5] Of that insured population, approximately one million were enrolled in LBPs, which represents less than one percent (0.6%) of all insureds with employer-sponsored coverage. In 2006, approximately 430,000 lives were insured in Maryland's small group market.[6] If Maryland were reflective of national statistics, Mercer would expect about 2, 600 lives to be enrolled in LBPs (430,000 x .006 = 2,580). There is almost no enrollment in these plans in Maryland, which indicates that: (a) these plans are not desirable in the Maryland market from an employer's perspective; (b) the current restrictions create too many barriers for employers to purchase and/or carriers to market; or (c) the comprehensive design requires a premium that is too high to be an attractive and affordable alternative.

Employer Perspective

There are two major markets for LBPs:

- Part-time, seasonal or employees who have not yet finished their probationary period and are not yet eligible to participate in their employer's comprehensive health insurance program but are eligible for the LBP; or

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[5] Employee Benefit Research Institute (EBRI), "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2007 Current Population Survey", Issue Brief No. 310, October 2007. http://www.ebri.org/pdf/briefspdf/EBRI_IB_10a-20071.pdf, Accessed December 3, 2007.

[6] Statistics provided by the Maryland Health Care Commission.

- Small employers seeking a low cost alternative to comprehensive coverage that is deemed unaffordable.

For some large employers, LBPs can be a powerful recruitment and retention tool when hiring part-time/hourly employees who typically may not have access to benefits. The presence of LBPs has steadily increased in the market as employers continue to offer more flexible work arrangements (part-time, seasonal, temporary, etc.). Most are 100% voluntary (no employer contribution). Some of these same attributes apply to small employers; i.e., the ability of the employer to offer access to some type of health insurance to their employees enhances an employer's ability to attract workers and compete with the benefits being offered by the "big players" for part-time workers. If the small employer elects to provide some contribution to the cost, then his competitiveness with large employers is enhanced.

The most critical component to the success of any LBP is to retain the "affordability" of the policy.[7] This is achieved by either: starting with a major medical type policy and incorporating low annual maximums and service specific limits; or starting with specific types of benefits and incorporating limits in both dollars and numbers, sometimes referred to as a "fixed dollar indemnity" approach. The key is to generate a premium that is perceived as affordable to both the employer and the employees.

LBPs available in the market today typically include coverage for the most utilized basic medical services, including:

- physician office visits, including preventive care;
- emergency room and urgent care;
- Inpatient and Outpatient care; and
- prescription drugs (may be optional or a discount program)

The benefits for the fixed dollar indemnity approach are not directly correlated to the provider's charge or the individuals need for service.

The following charts show LBPs currently being marketed in other states.

Transamerica is an example of a **fixed indemnity approach**.

Transamerica

TRANSAMERICA	STANDARD	PREFERRED	ELITE
Doctor's Office Visits • Calendar Year Maximum	Pays $50 per Visit, Maximum 5 Visits	Pays $75 per Visit, Maximum 5 Visits	Pays $75 per Visit, Maximum 5 Visits
Preventive Care • Calendar Year Maximum	Pays $50, 6 Month Wait, 1 Visit Per Year	Pays $75, 6 Month Wait, 1 Visit Per Year	Pays $100, 6 Month Wait, 1 Visit Per Year
Accident Benefit • Calendar Year Maximum	Not Available	Up to $300 per Occurrence, Maximum 5 Accidents	Up to $1,000 per Occurrence, Maximum 5 Accidents
Diagnostic, X-Ray, and Lab • Calendar Year Maximum	Pays $50 per Visit, Maximum 3 Testing Days	Pays $75 per Visit, Maximum 3 Testing Days	Pays $75 per Visit, Maximum 3 Testing Days
Surgical Benefit	Pays $1,000 per Year (According to a Schedule)	Pays $1,000 per Year (According to a Schedule)	Pays $1,500 per Year (According to a Schedule)
Anesthesia Benefit	20% of Surgical Benefit	20% of Surgical Benefit	20% of Surgical Benefit
Daily In-Hospital • Calendar Year Maximum	Pays $100 per Day, 30 Days per Confinement	Pays $200 per Day, 30 Days per Confinement	Pays $400 per Day, 30 Days per Confinement
Critical and Subsequent Critical Illness	Not Available	Pays $2,500	Pays $5,000
Life and AD&D Insurance • Employee • Spouse	Not Available	$5,000 $2,500	$10,000 $5,000

Aetna is an example of a **comprehensive major medical approach**.

Aetna/Strategic Resources Company (SRC)

Benefits	Basic - $10,000	Net Premier - $10,000	Net Premier - $15,000
Annual Maximum per coverage year	$10,000	$10,000	$15,000
In Network Coinsurance	80% UCR	80%	80%
Out of Network Coinsurance	60% UCR	60%	60%
Annual Deductible	$250	$100 in network/$200 out of network	$100 in network/$200 out of network
Hospital Services Limit	$1,000	$1,000 inpatient/$1,000 outpatient	$1,500 inpatient/$1,500 outpatient
Doctor's office visit	Limit of 5 visits per year	$1,000 outpatient maximum per year	$1,500 outpatient maximum per year
In Network	$10 copay, 100%	$15 copay, 100%	$15 copay, 100%
Out of Network	$10 copay, 80%	Deductible, the 50%	Deductible, the 50%
Wellness		$15 copay, $100 maximum per year	$15 copay, $100 maximum per year
Diagnostic/Surgical	Limit of 5 services and $400 per year	$1,000 outpatient maximum per year	$1,500 outpatient maximum per year
In Network	$15 copay, 100%		
Out of Network	$10 copay, 80%		
Emergency Room	$100 deductible, Maximum of $1,000 per year	Coverage not specified	Coverage not specified
Prescription Drug Coverage	$10 deductible per prescription, Maximum of $500 per year	$10 generic/$20 brands, 50% out of network, Maximum $35 per month	$10 generic/$20 brands, 50% out of network, Maximum $35 per month

CIGNA's plans are a **blend of the comprehensive major medical approach and the fixed indemnity approach.**

CIGNA

Benefit	Level 1	Level 2	Level 3 (optional)
Physician Office Visit*	$15 Co-pay – 100%	$10 Co-pay -100%	$10 Co-pay -100%
Outpatient Basic Medical Expense Benefit	$1,000 /Year Benefit Pays 80% after $50 annual deductible	$1,500/Year Benefit Pays 80% after $100 annual deductible	$2,000/Year Benefit Pays 80% after $150 annual deductible
Non-Emergency Care In Emergency Room*	$500 /Year Benefit Pays 50% after $100 per occurrence deductible	$500 /Year Benefit Pays 50% after $100 per occurrence deductible	$500 /Year Benefit Pays 50% after $100 per occurrence deductible
In-Hospital Medical Expense Benefit	$10,000 /Year Benefit	$25,000 /Year Benefit	$50,000 /Year Benefit
Daily In-Hospital Benefit	Pays 100%, Max. $100 per day for 100 days	Pays 100%, Max. $250 per day for 100 days	Pays 100%, Max. $500 per day for 100 days
Supplemental In-Hospital Surgery	Not Included	$1,500 per occurrence max.	$2,500 per occurrence max.
Supplemental Maternity Benefit	Not Included	$1,500 per occurrence max.	$2,500 per occurrence max.
Accident Medical Benefit	$5,000 /Year Benefit Pays 80%, Max. $2,500 per occurrence (max 2) after $50 per occurrence deductible	$10,000 /Year Benefit Pays 80%, Max. $5,000 per occurrence (max 2) after $100 per occurrence deductible	$15,000 /Year Benefit Pays 80%, Max. $5,000 per occurrence (max 3) after $150 per occurrence deductible
Accidental Death Benefit	$10,000	$15,000	$25,000
Prescription Discount	Brand Name or Generic Discount Included	Brand Name or Generic Discount Included	Brand Name or Generic Discount Included
Prescription Benefit*	Not Included	Per Prescription: Generic - $15 deductible Brand - $25 deductible $300 / Year Benefit	Per Prescription: Generic - $15 deductible Brand - $25 deductible $600 / Year Benefit

*The paid benefit will count toward the outpatient basic medical expense coverage year maximum

Unlike Maryland's Credit Fund Plan, none of these plans provide for any coverage at 100%, including preventive care. All of these plans have inside limits (meaning that they only pay up to a fixed dollar amount per day) for inpatient stays. All of these feature lower premiums.

Although Maryland's Capped Benefit Plan does incorporate inside limits, its benefits are rich, by LBP standards. For instance, the Capped Benefit Plan provides up to $1,000 per day for inpatient hospital facility benefits, with a maximum of 30 days per year. This equates to $30,000 of inpatient hospital benefits per year, which is an extremely rich benefit.

Note: Many states that have enacted LBP laws waive mandated benefits for these plans as a means of further reducing the premiums.

Eligibility requirements may be perceived as another barrier preventing employers from purchasing these plans. To qualify, the employer group must have an average wage that does not excced 75% of Maryland's average annual wage (approximately $34,000) and could not have provided insurance in the prior twelve months. Requiring that employers who purchase the Maryland LBP plan be uninsured for 12 months and have low income workers appears to be unnecessary barriers.

Mercer believes that if Maryland wants to retain its small group LBP, the benefits need to be redesigned to make it more representative of LBPs currently available in the marketplace. This should result in a reduction in premium and an uptake primarily from low wage employers. Mercer does not believe that a redesigned (i.e., more robust) LBP would result in small employers currently enrolled in the CSHBP to migrate to the LBP.

Carrier Perspective

In order to have a successful LBP in Maryland, carriers must "buy into" the concept as well. The lack of catastrophic coverage in LBPs, and the adverse publicity accompanying a catastrophic claim that is not paid because of the policy limits concerns many carriers. This is a very real concern since numerous articles have been published recently that cite insureds' "misunderstanding" of their benefits when presented with a large claim. A recent article in USA Today cited the following actions by state regulators pertaining to these types of plans:

- Connecticut Attorney General Richard Blumenthal testified before his State's Insurance and Real Estate Committee in February that such plans generally should be prohibited. Most states, including Connecticut, allow them. "Their benefits are illusory, offering consumers insurance that fails to cover most hospital visits or even basic health care services," Blumenthal testified.

- Massachusetts Attorney General filed suit last year against HealthMarkets, saying its policies failed to cover services required by the State, including contraceptives.
- Washington State temporarily barred limited medical plans last year, but lawmakers approved legislation in April to allow them, even though they do not include state-required mandates, such as coverage of drug-dependency treatment.

- Citizens for Economic Opportunity (CEO), a Connecticut coalition of labor unions and activists groups, filed suit against Aetna and Strategic Resources Company (SRC), a company purchased by Aetna in 2005, to stop selling these policies.

It appears that at a minimum, rigidly defined communication of the benefit limitations to brokers, employers and insureds is critical and probably requires additional resources compared to more traditional products.

Administrative expenses expressed as a percentage of premiums are higher for these types of policies, since the premiums are lower; however, such functions as billing and claims adjudication will remain fairly comparable to richer plans. This becomes extremely problematic if LBPs are subject to the same minimum loss ratio as the CSHBP (75%).

In order to be profitable, the LBP design must be one that a carrier can easily administer. This may be more challenging for carriers that have traditionally focused on comprehensive benefits and may not be in sync with their corporate vision.

Agents are hesitant to market these products since they require more time and resources, first to determine if the employer is eligible for this product, and then educating the employer as to the benefit limitations. However, the premiums are generally significantly lower. Since most agents' commissions are a function of premiums, this equates to lower earnings for the agents.

Mercer tried to access information regarding LBPs on the websites of the two dominant carriers in Maryland's small group market but were unable to locate any information regarding these plans. This indicates to us that these companies are not actively promoting these plans. It is not surprising that LBPs have not gained acceptance in Maryland. In fairness, it is important to note that of the thirteen states that have enacted legislation allowing LBPs, eleven allow LBPs in the small group market.[8] However, enrollment in these plans has been very minimal.[9]

Basic and Standard Plans

In the early 1990s, before HIPAA, many states were implementing reforms in the small group market. Few states required guaranteed issue of all policies. However, many required guaranteed issue of what were designated as "basic" and "standard" plans. Generally, the "basic" plan provided significantly lower benefits, in an effort to reduce premiums. The benefits for the "standard" plans were intended to reflect the average benefits sold in the marketplace. Acceptance of these plans was extremely low.

[8] State Coverage Initiatives, "State Coverage Matrix;" http://www.statecoverage.net/matrix/index.html; Accessed December 3, 2007. The 13 states are: AR, CO, FL, GA, KY, MD MN, MT, NJ, ND, TX, UT and WA. The two states that allow LBPs in the individual market are MT and NJ.
[9] Academy Health, "State of the States: Building Hope, Raising Expectations," January 2007.

Texas was one state that offered these basic and standard plans. According to a report presented to the 77th Texas Legislature in February 2001, of the more than 86,000 small employers that had purchased health insurance in Texas in 1998, only 25 had purchased either the basic or the standard plan.[10]

In December 2006, Arkansas introduced subsidized health coverage to low-income workers of small businesses. As of June 2007, fewer than 700 people were enrolled. The premiums are $15 per month. Only individuals with an annual income of less than 200% FPL are eligible to participate. The program has a $100 annual deductible and provides 85% coverage, with an out-of-pocket maximum of $1,000. Benefits are further limited to six physician office visits, seven days of inpatient hospital care and two outpatient hospital procedures or emergency visits per year. Prescription drug coverage is limited to two prescriptions per month.

Conclusions

The desirability of LBP policies is hotly debated. Some opponents assert that these policies are really "smoke and mirrors" because they do not provide comprehensive coverage and they leave policyholders vulnerable to catastrophic claims.[11] Advocates of LBPs subscribe to the school of thought that insurance really provides "access" - some coverage is preferable to no coverage.

LBPs are difficult to label as either good or bad. It is easy to disparage LBPs as not providing full, comprehensive coverage in the event of a catastrophic illness or injury. If a purchaser is interested in buying insurance coverage for the classic definition of insurance; i.e., covering catastrophic risk, then clearly these plans are not going to meet that need.

However, Mercer also has seen LBPs play an important role in helping lower income or low risk groups purchase health insurance coverage, especially in providing coverage for basic health care and preventive measures. However, if LBPs are considered, it is critically important to ensure that adequate communication about the coverage limitations of these types of plans is very clear to the insured.

These policies may be an avenue for employers that cannot or will not purchase comprehensive coverage to offer some type of benefit plan to their employees. However, based on historical experience, enrollment in these plans will be marginal.

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[10] Albritton, Bonnie, FSA, MAAA, "Financial Decision-Making Theory and the Small Employer Health Insurance Market in Texas", October 2006. http://www.soa.org/library/journals/actuarial-practice-forum/2006/october/APF0610_3.pdf

[11] "MCOs Launch 'LBPs' Plans, but Face Design, Communication and Liability Issues", Managed Care Week, February 5, 2007.

Appendix A

Limited Benefit Plan - Similar to Plan in Law in the Early 1990's

	Floor (Statutory requirements): Sunset 6/94
In-patient Hospitalization (either mental or physical)	10 days/year
Office Visits for diagnosis and treatment of any illness or injury, including reasonable coverage of medically necessary laboratory and diagnostic procedures and outpatient surgery	10 days/year (includes coverage for diagnosis and treatment of acute mental health conditions on an outpatient basis)
Prenatal Care	First trimester: 1 office visit per month; Second trimester: 1 office visit per month; 7th & 8th month: 2 office visits per month; 9th month: 1 office visit per week
Obstetrical Care	Coverage of services by a licensed health care provider, delivery room, post-partum care, and other medically necessary Hospital care. Would include federal 48-hour requirement.
Coverage for Newly Born Children	Coverage of injury or sickness including the necessary care and Treatment of medically diagnosed congenital defects and birth Abnormalities (§15-401)
Preventative Services	Covered, including well-child visits and immunization benefits
Cost-Sharing	Same as current CSHBP (pre-Oct 30th meeting)
Delivery Systems	HMO and PPO only

Appendix B

Credit Fund Limited Benefit Plan

Calendar Year Deductible		$1,000 individual with aggregate $2,000 family maximum. Applies to category one after credit is used and category two from the beginning of services use	
Contract Year Out-of-Pocket Max		None	
Annual Benefit Maximum		Category One and Two: $10,000 combined Category Three: $500	
Exclusions		In addition to the CSHBP exclusions, this plan excludes any infertility services including testing	
Category One	Preventive Care - Routine physician exams/well-baby care/immunizations - And other services recommend by the US Preventive Services Task Force Outpatient Professional & Diagnostic - Office visits including nutritional services, family planning/pregnancy & maternity/diabetes treatment - Diagnostic and laboratory services - Screenings - PT/OT/ST/Chiropractic ($1,000 max benefit) - DME/Medical Foods/Hearing Aids for Children/Blood ($1,000 max benefit)	First Dollar Services coverage (this is a credit – only for Category One services): $250 Individual $500 Family -------------- Then: Subject to Deductible, and - 70/30 coinsurance in-network - 50/50 coinsurance out-of-network	Member must use First Dollar Services Coverage Credit before Deductible or Coinsurance applies.
Category Two	Except services listed in Category One, Outpatient & Inpatient Services (professional and facility costs) - Hospital Services - Mental Health/Substance Abuse/Detox - Skilled Nursing Facility - Home Health Care & Hospice - Emergency room visits: $100 copay then coinsurance - Ambulance - Transplants - Other: Habilitative Services/Controlled Clinic Trials/Breast Reconstructive Surgery/ Charges related to Dental Care	Coinsurance Services Coverage: Subject to Deductible, and - 70/30 coinsurance in-network - 50/50 coinsurance out-of-network	Deductible and Coinsurance applies
Category Three	Prescription Drugs - Generic Only - Brand Name Drugs-Discount Card Only (100% coinsurance by enrollee after discount)	$15 copay on Generic Discount on Brand Name	No Generic Drug Deductible

Appendix B

Capped Benefit Limited Benefit Plan

	In-Network Coinsurance Paid by Carrier	Of-of-Network Coinsurance Paid by Carrier	Benefit Maximum per contract years
Physician and other provider office visits (Non-preventive). Includes PT/OT/ST/chiropractic services	100%	50%	$200 per covered person
Physician and other provide office visits (Preventive). Includes routine physical exams, well-baby care, Immunizations, and other services recommended by US Preventive Services Task Force	100%	50%	$150 per covered person
Outpatient diagnostic and laboratory services	100%	100%	$150 per covered person
Equipment and Supplies, including durable medical equipment, hearing aids for children, medical foods, and blood products	100%	50%	$250 per covered person
Emergency services, including ambulance services (Facility and Professional Services)	100%	100%	$200 per covered person
Hospital Inpatient Services (Facility Charges) includes: skilled nursing, home health and hospice	Up to $1,000 per day	Up to $700 per day	30 day annual maximum per covered benefit
Inpatient physician and other provider services includes: skilled nursing, home health and hospice	100%	50%	$700 per covered person
Outpatient surgical services (Facility Charges)	70%	50%	$10,000 per covered person
Outpatient non-surgical services (Facilities Charges)	0% (covered person pays 100% of discounted rate)	0%	NA
Outpatient physician and other provide services	100%	50%	$500 per covered person
Prescription drugs	Covered person pays $10 copay for generic; $30 copay for preferred brand name; and $50 for non-preferred brand name		$250 maximum for an individual; $750 maximum for a family
Note: No annual deductible or maximum out-of pocket limit Assumes no infertility services as well as all other exclusions in the Comprehensive Standard Health Benefit Plan.			

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