



Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L-

OMB Expiration date: 10/31/2014

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package

ABP3

Select one of the following:

- The state/territory is amending one existing benefit package for the population defined in Section 1.
- The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package:

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- Benchmark Benefit Package.
- Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- Secretary-Approved Coverage.
 - The state/territory offers benefits based on the approved state plan.
 - The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.

Please briefly identify the benefits, the source of benefits and any limitations:

The HIP Link benefits are benchmarked to any one of the commercial options that can be chosen as the Indiana Essential Health Benefits Benchmark. Through 2017, these options are the Anthem Small Group Blue Access PPO plan, the Anthem Lumenos PPO plan (benefits are equal to the Blue Access Plan), the United POS plan, and the Advantage Commercial HMO plan. HIP Link coverage will be offered through employer sponsored health plans. To be eligible for HIP Link, employer sponsored health plans will be reviewed by the state to confirm that (1) the Indiana Department of Insurance has already certified the plan as meeting the Indiana Essential Health Benefit requirements or (2) that the Indiana Family and Social Services HIP Link Employer Counseling Team has reviewed the benefits offered in the plan and indicated that the plan meets the HIP Link minimum value requirements and essential health benefit requirements present in one of the benchmark options that are the floor of coverage as detailed in the ABP 5 submissions. Variation in benefits from the essential benefits offered in one of the Indiana's Essential Health benefits benchmark options is permitted when the benefit is substantially equivalent in the applicable EHB category or the plan meets the benchmark-equivalence actuarial value on an aggregate basis as described in 42 CFR 441.335. Visit limits not aligned with the applicable EHB benchmark option will not prevent a plan from being HIP Link eligible provided that all other benefits meet one of the base benchmark's requirements or can be found to be substantially equivalent as noted above. HIP Link members are assured coverage to the applicable EHB base benchmark visit limits through their POWER account and HIP Link



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card. Processes for individuals that have depleted their POWER account are detailed in the HIP 2.0 1115 Demonstration and associated HIP Link protocol. EPSDT services for 19 and 20 year olds are assured separately without limitations and are covered through the HIP Link member eligibility card and POWER account. All other benefits and limitations are detailed in ABP 5 submissions, the HIP 2.0 1115 demonstration, and the associated HIP Link protocol.

Selection of Base Benchmark Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option. No

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- Any of the largest three state employee health benefit plans by enrollment.
- Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- Largest insured commercial non-Medicaid HMO.

Plan name:

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

The state assures that all services in the base benchmarks have been accounted for throughout the benefit chart found in the ABP5 submissions.

The state assures the accuracy of all information in the ABP5 submissions depicting amount, duration and scope parameters of services authorized in the base benchmark.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Benefits Description

ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Advantage HMO
Advantage Health Solutions

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved



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1. Essential Health Benefit: Ambulatory patient services

Collapse All

Benefit Provided:

Primary Care Physician (PCP) Services Office Visit

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Office visit services include supplies for treatment of the illness or injury, medical consultations, procedures performed in the physician's office, second opinion consultations and specialist treatment services provided by a PCP.

For second opinion consultations, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Specialty Physician Visits

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Referral Physician Office Visit included.

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Home Health Services

Source:

Base Benchmark Commercial HMO



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Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Remove

Amount Limit:

100 visits per year.

Duration Limit:

None

Scope Limit:

Services covered only if not considered custodial care and are prescribed in writing by a participating physician as medically necessary, in place of inpatient hospital care or convalescent nursing home and services provided under physician's care.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services include skilled medical services; nursing care given or supervised by RN; nutritional counseling furnished or supervised by RD; home hospice services; home health aides; medical supplies, laboratory services, drugs, and medicines prescribed by a physician in connection with home health care; medical social services and training of family members or significant other to provide services that can performed by layperson. Home hospice services are considered a separate service.
For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Outpatient Surgery

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Outpatient medical and surgical hospital services are covered when medically necessary. Includes diagnostic invasive procedures that may or may not require anesthesia.
For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Allergy Testing

Source:

Base Benchmark Commercial HMO

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan



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Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	<input type="button" value="Remove"/>
Scope Limit: <input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text" value="Includes allergy procedures-administration of serum."/>		
Benefit Provided: <input type="text" value="Chemotherapy-Outpatient"/>	Source: <input type="text" value="Base Benchmark Commercial HMO"/>	<input type="button" value="Remove"/>
Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="State Plan & Public Employee/Commercial Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text" value="Includes outpatient therapeutic injections which are medically necessary and may not be self-administered. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment."/>		
Benefit Provided: <input type="text" value="IV Infusion Services"/>	Source: <input type="text" value="Base Benchmark Commercial HMO"/>	
Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="State Plan & Public Employee/Commercial Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text" value="Includes coverage for outpatient infusion therapy. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to"/>		



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the number of services provided and duration of treatment.		Remove
Benefit Provided: Radiation Therapy- Outpatient	Source: Base Benchmark Commercial HMO	Remove
Authorization: Other	Provider Qualifications: State Plan & Public Employee/Commercial Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Includes coverage for outpatient services. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.		
Benefit Provided: Dialysis	Source: Base Benchmark Commercial HMO	Remove
Authorization: Other	Provider Qualifications: State Plan & Public Employee/Commercial Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Coverage provided for outpatient (including home) dialysis services provided by a participating provider. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.		
Benefit Provided: Outpatient Services	Source: Base Benchmark Commercial HMO	
Authorization: Other	Provider Qualifications: State Plan & Public Employee/Commercial Plan	



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Amount Limit:

None

Duration Limit:

None

Remove

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefits provided are PCP, specialty and referral for all physician services in an outpatient facility. Covered services include pacemaker and colonoscopy. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Clinical Trials for Cancer Treatment

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Items and services that are not routine care costs or unrelated to the care method will not be covered.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The clinical trial must be approved or funded by one of the following: National Institute of Health; cooperative group of research facilities that have an established peer review program that is approved by a National Institute of Health or center; FDA; United States Department of Veterans Affairs; United States Department of Defense; institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institute of Health Office for Protection from Research Risks; and research entity that meets eligibility criteria for a support grant from a National Institutes of Health center.

Coverage provided for routine care costs that are incurred in the course of a clinical trial. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Dental- Limited Covered Services- Accident/Injury

Source:

Base Benchmark Commercial HMO

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan



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Amount Limit:

Treatment complete within 1 year from initiation.

Duration Limit:

None

Remove

Scope Limit:

Coverage not provided for orthodontia, dental procedures, repair of injury caused by an intrinsic force, such as the force of the upper and lower jaw in chewing, repair of artificial teeth, dentures or bridges and other dental services.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Injury to sound and natural teeth including teeth that have been filled, capped or crowned. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Urgent Care- Walk-ins

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage includes after hours care and physician home visits.

Benefit Provided:

Routine Foot Care

Source:

Base Benchmark Commercial HMO

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Coverage not provided for supportive devices of the feet, including but not limited to foot orthotics, corrective shoes, arch supports for the treatment of plantar fasciitis, flat feet, fallen arches, weak feet, chronic foot strain, corns, bunions

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Scope limit continued- and calluses.



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Covered when medically necessary for the treatment of diabetes and lower extremity circulatory diseases. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided:

Infertility Diagnoses

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Coverage is for infertility diagnostic testing up to diagnosis of infertility only and infertility counseling.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit includes for medically necessary treatment to diagnose infertility, test for physical abnormalities of the reproductive system that might cause infertility and correct existing pathologies for the reproductive system.

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Non-Surgical Treatment Option Morbid Obesity

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

6 visits per calendar year.

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

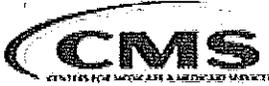
Benefit covered as an alternative to surgical treatment for morbid obesity. Coverage includes enrollment in an in-network physician-supervised weight loss treatment program when referred by your physician. The benefit is also covered under the EHB category for preventive and wellness services.

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.



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Add



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2. Essential Health Benefit: Emergency services

Collapse All

Benefit Provided:

Emergency Department Services

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Medical care provided outside of the U.S. is not covered. This services is not permissible under federal Medicaid rules.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Emergency room included.

Benefit Provided:

Emergency Transportation: Ambulance/Air Ambulance

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Other medically necessary ambulance transport (ambulance, medi-van or similar medical ground, air or water transport to or from the hospital or both ways and transfer from a hospital to a lower level of care) is covered.

For other medically necessary transportation, authorization may be required in which the member's primary coverage provided through the employer-sponsored insurance may require other details, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add



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3. Essential Health Benefit: Hospitalization

Collapse All

Benefit Provided:

General Inpatient Hospital Care

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products, and room and board when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services include semi-private room and board (private room provided when medically necessary); intensive care unit/coronary care unit; inpatient cardiac rehabilitation and rehabilitation therapy; general nursing care; use of operating room or delivery suite; surgical and anesthesia services and supplies; ordinary casts; splints and dressings; drugs and oxygen used in hospital; laboratory and x-ray examinations; electrocardiograms; special duty nursing (when requested by a physician and certified as medically necessary); and inpatient specialty pharmaceuticals.

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Inpatient Physician Services

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit includes PCP, specialty and may require a referral for physician services in the hospital. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.



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Benefit Provided: <input style="width: 90%;" type="text" value="Inpatient Surgical Services"/>	Source: <input style="width: 90%;" type="text" value="Base Benchmark Commercial HMO"/>	<input type="button" value="Remove"/>
Authorization: <input style="width: 90%;" type="text" value="Other"/>	Provider Qualifications: <input style="width: 90%;" type="text" value="State Plan & Public Employee/Commercial Plan"/>	
Amount Limit: <input style="width: 90%;" type="text" value="None"/>	Duration Limit: <input style="width: 90%;" type="text" value="None"/>	
Scope Limit: <input style="width: 95%;" type="text" value="Benefit does not include bariatric surgery, surgical and nonsurgical treatment of TMJ, personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products,"/>		
<p>Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:</p> <input style="width: 95%;" type="text" value="Scope Limit continued- and room and board when temporary leave permitted. Surgical hospital services are covered when medically necessary. Services include semi-private room and board (private room provided when medically necessary); intensive care unit/coronary care unit; general nursing care; use of operating room or delivery suite; surgical and anesthesia services and supplies; ordinary casts; splints and dressings; drugs and oxygen used in hospital; laboratory and x-ray examinations; electrocardiograms; special duty nursing (when requested by a physician and certified as medically necessary); and inpatient specialty pharmaceuticals. Surgical operations may include replacement of diseased tissue removed while a member. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment."/>		

Benefit Provided: <input style="width: 90%;" type="text" value="Non-Cosmetic Reconstructive Surgery"/>	Source: <input style="width: 90%;" type="text" value="Base Benchmark Commercial HMO"/>
Authorization: <input style="width: 90%;" type="text" value="Other"/>	Provider Qualifications: <input style="width: 90%;" type="text" value="State Plan & Public Employee/Commercial Plan"/>
Amount Limit: <input style="width: 90%;" type="text" value="Services begin within 1 year of the accident."/>	Duration Limit: <input style="width: 90%;" type="text" value="None"/>
Scope Limit: <input style="width: 95%;" type="text" value="Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products, and room and board when temporary leave permitted."/>	
<p>Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:</p> <input style="width: 95%;" type="text" value="Surgical hospital services are covered when medically necessary and approved by physician. Reconstructive procedures performed to restore or improve impaired physical function or defects resulting from an accident. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general"/>	



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member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided:

Mastectomy- Reconstructive Surgery

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products, and room and board when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Surgical hospital services are covered when medically necessary and approved by physician. Covered services include reconstruction of the breast upon which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications at all stages of mastectomy, including lymphedemas.
For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Transplants

Source:

Base Benchmark Commercial HMO

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Human organ and tissue transplant services for both the recipient and the donor, when the recipient is a member. No coverage is provided for the donor or the recipient when the recipient is not a member. Specialty Care Physician (SCP) provides pre-transplant evaluation. Non-experimental, non-investigational organ and other transplants are covered. Donor's medical expenses covered if the person receiving the transplant is a member, and donor's expenses are not covered by another issuer.
For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general



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member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided:

Congenital Abnormalities

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest meals, accommodations or personal hygiene products, and room and board when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Surgical hospital services are covered when medically necessary and approved by physician. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Anesthesia

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage includes anesthesia services and supplies. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Hospice Care

Source:

Base Benchmark Commercial HMO



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Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="State Plan & Public Employee/Commercial Plan"/>	<input type="button" value="Remove"/>
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="Room and board services are not covered when temporary leave permitted."/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text" value="Covered services include semi-private room (private room provided when medically necessary). Hospice care provided if terminal illness, in accordance with a treatment plan before admission to the program. Treatment plan must provide statement from physician that life expectancy is 6 months or less. Concurrent care is provided to children (19 & 20 year olds). For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment."/>		
Benefit Provided: <input type="text" value="Medical Social Services"/>	Source: <input type="text" value="Base Benchmark Commercial HMO"/>	<input type="button" value="Remove"/>
Authorization: <input type="text" value="None"/>	Provider Qualifications: <input type="text" value="State Plan & Public Employee/Commercial Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text" value="Hospital services to assist member and family in understanding and coping with the emotional and social problems affecting health status."/>		
Benefit Provided: <input type="text" value="Dialysis"/>	Source: <input type="text" value="Base Benchmark Commercial HMO"/>	
Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="State Plan & Public Employee/Commercial Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		



Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Inpatient dialysis services provided by a participating provider.
For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided:

Chemotherapy

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes coverage for inpatient services.
For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Radiation Therapy

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes coverage for inpatient services.
For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add



Alternative Benefit Plan

4. Essential Health Benefit: Maternity and newborn care

Collapse All

Benefit Provided:

Maternity Care

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Surrogate services not covered.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Professional routine obstetrical care, including prenatal visits, antepartum care, and one postpartum visit per pregnancy term regardless of date of conception. Including physician services, laboratory and x-ray services as medically necessary and appropriate.

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Maternity- Delivery

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Surrogate services not covered.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage includes inpatient hospital care and services, physician services, laboratory and x-rays services and other services as medically necessary and appropriate.

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add



Alternative Benefit Plan

Collapse All

5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

Benefit Provided:

Mental/Behavioral Health Inpatient

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Benefit does not include custodial care and residential treatment services; hypnotherapy, behavioral modification, or milieu therapy when used to treat conditions that are not recognized as mental disorders.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefits include evaluation and treatment in a psychiatric day facility and electroconvulsive therapy. Services also do not include personal comfort items and room and board when temporary leave available. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Mental/Behavioral Health Outpatient

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Coverage does not include self-help training or other related forms of non-medical self care; marriage counseling; hypnotherapy, behavioral modification, or milieu therapy when used to treat conditions that are not recognized as mental disorders.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage applies to individual therapy and group therapy sessions. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Substance Abuse Inpatient Treatment

Source:

Base Benchmark Commercial HMO



Alternative Benefit Plan

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Remove

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Benefit does not include custodial care and residential treatment services; services and supplies for the treatment of co-dependency or caffeine addiction; personal comfort items; and room and board when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit includes detoxification for alcohol or other drug addiction.
For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Substance Abuse Outpatient Treatment

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Benefit does not include services and supplies unrelated to mental health for the treatment of co-dependency or caffeine addiction.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage includes detoxification for alcohol or other drug addiction.
For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add



Alternative Benefit Plan

6. Essential Health Benefit: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):

- Limit on days supply
- Limit on number of prescriptions
- Limit on brand drugs
- Other coverage limits
- Preferred drug list

Authorization:

Yes

Provider Qualifications:

State licensed

Coverage that exceeds the minimum requirements or other:

The prescription drug benefit will offer comprehensive coverage. Formularies may vary by employer plan. All formularies will be reviewed for comprehensiveness and compliance with the CCHIO non-discriminatory benefit design checks as detailed in the ABP 5 supplemental plan review information.

Prescription supply may be limited to 30 days for retail pharmacy and up to 90 days for mail service.

Exclusions or non covered drugs may include over the counter drugs and drugs with over the counter equivalents; Drugs for weight loss; Nutritional and/or dietary supplements; drugs for the treatment of sexual or erectile dysfunction or inadequacies; infertility drugs; human growth hormone.

Exact coverage may vary by approved HIP Link employer plan. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of need for Rx related to the medical needs of the member and a planned course of treatment, if applicable, as related to the number of Rx provided and duration of treatment.



Alternative Benefit Plan

7. Essential Health Benefit: Rehabilitative and habilitative services and devices

Collapse All

Benefit Provided:

Physical, Occupational and Speech Therapies

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Short-Term Therapies are limited to a combined 60

Duration Limit:

None

Scope Limit:

Rehabilitative and habilitative services are offered at parity and share the same, comparable benefit limits. Coverage does not include nonsurgical treatment of TMJ.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount limit continued- visits per each distinct condition or episode, or as authorized through a medical management regimen. Short-term therapy services and limits include PT, OT, ST, cardiac and pulmonary rehabilitation.

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Durable Medical Equipment (DME)

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

DME does not include corrective shoes, arch supports, hearing aids, dental prostheses, deluxe equipment, common first aid supplies and non-durable supplies. Other non-covered services include but not limited to equipment not suitable for home use.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit includes but not limited to wheel chairs, crutches, respirators, traction equipment, hospital beds, monitoring devices, oxygen-breathing apparatus and insulin pumps. Training for use of DME is also covered and applicable rental services. Covered services are only for the basic type of DME necessary to provide for medical needs and does not include non-durable supplies that are not an integral part of the DME set-up.

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.



Alternative Benefit Plan

Benefit Provided:

Prosthetics

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Benefit does not include foot orthotics, devices solely for comfort or convenience and devices from a non-accredited provider.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

A prosthetic device means an artificial arm or leg or any portion thereof. Orthotic devices are also covered under this benefit as custom fabricated braces or supports designed as a component of an artificial arm or leg. Covered services include the purchase, replacement or adjustment of artificial limbs when required due to a change in your physical condition or body size due to normal growth. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Corrective Appliances

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Benefit does not include but not limited to artificial or prosthetic limbs, cochlear implants, dental appliances, dentures, foot orthotics, corrective shoes, arch supports for plantar fasciitis, flat feet, fallen arches and corns.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit must be medically necessary and used to restore function or to replace body parts. Benefit includes but not limited to hemodialysis equipment, breast prostheses, back braces, artificial eyes, one pair eyeglasses due to cataract surgery, ostomy supplies and prosthetics (all prosthetics except prosthetic limbs). Coverage not intended for non-durable appliances. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.



Alternative Benefit Plan

Benefit Provided: Cardiac Rehabilitation	Source: Base Benchmark Commercial HMO	Remove
Authorization: Other	Provider Qualifications: State Plan & Public Employee/Commercial Plan	
Amount Limit: Short-Term Therapies are limited to a combined 60	Duration Limit: None	
Scope Limit: Rehabilitative services are offered at parity and share the same, comparable benefit limits.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Amount limit continued- visits per each distinct condition or episode, or as authorized through a medical management regimen. Short-term therapy services and limits include PT, OT, ST, cardiac and pulmonary rehabilitation. Benefit includes services for the improvement of cardiac disease or dysfunction. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.		
Benefit Provided: Medical Supplies	Source: Base Benchmark Commercial HMO	Remove
Authorization: None	Provider Qualifications: State Plan & Public Employee/Commercial Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: Benefit does not include non-durable supplies and/or convenience items.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Benefits include casts, splints, other devices used for reduction of fractures and dislocations and medical supplies in connection with home health care. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.		
Benefit Provided: Pulmonary Rehabilitation	Source: Base Benchmark Commercial HMO	
Authorization: Other	Provider Qualifications: State Plan & Public Employee/Commercial Plan	



Alternative Benefit Plan

Amount Limit:

Short-Term Therapies are limited to a combined 60

Duration Limit:

None

Remove

Scope Limit:

Rehabilitative services are offered at parity and share the same, comparable benefit limits.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount limit continued- visits per each distinct condition or episode, or as authorized through a medical management regimen. Short-term therapy services and limits include PT, OT, ST, cardiac and pulmonary rehabilitation. Benefit consists of services that are for the improvement of pulmonary disease or dysfunction that has a poor response to treatment. Examples of poor response include but are not limited to patients with respiratory failure, frequent emergency room visits, progressive dyspnea, hypoxemia or hypercapnia.

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Skilled Nursing Facility (SNF)

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

100 days per benefit period.

Duration Limit:

None

Scope Limit:

A SNF does not include any institution or portion of any institution that is primarily for rest, the aged, non-skilled care, or care of mental diseases or substance abuse. Room and board services are not covered when temporary leave permitted.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Covered services include semi-private room (private room provided when medically necessary), drugs, specialty pharmaceuticals, medical social services, short term physical, speech, occupational therapies (subject to limits) and other services generally provided.

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Autism Spectrum Disorder Services

Source:

Base Benchmark Commercial HMO

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan



Alternative Benefit Plan

Amount Limit:

Short-Term Therapies are limited to a combined 60

Duration Limit:

None

Remove

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount limit continued- visits per each distinct condition or episode, or as authorized through a medical management regimen. Short-term therapy services and limits include PT, OT, ST, cardiac and pulmonary rehabilitation.

Benefit, formerly known as Pervasive Development Disorder (PDD), is a state mandate that must be covered as outlined in the Indiana insurance code. Benefit provides coverage for Asperger's syndrome and autism. Coverage for services are provided as prescribed by the treating physician in accordance with the treatment plan.

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Inpatient Cardiac Rehabilitation

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

90 days annual maximum.

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit includes services for the improvement of cardiac disease or dysfunction.

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Inpatient Rehabilitation Therapy

Source:

Base Benchmark Commercial HMO

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

90 days annual maximum.

Duration Limit:

None



Alternative Benefit Plan

Scope Limit:

Rehabilitative and habilitative services are offered at parity and share the same, comparable benefit limits.

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage includes physical, occupational, speech and pulmonary therapy of acute illness or injury to the extent that significant potential exists for progress toward a previous level of functioning. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add



Alternative Benefit Plan

8. Essential Health Benefit: Laboratory services

Collapse All

Benefit Provided:

Lab Tests

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Coverage does not include lab expenses related to physical exams when provided for employment, school, sports' programs, travel, immigration, administrative purposes or insurance purposes.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided as outpatient services when medically necessary.
For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

X-Rays

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Coverage does not include x-ray expenses related to physical exams when provided for employment, school, sports' programs, travel, immigration, administrative purposes or insurance purposes.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided as outpatient services when medically necessary.
For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Imaging- MRI, CT, MRA, PET and SPECT

Source:

Base Benchmark Commercial HMO

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan



Alternative Benefit Plan

Amount Limit: None	Duration Limit: None	Remove
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Benefit provided as outpatient services when medically necessary. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.		
Benefit Provided: Pathology	Source: Base Benchmark Commercial HMO	Remove
Authorization: Other	Provider Qualifications: State Plan & Public Employee/Commercial Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Benefit provided as outpatient services when medically necessary. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.		
Benefit Provided: Radiology	Source: Base Benchmark Commercial HMO	
Authorization: Other	Provider Qualifications: State Plan & Public Employee/Commercial Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		



Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided as outpatient services when medically necessary.
For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided:

EKG and EEG

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided as outpatient services when medically necessary.
For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add



Alternative Benefit Plan

9. Essential Health Benefit: Preventive and wellness services and chronic disease management

Collapse All

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided:

Preventive Care Services

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Preventive care provided in accordance with minimum requirements.

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Diabetes Self Management Training

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Covered services are limited to physician authorized visits after receiving a diagnosis of diabetes; after receiving a diagnosis that represents a significant change in symptoms or condition and there is a medically necessary change in self-management; and for re-education or refresher training.

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.



Alternative Benefit Plan

Benefit Provided:	Source:	
Health Education	Base Benchmark Commercial HMO	<input type="button" value="Remove"/>
Authorization:	Provider Qualifications:	
Other	State Plan & Public Employee/Commercial Plan	
Amount Limit:	Duration Limit:	
See Scope Limit.	None	
Scope Limit:		
Classes in nutrition or smoking cessation will be approved up to 3 visits when referred by your physician.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Benefit provided by the PCP as part of preventive health care and other health education classes approved by the insurer. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.		

Benefit Provided:	Source:	
Routine Prostate Specific Antigen (PSA) Test	Base Benchmark Commercial HMO	<input type="button" value="Remove"/>
Authorization:	Provider Qualifications:	
None	State Plan & Public Employee/Commercial Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
One test annually for an individual who is at least 50 years old or less than 50 if at high risk for prostate cancer.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.		



Alternative Benefit Plan

10. Essential Health Benefit: Pediatric services including oral and vision care

Collapse All

Benefit Provided:

Medicaid State Plan EPSDT Benefits

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Available to enrollees age 20 and under.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

This benefit will be provided by Medicaid if the service or treatment is not covered on the employer plan or if the employer plan limits coverage of any medically necessary 1905(a) benefit to the EPSDT population.

Add



Alternative Benefit Plan

11. Other Covered Benefits from Base Benchmark

Collapse All



Alternative Benefit Plan

12. Base Benchmark Benefits Not Covered due to Substitution or Duplication

Collapse All



Alternative Benefit Plan

<input checked="" type="checkbox"/> 13. Other Base Benchmark Benefits Not Covered		Collapse All <input type="checkbox"/>
Base Benchmark Benefit not Included in the Alternative Benefit Plan:	Source: Base Benchmark	<input type="button" value="Remove"/>
<input type="text" value="Emergency Services Outside the U.S."/>		
Explain why the state/territory chose not to include this benefit:		
<input type="text" value="Emergency care provided outside the U.S. is a covered service. Non-emergency services are not covered. This services is not permissible under federal Medicaid rules."/>		
Base Benchmark Benefit not Included in the Alternative Benefit Plan:	Source: Base Benchmark	<input type="button" value="Remove"/>
<input type="text" value="Lodging and Transportation for Transplants (Donor)"/>		
Explain why the state/territory chose not to include this benefit:		
<input type="text" value="Transportation and lodging services for the donor are covered under the base benchmark plan subject to a dollar limit. These services are not considered an EHB and are considered a non-covered benefit for the ABP. HIP Link employer plans may offer this benefit, but the \$10,000 of coverage for this benefit is not required for HIP Link."/>		
Base Benchmark Benefit not Included in the Alternative Benefit Plan:	Source: Base Benchmark	<input type="button" value="Remove"/>
<input type="text" value="Adult Vision"/>		
Explain why the state/territory chose not to include this benefit:		
<input type="text" value="Adult vision is covered in the base benchmark plan, but it is an excepted benefit and therefore not an Essential Health Benefit."/>		
		<input type="button" value="Add"/>



Alternative Benefit Plan

14. Other 1937 Covered Benefits that are not Essential Health Benefits

Collapse All



Alternative Benefit Plan

15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20131219



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L-

Benefits Description

ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

UHC POS
UnitedHealthcare Insurance Company

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved



Alternative Benefit Plan

1. Essential Health Benefit: Ambulatory patient services

Collapse All

Benefit Provided:

Primary Care Physician (PCP) Services Office Visit

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services provided in a physician's office for the diagnosis and treatment of a sickness or injury. Benefit includes allergy injections, diagnostic services, such as lab tests, and medical education services for patient self-management and knowledge of disease.

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Specialty Physician Visits

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Home Health Services

Source:

Base Benchmark Small Group

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan



Alternative Benefit Plan

Amount Limit:

60 visits per year.

Duration Limit:

1 visit equals up to 4 hours of services.

Remove

Scope Limit:

Services covered if not for IV infusion only, considered custodial care, not delivered for the purpose of assisting with ADLs or a caregiver is not available.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services are ordered by a physician and provided in home by RN, home health aide or LPN or supervised by RN. Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Outpatient Surgery

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Surgery and related services received on an outpatient basis. Coverage includes certain scopic procedures such as arthroscopy or laparoscopy; supplies and equipment; anesthesia, pathology or radiology. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Chemotherapy-Outpatient

Source:

Base Benchmark Small Group

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None



Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit includes outpatient therapeutic treatments. Services include medical education if needed; related supplies and equipment and related physician services.
For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided:

IV Infusion Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit includes coverage for outpatient therapeutic treatments. Services include medical education if needed; related supplies and equipment and related physician services.
For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Radiation Therapy- Outpatient

Source:

Base Benchmark Small Group

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit includes coverage for outpatient therapeutic treatments. Services include medical education if needed; related supplies and equipment and related physician services.
For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned



Alternative Benefit Plan

course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided:

Dialysis

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit includes coverage for outpatient therapeutic treatments (both hemodialysis and peritoneal dialysis). Services include medical education if needed; related supplies and equipment and related physician services.

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Outpatient Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefits provided are PCP or specialist (office visits), diagnostics, rehabilitation services or therapeutic services. Physician services for surgical procedures and other medical care received on an outpatient or inpatient basis in a hospital, skilled nursing facility, inpatient rehabilitation facility or alternate facility, or for physician house calls.

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.



Alternative Benefit Plan

Benefit Provided:	Source:	
Clinical Trials	Base Benchmark Small Group	Remove
Authorization:	Provider Qualifications:	
Other	State Plan & Public Employee/Commercial Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
Items and services that are not routine care costs or unrelated to the care method will not be covered.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
<p>Benefits covered for qualifying clinical trial for the treatment of cardiovascular disease, surgical musculoskeletal disorders of the spine, hip and knees or other diseases or disorders that meet the clinical trial criteria. Coverage includes the reasonable and necessary items and services used to diagnose and treat complications arising from participation in a qualifying clinical trial; some routine care costs associated with cancer or other clinical trials. Routine care costs not covered may include items and services solely used for data collection. The clinical trial must also have a written protocol that describes a sound study and approved by relevant review boards; and meet the definition of a covered services and not otherwise excluded.</p> <p>The clinical trial must be approved or funded by one of the following: National Institute of Health; cooperative group of research facilities that have an established peer review program that is approved by a National Institute of Health or center; FDA; United States Department of Veterans Affairs; United States Department of Defense; institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institute of Health Office for Protection from Research Risks; and research entity that meets eligibility criteria for a support grant from a National Institutes of Health center.</p> <p>For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.</p>		

Benefit Provided:	Source:	
Dental- Limited Covered Services- Accident/Injury	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
Other	State Plan & Public Employee/Commercial Plan	
Amount Limit:	Duration Limit:	
Treatment complete within 1 year from initiation.	None	
Scope Limit:		
Coverage not provided for orthodontia, damage as result of normal activities or extraordinary use of the teeth, periodontal surgery or congenitally missing, malpositioned or supernumerary teeth.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Dental services provided when treatment is necessary because of accidental damage. Treatment to start		



Alternative Benefit Plan

within three months of accident, unless medical reason. Dental services, such as endodontics, restorative treatment or other services are covered if accident related.
For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided:

Urgent Care- Walk-ins

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Covered health services received at an urgent care center.

Benefit Provided:

Routine Foot Care

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Coverage not provided for supportive devices of the feet, including but not limited to foot orthotics, corrective shoes, arch supports or shoe inserts. Benefits also not provided for the treatment of flat feet, subluxation of the foot, corns,

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Scope limit continued- calluses, nail trimming or hygienic foot care.
Benefits covered when medically necessary for the treatment of diabetes and persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.
For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Infertility Treatment

Source:

Base Benchmark Small Group



Alternative Benefit Plan

Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="State Plan & Public Employee/Commercial Plan"/>	<input type="button" value="Remove"/>
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="Coverage not provided for health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment, donor eggs or sperm or storage of reproductive material."/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text" value="Benefit includes services required to treat or correct underlying causes of infertility. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment."/>		
Benefit Provided: <input type="text" value="Manipulative Treatment"/>	Source: <input type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>
Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="State Plan & Public Employee/Commercial Plan"/>	
Amount Limit: <input type="text" value="Outpatient Therapy is limited to 20 visits"/>	Duration Limit: <input type="text"/>	
Scope Limit: <input type="text" value="Benefits can be denied for members who are not progressing with treatment or if treatment goals are met; benefit does not include maintenance/preventive treatment; massage therapy; acupuncture or other."/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text" value="Amount limit continued- per year. Services provided in physicians office or on an outpatient basis at a hospital or facility. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment."/>		
<input type="button" value="Add"/>		



Alternative Benefit Plan

2. Essential Health Benefit: Emergency services

Collapse All

Benefit Provided:

Emergency Department Services

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Medical care provided outside of the U.S. is not covered. This services is not permissible under federal Medicaid rules.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services that are required to stabilize or initiate treatment in an emergency which include facility charge, supplies and relevant professional services.

Benefit Provided:

Emergency Ambulance Transportation

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services include transportation to the nearest hospital where emergency services can be performed. Benefit includes ground or air transportation.

Benefit Provided:

Other Ambulance Transportation

Source:

Base Benchmark Small Group

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None



Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services may include ground or air ambulance as deemed appropriate between facilities when the transport is from non-network hospital to network hospital, to a hospital with higher level of care, to a more cost-effective acute care facility or from an acute facility to a sub-acute setting.

For other medically necessary transportation, authorization may be required in which the member's primary coverage provided through the employer-sponsored insurance may require other details, such as general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Add



Alternative Benefit Plan

3. Essential Health Benefit: Hospitalization

Collapse All

Benefit Provided:

General Inpatient Hospital Care

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest services.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services and supplies provided during inpatient stay in a hospital. Benefits are available for supplies and non-physician services received during the inpatient stay, room and board in a semi-private room (a room with two or more beds), physician services for anesthesiologists, emergency room physicians, consulting physicians, pathologists and radiologists.

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Inpatient Physician Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Physician services for surgical procedures and other medical care received on an outpatient or inpatient basis in a hospital, skilled nursing facility, inpatient rehabilitation facility or alternate facility, or for physician house calls. Services may include consulting physicians, emergency room physicians or other. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Inpatient Surgical Services

Source:

Base Benchmark Small Group



Alternative Benefit Plan

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Remove

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Benefit does not include bariatric surgery, surgical and nonsurgical treatment of TMJ or personal comfort items, including those services and supplies not directly related to care, such as guest services.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit includes physician services for surgical procedures.
For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Reconstructive Procedures

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Cosmetic Procedures are excluded from coverage. Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest services.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an injury, sickness or congenital anomaly. The primary result of the procedure is not a changed or improved physical appearance.
For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Mastectomy- Reconstructive Procedure

Source:

Base Benchmark Small Group

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan



Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

None

Remove

Scope Limit:

Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest services.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other covered health service. Benefits for any post-mastectomy services will be provided even if the covered person was not enrolled with us at the time the mastectomy was received.
For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Transplantation Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Health services connected with the removal of an organ or tissue from member for purposes of a transplant to another person. (Donor costs related to organ removal are covered).

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Service includes organ and tissue transplants at a designated facility when ordered by a physician. Benefits are available for transplants when the transplant meets the definition of a covered health service, and is not an experimental or investigational or unproven service. Examples of transplants for which benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea. (Cornea transplants not required to be performed at a designated facility). Donor costs that are directly related to organ removal are covered health services for which benefits are payable through the organ recipient's coverage under the policy.
For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Congenital Abnormalities

Source:

Base Benchmark Small Group



Alternative Benefit Plan

Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="State Plan & Public Employee/Commercial Plan"/>	<input type="button" value="Remove"/>
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="Benefit does not include personal comfort items, including those services and supplies not directly related to care, such as guest services."/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text" value="Services provided as a reconstructive procedure to treat a medical condition or improve, restore function. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment."/>		
Benefit Provided: <input type="text" value="Anesthesia"/>	Source: <input type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>
Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="State Plan & Public Employee/Commercial Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text" value="Coverage includes physician services and supplies for anesthesiologists. Other anesthesia services as part of covered health services. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment."/>		
Benefit Provided: <input type="text" value="Congenital Heart Disease Surgeries"/>	Source: <input type="text" value="Base Benchmark Small Group"/>	
Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="State Plan & Public Employee/Commercial Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	



Alternative Benefit Plan

Scope Limit:

None

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Congenital heart disease (CHD) surgeries which are ordered by a physician. CHD surgical procedures include, but are not limited to, surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels, and hypoplastic left or right heart syndrome. Includes supplies and equipment. Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Hospice Care

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services that provide comfort and support services for the terminally ill as recommended by a physician and received from a licensed hospice agency. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the member is receiving hospice care.

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add



Alternative Benefit Plan

4. Essential Health Benefit: Maternity and newborn care

Collapse All

Benefit Provided:

Pregnancy- Maternity Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Surrogate parenting are not covered.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefits include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications. Benefit also includes enrollment in prenatal programs. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Maternity- Delivery

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Surrogate services not covered.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefits include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Genetic Counseling

Source:

Base Benchmark Small Group

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan



Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

None

Remove

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Both before and during a pregnancy, benefits include the services of a genetic counselor when provided or referred by a physician. These benefits are available to all covered persons in the immediate family. Covered health services include related tests and treatment. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add



Alternative Benefit Plan

Collapse All

- 5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

Benefit Provided:

Mental Health Services Inpatient

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Benefit does not include custodial care and residential treatment services; hypnotherapy, services performed for unclassified conditions or personal comfort items, such as guest services.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Mental health services include those received on an inpatient basis in a hospital or an alternate facility. Benefits include diagnostic evaluations and assessment, treatment planning, referral services, medication management, individual, family, therapeutic group and provider-based case management services, crisis intervention, partial hospitalization/day treatment and services at a residential treatment facility. Coverage also includes semi-private room. Other special programs or services may be available as part of the mental health services benefit.

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Mental Health Services Outpatient

Source:

Base Benchmark Small Group

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Benefit does not include hypnotherapy or services performed for unclassified conditions.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Mental health services include those received on an outpatient basis in a provider's office or at an alternate facility. Benefits include diagnostic evaluations and assessment, treatment planning, referral services, medication management, individual, family, therapeutic group and provider-based case management services, crisis intervention and intensive outpatient treatment. Other special programs or services may be available as part of the mental health services benefit.

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general



Alternative Benefit Plan

member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided:

Substance Use Disorder Services Inpatient

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Benefit does not include custodial care and residential treatment services; services performed for unclassified conditions, some methadone treatment as maintenance or personal comfort items, such as guest services.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Substance use disorder services include those received on an inpatient basis in a hospital or an alternate facility. Benefits include diagnostic evaluations and assessment, treatment planning, referral services, medication management, individual, family, therapeutic group and provider-based case management services, crisis intervention, partial hospitalization/day treatment and services at a residential treatment facility. Coverage also includes semi-private room. Other special programs or services may be available as part of the substance use disorder benefit.

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Substance Use Disorder Services Outpatient

Source:

Base Benchmark Small Group

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Benefit does not include services performed for unclassified conditions or some methadone treatment as maintenance.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Substance use disorder services include those received on an outpatient basis in a provider's office or at an alternate facility. Benefits include diagnostic evaluations and assessment, treatment planning, referral services, medication management, individual, family, therapeutic group and provider-based case management services, crisis intervention and intensive outpatient treatment. Other special programs or



Alternative Benefit Plan

services may be available as part of the substance use disorder benefit.

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Add



Alternative Benefit Plan

6. Essential Health Benefit: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
<input checked="" type="checkbox"/> Limit on days supply	<input type="text" value="Yes"/>	<input type="text" value="State licensed"/>
<input checked="" type="checkbox"/> Limit on number of prescriptions		
<input checked="" type="checkbox"/> Limit on brand drugs		
<input checked="" type="checkbox"/> Other coverage limits		
<input checked="" type="checkbox"/> Preferred drug list		

Coverage that exceeds the minimum requirements or other:

The prescription drug benefit will offer comprehensive coverage. Formularies may vary by employer plan. All formularies will be reviewed for comprehensiveness and compliance with the CCHIO non-discriminatory benefit design checks as detailed in the ABP 5 supplemental plan review information.

Prescription supply may be limited to 31 days for retail pharmacy and up to 90 days for mail service.

Exclusions or non covered drugs may include over the counter drugs and drugs with over the counter equivalents; drugs for weight loss; nutritional and/or dietary supplements; infertility drugs; medications used for cosmetic purposes; growth hormone therapy; other.

Exact coverage may vary by approved HIP Link employer plan. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of need for Rx related to the medical needs of the member and a planned course of treatment, if applicable, as related to the number of Rx provided and duration of treatment.



Alternative Benefit Plan

7. Essential Health Benefit: Rehabilitative and habilitative services and devices

Collapse All

Benefit Provided:

Physical, Occupational and Speech Therapies

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Outpatient Therapies are limited to 20 visits

Duration Limit:

None

Scope Limit:

Rehabilitative and habilitative services are offered at parity and share the same, comparable benefit limits. Coverage does not include nonsurgical treatment of TMJ.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount limit continued- each per year for PT, OT and ST. Services provided in physicians office or on an outpatient basis at a hospital or facility. Benefits for speech therapy include treatment of disorders of speech, speech impediment, speech dysfunction, language, voice, communication and auditory processing only when the disorder results from injury, stroke, cancer, congenital anomaly or autism spectrum disorders.

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Durable Medical Equipment (DME)

Source:

Base Benchmark Small Group

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Limited to a single purchase of DME every 3 years

Duration Limit:

None

Scope Limit:

DME does not include corrective shoes, arch supports, shoe inserts, equipment not used for medical purposes, safety items, sport enhancement device, blood pressure cuff or ultrasonic nebulizers.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount limit continued- including repair/replacement. Benefits for repair and replacement do not apply to damaged due to misuse, lost or stolen items. Other non-covered services include devices to assist with communication and speech except when medically necessary (3 month rental required prior to purchase), personal comfort items, humidifiers, device implanted into the body or oral appliances for snoring. Benefit includes but not limited to wheel chairs, hospital beds, oxygen and equipment to administer oxygen, braces used to accommodate shoes, to stabilize injured body part or curvature of spine, external cochlear devices and systems, insulin pumps or equipment to treat respiratory failure. Benefits are available for equipment as outpatient use, to rent or purchase as determined by insurer and for medical purposes.



Alternative Benefit Plan

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided:

Prosthetics

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Limited to single purchase of each type of

Duration Limit:

None

Scope Limit:

Benefit does not include appliances that straighten/re-shape a body part, such as foot orthotics or cranial banding (may not apply to some orthotic devices), devices solely for comfort or convenience and device that is fully implanted into the body.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount limit continued- prosthetic device every 3 years, except for items required by the Women's Health and Cancer Rights Act.

An external prosthetic devices that replace a limb or a body part that meets the minimum specification of your needs, such as feet, hands (unless are portion of a prosthetic arm or leg as an orthotic device), artificial face, eyes, ears and nose and breast prosthesis. Benefits are available for repair and replacement except for damage due to misuse, lost or stolen items.

Orthotic Devices means a medically necessary custom fabricated brace or support that is designed as a component of an artificial arm or leg. Repair/replacement available as medically necessary.

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Cardiac Rehabilitation

Source:

Base Benchmark Small Group

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Outpatient Therapy is limited to 36 visits

Duration Limit:

None

Scope Limit:

Rehabilitative services are offered at parity and share the same, comparable benefit limits.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount limit continued- per year. Services provided in physicians office or on an outpatient basis at a hospital or facility.



Alternative Benefit Plan

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided:

Medical Supplies

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Benefit does not include elastic stockings, ace bandages, gauze/dressings, urinary catheters or personal comfort items. This may not apply to disposable supplies necessary for the use of DME, such as tubing and masks.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefits include prescribed medical supplies or disposable supplies.
For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Pulmonary Rehabilitation

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Outpatient Therapy is limited to 20 visits

Duration Limit:

None

Scope Limit:

Rehabilitative services are offered at parity and share the same, comparable benefit limits.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount limit continued- per year. Services provided in physicians office or on an outpatient basis at a hospital or facility.
For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.



Alternative Benefit Plan

Benefit Provided:	Source:	<input type="button" value="Remove"/>
Skilled Nursing Facility (SNF)	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
Other	State Plan & Public Employee/Commercial Plan	
Amount Limit:	Duration Limit:	
60 days per year.	None	
Scope Limit:		
A SNF does not include skilled care services that are primarily custodial care, services for ADLs or the use of skilled services because there is not an available caregiver.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Coverage includes inpatient rehabilitation facility and includes skilled nursing, teaching or rehabilitation services that are ordered by a physician. Benefits include supplies and non-physician services received during the inpatient stay, room and board in a semi-private room, physician services for anesthesiologists, consulting physicians, pathologists, radiologists or other services generally provided. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.		

Benefit Provided:	Source:	<input type="button" value="Remove"/>
Autism Spectrum Disorder Services	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
Other	State Plan & Public Employee/Commercial Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
Services provided that are not backed by credible research to treat the condition or clinically appropriate, or providing treatment for conditions that are not part of the disorder.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Benefit, formerly known as Pervasive Development Disorder (PDD), is a state mandate that must be covered as outlined in the Indiana insurance code. Benefit provides coverage for Asperger's syndrome and autism. Coverage for services are provided as prescribed by the treating physician in accordance with the treatment plan. Benefit also includes medical treatment for neurological disorders and provides the same services as the mental health inpatient/outpatient benefits. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.		



Alternative Benefit Plan

Benefit Provided:	Source:	
<input type="text" value="Inpatient Rehabilitation Facility Services"/>	<input type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>
Authorization:	Provider Qualifications:	
<input type="text" value="Other"/>	<input type="text" value="State Plan & Public Employee/Commercial Plan"/>	
Amount Limit:	Duration Limit:	
<input type="text" value="Limited to 60 days per year."/>	<input type="text" value="None"/>	
Scope Limit:		
<input type="text" value="Services do not include skilled care services that are primarily custodial care, services for ADLs or the use of skilled services because there is not an available caregiver."/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
<input type="text" value="Coverage includes physical, occupational and speech therapy and is ordered by a physician. Benefits include goal-directed rehabilitation services and provide the same services as the skilled nursing facility benefit. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment."/>		

Benefit Provided:	Source:	
<input type="text" value="Hearing Aids"/>	<input type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>
Authorization:	Provider Qualifications:	
<input type="text" value="Other"/>	<input type="text" value="State Plan & Public Employee/Commercial Plan"/>	
Amount Limit:	Duration Limit:	
<input type="text" value="Limited to a single purchase every 3 years"/>	<input type="text" value="None"/>	
Scope Limit:		
<input type="text" value="Coverage does not include bone anchored hearing aids except for craniofacial anomalies or severe hearing loss."/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
<input type="text" value="Amount limit continued- including repair/replacement. Bone anchored hearing aids limited to one for eligible members. Benefits provided as order by physician and include the associated fitting and testing. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment."/>		

Benefit Provided:	Source:	
<input type="text" value="Post-Cochlear Implant Aural Therapy"/>	<input type="text" value="Base Benchmark Small Group"/>	



Alternative Benefit Plan

Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="State Plan & Public Employee/Commercial Plan"/>	<input type="button" value="Remove"/>
Amount Limit: <input type="text" value="Outpatient Therapy is limited to 30 visits"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="Benefits can be denied for members who are not progressing with treatment or if treatment goals are met."/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text" value="Amount limit continued- per year. Services provided in physicians office or on an outpatient basis at a hospital or facility. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment."/>		
Benefit Provided: <input type="text" value="Ostomy Supplies"/>	Source: <input type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>
Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="State Plan & Public Employee/Commercial Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed."/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text" value="Benefits are limited to pouches, face plates, belts, irrigation sleeves, bags, ostomy irrigation catheters and skin barriers. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment."/>		
<input type="button" value="Add"/>		



Alternative Benefit Plan

8. Essential Health Benefit: Laboratory services

Collapse All

Benefit Provided:

Lab Tests

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Coverage does not include lab expenses for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided as outpatient services for diagnostic purposes when medically necessary and includes supplies/equipment and physician services for anesthesiologists, pathologists and radiologists as applicable. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

X-Rays/Radiology

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Coverage does not include lab expenses for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided as outpatient services for diagnostic purposes when medically necessary and includes supplies/equipment and physician services for anesthesiologists, pathologists and radiologists as applicable. Other diagnostic services include mammography. For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Imaging- MRI, CT, MRA, PET and Nuclear Medicine

Source:

Base Benchmark Small Group



Alternative Benefit Plan

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Remove

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit provided as outpatient services for major diagnostic purposes when medically necessary and includes supplies/equipment and physician services for anesthesiologists, pathologists and radiologists as applicable.

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Scopic Procedures

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Benefits do not include surgical scopic procedures.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefits include diagnostic and therapeutic scopic procedures and related services received on an outpatient basis when medically necessary and includes supplies/equipment and physician services for anesthesiologists, pathologists and radiologists as applicable. Diagnostic scopic procedures are those for visualization, biopsy and polyp removal and may include colonoscopy, sigmoidoscopy and endoscopy.

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add



Alternative Benefit Plan

9. Essential Health Benefit: Preventive and wellness services and chronic disease management

Collapse All

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided:

Preventive Care Services

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Preventive care provided in accordance with minimum requirements.
For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Diabetes Services- Self Management Training

Source:

Base Benchmark Small Group

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services as ordered by a physician. Benefits also include re-education or refresher training, medical eye examinations (dilated retinal examinations) and preventive foot care.
Diabetic self-management items/equipment include insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the member. Other diabetic supplies include blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices.
For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general



Alternative Benefit Plan

member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided:

Health Education

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Benefit does not include individual and group nutritional counseling or weight loss programs.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit may provide additional services to the member, such as disease management programs or medical education for self management and knowledge of the disease.
For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:

Routine Prostate Specific Antigen (PSA) Test

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

1 annual test.

Duration Limit:

None

Scope Limit:

One test annually for an individual who is at least 50 years old or less than 50 if at high risk for prostate cancer.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For authorization, the member's primary coverage provided through the employer-sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Add



Alternative Benefit Plan

10. Essential Health Benefit: Pediatric services including oral and vision care

Collapse All

Benefit Provided:

Medicaid State Plan EPSDT Benefits

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Available to enrollees age 20 and under.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

This benefit will be provided by Medicaid if the service or treatment is not covered on the employer plan or if the employer plan limits coverage of any medically necessary 1905(a) benefit to the EPSDT population.

Add



Alternative Benefit Plan

11. Other Covered Benefits from Base Benchmark

Collapse All



Alternative Benefit Plan

12. Base Benchmark Benefits Not Covered due to Substitution or Duplication

Collapse All



Alternative Benefit Plan

<input checked="" type="checkbox"/> 13. Other Base Benchmark Benefits Not Covered		Collapse All <input type="checkbox"/>
Base Benchmark Benefit not Included in the Alternative Benefit Plan:	Source: Base Benchmark	<input type="button" value="Remove"/>
<input type="text" value="Emergency Services Outside the U.S."/>		
Explain why the state/territory chose not to include this benefit:		
<input type="text" value="Emergency care provided outside the U.S. is a covered service. Non-emergency services are not covered. This services is not permissible under federal Medicaid rules."/>		
Base Benchmark Benefit not Included in the Alternative Benefit Plan:	Source: Base Benchmark	<input type="button" value="Remove"/>
<input type="text" value="Lodging and Transportation for Transplants (Donor)"/>		
Explain why the state/territory chose not to include this benefit:		
<input type="text" value="Transportation and lodging services for the donor are covered under the base benchmark plan subject to a dollar limit. These services are not considered an EHB and are considered a non-covered benefit for the ABP. HIP Link employer plans may offer this benefit, but the \$10,000 of coverage for this benefit is not required for HIP Link."/>		
Base Benchmark Benefit not Included in the Alternative Benefit Plan:	Source: Base Benchmark	<input type="button" value="Remove"/>
<input type="text" value="Adult Vision"/>		
Explain why the state/territory chose not to include this benefit:		
<input type="text" value="Adult vision is covered in the base benchmark plan, but it is an excepted benefit and therefore not an Essential Health Benefit."/>		
		<input type="button" value="Add"/>



Alternative Benefit Plan

14. Other 1937 Covered Benefits that are not Essential Health Benefits

Collapse All



Alternative Benefit Plan

<input type="checkbox"/> 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)	Collapse All <input type="checkbox"/>
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PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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ABP 5 Supplemental Information

The benefits present in the ABP 5 submissions are provided to HIP Link members through employer-sponsored coverage that is deemed substantially equal to one of the base-benchmark benefit packages documented in the ABP 5 submissions upon review by the state. The benefit packages include the Anthem Small Group Blue Access PPO plan, the Anthem Lumenos PPO plan (benefits are equal to the Blue Access Plan), the United POS plan, and the Advantage Commercial HMO plan. Benefits in any HIP Link approved plan may vary from the benefits described in these base benchmark submissions; but coverage is assured to be substantially equivalent by using the evaluation methods described below.

Employer Attestations

Prior to any member receiving HIP Link benefits through their employer-sponsored plan, the employer must submit an application and attest to offering at least the required essential health benefits categories, minimum value requirements, providing mental health parity, and not offering abortion services for which use of federal funds is prohibited. This attestation must be submitted before the employer-sponsored plan may be deemed eligible for HIP Link.

Plan Review - Benefits

As part of the HIP Link application process, employers must submit their benefit plans and supporting documentation including formulary information to the state. Once the employer has completed the submission of their benefit plans, the HIP Link Employer Counseling Team (ECT) reviews the plan. If on review the plan is identified as a plan that has already been reviewed and certified as meeting the Indiana Essential Health Benefit requirements by the Indiana Department of Insurance, such as an ACA compliant small group plan, then the Employer Counselor Team will not complete additional review and the plan will be considered to meet the minimum HIP Link benefit requirements. For all other plans, including grandfathered and transitional small group plans, large group plans that are not filed with ACA compliant small group plans and self-funded plans that are not required to meet the EHB, the ECT team will review the plan to ensure that no essential health benefit categories are excluded on the plan exclusions and that benefits and limits present in the plan align with the benefits and limits present in one of the Indiana essential health benefits base benchmark options as documented in the ABP 5 submission. Additional review will be done on some specific EHB requirements, such as assuring mental health parity.

In addition, the prescription drug benefits are directly verified with each employer's or plan's Pharmacy Benefit Manager. ESI health plan formularies are also reviewed for non-discrimination on health status in alignment with the Center for Consumer Information and Insurance Oversight process.

Pathway for Indiana to review and approve ESI plans for the HIP Link ABP

Coverage up to the benefit limits present in the applicable HIP Link ABP 5 submission will be assured through the HIP Link POWER account when all benefits detailed in the ABP are covered benefits in the employers ESI Plan. When a submitted employer plan does not provide a benefit listed in the applicable

ABP 5 submission, the plan may still qualify for HIP Link as a substantially equivalent plan through one of the below methods as assured in ABP 3:

- The plan offers another benefit or benefits in the same essential health benefit category that is offered above the level of benefits present in the applicable ABP 5. Actuarial documentation confirms that this benefit is substantially equal to the benefit that is offered with more restrictive limits or absent from the essential health benefit category. This plan will be considered eligible for HIP Link as it demonstrates actuarial equivalence on a benefit to benefit basis within the same EHB category for those differing benefit/s offered in the ESI Plan to those offered in the HIP Link ABP.
- The plan offers a benefit or benefits in another essential health benefit category that is offered above the level of the benefits present in the applicable ABP 5. An actuarial analysis using the benchmark equivalence methodology confirms that the total actuarial value of the plan is at least equivalent to the actuarial value of ABP 5. This plan will be considered eligible for HIP Link as it uses the benchmark-equivalent pathway to determine the aggregate actuarial value of an ESI plan and compare it to the actuarial value of the HIP Link ABP, following the process described in 42 CFR 441.335 and 441.340.

Plans that meet the standards outlined above, will be benefit eligible for HIP Link. The process of employer attestation and the plan review and approval by the employer counseling team is the method by which HIP Link assures access to benefits substantially equivalent to one of the Indiana essential health benefits benchmark options and a benefit package that meets the actuarial value requirements.

Supplemental Information ABP 7

Prescription Drugs

Prescription drug coverage is assured in accordance with the ABP 5 supplemental benefit review documentation and Indiana's HIP 2.0 1115 Demonstration and associated HIP Link protocol.

Actuarial Value and Essential Health Benefits

Essential Health Benefits substantially equal and/or at least actuarially equivalent to one of the base benchmark options documented in the ABP 5 submissions is assured in accordance with the assurance in ABP 3 and the ABP 5 supplemental benefit review documentation and Indiana's HIP 2.0 1115 Demonstration and associated HIP Link protocol.

Federally Qualified and Rural Health Centers

Federally Qualified and Rural Health Centers and services are covered even when not in network with the HIP Link approved employer health plan. HIP Link members may access these services with their HIP Link member card.

Mental Health Parity

Mental health parity is assured in accordance with the ABP 5 supplemental benefit review documentation and Indiana's HIP 2.0 1115 Demonstration and associated HIP Link protocol.

Non-emergency transportation

Coverage for non-emergency transportation in HIP Link is limited to low-income parents and caretakers and 19 and 20 year olds, individuals eligible for transitional medical assistance, and pregnant women who elect to remain in HIP Link at their regularly scheduled annual redetermination.

In alignment with Indiana's HIP 2.0 1115 Demonstration and associated HIP Link protocol, all individuals eligible in the adult group age 21 and older are not eligible for non-emergency transportation in HIP Link.

Preventive Services

Preventive services are assured in accordance with the ABP 5 supplemental benefit review documentation and Indiana's HIP 2.0 1115 Demonstration and associated HIP Link protocol.



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L-

Employer Sponsored Insurance and Payment of Premiums ABP9

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.

No

The state/territory otherwise provides for payment of premiums.

Yes

Provide a description including the population covered, the amount of premium assistance by population, required contributions, cost-effectiveness test requirements, and benefits information.

HIP Link is an optional defined contribution insurance program for all HIP eligible individuals including individuals eligible in the adult group, as low income parent and caretakers or 19 and 20 year olds, or TMA eligibles who have access to HIP Link qualifying employer sponsored insurance (ESI). As detailed in ABP 1, HIP Link also offers the opportunity for continued coverage under employer sponsored insurance for women who are pregnant at their redetermination. HIP Link allows these HIP eligible individuals to choose to enroll into their qualifying ESI instead of into HIP or Medicaid as applicable.

HIP Link enrollees receive a HIP Link card, in addition to the insurance card supplied by the ESI health plan, which serves as proof of their supplemental coverage. At the time of service, enrollees will present both the ESI primary and HIP Link supplemental coverage cards. 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. Provided the individual has HIP Link funds and uses a provider that is both in network with Medicaid and with their primary insurance, they will not be responsible for any cost sharing for services covered by their primary insurance. If the individual does not have sufficient HIP Link funds or uses a provider that is not in network for Medicaid but is in-network for their primary insurance, they will be responsible for the maximum allowable Medicaid cost sharing amounts. Cost sharing will not be applied to pregnant members, Native American members, or members that have met their 5 percent of quarterly income cost sharing limit.

HIP Link provides enrolled individuals with a \$4,000 HIP Link Personal Wellness and Responsibility (POWER) account. 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.

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.

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 (remove since stated below, and the state will mail the employee pre-payment checks for the difference between the premium amount and their 2 percent POWER account contribution.) Individuals 2 percent contributions are in addition to the \$4,000 provided by the state to cover premiums and out of pocket costs. 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. To ensure that the pre-payment 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.

To be eligible for HIP Link, an employer plan must meet the HIP Link (added-benefit requirements and) 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 may vary by employer, it is possible that a small group plan that is HIP Link eligible with one employer is not HIP Link eligible with another employer due to a higher premium amount or not offering an HRA.



Alternative Benefit Plan

The state's actuary, Milliman Inc., has developed a plan 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.), average HIP Link enrollee 2% contribution limits, the projected costs of coverage on HIP Link with the applicable cost sharing limits, and the costs of coverage in HIP. If the affordability tool analysis determines that the employer plan is less costly than standard HIP, then the plan will be considered affordable and eligible for HIP Link.

Individuals enrolled in 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. Benefits offered on the employer plan are reviewed for alignment with the benefits in one of the ABP 5 submissions which are based on the state essential health benefits benchmark options and coverage in all EHB categories, with the exception of pediatric dental and vision is required.

HIP Link will also cover services, required by the alternative benefit plan that may not be covered by the primary insurer including family planning at non-network providers (is non correct?), 72 hour emergency supply of pharmaceuticals, FQHC and RHC services, and non-emergency transportation for low-income parents and caretakers (and EPSDT?). Payments for these services will come from the HIP Link POWER account and be accessed by providers submitting claims to HIP Link utilizing the information on the member's HIP Link card. 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.

HIP Link members that complete a year of coverage in HIP Link will be eligible for rollover. HIP Link rollover is similar to HIP Basic Rollover in the initial coverage year and 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.

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

The beneficiary will receive a benefit package that includes a wrap of the following: FQHC and RHC services, family planning services, EPSDT for individuals under 21 and, for applicable populations as specified in this ABP SPA, non-emergency transportation (? 72 hour). Further information related to ABP9 is contained in Indiana's HIP 2.0 1115 Demonstration and associated HIP Link protocol.

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