Filing at a Glance

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Submitted By: Rick Kramer

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Indiana only on FFM.

Company and Contact

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Filing Company Information

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State:	*Indiana*	***Filing Company:***	*Southeastern Indiana Health Organization, Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*		
Product Name:	*Individual QHP Plans*		
Project Name/Number:	*2015 Exhange/QHP INDV-05.2014*		

Form Schedule

Lead Form Number: QHP INDV-05.2014

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Certificate of Coverage	QHP	CER	Initial		43.000	SIHO FI SPD template 2014 Individual Market - 8.5.14 Final.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

SOUTHEASTERN INDIANA HEALTH ORGANIZATION, INC

INDIVIDUAL CERTIFICATE OF COVERAGE

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, You may return it to SIHO or the agent who sold it to you within 10 days after you receive it or have access to it electronically, whichever is earlier. Your premium will be refunded and this Contract will be void from its start.

Guaranteed Renewable: Coverage under this Contract is guaranteed renewable, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Contract by payment of the renewal premium by the end of the grace period of any Premium due date. The Exchange may refuse renewal only under certain conditions.

SIHO Insurance Services
417 Washington St.
Columbus, IN 47203

Form No. QHP INDV-05.2014

Revised May 2014

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DECLARATIONS

A. Agreement to Offer Plan

SIHO is offering this Health Plan to Individuals and their eligible Dependents.

B. Term

The term of this Agreement begins on the Effective Date of coverage.

C. Eligibility

The eligibility of the Individual and any eligible Dependents to enroll in thee Health Plan will be defined in terms of the eligibility requirements in Article II subject to the following limitations:

1. Each person making application outside of open enrollment to be a Participant is required to provide evidence of a qualifying event for coverage, excluding newborns and adopted children.

D. Effective Date of Coverage

1. Open Enrollment Period Open Enrollment periods will be held each year according to rules established by the Exchange.

2. Newborn & Adopted Child Coverage is automatic for newborn children and newly adopted children during the first 31 days of their eligibility. Coverage for newborns and newly adopted children will continue beyond the first 31 days as long as they are enrolled within 31 days of becoming eligible, the applicable enrollment fees have been paid, and other provisions of this Agreement have been met. Newborn children will be treated as Dependents from birth. Legally adopted children will be treated as Dependents from the earlier of the date of placement for the purpose of adoption; or the date of the entry of an order granting the adoptive Participant custody of the Child for purposes of adoption.

3. Special Enrollment If an individual does not enroll himself or dependents in the Health Plan during open enrollment, the individual may be eligible to enroll himself and his dependents in the Health Plan in a special enrollment if he or his dependents experience a qualifying life event, such as marriage, divorce, or involuntary loss of coverage. Events which allow a Qualified Individual or enrollee to enroll in a Qualified Health Plan or switch coverage to another QHP, outside of the Open Enrollment Period, include:

    a. Loss of Minimum Essential Coverage;

b. Enrollee gains or loses a Dependent, including situations where the enrollee becomes a Dependent on other coverage, due to marriage, birth, adoption or placement for adoption;

c. Change in citizenship status;

d. Loss of coverage in a QHP through an unintentional error or mistake;

e. A Qualified Individual demonstrates to the Exchange that their current QHP has violated its contract with the Qualified Individual;

f. A Qualified Individual becomes eligible or ineligible for Advance Payments of the Premium Tax Credit or has a change in eligibility for cost-sharing reductions, regardless of current enrollment status of the Qualified Individual;

g. A Qualified Individual loses existing coverage through an employer sponsored plan, or the employer sponsored plan will no longer be affordable or provide minimum value for the upcoming Plan Year. Such Qualified Individuals' Special Enrollment rights run through the end of their coverage under the eligible employer sponsored plan.

h. A Qualified Individual moves into or out of the Service Area.

For other examples of qualifying events that trigger special enrollment rights, please see **https://www.healthcare.gov/glossary/qualifying-life-event/**.

To qualify for this special enrollment, the individual must submit an enrollment form within 30 days after the other health coverage ends and provide sufficient information to establish that the individual lost the other health coverage involuntarily, if applicable. The effective date of coverage for special Enrollees is the eligible date of the qualifying life event. If an individual or his Dependents lose coverage under Medicaid or a state child health program the individual has 60 days after the coverage ends to enroll in the Health Plan.

4. Late Enrollment If an individual fails to enroll during an open enrollment period or within 31 days of becoming newly eligible, the individual must wait for an open enrollment period to enroll unless the individual qualifies for special enrollment.

E. Misstatement of Age

If premium fees and/or benefits are based upon age, and a misstatement of age is discovered, the corrected benefits and premium fees will be adjusted retroactively for 60 days.

F. Incontestability

The validity of the policy may not be contested, except for nonpayment of premiums, after the policy has been in force for 2 years. No statement made by a covered person, relating to the covered person, will be used in contesting the validity of the coverage unless the statement is in written form and signed by the covered person.

G. Health Insurance Portability and Accountability Act of 1996

This policy complies with the provisions of HIPAA and provides portability and guaranteed renewability as described in this federal regulation.

I. GENERAL PROVISIONS

A. Definitions

Wherever used in this document, the following words and terms, when capitalized, have the following meanings, unless a different meaning is clearly indicated by the context.

"ACA" means the Patient Protection and Affordable Care Act, as amended (including the amendments contained in the Health Care and Education Affordability Reconciliation Act of 2010), and all applicable regulations issued hereunder.

"Acute Rehabilitation Hospital" means a licensed and accredited institution which provides professional services to those needing intensive therapies to regain normal body function. Services include: physical, occupational, pulmonary and speech therapies. Services must be delivered by a licensed therapist for a minimum of 3 hours per day, and the institution must have 24 hour nursing by a licensed nurse under the direction of a full-time RN, complete medical records for each patient, utilization review and discharge plan, and a physiatrist or licensed physician overseeing the care on staff.

"Agreement" means this Certificate of Coverage, including all attachments, endorsements, amendments, and addenda.

"Appeals Hearing Committee" means a committee designated by SIHO to investigate appeals of decisions on Grievances.

"Autism Spectrum Disorder (ASD)" means a group of developmental brain disorders including: classic Autism, Asperger's disorder, Pervasive developmental disorder, Rett's disorder, and Childhood disintegrative disorder. ASD is diagnosed according to the most current guidelines listed in the Diagnostic and Statistical Manual of Mental Disorders.

"Centers of Excellence" means a specialized network of providers that have expertise in the transplantation of human organs and tissues with whom SIHO has a contract to provide transplant services to Enrollees. Networks considered to be Centers of Excellence are determined by SIHO and/or its reinsurance carrier.

"Child" or **"Children"** means any of the following individuals age 25 or under:

a. A Participant's natural born child;

b. A Participant's stepchild;

c. A Participant's legally adopted child, from the earlier of the date of placement for adoption or the date of entry of an order granting the Participant custody of the child for the purpose of adoption;

d. Any child for whom the Participant is subject to legal guardianship or legal custody

e. Any child for whom the Participant is legally responsible for Medical Care by a qualified medical child support order, as defined in ERISA.

"Claim" means any claim for benefits under the Health Plan, including Urgent Care Claims, Concurrent Care Claims, Pre-Service Claims and Post-Service Claims.

"Clean Claim" means a claim received by SIHO with all the information needed to complete the review of the claim and apply the appropriate benefit or exclusion provision. SIHO will pay or deny a clean claim within 30 days of submission if filed electronically or 45 days of submission if filed via paper.

"COBRA" means the health continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

"Coinsurance" means the percentage of covered charges for which an Enrollee is responsible under the terms of this Agreement.

"Concurrent Care Claim" means any Claim with respect to an ongoing course of treatment provided over a period of time or number of treatments that SIHO has approved.

"Consulting Provider" means any Individual Health Care Provider or Institutional Health Care Provider who or which is not a Participating Provider, but who or which has entered into a contractual arrangement with SIHO to provide services within the range of a designated specialty area of practice.

"Continuation Coverage" means Coverage provided under this Agreement in accordance with the provisions of Article XI.

"Copayment" means a specific amount as set forth in Article IV that an Enrollee must pay in connection with the receipt of services.

"Coverage" means coverage for an Enrollee under the Health Plan.

"Covered Benefits" means the Medical Care specified in this Agreement for which benefits will be provided. In order to be considered a Covered Benefit, charges for the Medical Care must be incurred while the Enrollee's Coverage is in force.

"Custodial Care" means care or service that is primarily designed to assist an Enrollee in the activities of daily living or is provided in order to maintain the Enrollee's state of health and cannot be expected to improve a medical condition. Custodial Care can be performed by individuals without professional skills. Custodial Care includes, but is not limited to:

a. Administration of medicines, dressings or therapies that can be self-administered;

b. Routine monitoring of vital signs; and

c. Help in walking, getting in and out of bed, bathing, dressing, and eating.

"Deductible" means the specified dollar amount of covered charges that an Enrollee must pay before benefits that are subject to the Deductible will be paid.

"Delegated Network" means an organization contracted with SIHO to provide a network of health care providers. Designated as "in-network" with respect to the Health Plan.

"Dependent" means a Child or spouse of a Participant who meets the Dependent eligibility requirements of this Agreement, has enrolled in the Health Plan, and has paid (and SIHO has received) the enrollment fee required by this Agreement.

"Designated Representative" means an individual who represents and acts on behalf of an Enrollee, and may be, without limitation, a provider. As used in Article XIII, Procedures for Claiming Benefits, all references to an Enrollee or claimant will also include the Enrollee's or claimant's Designated Representative.

"Eligible Charges" for services provided by a Participating Provider shall mean the lesser of billed charges or the contracted rates between the provider and SIHO for Covered Benefits. For services provided by Non-Participating Providers, eligible Charges shall mean the lesser of the providers' billed charges or the most recently published Medicare reimbursement rates for the Covered Benefits provided, except for emergency services which are calculated as described in Article IV.

"Emergency Accident" or **"Emergency Illness"** means a medical condition of such an acute nature that a prudent person, with average knowledge of medicine and health, would believe that the absence of immediate medical attention could result in serious medical complications, loss of life, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

"Enrollee" means any Participant or Dependent.

"Evidenced Based Pharmacy Plan (EBPP)" means a prescription drug benefit plan available to Enrollees with specified chronic medical conditions and who are actively participating, as determined by SIHO, in their Disease Management, Case Management, and/or other Medical Management programs.

"Experimental" or **"Investigational"** means any treatment, equipment, technology, drug, procedure or supply that does not satisfy all of the following requirements:

a. The treatment, equipment, technology, drug, procedure or supply has received final approval from the appropriate governmental regulatory bodies;

b. Scientific evidence permits conclusions concerning the effect of the treatment, equipment, technology, drug, procedure or supply on health outcomes;

c. The treatment, equipment, technology, drug, procedures or supply improves the net health outcome;

d. The improvement is attainable outside the research setting; and

e. The treatment, equipment, technology, drug, procedure or supply is generally accepted as standard medical treatment of the condition being treated.

In addition, clinical trials for which the law requires coverage are not considered "Experimental" or "Investigational."

"Grievance" means an expression of dissatisfaction, either oral or written, regarding the availability, delivery, appropriateness, or quality of Medical Care; handling or payment of claims for health care services; or matters pertaining to the contractual relationship between the Participant and the Health Plan.

"Health Plan" means the SIHO health care delivery plan as set forth in this Agreement.

"Health Plan Medical Director" means the physician(s), or his appointee, designated by SIHO to provide clinical oversight of SIHO's medical management.

"Health Plan Enrollee Services" means the SIHO office that is primarily responsible for responding to the concerns and questions of Enrollees about Health Plan Coverage and procedures and for handling Claims.

"Individual Health Care Provider" means an individual licensed to provide health services.

"Inherited Metabolic Disease" means a disease caused by inborn errors of amino acid, organic acid, or urea cycle metabolism and treatable by the dietary restriction of one or more amino acids.

"Inpatient Rehabilitation Services" means those services that are part of a separate and distinct inpatient program that provides highly skilled rehabilitation care.

"Institutional Health Care Provider" means a facility licensed to provide health services.

“Long Term Acute Care Hospital (LTACH) Services” means comprehensive inpatient services in a licensed acute care hospital for patients who require specialized, complex services, and are stable enough to move to an LTACH. These services require daily physician monitoring and intensive nursing care, generally with a length of stay of twenty-five (25) days or more. Examples include ventilator dependent patients and patients requiring wound care management, IV therapy, dialysis, and telemetry. Intensive Care Unit days are not considered LTACH Services.

"Medical Food" means a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered entirely under the direction of a physician.

"Medically Necessary" means Medical Care that is (1) consistent with the diagnosis of and prescribed course of treatment for the Enrollee's illness or injury; (2) required to treat the Enrollee's illness or injury; (3) not provided solely for the convenience of the Enrollee or provider and not required solely for Custodial Care or for comfort or maintenance reasons; (4) performed in the most cost-effective setting appropriate for the injury or illness; (5) not Experimental or Investigational; (6) appropriate treatment according to generally accepted medical standards and rendered at the frequency that is accepted in the medical community; (7) likely to be effective in treating the injury or illness; and (8) not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment to the Enrollee. The fact that a physician prescribes, orders, recommends, or approves the Medical Care does not necessarily mean that the Medical Care is Medically Necessary.

"Medical Care" means the services and supplies that Individual Health Care Providers or Institutional Health Care Providers provide within the scope of their licenses and any of the medical supplies and ancillary services listed in Article IV.

"Medicare" means the program of medical care benefits for the aged and disabled described in Title XVIII of the federal Social Security Act of 1965, as amended.

"Morbid Obesity" means (1) a body mass index of at least 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or (2) a body mass index of at least 40 kilograms per meter squared without comorbidity.

"Network Benefit" means a Covered Benefit provided by a Participating Provider or, with prior written authorization from the Health Plan Medical Director, by a Consulting Provider or Non-Participating Provider.

“Never Events” mean serious reportable adverse events as defined by the National Quality Forum (NQF), or other national bodies, including but not limited to Health and Human Services (HHS). Medical errors that should never happen.

"Non-Network Benefit" means a Covered Benefit rendered by a Consulting Provider or Non-Participating Provider, without prior written authorization from the Health Plan Medical Director.

"Non-Participating Provider" means any Individual Health Care Provider or Institutional Health Care Provider who or which is neither a Participating Provider nor a Consulting Provider.

"Participant" means an individual who has enrolled in the Health Plan, and has paid (and SIHO has received) the enrollment fee required by this Agreement.

"Participating Physician" means a doctor of medicine, osteopathy, or oral surgery who is a Participating Provider.

"Participating Provider" means an Individual Health Care Provider or an Institutional Health Care Provider who or which, at the time care is rendered to an Enrollee, has a provider agreement in effect with SIHO or its Delegated Network.

"Post-Service Claim" means any Claim for benefits under the Health Plan that is not a Pre-Service Claim, Urgent Care Claim or Concurrent Care Claim.

"Precertification" means the process used to determine that Medical Care is Medically Necessary before it is provided to the Enrollee. The description of Covered Benefits in Article IV and the Schedule of Benefits indicate the types of Medical Care that require Precertification.

"Pregnancy" means the condition of being pregnant and includes childbirth, spontaneous abortion, or miscarriage.

"Pre-Service Claim" means any Claim for benefits under the Health Plan for which the Health Plan requires Precertification.

"Prevailing Rates" means the rates generally prevailing in the Service Area for medical, surgical, hospital and related health care services.

"Preventive Health Benefits Guidelines" means the guidelines established by SIHO in accordance with the ACA that describe the schedules for receiving preventive health care services in accordance with the Agreement.

"Primary Care Physician" or **"PCP"** means a Participating Physician specializing in general practice, family practice, internal medicine, or pediatrics.

Qualified Health Plan (QHP) means a health plan that has a certification from each Exchange through which such health plan is offered.

Qualified Individual means an individual who has been determined to be eligible for enrollment in a QHP, through the Exchange, and who meets all eligibility requirements.

"Service Area" means the geographic area set forth in Attachment A.

"SIHO" means Southeastern Indiana Health Organization, Inc., an Indiana corporation operating as a health maintenance organization under Indiana Code § 27-13-1-1 et seq.

"Skilled Nursing Facility" or **"SNF"** means a licensed institution, as defined in Medicare, 42 U.S.C. § 1395x (j), that is primarily engaged in providing skilled nursing facility services and related services. "Skilled Nursing Facility" does not mean a facility that operates primarily for the aged, alcoholics, or drug addicts, for treatment of nervous disorders or mental disease, or for rest, educational, or Custodial Care purposes. It also does not include a community-based residential treatment facility or a community re-entry program.

"Urgent Care Claim" means any Claim, if processing the Claim within the Health Plan's normal time frames (1) could seriously jeopardize an Enrollee's life, health, or ability to regain maximum function; or (2) in the opinion of a physician with knowledge of the Enrollee's medical condition, would subject the Enrollee to severe pain that cannot be adequately managed without the Medical Care requested in the Claim.

B. Rules of Construction

1. Words used in the masculine gender will be construed to include the feminine gender, where appropriate, and vice versa.

2. Words used in the singular will be construed to include the plural, where appropriate, and vice versa.

3. The headings and subheadings in this Agreement are inserted for convenience of reference only and are not to be considered in the construction of any provision of the Agreement.

4. If any provision of this Agreement or the Health Plan is held to violate any state or federal law or to be invalid for any other reason, that provision will be deemed to be null and void. The invalidation of a provision will not otherwise impair or affect the remainder of the Agreement.

5. The Agreement will be construed and governed in all respects under and by the internal laws of the State of Indiana and federal laws and statutes, as applicable.

6. As an HMO, SIHO operates primarily on the basis of arranging for network services on a negotiated rate, direct service basis rather than an indemnity basis. This Agreement will be interpreted with this prepaid, direct service nature of SIHO's services in mind.

II. ELIGIBILITY

Unless SIHO and Employer agree otherwise, the following eligibility rules apply:

A. Participant Eligibility

To enroll as a Participant an individual must reside in the Service Area and must be eligible for coverage as defined under the ACA and the applicable rules of the Exchange, as set forth by the Indiana Department of Insurance. Eligibility requirements for a Qualified Individual under a Qualified Health Plan include:

1. U.S. citizenship, or be a qualified U.S. national;
2. For a non-citizen, be lawfully present in the United States for the entire coverage period;
3. Be an Indiana resident, and living within the service area covered by this contract;
4. Not institutionalized (whether in a penal institution, a mental institution, or other similar arrangements);
5. Not be covered by, nor eligible for, Medicare, whether Parts A, B or D;
6. Not covered by any other health benefit plan, whether group or individual;
7. Not receiving any SSP (State Supplementary Payments) or similar subsidies;
8. Be over 21 years of age, and have the capacity to legally enter into a contract;
    a. If under 21 years of age, a Participant must;
        i. Not be eligible for Medicaid, SSP, or similar government programs, whether federal or state;
        ii. Not be institutionalized;
        iii. Not be emancipated;
        iv. Be capable of legally entering into a contract, or be capable of having a guardian sign;
9. Willing to reveal any and all other health benefit arrangements, including any that affect coordination of benefits, both at the outset of coverage and at any time during the coverage under this contract.
10. Willing to and agree to pay the required premiums for coverage under this contract.

B. Dependent Eligibility

To enroll as a Dependent an individual must be:

1. The spouse of a Participant, except a divorced spouse; or

2. A Child

A Dependent Child's Coverage will terminate when the Child attains the age of 26, unless the Child has a mental or physical disability that manifested itself prior to the age of 26 and renders the Child incapable of self-sustaining employment and the Child depends upon the Participant for support and maintenance.

The Participant must furnish SIHO with proof of the Dependent's incapacity within 120 days of the date the Child attained the age of 26 and at each subsequent open enrollment period. SIHO may continue to require such proof at reasonable times each year except that, after the first two years, SIHO may not request proof more than once a year.

C. Other Rules of Eligibility

1. No one will be denied enrollment or re-enrollment in the Health Plan because of health status, requirements for Medical Care, or the existence of a pre-existing physical or mental condition.

2. No one may re-enroll in the Health Plan if his Coverage has been terminated under Article IX, Section A3, for failure to furnish information or furnishing incorrect or incomplete information, or under Article IX, Section A4, for misuse of identification card. Also, no one may re-enroll in the Health Plan if his Coverage has been terminated under Article IX, Section A5, for failure to pay certain amounts due unless the amounts have been fully paid subsequent to the termination and re-enrollment is approved by SIHO in its discretion.

3. A Participant may not enroll the spouse or dependent of a Child as a Dependent in the Health Plan.

D. Enrollment

Individuals and their eligible dependents who meet the requirements of this Article II may enroll by completing SIHO's enrollment applications and submitting them to SIHO. SIHO must receive the applications before applicants will be considered for enrollment.

III. MANAGED CARE

The goal of managed care is to reduce the cost of Medical Care while maintaining or improving the quality of those services. Managed care methods include, but are not limited to,

utilizing Primary Care Physicians to manage the Enrollee's health care, Precertification, case management, disease management, and utilization review.

A. Non-Network Benefits: Out-of-Plan Deductibles and Higher Coinsurance.

If an Enrollee receives Medical Care from a Consulting Provider or Non-Participating Provider without a written authorization from the Health Plan Medical Director, the Covered Benefits will be subject to higher Deductibles and Coinsurances. These provisions may not apply to coverage for Emergency Accident or Emergency Illness

B. Non-Network Benefits: Non-Participating Provider Reimbursement

If an Enrollee receives Medical Care from a Non-Participating Provider, SIHO will pay the Non-Participating Provider no more than the most recently published Medicare reimbursement rates for those services. The Non-Participating Provider may bill the enrollee for any difference between their billed charges and the Medicare reimbursement rates, if applicable. These provisions may not apply to coverage for Emergency Accident or Emergency Illness.

C. Precertification

Precertification ensures that the Medical Care an Enrollee will receive is covered by the Health Plan. The description of Covered Benefits in Article IV and the Schedule of Benefits indicate the types of Medical Care that require Precertification. If an Enrollee needs Precertification of Medical Care, the Enrollee or someone on the Enrollee's behalf (such as a family member or PCP) needs to call SIHO or their Delegated Network at the number indicated on the Enrollee's identification card. See Article XV for additional information regarding Precertification.

D. Individual Case Management

The goal of case management is to ensure that an Enrollee receives appropriate care in the most cost-effective setting. If an Enrollee has a catastrophic injury or illness or otherwise needs long-term medical care, SIHO will work with the Enrollee, the Enrollee's PCP or specialist, and the Enrollee's family members, if appropriate, to develop a treatment plan. As part of the treatment plan, SIHO may provide benefits for services that are not otherwise covered by the Health Plan. SIHO must approve and arrange for all customized services and alternative care arrangements. Coverage for alternative care is subject to the same maximums, Deductibles, Coinsurances and Copayments that apply to Medical Care being replaced.

E. Chronic Disease Management

If an Enrollee has a chronic disease, SIHO will work with the Enrollee and the Enrollee's PCP or specialist to whom the Enrollee is properly referred to develop an appropriate treatment plan in a cost-effective manner. Examples of chronic diseases include, but are not limited to, diabetes, asthma, and heart disease.

F. Medical Necessity, Experimental or Investigational Determinations and Utilization Review

The Health Plan Medical Director, or his designee, is responsible for determining whether Medical Care is Medically Necessary, Experimental or Investigational and for making all other medical benefit determinations. Whenever a benefit determination is based on a decision of whether the service is Medically Necessary, the decision is subject to utilization review by a member of a qualified panel appointed by SIHO.

G. Qualifications of Medical Provider

The Health Plan Medical Director, or his designee, has discretion to decide whether certain Medical Care must be provided by a physician or may be provided by other appropriately licensed health professionals.

IV. BENEFITS AND COVERAGE

This Article describes the Medical Care that will be covered by the Health Plan. The Schedule of Benefits attached indicates the extent of Coverage that will be provided, including any Deductible, Copayment, or Coinsurance requirements and maximum Coverage limitations. Article V lists any exclusions and limitations applicable to the services or supplies described in this Article. All Medical Care must be Medically Necessary and provided in accordance with the provisions of this Agreement. SIHO may change the benefits described in this Article IV and the Schedule of Benefits in accordance with any changes in applicable federal or state law.

A. Inpatient Hospitalization and Surgery (Requires Precertification)

Room and Board: semi-private room.

> Note: If an Enrollee chooses a private room, the Enrollee is responsible for paying any amount in excess of the Prevailing Rate for the average semi-private hospital room, unless use of a private room is Medically Necessary or the hospital only has private rooms.

Room and board: ancillary charges.

Specialty care units such as intensive care, cardiac care, and burn care units.

Surgery services including diagnostic services and therapy services directly related to the covered surgery, x-rays, assistant surgery services, and other physician or specialist fees.

Anesthesia, including local and general anesthesia.

Inpatient medical visits.

Pregnancy services and supplies, including examination and testing of newborns

Coverage for the Inpatient postpartum stay for you and your newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care. Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if your attending Physician determines further Inpatient postpartum care is not necessary for you or your newborn child, provided the following are met and the mother concurs:

- • In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:

  1. the antepartum, intrapartum, and postpartum course of the mother and infant;
  2. the gestational stage, birth weight, and clinical condition of the infant;
  3. the demonstrated ability of the mother to care for the infant after discharge; and
  4. the availability of post-discharge follow-up to verify the condition of the infant after discharge.

Hospital ancillary services, including diagnostic services.

Human organ and tissue transplants when provided by a Center of Excellence as follows:

1. Precertification Requirement for Transplant Evaluation

   Expenses incurred in connection with the evaluation of an Enrollee for any human organ or tissue transplant will be covered but only after Precertification through SIHO has occurred. The Enrollee or his physician should contact SIHO for Precertification of the evaluation process.. SIHO will assign a case manager to work with the Enrollee closely through the transplant process.

2. Precertification Requirement for Transplant Procedure

   After the evaluation by a Health Plan-designated transplant physician has occurred, the Enrollee or the transplant physician should contact the case manager. Medical information about the Enrollee's condition and the proposed transplant protocol will be requested for review. The case manager will coordinate the review of the medical information for coverage determination and to determine whether the transplant is Medically Necessary. The case manager will communicate the determination to the Enrollee and transplant physician.

3. Definitions

a. **"Covered Transplant Procedures"** means any of the following human organ and tissue transplant procedures determined to be Medically Necessary:

(1) Heart

(2) Liver

(3) Bone Marrow (related or unrelated)

(4) Lung

(5) Kidney

(6) Cornea

(7) Simultaneous Pancreas/Kidney

(8) Simultaneous Heart/Lung

(9) Intestinal

(10) Simultaneous Intestinal/Liver

(11) Simultaneous Intestinal/Pancreas

b. **"Transplant Services"** means any services directly related to a Covered Transplant Procedure and performed at a Center Of Excellence including, but not limited to, inpatient and outpatient hospital services, physician services for diagnosis, treatment, and surgery for a Covered Transplant Procedure, diagnostic services, and procurement of an organ or tissue, including services provided to a living donor of an organ or tissue for procurement of an organ or tissue, as well as surgical, storage and transportation costs incurred and directly related to the successful acquisition of an organ or tissue used in a Covered Transplant Procedure. Transplant Services also includes, but is not limited to, durable medical equipment rental outside of the hospital, prescription drugs including immunosuppressive, surgical supplies and dressings, and home health care.

Note: Transportation and lodging are covered, as approved by the Plan, up to a $10,000 benefit limit per transplant. Unrelated donor searches for bone marrow/stem cell transplants for a Covered Transplant Procedure are covered, as approved by the Plan, up to a $30,000 benefit limit.

4. Specific Exclusions for Organ/Tissue Transplants

There are no benefits for:

a. Services and supplies of any provider located outside the United States of America, except for procurement services which will be limited to those nations which share the same protocols, standards and registry with the United States.

b. Services and supplies which are eligible to be repaid under any private or public research fund, whether or not such funding was applied for or received.

c. Implant of an artificial or mechanical heart or part thereof. This does not include replacement of a heart valve.

d. Services for non-human organ transplants.

e. All other exclusions, limitations or conditions set forth in this Health Plan shall apply to Transplant Services unless otherwise provided in this Transplant Services section.

B. Physician Services and Outpatient Services

Physician office and home visits.

Physical examinations as set forth in the Preventive Health Benefits Guidelines

Well baby care, including immunizations and infant screening tests, as set forth in the Preventive Health Benefits Guidelines.

Specialist care/consultation.

Pregnancy services including prenatal and postnatal care.

X-ray, lab, and diagnostic services.

Breast cancer screening Coverage includes:

a. One mammography for female Enrollees age 35 to 39;

b. One mammography per year for female Enrollees under age 40 who are considered "at risk." An Enrollee is considered "at risk" if she meets one of the following criteria:

(1) The Enrollee has a personal history of breast cancer;

(2) The Enrollee has a personal history of breast cancer that was proven benign by biopsy;

(3) The Enrollee's mother, sister, or daughter has had breast cancer; or

(4) The Enrollee is at least 30 years old and has not given birth.

c. One mammography per year for female Enrollees age 40 or older; and

d. Any additional mammography and ultra sound services that are Medically Necessary

Breast reconstruction and prosthesis following a mastectomy

Colorectal cancer screening Coverage includes:

1. Testing for Enrollees age 50 or older; and

2. Testing for Enrollees under age 50 that is considered at high risk for colorectal cancer according to the most recent published guidelines at the American Cancer Society.

Prostate cancer screening Coverage includes:

1. One screening per year for male Enrollees age 50 or older; and

2. One screening per year for male Enrollees under age 50 who are considered at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

Outpatient surgery (Requires Precertification)

Radiation therapy for the treatment of disease by x-ray, radium or radioactive isotopes (Requires Precertification)

Chemotherapy for the treatment of disease by chemical or biological antineoplastic agents (Requires Precertification)

Dialysis treatment for acute renal failure or chronic irreversible renal insufficiency for removing waste materials from the body. Dialysis requires Precertification. Please review the Schedule of Benefits for specific limits.

Respiratory inhalation therapy for the introduction of dry or moist gases and water vapor into the lungs.

Family planning, infertility screening, diagnostic testing, and counseling to determine infertility. Covered Benefits may include treatment or surgical procedures for infertility/fertility conditions. Please refer to the Schedule of Benefits.

Chiropractic and other manipulative services to treat structural imbalance or to remove nerve interference in connection with distortion, misalignment or sublaxation of or in the vertebral column. Chiropractic and other manipulative services are subject to an annual maximum.

Routine vision screening (Snellen eye chart) by Primary Care Physician during an office visit.

Routine hearing screening (Audiometric testing) by Primary Care Physician during an office visit.

Physical medicine therapies, which include the following:

> Physical therapy, hydrotherapy, heat or similar therapies, and therapies using physical agents or bio-mechanical and neuro-physiological methods. The therapies must be designed to relieve pain, restore function, and prevent disability following disease, injury, or loss of body part.
>
> Speech therapy for speech impairment resulting from disease, surgery or injury. Speech therapy does not include language training for educational, psychological or developmental speech delays. Benefits will not be provided for speech therapy provided by schools.
>
> Occupational therapy for the treatment of physically disabled Enrollees. The therapies must be designed to restore the Enrollee's ability to perform ordinary tasks of daily living.
>
> Note: The Health Plan covers a limited number of visits for physical medicine therapies. Please review the Schedule of Benefits for specific limits.

Immunizations as set forth in the Preventive Health Benefits Guidelines.

Cardiac rehabilitation, which is an individually prescribed exercise program for cardiac patients. Cardiac rehabilitation is designed for Enrollees who have had bypass surgery, stable angina pectoris, or acute myocardial infarction within the past twelve months. Home exercise programs, on-going conditioning and maintenance are not covered.

> Note: The Health Plan covers a limited number of visits for cardiac rehabilitation. Please review the Schedule of Benefits for specific limits.

Treatment for Autism Spectrum Disorder as prescribed by a Participating Physician in a treatment plan for the Enrollee. Treatment is subject to the same Coinsurance, Copayments and Deductibles as other primary health care services and benefits.

> Note: Exclusions and limitations contained elsewhere in the Health Plan do not apply to the treatment of Autism Spectrum Disorder.

C. Mental Illness and Substance Abuse. (Requires Precertification)

Inpatient, outpatient and physician office services for treatment of mental health disorders and substance abuse. Services covered include:

- Inpatient services
- Individual psychotherapy
- Psychological testing
- Family counseling to assist in diagnosis and treatment of Enrollee
- Convulsive therapy, including electroshock treatments and convulsive drug therapy
- Partial hospitalization/intensive outpatient therapy
- Outpatient services

Please review the Schedule of Benefits for specific limits.

D. Other Benefits and Services.

Ambulance Services; Local transportation by a vehicle designed, equipped and used only to transport the sick and injured. The following services, if Medically Necessary, are covered: (1) transportation from the home of the Enrollee, the scene of the accident or the scene of the medical emergency to a hospital, (2) transportation between hospitals, (3) transportation between a hospital and a Skilled Nursing Facility, and (4) transportation from a hospital or skilled nursing facility to the home of the Enrollee. Ambulance trips must be made to the closest local facility that can give Covered Services appropriate for the condition.

Emergency care services received at a hospital or other health care provider facility for an Emergency Accident or Emergency Illness.

Note: Benefits for emergency care services performed by Non-Participating Providers will be calculated by the greater of:

- The amount negotiated with Participating Providers for emergency care services;
- The amount for emergency care services as calculated elsewhere in this Agreement for Non-Participating Providers, but substituting cost sharing provisions applicable to a Participating Provider
- Applicable Medicare reimbursement

Allergy testing and treatment.

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Benefit under this Plan. Covered Benefits are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child.
- Breast reconstruction resulting from a mastectomy.
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Prescription drugs limited to those medicines requiring a prescription under federal law (Experimental or Investigational drugs are not included), insulin, and insulin syringes. The Health Plan does not provide Coverage for vitamins. The Health Plan will provide Coverage for pre-natal vitamins if pregnancy services and supplies are otherwise covered. The Health Plan may provide Coverage for other categories of drugs. Please refer to the Schedule of Benefits for specific exclusions.

Note: Coverage is provided for "off label drug treatment" to the extent required by Indiana law.

Medical supplies received during a primary or specialty care office visit or on an inpatient basis. The supplies must be primarily and customarily used to serve a medical purpose and generally not useful to an individual in the absence of an illness or injury.

Medical aids, including prosthetic devices, durable medical equipment, and orthotic appliances. Precertification is required for all rentals of medical aids and for purchases of medical aids that cost more than $200.

Covered Benefits for prosthetic devices are limited to the initial purchase, fitting, repair and replacement of fitted devices that replace body parts or perform bodily functions. Routine maintenance is not a Covered Benefit and charges for deluxe items are limited to the cost of standard items.

Covered Benefits for durable medical equipment are limited to the rental, repair and replacement of equipment that is appropriate for home use and manufactured mainly to treat the injured or ill. Routine maintenance is not a Covered Benefit and charges for deluxe items are limited to the cost of standard items.

Covered Benefits for orthotic appliances are limited to the initial purchase, fitting, repair, and replacement of braces, splints, and other appliances, used to support or restrain a weak or deformed part of the body. Covered Benefits do not include foot support devices, such as arch supports and corrective shoes (unless they are an integral part of a leg brace), and standard elastic stockings, garter belts, and other supplies not specifically made or fitted. Routine maintenance is not a Covered Benefit and charges for deluxe items are limited to the cost of standard items.

Diabetes treatment, supplies, equipment, and self-management training.

Eyeglasses after cataract surgery. Limited to one initial pair of eyeglasses after cataract surgery is performed.

Medical Food that is Medically Necessary and prescribed for an Enrollee by a physician for treatment of the Enrollee's Inherited Metabolic Disease.

Medical Services for treatment of victims of abuse.

Covered Benefits for Clinical Trials

Routine patient care costs that are covered:

- That payer would cover for a patient not enrolled in a clinical trial
- Services required for the provision of the investigational item or service
- Services needed for reasonable and necessary care arising from the provision of the investigational item or service.

Routine patient care costs that are not covered:

- Investigational item, device, or service, itself;
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

In order to be considered a Covered Benefit the following criteria must be met:

- A physician must determine and document that the member is appropriate for a clinical trial; and
- The member must meet the eligibility criteria of the trial.

- The trial must be:
    - Conducted for the prevention, detection or treatment of cancer or other life threatening disease or condition**; and is**
    - Federally funded; or
    - Sponsored by FDA; or
    - A drug trial exempt from Investigational New Drug (IND) requirements.

A trial is considered federally funded if it is approved and funded by one or more of these agencies:

- National Institutes of Health
- Centers for Disease Control
- Agency for Healthcare Research Quality
- Centers for Medicare and Medicaid Services
- Department of Defense
- Veterans Administration; or the
- Department of Energy.

E. Alternative Care Facilities. (Requires Precertification)

Skilled Nursing Facility (SNF).

Room and board.

Note: If the Enrollee chooses a private room, the Enrollee is responsible for paying any amount in excess of the Prevailing Rate for the average semi-private SNF room unless use of a private room is Medically Necessary or the SNF has only private rooms. In those cases the private room is covered subject to the same Deductible, Copayment and Coinsurance as a semi-private room.

Note: The Health Plan covers a limited number of days in a SNF. Please review the Schedule of Benefits for the specific limits.

Ancillary services including diagnostic services.

Home Health Care for home confined Enrollees referred to a home health care agency by a Participating Physician and approved by the Health Plan Medical Director. Covered Benefits are for non-custodial medical and nursing care. Home infusion therapy will be paid only if you obtain prior approval from our home infusion therapy administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy. Covered Benefits also include nutritional counseling.

Note: The Health Plan may cover a limited number of days of Home Health Care. Please review the Schedule of Benefits for any specific limits.

Hospice Care

Note: Requires a physician's statement of life expectancy less than 6 months.

F. Acute Inpatient Rehabilitation Facility. (Requires Precertification)

Note: To be eligible for Acute Inpatient Rehabilitation Services, an Enrollee must be able to participate in a comprehensive level of rehabilitation services. The services will include a minimum of three hours of therapy treatments per day with goals that can be accomplished through hospitalization. These services must happen immediately following inpatient hospital services.

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Note: The Health Plan covers a limited number of days in an Acute Inpatient Rehabilitation Facility. Please review the Schedule of Benefits for specific limits.

G. Long Term Acute Care Hospital (LTACH) Services (Requires Precertification)

Note: The Health Plan covers a limited number of days for LTACH Services. Please review the Schedule of Benefits for specific limits.

H. Preventive Health Services

The Health Plan provides Coverage for well-baby care, regular periodic health evaluations for adults and children, periodic health screenings, and routine immunizations appropriate to the age and sex of the Enrollee. All of the preventive health services are described in the Preventative Health Benefits Guidelines, which SIHO makes available to Enrollees.

I. Treatment of Dental Conditions Caused by Accidental Injuries

The Health Plan provides Coverage for the treatment of dental conditions caused by accidental injuries. The injuries must have occurred after the effective date of the Enrollee's Coverage. Benefits will be denied if the dental condition was not caused by an accidental injury. Enrollees must report the date of the accident and may be asked to supply other information about the accident before accidental dental benefits will be provided. Covered Benefits do not include damage to teeth or gums resulting from chewing or biting in the normal course of day-to-day activity

.**Note:** The Health Plan provides an annual maximum of $3,000 dollars for the treatment of dental conditions for the repair of fractures, dislocations, and other

injuries of the mouth and jaw as related to Dental Conditions Caused by Accidental Injury.

J. Temporomandibular Joint Disorder

The Health Plan provides Coverage for Temporomandibular Joint Disorder (TMJ) if medically necessary.

K. Pediatric Vision Essential Benefit

The Health Plan provides Coverage for pediatric vision as mandated under the ACA. Pediatric vision benefits are provided until the Child attains age 19. Refer to Attachment C for the schedule of benefits.

V. EXCLUSIONS AND LIMITATIONS ON BENEFITS

A. Exclusions

SIHO's obligations under this Agreement are subject to the following exclusions. (Note: these exclusions do not apply to the treatment of Autism Spectrum Disorder, as prescribed by a Participating Physician in a treatment plan for the Enrollee.)

1. Institutional care in a hospital or other facility primarily for domiciliary, convalescent or Custodial Care purposes.

2. Court ordered services unless Medically Necessary and approved by the Health Plan Medical Director.

3. Personal comfort items such as televisions, telephones, private rooms, housekeeping services, meals or special diets, except as specifically provided in this Agreement.

4. Medical Care to treat injury or sickness caused by or related to an act of declared or undeclared war; serving in the military forces of any country, which includes serving in a non-military unit that supports such forces; the Enrollee’s committing, attempting to commit, or participating in a civil battery, illegal act, or any other crime; and taking part in a riot.

5. Medical Care for disabilities related to military service if the Enrollee is legally entitled to receive services from the Veterans Administration and adequate facilities are reasonably available to the Enrollee in SIHO's Service Area.

6. Care for conditions for which state or local law requires treatment in a public facility.

7. Hospital admission from Friday 8:00 p.m. through Monday 12:01 a.m. unless surgery is performed on that day or because of an Emergency Accident or Illness.

8. Cosmetic or plastic surgery primarily intended to improve appearance. Benefits are provided for care or treatment intended to restore bodily function or correct a deformity that results from disease, accidental injury, birth defects, or medical procedures. The medical procedure must have been a Covered Benefit. The Health Plan covers reconstructive surgery as required under the Women's Health and Cancer Rights Act of 1998.

9. Sclerotherapy, for the treatment of varicose veins of the extremities.

10. Services and supplies rendered to treat hair loss or to promote hair growth, including but not limited to hair transplants and wigs, except as mandated under the Affordable Care Act.

11. Medical, surgical or other health care procedures deemed Experimental or Investigational by the Health Plan.

12. Organ transplants deemed Experimental by the Health Plan.

13. Medical Care rendered on behalf of a donor or prospective donor when the recipient of an organ transplant is not a Health Plan Enrollee.

14. Care for mental illness, alcoholism, and drug addiction, except as provided in this Agreement.

15. Developmental treatment and education for mental retardation and mental deficiency to the extent not Medically Necessary.

16. Routine eye examinations or refraction for eyeglasses or contact lenses and furnishing, fitting, installation or use of eyeglasses or contact lenses except those pediatric essential vision benefits described in Article IV.

17. Radial keratotomy, corneal modulation, refractive keratoplasty, or any similar procedure.

18. Furnishing, fitting, installation or use of hearing aids. Surgical implantation and cochlear stimulating devices.

19. Routine injection of drugs and immunizations, except as otherwise provided in this Agreement.

20. Transportation services, unless Medically Necessary and authorized by SIHO or necessitated by an Emergency Accident or Emergency Illness.

21. Dental or oral surgical services or devices for teeth and gums. Covered Benefits include, however, oral surgical procedures related to the following: (a) excision of tumors and cysts of the jaw and mouth; (b) repair of fractures, dislocations, and other injuries of the mouth and jaw, as described in Article IV under the heading "Treatment of Dental Conditions Caused by Accidental Injuries "; (c) treatment of oral and facial cancer; (d) external incisions and drainage of cellulitis; (e) incision of accessory sinuses, salivary glands and ducts; (f) repair and treatment of congenital defects and birth abnormalities including dental treatment involved in the management of birth defects known as cleft lip and cleft palate. Covered Benefits also include anesthesia and hospital services for dental care for an Enrollee whose mental or physical condition requires dental treatment to be rendered in a hospital or an ambulatory outpatient surgical center.

22. Over-the-counter medications, except for those for which the Enrollee has a prescription and for which coverage is required under the ACA.

23. The cost of durable medical equipment, except as provided in this Agreement.

24. The cost of prosthetic devices except as provided in this Agreement.

25. The cost of medical supplies except as provided in this Agreement.

26. Transsexual surgery and related services, except in those instances when Medically Necessary due to congenital defects.

27. Reversal of voluntary sterilization.

28. Genetic counseling.

29. Sex therapy and counseling.

30. Vocational rehabilitation.

31. Family or marriage counseling.

32. Blood tests required in order to obtain a marriage license.

33. Diagnosis and treatment of:

    a. weak, strained, unstable or flat feet which includes supportive devices for the feet such as corrective shoes and arch supports; or

    b. any tarsalgia, metatarsalgia or bunion; except for surgeries which involve the exposure of bones, tendons or ligaments; or

    c. trimming of corns, calluses, or nails, other than the removal of nail matrix or roots; or

d. superficial lesions of the feet, such as corns, calluses and hyperkeratoses.

Note: Treatment will be provided to Enrollees with neurovascular conditions or diabetes to prevent foot ulcerations.

34. Acupuncture, biofeedback, hypnotherapy, sleep therapy, and behavioral training.

35. Chiropractic or manipulative services except as provided in this Agreement.

36. Speech therapy, except as provided for in this Agreement.

37. Expenses resulting from or relating to premarital exams, infertility or impotency, except as otherwise provided in the Agreement.

38. Surgical procedures performed for the purpose of correcting myopia, (nearsightedness), hyperopia (farsightedness), astigmatism and expenses related to such procedures.

39. Biomicroscopy, field charting, aniseikonic investigation, orthoptic or visual training.

40. Drugs considered Experimental or Investigational.

41. Health exams except those resulting from an accidental injury or sickness and those covered under the Preventive Health Benefits Guidelines.

42. Medical care which SIHO determines is not Medically Necessary or does not meet its medical or benefit policy guidelines.

43. Medical care required while incarcerated in a penal institution or while in custody of law enforcement authorities.

44. Charges arising out of or in the course of any employment or occupation for wage or profit if benefits are available under any Workers Compensation Act or similar law. If Workers Compensation Act benefits are not available then this Exclusion does not apply.

45. Charges in excess of SIHO's Prevailing Rates.

46. Medical care received in an emergency room which is not related to an Emergency Accident or Emergency Illness, except as specified elsewhere in this Agreement.

47. Medical costs associated with artificial or mechanical hearts and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the devices remain in place. This exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

48. Supplies, devices or medications with over the counter equivalents and any supplies, devices, or medications that are therapeutically comparable to an over the counter supply, device, or medication.

49. Human organ and tissue transplants performed by a provider not affiliated with a SIHO approved Center of Excellence.

50. Charges incurred outside the United States (a) if the Enrollee traveled to a location outside of the United States for the primary purpose of obtaining medical services, drugs or supplies or (b) if the drugs or supplies were delivered to the Enrollee from a location outside of the United States.

51. Charges arising out of any Never Events or other conditions acquired during a stay at an Institutional Health Care Provider, that are present at discharge.

52. Complications directly related to a service or treatment that is determined to be Experimental/Investigational or non-Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non-Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non-Medically Necessary service.

53. Massage Therapy care and treatment whether or not performed by a massage therapist unless part of a physical treatment plan.

54. For any services or supplies provided to a person, whether covered under this Plan or not, in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

55. Abortion services, supplies, care or treatment unless the life of the mother is endangered by the continued pregnancy or the pregnancy is the result of rape or incest.

56. [Treatment for weight loss, including but not limited to gastric bypass; gastric stapling or balloon catheterization; liposuction or reconstructive surgery; diet, health or exercise programs; health club dues; weight reduction medications; or weight reduction clinics. Nonexperimental, surgical treatment of Morbid Obesity is covered to the extent required by law. Please review Article IV for a description of Coverage provided for treatment of Morbid Obesity.]

B. Limitations.

The rights of Enrollees and obligations of SIHO and Participating Providers are subject to the following limitations:

1. Circumstances Beyond Health Plan's Control. Neither SIHO nor any Participating Provider will be responsible for providing Covered Benefits if circumstances outside SIHO's control render the provision of Covered Benefits impracticable. These circumstances include, but are not limited to, unplanned computer system or power outages, labor unrest, complete or partial destruction of facilities, major disaster, epidemic, war, riot, civil insurrection, disability of a significant part of Participating Provider's personnel, or similar causes. SIHO will make a good faith effort to arrange for alternative methods to provide the Covered Benefits.

2. Refusal of Treatment. Certain Enrollees may, for personal reasons, refuse to accept procedures or treatment recommended by Participating Providers. A Participating Provider may regard Enrollee's refusal as incompatible with continuing the provider-patient relationship and an obstruction of proper Medical Care. If an Enrollee refuses to accept treatment or procedures recommended by a Participating Provider, the Enrollee may consult with another Participating Provider of his or her choosing. If, after having adequate time to consider treatment alternatives, the Enrollee refuses to accept that Participating Provider's recommended course of treatment or procedures and both the Participating Providers and SIHO believe that no medically acceptable alternative exists, the Enrollee will be so advised. If the Enrollee still refuses to accept a recommended treatment or procedure, then neither the Participating Providers nor SIHO will have further responsibility to provide or arrange for treatment of the condition. This provision does not affect the Health Plan's obligation to provide Coverage for medically acceptable treatments for the condition otherwise covered by the Health Plan.

3. Medical Non-Compliance It is expected that the Enrollee will follow the advice of the Provider rendering or arranging services. If the Enrollee is receiving health services in a harmful or abusive quantity or manner or with harmful frequency, as determined by SIHO, the Enrollee may be required to select a single Participating Physician and a single Participating Hospital (with which the single Participating Physician is affiliated) to provide and coordinate all future health services. If the Enrollee fails to make the required selection of a Participating Physician and a single Participating Hospital within thirty-one (31) days of written notice of the need to do so, then SIHO shall designate the required single Participating Physician and Participating Hospital for the Enrollee. In the case of a medical condition which, as determined by SIHO, either requires or could benefit from special services, the Enrollee may be required to receive covered health services through a single Participating Provider designated by SIHO. Following selection or designation of a single Participating Provider, coverage is contingent upon all health services being provided by or through written referral of the designated Participating Provider.

4. Failure to Render Services. If a Participating Provider fails to or is unable to render Medical Care to an Enrollee, SIHO will arrange for another Participating Provider to provide the Medical Care.

VI. OTHER PARTY LIABILITY

A. Subrogation.

If SIHO provides benefits under this Agreement for an illness or injury caused by a third party's alleged wrongdoing and the Enrollee recovers on a claim against the third party, SIHO has a right to be reimbursed for the reasonable cash value of the benefits provided. If the Enrollee does not recover the full value of his claim, SIHO will be reimbursed out of the recovery on a pro rata basis. SIHO may take whatever legal action it sees fit against the third party to recover any benefits provided under this Agreement. SIHO's exercise of this right will not affect the Enrollee's right to pursue other forms of recovery, unless the Enrollee or his legal representative consents otherwise.

SIHO has the right to the Enrollee's full cooperation in any case involving the alleged wrongdoing of a third party. The Enrollee is obligated to provide SIHO with whatever information, assistance, and records SIHO needs to enforce its rights under this provision, including, but not limited to, any consents, releases, and assignments.

B. Coordination of the Agreement's Benefits with other Benefits (COB).

1. Applicability.

This Coordination of Benefits ("COB") section applies when an Enrollee has health care coverage under more than one "Plan," as defined below. The Order of Benefit Rules in Subsection 3 determines whether the benefits of this Health Plan are determined before or after those of another Plan. If the Order of Benefit Rules determines that this Health Plan is the "Primary Plan," as defined below, then the benefits of this Health Plan will not be reduced. If the Order of Benefit Rules determines that this Health Plan is the "Secondary Plan," as defined below, then the benefits of this Health Plan may be reduced.

2. Definitions.

The following definitions apply throughout this Article VI, Section B, but do not apply to the rest of this Agreement:

a. **"Allowable Expense"** means a necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more Plans covering the individual for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is Medically Necessary. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. When benefits are reduced under a Primary Plan because a covered individual does not comply with the plan

provisions, the amount of the reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

b. **"Claim Determination Period"** means a calendar year. However, it does not include any part of a year during which an individual does not have Coverage under this Health Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

c. **"Plan"** means this Health Plan and any of the following arrangements that provide benefits or services for, or because of, medical or dental care or treatment:

(1) Employer insurance or Employer-type coverage, whether insured or uninsured. This includes prepayment, Employer practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

(3) Coverage under an individual health or HMO policy, excluding accident only, specified disease, limited benefit plan, fixed indemnity, or Medicare supplement plans.

(4) The medical benefits coverage in group, group-type, and individual automobile "no-fault" and traditional "fault" type contracts.

(5) Any other coverage which, as defined by the Employee Retirement Income Security Act of 1974, is a union welfare plan, an employee organization plan, a labor management trustee plan, or an employee benefit organization.

(6) Medical care components of long term care contracts, such as skilled nursing care.

(7) Any other coverage provided because of membership in or sponsorship by any other union, association, or similar organization.

Each arrangement described above is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

d. **"Plan Year"** means, for the initial Plan Year, the twelve-month period commencing with the date that Employer's coverage under this Health Plan becomes effective. Thereafter, it means the twelve-month period commencing on the anniversary of Employer's Coverage under this Health Plan.

e. **"Primary"** or **"Primary Plan"** means the Plan that provides benefits for an individual before another Plan that covers the same individual. If this Health Plan is Primary to another Plan, this Health Plan's benefits will be determined before those of the other Plan without considering the other Plan's benefits.

f. **"Secondary"** or **"Secondary Plan"** means the Plan that provides benefits for an individual after another Plan that covers the same individual. If this Health Plan is Secondary to another Plan, this Health Plan's benefits will be determined after those of the other Plan and may be reduced as a result of benefits provided by the other Plan.

3. Order of Benefit Rules.

a. General. If there is a basis for benefits under this Health Plan and another Plan, this Health Plan is the Secondary Plan unless (1) the other Plan has rules coordinating its benefits with those of this Health Plan, and (2) the rules of this Health Plan and the other Plan require this Health Plan to be the Primary Plan.

b. Specific Rules. The following rules will be applied in the order they appear to determine whether this Health Plan is Primary or Secondary to another Plan:

(1) Non-Dependent/Dependent. The Plan that covers the individual as an active employee or inactive employee (i.e., laid-off or retired) rather than as a dependent is the Primary Plan except in the following situation. The Plan that covers the individual as a dependent is Primary to the Plan that covers the individual as an employee if the individual is also a Medicare beneficiary, and, as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is Secondary to the Plan covering the individual as a dependent and Primary to the Plan covering the individual as an employee.

(2) Medicare Election. For Medicare eligible individuals, the order of benefits and benefits paid will be determined presuming the eligible individual has enrolled in both Medicare Part A and Medicare Part B, irrespective of whether the individual has in fact enrolled in both parts. This provision does not apply if Medicare

coverage is Secondary to this Plan based on the size of the Employer Group.

(3) Dependent Child/Parents not Separated or Divorced. If two Plans cover the same child as a dependent of his parents, the Plan of the parent whose birthday falls earlier in a calendar year will be Primary. If both parents have the same birthday, then the Plan that has covered one parent longer will be the Primary Plan. However, if the other Plan has a rule based on gender instead of this birthday rule and, as a result, the Plans do not agree on the order of benefits, then the rule in the other Plan will determine the order of benefits.

(4) Dependent Child/Separated or Divorced. If two or more Plans cover the same child as a dependent of divorced or separated parents the following rules apply unless a qualified medical child support order ("QMCSO"), as defined in ERISA, specifies otherwise:

(a) the Plan of the parent with custody of the Child is Primary;

(b) the Plan of the spouse of the parent with custody of the child is the next Plan to be Primary; and

(c) the Plan of the parent without custody of the child is the last Plan to be Primary.

If a QMCSO states that a parent is responsible for the health care expense of a child, that parent's Plan is Primary as long as the administrator of the Plan has actual knowledge of the QMCSO. The plan of the other parent is the Secondary Plan. Until the plan administrator has actual knowledge of the QMCSO, then the rules stated in (a), (b), and (c) above apply for any Claim Determination Period or Plan Year during which benefits are paid or provided.

(5) Joint Custody. If a court order states that a child's parents have joint custody of the child but does not specify that one parent is responsible for the health care expenses of the child, the order of benefit rules in Paragraph b(3), Dependent Child/Parents not Separated or Divorced will apply.

(6) Active/Inactive Employee. A Plan that covers an individual as an active employee is Primary to a Plan that covers the individual as an inactive employee (i.e., laid-off or retired). This rule will be ignored if the other Plan does not have this rule and, as a result, the Plans do not agree on the order of benefits.

(7) Dependent of Active/Inactive Employee. A Plan that covers an individual as a dependent of an active employee is Primary to a Plan that covers an individual as a dependent of an inactive employee (i.e., laid-off or retired). This rule will be ignored if the other Plan does not have this rule and, as a result, the Plans do not agree on the order of benefits.

(8) Continuation Coverage. If an individual has Continuation Coverage under this Health Plan and also has coverage under another Plan as an employee or dependent, the other Plan is Primary to this Health Plan. This rule will be ignored if the other Plan does not have this rule and, as a result, the Plans do not agree on the order of benefits.

(9) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that has covered the individual longer will be Primary to the Plan that has covered the individual for a shorter term.

4. Effect on the Benefits of this Agreement.

a. Application. This Subsection 4 applies when the Order of Benefit Rules above determine that this Health Plan is Secondary to one or more other Plans.

b. Reduction of Health Plan's Benefits. This Health Plan's benefits will be reduced when the sum of (1) and (2) below exceeds the Allowable Expenses in a Claim Determination Period:

(1) The benefits that would be payable for the Allowable Expenses under this Health Plan in the absence of this COB provision; and

(2) The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of COB provisions like this Health Plan's COB provisions, whether or not a claim is made.

The benefits of this Health Plan will be reduced so that they and the benefits payable under the other Plans do not exceed the Allowable Expenses. Each benefit will be proportionally reduced and then charged against any applicable benefit limit of this Health Plan.

5. Facility of Payment.

If another Plan provides a benefit that should have been paid or provided under this Health Plan, SIHO may reimburse the Plan for the benefit. SIHO may then treat the amount as if it were a benefit provided under this Agreement and will not be responsible for providing that benefit again. This provision applies to the

payment of benefits as well as to providing services. If services are provided, then SIHO will reimburse the other Plan for the reasonable cash value of those services.

6. Right of Recovery.

If this Health Plan provides a benefit that exceeds the amount of benefit it should have provided under the terms of these COB provisions, SIHO may seek to recover the excess of the amount paid or the reasonable cash value of services provided from the following:

a. The individuals SIHO has paid or for whom SIHO has provided the benefit;

b. Insurance Companies; or

c. Other Organizations.

C. Worker's Compensation.

If an Enrollee is entitled to a benefit under this Health Plan that is also covered by workers' compensation laws, occupational disease laws, or other similar laws, then the benefit provided by this Health Plan will be reduced by the amounts payable under the other laws. This Health Plan will not provide benefits for services denied by the worker's compensation or other similar carrier due to the Enrollee's noncompliance with that carrier's policies, procedures, or medical provider's recommended treatment plan.

D. Right of Recovery.

If SIHO provides a benefit that, according to the terms of this Agreement, should not have been provided, SIHO may recover the reasonable cash value of the benefit provided or payment made from the recipient or other appropriate party. SIHO may recover under this Section, even if the benefit provided was the result of SIHO's error. If SIHO makes an incorrect payment to an Enrollee, SIHO may deduct the payment from future payments to be made to or on the behalf of the Enrollee.

E. Releasing or Obtaining Information.

Unless otherwise required by law, SIHO may release to or obtain from any other company, organization, or individual any information that SIHO deems necessary to apply this Article without obtaining the consent of or providing notice to the individuals involved. Any individual claiming benefits under this Health Plan must furnish SIHO with all of the information that SIHO deems necessary to implement the provisions of this Article VI.

VII. RELATIONS AMONG PARTIES AFFECTED BY THIS AGREEMENT

A. Health Plan and Participating, Consulting and Non-Participating Providers.

Participating Providers and Consulting Providers are independent contractors with respect to SIHO and the Health Plan. They are not employees or agents of SIHO. Non-Participating Providers do not have any contractual relationship with SIHO. They are not independent contractors, employees or agents of SIHO. SIHO is not liable for any act, error or omission of any Participating Provider, Consulting Provider, Non-Participating Provider, or any employee or agent thereof. Without limiting the foregoing, it is expressly understood and agreed that neither SIHO nor the Health Plan is engaged in the practice of medicine by virtue of providing for the payment of benefits hereunder, and all medical decisions are made solely by Enrollees and their medical providers.

VIII. ENROLLMENT FEES

A. Enrollment Fees.

Enrollee will pay SIHO the enrollment fees set forth in the Declarations. An Enrollee is not entitled to Coverage until SIHO receives an initial Enrollment Fee for the Enrollee. Thereafter, an Enrollee's Coverage will terminate if SIHO does not receive the monthly enrollment fee for the Enrollee by the time specified in the Declarations. If an Enrollee's Coverage is terminated for non-payment of the Enrollment Fee, the Coverage may be reinstated in accordance with the renewal application and re-enrollment provisions of this Agreement.

B. Grace Period.

1. Enrollees will have a grace period of 90 days to pay their premiums for coverage, provided that the first month's premiums are paid timely. If the first month's premiums are paid, and subsequent month's premiums are not paid timely, claims incurred in those months will be held until the premiums are paid. If premiums are not paid for 90 days, coverage will be cancelled.

C. Other Charges.

Enrollees will be required to pay Copayments, Deductibles and Coinsurance for services in the amounts indicated in the Schedule of Benefits.

D. Change in Benefits.

SIHO reserves the right to increase the benefits provided by the Health Plan without Employer's express written consent as long as the increase in benefits does not increase Employer's enrollment fees during the contract period. SIHO will notify Employer of any increase in benefits.

IX. TERMINATION OF BENEFITS

A. Termination of Benefits.

1. Loss of Eligibility.

   If an Enrollee ceases to meet the eligibility requirements of Article II, then (subject to the continuation of coverage provisions of Article X), Coverage under this Agreement for the Enrollee terminates automatically at midnight of the last day of the billing period during which SIHO receives notice of the termination. Enrollee must notify SIHO immediately if the Enrollee ceases to meet the eligibility requirements.

2. Disenrollment.

   If a Participant enrolls in an Alternative Health Benefits Plan or other benefit plan for health coverage offered through Employer, then Coverage for the Participant and Participant's Dependent(s) will terminate automatically at midnight of the last day of the billing period during which SIHO receives notice of the termination.

3. Failure to Furnish or Furnishing Incorrect or Incomplete Information.

   To enroll in the Health Plan, each Enrollee must represent to the best of his knowledge and belief that all information provided SIHO in the enrollment applications, questionnaires, forms or statements for himself and his Dependents is true, correct and complete. If an Enrollee fails to furnish SIHO with information required under this Agreement or furnishes SIHO with false or misleading information, SIHO may (1) revise the enrollment fees to the amount that SIHO would have charged had it been provided complete and accurate enrollment information and (2) if the Enrollee refuses to pay the revised rate, SIHO will pursue all legal means available to collect the owed and unpaid premium. If an Enrollee's failure to furnish SIHO with information required under this Agreement or the furnishing of false or misleading information is determined to be fraudulent or intentional misrepresentation of material fact, SIHO may also terminate all rights and benefits provided to the Enrollee and his Dependents under the Health Plan retroactive to the date the Enrollee failed to furnish the information or furnished false or misleading information. The Enrollee will be responsible for reimbursing SIHO for its cost of any benefits provided after the effective date of the termination. SIHO's costs will be based on the Prevailing Rates charged for the services in the community less any Copayments or enrollment fees paid by the Enrollee and his Dependents. SIHO will notify the Enrollee in the event SIHO terminates Coverage for the Enrollee and/or his Dependents under this Subsection.

4. Misuse of Identification Card.

Participant shall not permit another individual to use the Participant's or his Dependent's Health Plan identification card to obtain services, nor shall the Participant use an invalid identification card to obtain services. If Participant violates this provision, SIHO will terminate the Coverage of the Participant and his Dependents effective immediately upon written notice to the Participant. Any Participant involved in the misuse of a Health Plan identification card will be liable to SIHO for the Prevailing Rates of any services rendered in connection with the misuse. If a Participant's card is lost or stolen, contact SIHO immediately to obtain a new card. SIHO reserves the right to charge a fee for any replacement card.

5. Nonpayment.

If a Participant fails to pay or make satisfactory arrangements to pay SIHO or any Participating Providers any amounts due under this Agreement, including any Copayments, SIHO may terminate the Coverage of the Participant and his Dependents effective immediately upon SIHO's written notice to Participant.

6. Termination of Agreement.

If this Agreement is terminated, then the rights of all Enrollees (except any rights to continuation of benefits specifically provided by this Agreement) will terminate on the termination date of the Agreement. Notwithstanding the termination for any of the reasons described in this Section IX.A., payments for enrollment fees or other amounts due to SIHO are due for the full month during which the termination occurred without pro-rata adjustment.

B. Cancellation.

This Agreement will continue in effect for the term indicated in the Declarations subject to the following:

1. Default in Payment.

Enrollee will have a grace period of 90days to pay SIHO any enrollment fees due under the Agreement after the due date of the enrollment fees. If Enrollee fails to pay SIHO the enrollment fees by the due date or within 90 days thereafter, all benefits provided under the Health Plan will terminate at the end of the period for which the enrollment fees have been paid. SIHO may deem Enrollee's failure to pay the enrollment fees as an action by Enrollee to cancel this Agreement and will notify Enrollee of the effective date that this Agreement is canceled. If Enrollee receives services under this Agreement during the 90-day grace period and cancellation follows, the Enrollee will be liable to SIHO for the Prevailing Rates, less any Copayments made, for any services provided during that 90-day grace period. SIHO may hold Claims incurred and received within the grace period until premiums are received before the end of the grace period.

2. Fraud.

If Enrollee performs an act or practice that constitutes fraud or an intentional misrepresentation of a material fact in connection with any Coverage under the Health Plan, SIHO may terminate all rights and benefits provided to Enrollees under the Health Plan. SIHO will notify Enrollees of the effective date of the Agreement's cancellation for fraud and will return any unused enrollment fees. Notwithstanding the termination for any of the reasons described in this Section IX.B.2., payments for enrollment fees or other amounts due to SIHO are due for the full month during which the termination occurred without pro-rata adjustment.

3. Violation of Participation Rules and Participants' Movement Outside Service Area.

In accordance with the Health Insurance Portability and Accountability Act of 1996, SIHO may terminate all rights and benefits hereunder if Enrollee fails to comply with a material Agreement provision relating to the participation of Enrollees in this Agreement or if no Enrollees live, reside or work in the Service Area.

4. Discontinuance of Product.

SIHO reserves the right to discontinue offering this Health Plan in this market. If SIHO discontinues the Health Plan, SIHO will notify Enrollees in writing at least 90 days before the discontinuance and will provide Enrollee with the option to choose coverage under an alternative health care delivery product offered by SIHO in this market.

5. Discontinuance of Health Care Coverage in Market.

SIHO reserves the right to discontinue offering all health care coverage in this market. If SIHO discontinues all health care coverage, SIHO will notify Enrollees in writing at least 180 days before the discontinuance.

C. Reinstatement.

1. Enrollee.

To reinstate Coverage after termination, an Enrollee must complete a reinstatement application unless termination resulted from inadvertent clerical error. No Enrollee's Coverage shall be adversely affected due to SIHO's clerical error.

D. Continuation of Coverage After Termination by Health Plan.

Upon termination of this Health Plan, inpatient Covered Benefits provided by a hospital for an Enrollee who is hospitalized on the effective date of termination will continue until the earliest of:

1. The date the Enrollee is discharged from the Hospital;

2. The passage of 60 days after the effective date of termination;

3. The date the Enrollee acquires health care coverage from another carrier that includes the coverage provided under the Health Plan;

4. The date SIHO terminates the Enrollee's Coverage because the Enrollee knowingly provided false information to SIHO, the Enrollee failed to comply with the terms of this Agreement, or the Employer failed to pay an enrollment fee;

5. The date the Enrollee terminates Coverage.

The provisions of this Section D do not apply to the termination of Coverage as a result of the receivership of SIHO.

X. RECORDS

SIHO will keep enrollment and eligibility records of each Enrollee. Enrollee must send SIHO information, in the form requested by SIHO, reflecting any changes in an Enrollee's enrollment or eligibility by the due date for the applicable monthly enrollment fee. SIHO is not liable under this Agreement in connection with any enrollment or eligibility changes until SIHO receives accurate information about the changes. If Enrollee supplies SIHO with incorrect or incomplete information, SIHO will not be liable in connection with the information until SIHO receives correct and complete information. Enrollee and SIHO will take appropriate action to prevent SIHO from incurring any financial loss as a result of incorrect or incomplete information supplied by an Enrollee. If SIHO incurs a financial loss as a result of such incorrect or incomplete information, then SIHO has the right to seek reimbursement for the loss from the Enrollee.

SIHO will comply with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and it's implementing regulations applicable to SIHO in handling health information protected by HIPAA. SIHO will not use or disclose an Enrollee's health information without authorization, except to the extent permitted or required under HIPAA. SIHO will not disclose health information protected by HIPAA to the Employer except to the extent required or permitted by law or authorized by the Enrollee.

XI. PROCEDURES FOR CLAIMING BENEFITS

A. Claim Filing.

If an Enrollee receives a bill directly from a provider, is required to pay for services at the time they are provided, or assigns his or her right to reimbursement to a provider with the consent of SIHO, the Claim may be submitted to SIHO for payment. In order to be

eligible for payment, the Claim must be submitted with receipts within 90 days of the date the services were rendered or, in the case of a Consulting or Participating Provider, within the timeframe for submitting claims set forth in the provider agreement in effect between the Consulting or Participating Provider and SIHO. Non-Participating Providers must submit claims to SIHO within 90 days of the date services were provided to be eligible for payment. If SIHO approves the Claim, SIHO will reimburse the Enrollee or provider, as appropriate, for Covered Benefits less any applicable Copayments, Deductible, Coinsurance, penalty, and any amounts that SIHO has already paid to the Enrollee or the provider prior to receiving the Claim. The Claim should describe the occurrence, character, and extent of the Medical Care provided by the provider. Notwithstanding anything herein to the contrary, Enrollees may not assign any claims or other rights to receive Benefits hereunder to any Non-Participating Provider without the prior approval of SIHO. In the absence of such prior approval, SIHO reserves the right to pay Claims or other Benefits directly to the Enrollee, and such payment shall fully discharge SIHO's obligation under this Agreement with respect to such Claims or other Benefits. In such a case, the Enrollee is responsible for all payments that may be due to the Non-Participating Provider.

1. Claim Forms. Submission of claims by an Enrollee must be accompanied by a claim form. These forms can be obtained from SIHO via mail, email or website.

B. Claim Determination.

1. Pre-Service Claims. With respect to a Pre-Service Claim, SIHO will notify the claimant of its decision within 15 days of receipt of the Claim.

    a. This 15-day period may be extended for an additional 10 days if SIHO determines that an extension is necessary due to matters beyond the Health Plan's control and notifies the claimant of the circumstances requiring the extension of time and the date by which SIHO expects to render a decision.

    b. If an extension is necessary because the claimant has not submitted information necessary to decide the Claim, SIHO will provide the claimant with a notice of extension which will specifically describe the additional information required. If the extension is necessary because the Claim does not properly identify the individual requesting a benefit, specify the medical condition or symptom, and the specific treatment, service, or product for which approval is requested, SIHO will provide the notice of extension and an explanation of the proper procedures to be followed in filing a Claim. Any notice of extension may be oral, unless the claimant requests a notice in writing. The claimant will have at least 45 days to provide any requested information.

2. Precertification of Urgent Care Claims. In the case of a request for Precertification of an Urgent Care Claim, SIHO will notify the claimant of its determination by the

earlier of seventy-two hours or two business days after its receipt of the request and all information necessary to make a determination.

If the claimant has not provided sufficient information for SIHO to determine the request for Precertification of an Urgent Care Claim, SIHO will notify the claimant within 24 hours after receiving the request of the specific information that must be submitted for SIHO to complete the processing of the Claim. The claimant will have at least 48 hours in which to provide the additional information. SIHO will notify the claimant of its decision within 24 hours after it receives the additional information, or, if the claimant does not provide the requested information, 24 hours after the end of the period of time that the claimant was given to provide the information.

3. Concurrent Care Claims. With respect to a Concurrent Care Claim, if SIHO reduces or terminates benefits for a course of treatment (for reasons other than amendment or termination of the Health Plan) before the end of the period of time or number of treatments, the claimant must be notified sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of SIHO's decision before it becomes effective. The claimant may request the Health Plan to extend the course of treatment beyond the already approved time or number of treatments. SIHO will notify the claimant of its decision within 24 hours of its receipt of the request, provided that the claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, and within 72 hours of its receipt if the request is received less than 24 hours prior to the expiration of the prescribed period or number of treatments.

C. Grievances.

An Enrollee may initiate a Grievance procedure by contacting us verbally or in writing. Enrollees have the right to appoint a Designated Representative to act on their behalf with respect to the Grievance by filing a signed form that may be obtained from SIHO upon request; provided, that if a provider files a Grievance relating to precertification of an Urgent Care Claim, then SIHO will treat such provider as a Designated Representative with respect to that matter even without the submission of a signed form.

SIHO will accept oral or written comments, documents or other information relating to the Grievance from the Enrollee or his/her Designated Representative by telephone, mail or other reasonable means. Enrollees are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Grievance.

Enrollees may obtain information regarding SIHO’s Grievance procedures by calling the toll-free number on the back of the Enrollee’s identification card during normal business hours.

Once a Grievance has been initiated by an Enrollee, SIHO will respond within 3 business days to acknowledge its receipt of the Grievance. Such response will be in writing, unless the Grievance was received orally, in which case the response may be oral. Grievances will be resolved within 20 business days after they are filed if all information needed to complete a review is available. If additional information is needed and the Grievance does not involve Precertification matters, SIHO may notify you before the 19th business day of its election to take an additional 10 business days to receive information and address the Grievance.

If an Enrollee's Grievance is denied in whole or in part, SIHO will notify the claimant, in writing or electronically, and the notice will include the following:

1. the specific reason or reasons for the denial;

2. reference to specific Health Plan provisions on which the denial is based;

3. a description of any internal rule, guideline, protocol or similar criterion relied on in making the adverse determination (or a statement that the information will be provided free of charge upon request);

4. an explanation of any scientific or clinical judgment on which the denial is based (or a statement that the explanation will be provided free of charge upon request);

5. a description of any additional material or information that the claimant may need to provide with an explanation as to why the material or information is necessary;

6. an explanation of the claimant's right to appeal under the Health Plan's appeal procedures, and the claimant's right to bring a civil action in federal court; and

7. the name, address, and phone number of a SIHO representative who can provide the claimant with more information about the decision and the right to appeal.

SIHO may provide the above information to the claimant orally, provided that a written notice is furnished to the claimant within 3 days after the oral notification.

D. Appeal Procedures.

If SIHO's Grievance decision is satisfactory to the Enrollee, then the matter is concluded. If, however, the Enrollee is unsatisfied with SIHO's decision, the Enrollee may initiate an appeal of the Grievance in accordance with this Section.

1. General.

   a. The claimant will have 180 days from the receipt of SIHO's decision to appeal.

b. The claimant may submit an appeal verbally or in writing. Any SIHO employee who has been unable to resolve the Grievance may take the appeal information.

c. All written notices requesting an appeal will be forwarded to an appeals coordinator.

d. All verbal requests must be documented by the SIHO associate who is assisting the claimant. Upon request, the notice will be forwarded to the appeals coordinator.

e. An acknowledgement notice will be sent to the claimant within 3 business days of receipt of the written or verbal appeal request.

2. Claimant's Rights on Appeal.

a. The claimant will have the opportunity to submit written comments, documents, or other information relating to the Grievance. All such information must be submitted by the enrollee or provider within 180 days of receipt.

b. Upon request and free of charge, the claimant will be provided with reasonable access to and copies ofall documents, records and other information relevant to the Grievance.

c. The review will take into account all comments, documents, records and other information the claimant submits, whether or not presented or considered in the initial determination.

d. No deference will be afforded to the initial determination.

e. The review will be conducted by a person or persons different from the person who made the initial determination and who is not the original decision-maker's subordinate.

f. If the decision is made on the grounds of a medical judgment, SIHO will consult with a health care professional with appropriate training and experience. The health care professional will not be the individual who was consulted during the initial determination or that person's subordinate.

g. SIHO will provide the claimant with the name of any medical or vocational expert who advised SIHO with regard to the Grievance.

3. Appeals Hearing Committee.

a. The appeals coordinator will investigate the issue and gather the data needed to review the circumstances surrounding the appeal.

b. The appeals coordinator will convene an Appeals Hearing Committee consisting of at least one person. None of the Committee will have been involved in any of the previous determinations, or involved in a direct business relationship with the Enrollee or health care provider whose care is at issue.

c. The appeals coordinator will send notice of the hearing date, time, and location to the claimant, at least 72 hours in advance of the hearing. The hearing process will make any reasonable accommodations to convenience the claimant, including arranging for a teleconference in situations where the claimant is unable to attend.

d. If the claimant attends the appeal hearing or participates via teleconference, the claimant may present his case. The hearing provides an opportunity for the claimant to explain his position as well as allow the Appeals Hearing Committee members to ask the claimant any pertinent questions they may have.

E. Notification of Resolution of Appeal.

1. Pre-Service Grievances. In the case of a Grievance not involving urgent care, SIHO will notify the claimant of its decision within 30 days after it receives the request for review and sufficient information to make its determination.

2. Urgent Care Grievances. In the case of a Grievance that relates to an Urgent Care matter, SIHO will notify the claimant of its decision within 48 hours after it receives the request for review and sufficient information to make its determination.

3. Other Grievances. In the case of all other Grievances, SIHO will notify the claimant within 30 days after it receives the written request for review and sufficient information to make its determination.

F. Expedited Appeals.

1. A claimant may request an expedited appeal or SIHO may independently determine that the process should be expedited. The expedited process is considered a stand-alone procedure and is in lieu of the standard appeal procedure.

2. The claimant may request an expedited appeal orally or in writing. All information, including SIHO's decision, may be transmitted between the claimant and SIHO by telephone, facsimile, or other available similar method.

3. Resolution of the expedited appeal will be made as expeditiously as the appellant's health warrants but will occur no later than 48 hours after the filing of the appeal.

G. Notice of Decision on Appeal.

If an appeal is denied, SIHO will notify the claimant, in writing or electronically. The notice will contain the following information:

1. the specific reason(s) for SIHO's denial;

2. a reference to the specific Health Plan provision(s) on which the denial is based;

3. a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse determination;

4. an explanation of any scientific or clinical judgment on which the denial is based;

5. a statement that the claimant is entitled to receive, upon request and without charge, reasonable access to and copies of all documents, records or other information relevant to the appeal;

6. a statement describing the voluntary appeal procedures via the external review offered by the Health Plan and the claimant's right to obtain information about the procedures;

7. the statement that "You or your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency";

8. a statement describing the claimant's right to bring a civil suit under federal law; and

9. the name, address and telephone number of the appeals coordinator whom the claimant may contact for more information.

H. External Review of Appeals Process.

1. If the claimant is dissatisfied with the Appeal Hearing Committee's resolution, and the matter involves (i) an adverse determination of appropriateness, (ii) an adverse determination of Medical Necessity, (iii) a determination that the proposed service is Experimental or Investigational, or (iv) a rescission of coverage by SIHO, he or she may file a written request to initiate an External Review Appeal. This request must be filed no later than 120 days after the claimant is notified of the resolution of the Appeal Hearing Committee’s decision. External Review Appeal is not available for matters other than those specified in this paragraph.

2. The claimant may not file more than one (1) External Review Appeal request on the same appeal.

3. Upon receipt of the request for External Review Appeal, the appeals coordinator will select an independent review organization that is certified to perform external review in the State of Indiana.

4. The external review organization will assign a medical review professional who is board certified in the applicable specialty for resolution of the appeal.

5. The external review organization and the medical review professional conducting the external review may not have a material professional, familial, or financial, or other affiliation with SIHO; any officer, director, or management employee of SIHO; the physician or the physician's medical group that is proposing the service; the facility at which the service would be provided; or the development or manufacture of the principal drug, device, procedure, or other therapy that is proposed by the treating physician. However, the medical review professional may have an affiliation under which the medical review professional provides health care services to Enrollees of SIHO and may have an affiliation that is limited to staff privileges at the health facility if the affiliation is disclosed to the claimant and to SIHO before commencing the review and neither the claimant nor SIHO objects to the affiliation.

6. A claimant who files an appeal under this final alternative is not subject to retaliation for exercising his or her right to an appeal by an external review organization. The claimant may be permitted to utilize the assistance of other individuals, including physicians, attorneys, friends, and family members throughout the external review process. The claimant shall be permitted to submit additional information relating to the proposed service throughout the review process and may cooperate with the external review organization by providing any requested medical information or authorizing the release of necessary medical information.

7. SIHO shall cooperate with the external review organization by promptly providing any information requested by the external review organization.

8. The external review organization shall make a determination to uphold or reverse SIHO's appeal resolution based on information gathered from the claimant, SIHO, the treating physician, or any additional information that the external review organization considers necessary and appropriate. For standard appeals, the determination shall be made within 15 business days from the filing date of the request for external review. For expedited appeals, the determination shall be made within 72 hours after the external review request is filed.

9. When making the determination of the resolution of the appeal, the external review organization shall apply the standards of decision making that are based on objective clinical evidence and the terms of the appellant's benefit contract.

10. The external review organization shall notify SIHO and the claimant of the determination made under this section within 72 hours after making the determination. For expedited appeals, the notification will occur within 24 hours of the determination. The result of the determination is binding on SIHO.

11. If at any time during the external review process the claimant submits information to SIHO that is relevant to SIHO's previous appeal resolution and was not considered by SIHO during the appeals hearing phase, SIHO shall reconsider the previous resolution under the appeals hearing process. The external review organization shall cease the external review process until the reconsideration by SIHO is completed.

12. If additional information from the claimant results in SIHO's reconsideration of the appeal at the hearing level, SIHO will notify the claimant of its decision within 15 days after the information is received. If the appeal is related to an Urgent Care Claim, SIHO will make a determination within 72 hours of receipt of the additional information.

13. If the reconsideration determination made by SIHO is adverse to the claimant, the claimant may request that the external review organization resume the external review.

XII. MISCELLANEOUS

A. Agreement Generally.

All Enrollees or their legal representatives (if the Enrollees are incapable of contracting) must agree to all the terms, conditions and provisions of this Agreement.

B. Applications, Questionnaires, Forms and Statements.

1. Enrollees and applicants for enrollment in the Health Plan must complete all applications, medical review questionnaires, and other forms or statements that SIHO reasonably requests. Enrollees must represent to the best of their knowledge and belief that all information contained in the applications, questionnaires, forms, or statements submitted to SIHO are true, correct, and complete. All rights to benefits under the Health Plan are subject to the truth and accuracy of an Enrollee's representations. Any misrepresentation may cause SIHO to terminate the Enrollee's Coverage. If an Enrollee is eligible for Medicare and fails to submit the documents requested under this Agreement, the Enrollee must pay for services received at Prevailing Rates.

2. If this Agreement is provided in electronic format, the Enrollee may request a paper copy.

C. Identification Cards.

The identification cards that SIHO issues to Enrollees are for identification only. Possession of a Health Plan identification card confers no rights to services or other benefits under this Agreement. To be entitled to benefits under the Health Plan, the holder of the card must, in fact, be an Enrollee on whose behalf all applicable enrollment fees, Copayments, Deductibles and Coinsurance amounts have been paid. SIHO will charge any individual who receives benefits under the Health Plan to which the individual is not entitled the Prevailing Rates for the services.

D. Policies, Procedures, Rules and Interpretations.

SIHO may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Agreement.

E. Liability Prior to Effective Date.

SIHO will not be liable for fees and bills for Medical Care received by an Enrollee prior to the effective date of the Enrollee's Coverage.

F. Authority to Change Agreement on Behalf of SIHO.

No agent or other person, except an officer of SIHO, has the authority to waive any conditions or restrictions of this Agreement; to extend the time for making payment; or to bind SIHO by making any promise or representation, or by giving or receiving information. No change to this Agreement will be valid unless Enrollee and SIHO agree to a written amendment and an officer of SIHO signs the amendment.

G. Mailing of Notices.

Any notice under this Agreement must be sent by United States mail, first class, postage prepaid, addressed as follows:

1. If to SIHO, to the address appearing on page one of this Agreement;

2. If to an Enrollee, to the Enrollee's last address known to SIHO.

H. Department of Insurance

Questions regarding your policy or coverage should be directed to:

SIHO Insurance Services
(812) 378-7070

If you need the assistance of the governmental agency that regulates insurance; or have a complaint you have been unable to resolve with your insurer, you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461
Complaints can be filed electronically at www.in.gov/idoi

I. Dissemination of Notices.

SIHO agrees to disseminate all notices regarding matters material to this Agreement to Participants in the next regular communication to Enrollees or in a special communication to Participants within 30 days after SIHO receives the material information.

J. Entire Agreement.

This Agreement and the individual enrollment applications of Enrollees constitute the entire agreement between the parties and, as of the effective date of this Agreement, supersede all other agreements between the parties.

K. Invalid Provisions.

If any provision of this Agreement is held to violate Indiana law or applicable federal law or be illegal or invalid for any other reason, that provision will be deemed to be void, but the invalidation of that provision will not otherwise impair or affect the rest of the Agreement.

L. Legal Actions.

No legal action may be filed to recover under the policy before 60 days after a claim is filed, and not later than 3 years after the claim is required to be filed.

M. Examination

SIHO reserves the right to have an Enrollee examined (including by autopsy) by a medical provider of SIHO's choice to assist in the evaluation of the appropriateness of a Claim, Precertification request, appeal or any other matter related to this agreement.

XIII. NETWORK AND NON-NETWORK SERVICES

A. Network Services.

An Enrollee is entitled to receive Network Services in the Service Area subject to the Deductibles, Coinsurance and Copayments described in Article IV. It is the Enrollee's

responsibility to secure proper Precertification of such services, if required under this Agreement.

[Coverage for Network Services may vary based on whether the treating Provider participates in the Tier 1 or Tier 2 provider network. The applicable Deductibles, Coinsurance, and Copayments for each Tier are described in Attachment B, Schedule of Benefits. SIHO will make available to all enrollees a provider directory that specifies which Participating Providers participate in the Tier 1 or Tier 2 network.]

B. Emergency Accident or Emergency Illness Services.

1. An Enrollee who is temporarily outside of the Service Area and who cannot access a Participating Provider, may receive treatment of an Emergency Accident or Emergency Illness from a Non-Participating Provider, subject to the Deductibles, Coinsurance and Copayments described in Article IV.

2. If the Enrollee is admitted to a Non-Participating Provider hospital as the result of an Emergency Accident or Emergency Illness, Enrollee or his representative must contact SIHO or their Delegated Network within 48 hours of admission to obtain Precertification of any further inpatient services.

C. Non-Network Services.

A Non-Network Benefit is a Covered Benefit (other than treatment for an Emergency Accident or Emergency Illness) provided by a Non-Participating Provider, without the prior written approval of the Health Plan Medical Director. Non-Network Benefits are subject to the Deductible, Coinsurance and Copayments described in Article IV and to the Precertification requirements described in this Section C, below. Non-Participating Providers will be paid no more than the most recently published Medicare reimbursement rates and may bill the enrollee for any difference between their billed charges and the Medicare reimbursement rates if applicable.

D. Precertification.

The Health Plan Medical Director or his designee must precertify all inpatient care, outpatient surgery, and durable medical equipment, and other services identified in the Health Plan and the Schedule of Benefits.

1. <u>Procedures to Request Precertification</u>.

   a. For elective care an Enrollee or his physician must send a Precertification request to SIHO by mail, at least 14 working days before the services/equipment are provided. If the need for services/equipment is unforeseen, the Enrollee or his physician must call SIHO (812-378-7050 or 800-553-6027) at least one working day before the services/equipment is provided to request Precertification.

b. For maternity admissions the Enrollee or her physician should call SIHO to request Precertification on the second or fourth day after admission, respectively, if the inpatient admission is expected to exceed two days for a vaginal delivery or four days for a cesarean section. If the maternity admission is for reasons other than delivery, then the Enrollee or physician must call SIHO within one working day of the admission.

c. For other Precertification requests, the Enrollee or his physician should call SIHO or their Delegated Network at the number indicated on the Enrollee's identification card.

2. Precertification Decisions. If SIHO or their Delegated Network finds that proposed Medical Care is Medically Necessary and the setting is appropriate, SIHO or their Delegated Network will precertify the quantity and character of the Medical Care. SIHO will not precertify any extra inpatient days for tests that can be obtained on an outpatient basis before the Enrollee is admitted. If Precertification is obtained, SIHO will pay the benefits for the services as described in Article IV.

3. If Precertification has not been obtained, SIHO will reduce the benefits paid for the Medical Care as follows:

   a. Medical Care that is not Medically Necessary. SIHO will not provide benefits for any Medical Care that is not Medically Necessary. Charges for such Medical Care will not apply toward any Health Plan Deductible or stop-loss limitations. If Precertification is denied, a Enrollee or his Participating Physician may request a review of the denial and may submit evidence to support Precertification as provided in the Health Plan's Claim Procedures.

   b. Precertification not Requested. If Precertification is not obtained for Medical Care that is Medically Necessary and requires Precertification, SIHO will reduce the amount of benefits it will pay for the Medical Care to the lesser of 50% of the Prevailing Rates for the Medical Care or the applicable Medicare reimbursement rate for the Medical Care. This 50% reduction will not apply toward any plan Deductible or stop-loss limitations.

4. Precertification does not guarantee coverage for or payment of the service or procedure reviewed. For benefits to be paid, the Enrollee must be and remain eligible for benefits, all enrollment fees owed must be paid, and the service or procedure must be a Covered Benefit and not subject to an exclusion or limitation.

ATTACHMENT A

The following Indiana counties are part of Southeastern Indiana Health Organization's (SIHO) Service Area:

Bartholomew
Brown
Decatur
Jackson
Jennings
Scott

ATTACHMENT B

SCHEDULE OF BENEFITS

PRE-ADMISSION CERTIFICATION

[If precertification is not requested and obtained prior to receiving Medical Services that require precertification, the benefits paid by SIHO will be reduced by a penalty of 30% of the Prevailing Rate for the services provided. The penalty will not be applied toward any Deductible . It is important to note that this Agreement does not cover weekend admissions and any associated Medical Services unless they are Medically Necessary. To use the Pre-Admission Certification program, contact the Health Plan Medical Director of the designee at:_____.

[If precertification is not requested and obtained prior to receiving Medical Services that require precertification, the benefits paid by SIHO will be reduced by a penalty of [%] of the Prevailing Rate for the services provided [, to a maximum of [$500-$5,000] per confinement]. The penalty will not be applied toward any Deductible limitations. It is important to note that this Agreement does not cover weekend admissions and any associated Medical Services unless they are Medically Necessary. To use this Pre-Admission Certification program, contact the Health Plan Medical Director of the designee at:_____]

ADMINISTRATOR:_____
ADDRESS:_____
PHONE NUMBER:(_____)-_____-_____

[Many individual services and benefits also require precertification in order to be included as Covered Services. Those services are identified in the Provider and Service Schedule portion of this Schedule of Benefits.]

ADDITIONAL FEATURES

Some additional general terms and limitations will have impact upon the Covered Services under this Agreement and need to be highlighted below. If the YES box next to the specific feature is checked, it will apply to this Agreement. If the NO box is checked, it will not apply to this Agreement. Read the Provider and Service Coverage portion of the Schedule of Benefits for a detailed explanation of all individual benefits and features, and how they are impacted by the following:

YES	NO	
[___]	[___]	Medicare Reimbursement Rates [plus an additional ____%] will be used as the limit for the Non-Network Service charges.
[___]	[___]	Network and Non-Network Service charges/payments combined for limitations.
[___]	[___]	[Tier 1 and Tier 2 charges/payments combined for limitations.]
[___]	[___]	In instances of Copayments, the *lesser* of the Copayment or billed charges will

apply.

[PRESCRIPTION DRUG BENEFITS:

[Eligible charges for prescription drug benefits will be limited to the cost of generic prescription drugs, wherever available.] [The following Prescription Drug Deductible will apply to coverage for Prescription Drugs]
[Combined Network and Non-Network Deductible per year:
Individual: $0 to $1,000
Family: $0 to $3,000]

[The following Copayments will apply to Coverage for prescription drugs:

Network	[$0-$50] per Generic Rx, [After Prescription Drug Deductible] [$0-$75] per Brand Rx [plus the difference between available Generic and chosen Brand] [After Prescription Drug Deductible]
Non-Network	[$0-$100] per Generic Rx, [After Prescription Drug Deductible] [$0-$100] per Brand Rx [plus the difference between available Generic and chosen Brand] [After Prescription Drug Deductible]
[Formulary	[$0-$75] per non-Formulary compliance Rx [After Prescription Drug Deductible] [plus the minimum difference, not to be less than $__, between formulary Rx and non-formulary Rx chosen] [After Prescription Drug Deductible]

[Biotech or Specialty Injectable Drugs other than insulin and anti neoplasm drugs
[10% to 40%] Coinsurance up to a maximum of [$100 to 500] per Rx. Coinsurance does [not] apply to the annual out-of-pocket maximum. Annual Benefit Maximum of [$50,000 to Unlimited].]

[Annual Maximum $5,000, $10,000, $15,000, Unlimited]
[Rx defined as 1 to 30 day supply]

[**Evidence Based Pharmacy Plan (EBPP)**
The Deductible, Coinsurance, or Copayment for selected maintenance medications will be waived or reduced for Enrollees identified with specific chronic conditions and who are actively participating, as determined by SIHO, in their Disease Management, Case Management, and/or other Medical Management programs.]

[**Step Therapy Programs**
Use of a Generic drug in a given Class may be required before a Non-Preferred Brand Drug is Covered. Affected Enrollees will be notified of the Step Therapy Program prior to it's effective date so that they can contact their physician and discuss a new prescription. Medical exceptions to the program may be granted based on clinical justification supplied by the Enrollee's physician.]

[Orally Administered Cancer Chemotherapy
As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.]

[PRIMARY CARE PHYSICIAN:

An Enrollee must get approval from his Primary Care Physician to receive Network Services. Covered Services must be accessed through the Enrollee's current Primary Care Physician in order to obtain any Coverage. Any Medical Services that are not provided, arranged, authorized, or approved by the Enrollee's Primary Care Physician or the Health Plan Medical Director is excluded. This limitation does not apply to Medically Necessary emergency services.]

GEOGRAPHIC SERVICE AREA:

The geographic Service Area includes [the following counties:_____.] [the area represented by the following zip codes:_____.] [the area within a [25-60] mile radius of:_____.]

All Covered Services are subject to calendar year Deductible amounts UNLESS STATED OTHERWISE. All calendar year deductibles are applied [after, before] the applicable service Copayments. All plan payments accrue towards annual maximums.

	NETWORK SERVICES [LEVEL 1] [TIERS 1 AND 2]		**NON-NETWORK SERVICES** [LEVEL II] [TIER 3]	
	[Level I benefits apply to Medical Care received from a Participating Provider or from a Non-Participating Provider with written authorization from the Health Plan Medical Director.] [Tier 1 and 2 benefits apply to Medical Care received from a Participating Provider or from a Non-Participating Provider with written authorization from the Health Plan Medical Director.]		[Level II benefits apply to Medical Care received from a Non-Participating Provider without a written authorization from the Health Plan Medical Director] [Tier 3 benefits apply to Medical Care received from a Non-Participating Provider without a written authorization from the Health Plan Medical Director.]	
	[TIER 1] [TIER 2]		[TIER 3]	
General Services	**Enrollee Pays**	**Health Plan Pays**	**Enrollee Pays**	**Health Plan Pays**
All covered services are subject to these conditions unless otherwise provided	**Network Deductible per year:** Individual : [0-$5,000] Family: [0-$15,000] [The Individual Deductible applies only to Enrollees with self-only coverage. If an individual has family coverage, the Family Deductible applies. Except for Preventive Health Benefits, the Health Plan will not pay benefits for any Enrollee with family coverage until the eligible medical charges incurred by the Enrollee's family exceed the Family Deductible.] **Coinsurance:** Individual [0-40%] Family [0-40%] **Network Out-of-Pocket Maximum per year:** Individual: [$0-unlimited] Family [$0-unlimited] **General Services Copayment:** [None] or [$0-60].	[60-100]% of eligible charges after Enrollee Pays: [General Services Copayment] [Network Deductible] [After the Enrollee's Network Out-of-Pocket Maximum is reached, the Health Plan will pay 100% of the Enrollee's expenses.] [The Health Plan's payments are subject to the following limits: Annual maximum: $[0 - Unlimited] Lifetime maximum: $[0-Unlimited]]	**Non-Network Deductible per year:** Individual: [$0-$10,000] Family: [$0-$30,000] [The Individual Deductible applies only to Enrollees with self-only coverage. If an individual has family coverage, the Family Deductible applies. Except for Preventive Health Benefits, the Health Plan will not pay benefits for any Enrollee with family coverage until the eligible medical charges incurred by the Enrollee's family exceed the Family Deductible.] **Coinsurance:** Individual: [0-50%] Family: [0-50%] **Non-Network Out-of-Pocket Maximum per year:** Individual: [$0-unlimited] Family: [$0-unlimited] **General Services Copayment:** [None] or [$0-60]	[50-100]% of Medicare Reimbursement Rates after Enrollee pays: [General Services Copayment] [Network Deductible] [Non-Network Deductible] [After the Enrollee's Network Out-of-Pocket Maximum is reached, the Health Plan will pay 100% of the Enrollee's expenses.] [The Health Plan's payments are limited to following: Annual maximum: $[0 - Unlimited] Lifetime maximum: $[0-Unlimited]]

Primary Health Care Physician Services	Enrollee Pays	Health Plan Pays	Enrollee Pays	Health Plan Pays
One Copayment will apply per [visit, service]. ** Indicates that the Non-Network Deductible applies [before, after] applicable Copayments.				
Office Visit	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [$0-$60] [**] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Home Visit	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [$0-$60] [**] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Immunizations	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or [$0-$60] [**] Coinsurance: [None] or [0-50]%	[Not Covered], [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Health Education	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or [$0-$60] [**] Coinsurance: [None] or [0-50]%	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Wellness Education [Per the SIHO schedule]	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or [$0-$60] [**] Coinsurance: [None] or [0-50]%	[Not Covered] [50-100]% of eligible charges after the Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Hearing and Vision Screening	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or [$0-$60] [**] Coinsurance: [None] or [0-50]%	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]

Specialty Health Care (Physician Services)	Enrollee Pays	Health Plan Pays	Enrollee Pays	Health Plan Pays
One Copayment will apply per [visit, service]. ** Indicates that Non-Network deductible applies [before, after] applicable Copayments.				
Office Visit	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]%	[Not covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Home Visit	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]%	[Not covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Consultations, In-Patient	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]%	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Consultations, non in-Patient	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]%	[Not covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Allergy	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]%	[Not covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]

Chiropractor, Manipulative Services [Requires Precertification] Annual Maximum: 12 Visits	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Lifetime Maximum is reached.]	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Lifetime Maximum is reached.]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Lifetime Maximum is reached.]	[Not covered] [Limited to [ ] visits per month] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Lifetime Maximum is reached.]
Dermatology	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]%	[Not covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
[Family Planning/ Infertility]	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Lifetime Maximum is reached.]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Lifetime Maximum is reached.]	[Not covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Lifetime Maximum is reached.]
Podiatry Excludes routine foot care	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Network Deductible] [Copayment]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]%	[Not covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Temporomandibular Joint Disorder	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]%	[Not covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]

Psychologist or Psychiatrist Mental Health Treatment: Outpatient [Requires Precertification]	Copayment: [None] or [$0-$60] Coinsurance: [None] or [percentage listed for general services]%	[60-100]% of all eligible charges after Enrollee pays: [Network Deductible] [Copayment]	[Not covered] Copayment: [None] or $[0-400] [**] Coinsurance: [None] or [percentage listed for general services]%	[Not covered] [50-100]% of covered service charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Substance Abuse Treatment: Outpatient [Requires Precertification]	Copayment: [None] or [$0-$60] Coinsurance: [None] or [percentage listed for general services]%	[60-100]% of all eligible charges after Enrollee pays: [Network Deductible] [Copayment]	[Not covered] Copayment: [None] or $[0-400] [**] Coinsurance: [None] or [percentage listed for general services]%	[Not covered] [50-100]% of covered service charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Surgery and Hospital (Physician Services)	**Enrollee Pays**	**Health Plan Pays**	**Enrollee Pays**	**Health Plan Pays**
One Copayment will apply per [day, visit].				
Anesthesia	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Network Deductible] [Copayment]	Copayment: [None] or [$0-$80] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Medical Visits in Hospital, Primary Physician	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Network Deductible] [Copayment]	Copayment: [None] or [$0-$80] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Medical Visits in Hospital, Specialty Physician	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Network Deductible] [Copayment]	Copayment: [None] or [$0-$80] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Medical Visits in SNF, Primary Physician	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Network Deductible] [Copayment]	Copayment: [None] or [$0-$80] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]

Medical Visits in SNF, Specialty Physicians	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Network Deductible] [Copayment]	Copayment: [None] or [$0-$80] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Surgery	Copayment: [None] or [$0-$100] per procedure Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Network Deductible] [Copayment]	Copayment: [None] or [$0-$200] per procedure Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Institutional Health Care: Outpatient	**Enrollee Pays**	**Health Plan Pays**	**Enrollee Pays**	**Health Plan Pays**
[Copayment applies per visit.] [Copayment applies in addition to any other Copayments for each service]				
Outpatient Diagnostic [MRIs and CT Scans Require Precertification]	Copayment: [None], [$0-$500] or [$0-$150] per test whenever there is no accompanying facility charge [Facility Charge] Coinsurance: [None] or [0-40]% [80% Coinsurance will apply for Procedures greater than [$250-$1,000]	[60-100]% of eligible charges after Enrollee pays: [Network Deductible] [Copayment] [Facility Charge]	Copayment: [None] or [$0-$250] Coinsurance: [None] or [0-50]% [Facility Charge]	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [Facility Charge]
Emergency Department	Copayment: [None] or [$0-$500] [Facility Charge] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after the Enrollee pays: [Network Deductible] [Copayment] [Facility Charge]	Copayment: [None] or [$0-$500] Coinsurance: [None] or [0-50]% [Facility Charge]	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [Facility Charge]
Urgent Care Facility	Copayment: [None] or [$0-$500] [Facility Charge] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after the Enrollee pays: [Network Deductible] [Copayment] [Facility Charge]	Copayment: [None] or [$0-$500] Coinsurance: [None] or [0-50]% [Facility Charge]	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [Facility Charge]
Outpatient Mental Health Services [Requires Precertification]	Copayment: [None] or $[0-400] Coinsurance: [None] or [percentage listed for General Services	[60-100]% of all eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or $[0-400] Coinsurance: [None] or [percentage listed for General Services]	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]

Outpatient Substance Abuse Services [Requires Precertification]	Copayment: [None] or $[0-400] Coinsurance: [None] or [percentage listed for General Services	[60-100]% of all eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or $[0-400] Coinsurance: [None] or [percentage listed for General Services]	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Outpatient Surgery [Requires Precertification]	Copayment: [None] or [$0-$500] per procedure Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after the Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [$0-$750] per procedure Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Outpatient Hospital Ancillaries	Copayment: [None] or [O/P Copayment] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after the Enrollee pays: [O/P Copayment] [Network Deductible]	Copayment: [None] or [O/P Copayment] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [O/P Copayment] [Network Deductible] [Non-Network Deductible]
Outpatient Therapy [Requires Precertification] Annual Maximum: [20] visits each for physical, pulmonary, occupational, and speech therapies. Separate limits between Outpatient Rehabilitation Services and Habilitation Services. Annual Maximum: 36 visits for Cardiac Rehabilitation.	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]% An Enrollee is responsible for 100% of the cost after the number of treatment visits reaches the Annual or Lifetime Maximum.	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] The Health Plan will not pay any amounts after the number of treatment visits reaches the Annual or Lifetime Maximum.	[Not Covered] Copayment: [None] or [$0-$80] Coinsurance: [None] or [0-50]% An Enrollee is responsible for 100% of the cost after the number of treatment visits reaches the Annual or Lifetime Maximum.	[Not Covered], [Limited to [15] visits per month] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] The Health Plan will not pay any amounts after the number of treatment visits reaches the Annual or Lifetime Maximum.

Outpatient Therapy Facility [Therapy Program Requires Precertification] Annual Maximum: [20] visits each for physical, pulmonary, occupational, and speech therapies. Separate limits between Outpatient Rehabilitation Services and Habilitation Services. Annual Maximum: 36 visits for Cardiac Rehabilitation.	Copayment: [None] or [$0-$250] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or [$0-$250] Coinsurance: [None] or [0-50]%	[Not covered], [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Institutional Health Care: Inpatient	**Enrollee Pays**	**Health Plan Pays**	**Enrollee Pays**	**Health Plan Pays**
Hospital Room and Board [Requires Precertification]	Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Specialty Care	Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Pregnancy Services [Requires Precertification]	Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [0-50]%	[Not covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Mental Health Services [Requires Precertification]	Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [percentage listed for General Services]	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [percentage listed for General Services]	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]

Substance Abuse Services [Requires Precertification]	Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [percentage listed for General Services]	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [percentage listed for General Services]	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Hospital; Ancillaries	Copayment: [None] or [I/P Copayment] Coinsurance: [None] or [0-40]% [Deductible: I/P Deductible]	[60-100]% of eligible charges after Enrollee pays: [Copayment] [I/P Deductible] [Network Deductible]	Copayment: [None] or [I/P Copayment] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Acute Inpatient Rehabilitation Services [Requires Precertification Annual Maximum: 60 days	Copayment: [None] or $[0-1,000] per [Day, admission] Coinsurance: [None] or [0-40]% [Includes days in Non-Network facility]	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] The Health Plan will not pay any amounts after the number of treatment days reaches the Annual or Lifetime Maximum	[Not Covered] Copayment: [None] or $[0-1,000] per [Day, Admission] . Coinsurance: [None] or [0-50]% An enrollee is responsible for 100% of the cost after the number of treatment days reaches the Annual or Lifetime Maximum. [Includes days in Network facility]	[Not Covered] [50-100]% of eligible charges up to a maximum of $750 per day after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] The Health Plan will not pay any amounts after the number of treatment days reaches the Annual or Lifetime Maximum
SNF Room and Board and Ancillaries [Requires Precertification] Annual Maximum: 90 days	Copayment: [None] or [$0-$30] per SNF day if it immediately followed a Hospital Confinement [plus a [$0-$1,000] per SNF [day, confinement] if admitted directly to an SNF without a hospital Confinement] Coinsurance: [None] or [0-40]% The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual Maximum is reached.	[60-100]% of the eligible charges [up to a maximum of $500 per day] after Enrollee pays: [Copayment] [Network Deductible] The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.	Copayment: [None] or [$0-$60] per SNF day if it immediately followed a Hospital Confinement [plus a [$0-$1,000] per SNF [day, confinement] if admitted directly to an SNF without a hospital Confinement]] Coinsurance: [None] or [0-40]% The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual Maximum is reached.	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.

Long Term Acute Care Hospital (LTACH) Services [Requires Precertification and Referral] Annual Maximum: 90 days	Copayment: [None] or $[0-1,000] per [Day, admission] Coinsurance: [None] or [0-40]% An Enrollee is responsible for 100% of the cost after the number of treatment days reaches the Annual or Lifetime Maximum. [Includes days in Non-Network facility]	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] The Health Plan will not pay any amounts after the number of treatment days reaches the Annual or Lifetime Maximum	[Not Covered] Copayment: [None] or $[0-1,000] per [Day, Admission] . Coinsurance: [None] or [0-50]% An enrollee is responsible for 100% of the cost after the number of treatment days reaches the Annual or Lifetime Maximum. [Includes days in Network facility]	[Not Covered] [50-100]% of eligible charges up to a maximum of $750 per day after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] The Health Plan will not pay any amounts after the number of treatment days reaches the Annual or Lifetime Maximum
Medical Supplies and Ancillary Services	**Enrollee Pays**	**Health Plan Pays**	**Enrollee Pays**	**Health Plan Pays**
Ambulance, medically necessary	Copayment: [None] or [$0-$250] per service Coinsurance: [None] or [0-40]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual Maximum is reached.]	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.]	Copayment: [None] or [$0-$250] per service Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual Maximum is reached.]	[50-100]% of eligible charges Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.]
Blood	[Included within the corresponding Individual Health Care Provider/Institutional Copayment] or [Copayment: [None] or [$0-$200] per service] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [$0-$200] per service Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Home Health Care [Requires Precertification] Annual Maximum: 90 days Note: Maximum does not include Private Duty Nursing rendered in home. Private Duty Nursing: Annual Maximum [82 visits] Lifetime Maximum [164 visits]	Copayment: [None] or [$0-$50] per [day, provider service] of a prescribed continuous period of care Coinsurance: [None] or [0-40]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual or Lifetime Maximum is reached.]	[60-100]% of eligible charges [up to a maximum of $500 per day] after Enrollee pays: [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual or Lifetime Maximum is reached.]	Copayment: [None] or [$0-$50] per [day, provider service] of a prescribed continuous period of care Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual or Lifetime Maximum is reached.]	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] Maximum Charges: [$500 per day] [The Health Plan will not pay any amounts for this Specific Service after the Annual or Lifetime Maximum is reached.]

Hospice, Facility [Requires Precertification]	Copayment: [None] or [$0-$50] per day Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges [up to a maximum of $500 per day] after Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [$0-$50] per day Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Hospice, Home Care [Requires Precertification]	Copayment: [None] or [$0-$50] per [day, provider service] Coinsurance: [None] or [0-40]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Lifetime Maximum is reached.]	[60-100]% of eligible charges [up to a maximum of $500 per day] after Enrollee pays: [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Lifetime Maximum is reached.]	Copayment: [None] or [$0-$50] per [day, provider service] Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Lifetime Maximum is reached.]	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Lifetime Maximum is reached.]
Medical Aids: Prosthetic Devices [Requires Precertification]	Copayment: [None] or [$0-$50] per device Coinsurance: [None] or [0-40]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual or Lifetime Combined Maximum is reached.]	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual or Lifetime Combined Maximum is reached.]	[Not Covered] Copayment: [None] or [$0-$100] per device Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual or Lifetime Combined Maximum is reached.]	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual or Lifetime Combined Maximum is reached.]
Medical Aids: Durable Medical Equipment [Requires Precertification]	Copayment: [None] or [$0-$50] per device Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Subject to combined maximums for Medical Aids.]	[Not Covered] Copayment: [None] or [$0-$100] per device Coinsurance: [None] or [0-40]% [Subject to combined maximums for Medical Aids.]	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [Subject to combined maximums for Medical Aids.]

Medical Aids: Orthotic Appliances [Requires Precertification]	Copayment: [None] or [$0-$50] per device Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Subject to combined maximums for Medical Aids.]	[Not Covered] Copayment: [None] or [$0-$100] per device Coinsurance: [None] or [0-50]% [Subject to combined maximums for Medical Aids.]	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [Subject to combined maximums for Medical Aids.]
Medical Supplies	Copayment: [None] or [amount set by Health Care Provider] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [amount set by Health Care Provider] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Renal Dialysis Annual Maximum [90 days	Copayment: [None] or [amount set by Health Care Provider] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [amount set by Health Care Provider] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]

Prescription Drugs Biotech or Specialty Injectable Drugs other than insulin and anti neoplasm drugs Annual Benefit Maximum of $50,000 to Unlimited	[Prescription Drug Deductible: Individual: $0-$1,000 Family: $0-$3,000 Deductibles cross apply Network and Non-Network] Copayment: Generic: [None] or [$0-$50] [Brand Name: [None] or [$0-$75] [plus the difference between the brand and available generic drugs] [$30 to $100 benefit allowance] [Non-Formulary: [None] or [$0-$75] [plus the positive difference between the formulary and the non-compliant drugs] [$10 to $100 benefit allowance]] [Biotech or Specialty Injectable Drugs other than insulin and anti neoplasm drugs coinsurance [10% to 40%] to a maximum of [$100 to $500] per Rx] Coinsurance: [None] or [0-40]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual Maximum is reached.]	[60-100]% of eligible charges after Enrollee pays: [Prescription Drug Deductible] [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.]	[Prescription Drug Deductible: Individual: $0-$1,000 Family: $0-$3,000 Deductibles cross apply Network and Non-Network] Copayment: Generic: [None] or [$0-$50] [Brand Name: [None] or [$0-$75] [plus the difference between the brand and available generic drugs] Non-Formulary: [None] or [$0-$75] [plus the positive difference between the formulary and the non-compliant drugs] Coinsurance: [None] or [0-50]% [Biotech or Specialty Injectable Drugs other than insulin and anti neoplasm drugs not covered] [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual Maximum is reached.]	[Not Covered], [50-100]% of eligible charges after Enrollee pays: [Prescription Drug Deductible] [Copayment] [Network Deductible] [Non-Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.]
[Evidenced Based Pharmacy Plan] .	[Prescription Drug Deductible: Individual: $0-$1,000 Family: $0-$3,000 Deductibles cross apply Network and Non-Network] Copayment: Generic: [None] or [$0-$50] Brand Name: [None] or [$0-$75] [plus the difference between the brand and available generic drugs] Non-Formulary: [None] or [$0-$75] [plus the positive difference between the formulary and the non-compliant drugs] Coinsurance: [None] or [0-40]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual Maximum is reached.]	[60-100]% of eligible charges after Enrollee pays: [Prescription Drug Deductible] [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.]	[Prescription Drug Deductible: Individual: $0-$1,000 Family: $0-$3,000 Deductibles cross apply Network and Non-Network] Copayment: Generic: [None] or [$0-$50] Brand Name: [None] or [$0-$75] [plus the difference between the brand and available generic drugs] Non-Formulary: [None] or [$0-$75] [plus the positive difference between the formulary and the non-compliant drugs] Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual Maximum is reached.]	[Not Covered], [50-100]% of eligible charges after Enrollee pays: [Prescription Drug Deductible] [Copayment] [Network Deductible] [Non-Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.]

Specified Health Care Benefit Services	Enrollee Pays	Health Plan Pays	Enrollee Pays	Health Plan Pays
Donor Organ Procurement [I/P stay Requires Precertification] Lifetime Maximum: [$20,000-Unlimited	Copayment: [None] or [I/P Copayment] Coinsurance: [None] or [0-40]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Lifetime Maximum is reached.]	[60-100]% of eligible charges Enrollee pays: [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Lifetime Maximum is reached.]	Copayment: [None] or [I/P Copayment] Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Lifetime Maximum is reached.]	[50-100]% of eligible charges Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Lifetime Maximum is reached.]
Pre-Admission Testing	Copayment: [None] or [amount set by Health Care Provider] Coinsurance: [0-40]% [Deductible: set by Health Care Provider]	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Health Care Provider Deductible] [Network Deductible]	Copayment: [None] [$0-$75 per test] or [amount set by Health Care Provider] Coinsurance: [0-50]% [Deductible: set by Health Care Provider]	[50-100]% of eligible charges Enrollee pays: [Copayment] [Health Care Provider Deductible] [Network Deductible] [Non-Network Deductible]
Special Routine Care-Mammography-Pap Smear	Copayment: [None] or [amount set by Health Care Provider] Coinsurance: [0-40]% [Deductible: set by Health Care Provider]	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Health Care Provider Deductible] [Network Deductible]	Copayment: [None] or [$0-$200 per test] or [amount set by Health Care Provider] Coinsurance: [0-50]% [Deductible: set by Health Care Provider]	[50-100]% of eligible charges Enrollee pays: [Copayment] [Health Care Provider Deductible] [Network Deductible] [Non-Network Deductible]
Supplemental Emergency Accident	Copayment: [None] or [$0-$250] Coinsurance: [None] or [0-40]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual Maximum is reached.]	100% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.]	Copayment: [None] or [$0-$500] Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual Maximum is reached.]	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.]

[Surgical Treatment of Morbid Obesity, including Complications [Requires Precertification] Annual Maximum: $10,000 – Unlimited	Copayment: [None] or [$0-$5,000] per procedure Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after the Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [$0-$5,000] per procedure Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]]
Preventative Health Benefit	**Enrollee Pays**	**Health Plan Pays**	**Enrollee Pays**	**Health Plan Pays**
Physical Medicine Therapies	Copayment: [None] or [$0-$30] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [$0-$40] Coinsurance: [None] or [0-50]%	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]

ATTACHMENT C

SCHEDULE OF BENEFITS
PEDIATRIC VISION ESSENTIAL BENEFIT

GENERAL
This Schedule list the vision care services and vision care materials to which Enrollees under the age of 19 are entitled, subject to any conditions, limitations and/or exclusions stated herein or in the Certificate of Coverage to which this is attached. Vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, who are Participating Providers.

Participating Provider are those doctors who have agreed to participate in VSP's Choice Network, available at www.vsp.com.

When Covered Benefits are received from Participating Providers, benefits are applicable as stated below.

COVERED BENEFIT	PARTICIPATING PROVIDER BENEFIT
VISION CARE SERVICES	
Vision Examination	Covered in Full
VISION CARE MATERIALS	
Lenses	
Single Vision	Covered in Full*
Bifocal	Covered in Full*
Trifocal	Covered in Full*
Lenticular	Covered in Full*

Frames	Covered in Full from a Pediatric Exchange Collection
CONTACT LENSES	
Necessary	
Professional Fees and Materials	Covered in Full
Elective	
Professional Fees**	Covered in Full
Materials	Covered in full with the following service limitations: Standard (one pair annually) = 1 contact lens per eye (total 2 lenses) Monthly (six-month supply) = 6 lenses per eye (total 12 lenses) Bi-weekly (3 month supply) = 6 lenses per eye (total 12 lenses) Dailies (one month supply) = 30 lenses per eye (total 60 lenses)

Necessary Contact Lenses are a Covered Benefit when specific benefit criteria are satisfied and when prescribed by a Participating Provider or Non-Participating Provider. Prior review and approval by VSP are not required to be eligible for Necessary Contact Lenses.

*Coverage includes lenses in polycarbonate, plastic or glass, scratch resistant or UV coatings also covered.

**15% discount applies to Participating Provider's usual and customary professional fees for contact lens evaluation and fitting.

COPAYMENT
There shall be no Copayment for the examination or materials payable to the Participating Provider at the time services are rendered.

State: Indiana **Filing Company:** Southeastern Indiana Health Organization, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Individual QHP Plans
Project Name/Number: 2015 Exhange/QHP INDV-05.2014

Rate Information

Rate data applies to filing.

Filing Method:
Rate Change Type: Neutral
Overall Percentage of Last Rate Revision: %
Effective Date of Last Rate Revision:
Filing Method of Last Filing:

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	Number of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Southeastern Indiana Health Organization, Inc.	New Product	0.000%	0.000%	$0	0	$0	0.000%	0.000%

State: *Indiana* ***Filing Company:*** *Southeastern Indiana Health Organization, Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
Product Name: *Individual QHP Plans*
Project Name/Number: *2015 Exhange/QHP INDV-05.2014*

Rate Review Detail

COMPANY:

Company Name: Southeastern Indiana Health Organization, Inc.
HHS Issuer Id: 67920

PRODUCTS:

Product Name	HIOS Product ID	HIOS Submission ID	Number of Covered Lives
SIHO HMO Individual Exchange	67920IN051	67920-814414	2000

Trend Factors: Overall trend 8%, medical trend 7%, pharmacy and specialty drug trend 14.3%

FORMS:

New Policy Forms: QHP INDV-05.2014
Affected Forms:
Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
Member Months: 24,000
Benefit Change: None
Percent Change Requested: Min: 0.0 Max: 0.0 Avg: 0.0

PRIOR RATE:

Total Earned Premium: 0.00
Total Incurred Claims: 0.00
Annual $: Min: 0.00 Max: 0.00 Avg: 0.00

REQUESTED RATE:

Projected Earned Premium: 13,400,000.00
Projected Incurred Claims: 10,960,000.00
Annual $: Min: 558.48 Max: 558.48 Avg: 558.48

SERFF Tracking #:	*SEIH-129537625*	***State Tracking #:***	*QHP INDV-05.2014*	***Company Tracking #:***	*QHP INDV-05.2014*

State:	*Indiana*	***Filing Company:***	*Southeastern Indiana Health Organization, Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*		
Product Name:	*Individual QHP Plans*		
Project Name/Number:	*2015 Exhange/QHP INDV-05.2014*		

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Actuarial Memorandum	QHP IN SG-05.2014	New		10-Actuarial Memorandum - 2015 - Individual.pdf, DOI_Response_20140730_INDV.pdf,

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SOUTHEASTERN INDIANA HEALTH ORGANIZATION

Health Maintenance Organization Individual Product
Actuarial Memorandum
Form QHP INDV-05.2014

A. INTRODUCTION

Milliman, Inc. (Milliman) was retained by Southeastern Indiana Health Organization (SIHO) to develop an individual market rate filing with on-exchange and off-exchange plans to be filed with the Indiana Department of Insurance for 2015. This actuarial memorandum has been prepared in accordance with Indiana insurance laws and ACA Market Rating Rules. The purpose of this actuarial memorandum is to present the premium rates for SIHO's plans to be offered in the individual market in 2015. This material should not be used for any other purpose.

This actuarial memorandum has been prepared for the use of SIHO. We understand that the actuarial memorandum will be provided to the Indiana Department of Insurance and its subcontractors to assist in the review of SIHO's individual market rate filing. No portion of the actuarial memorandum may be provided to any other party without Milliman's prior written consent. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work.

The rating factors were developed from information published in the Milliman Health Cost Guidelines, and applicable state and federal regulations, as well as from information provided by SIHO. Additionally, we relied on exchange enrollment information provided within the April 2014 HHS Marketplace Enrollment report, along with information on the Medicaid spend-down population provided by the Indiana Department of Insurance (IDOI). The memorandum does not guarantee that the rates will be adequate. Rather, the filing shows that the rates will be adequate if the assumptions underlying their development are realized.

This actuarial memorandum has been updated based on information made available following the initial filing submission. We were provided with additional information related to the Medicaid spend-down population from the IDOI on May 15, 2014 and May 20, 2014. Additionally, on May 15, 2014 a Medicaid expansion plan was announced for Indiana through the Healthy Indiana Plan (HIP). If implemented, this expansion could have a significant impact to the demographics of the Marketplace population. These items were considered in updating the morbidity and demographics assumptions underlying the rate development process.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

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B. STATE OF INDIANA 4.1 (A) INDIVIDUAL RATE REQUIREMENTS

1. Benefit Structure

This is an individual medical expense service agreement offered as a health maintenance organization product. It provides for hospital, medical, and surgical expenses resulting from an eligible illness or injury. It also provides for prescription drug expenses and certain preventive care services. It is subject to various managed care provisions as described in the certificate of coverage. These are new products that will be offered beginning in 2015; SIHO does not currently offer any products in the individual market.

This policy provides for coverage of medical expenses with applicable member cost sharing, *i.e.*¸co-payments, deductibles, and coinsurance amounts. Various benefit provisions are available under this policy form. Covered benefits and copayment schedules have been included with the certificates of coverage.

Attachment 1 provides a summary of benefit provisions for the benefit plan designs that are the subject of this actuarial memorandum. Complete descriptions of covered benefits and cost sharing arrangements are contained in the certificates of coverage.

The benefit plan designs included in this rate filing will be sold to individuals in Indiana. The following qualified health plans (QHPs) will be offered both on-exchange and off-exchange:

- SIHO Marketplace Bronze;
- SIHO Marketplace Bronze HSA;
- SIHO Marketplace Silver;
- SIHO Marketplace Silver HSA; and
- SIHO Marketplace Gold.

Covered services include the Indiana essential health benefits (EHB), inclusive of state mandated benefits. The following supplemental benefits are also covered:

- Diabetes education;
- Nutrition counseling; and
- An additional 3 chiropractic visits.

2. Proposed Rates

a. <u>Premium Rate Development</u>

The proposed premium rating factors were developed based on a manual rate development process. SIHO's group experience was utilized where appropriate in developing the manual rates, and was adjusted for the following:

- Trend, i.e., medical inflation and increased utilization;
- Regional, demographical and benefit cost-sharing differences between SIHO's group experience and the projected 2015 individual market;

- The morbidity of individuals anticipated to elect to be enrolled in ACA-compliant policies during 2015, including the impact of the Medicaid spend-down population;
- Impact of federal transitional reinsurance; and
- Differences in retention components between the group and individual blocks of business.

b. Premium Rate Calculation

Consumer Adjusted Premium Rates are calculated as the product of four factors:

i. Plan Adjusted Index Rate (Calibrated);
ii. Geographic rating area factor;
iii. Age factor; and
iv. Tobacco status factor.

Monthly Premium Rates to be charged to a specific policyholder are determined by summing the Consumer Adjusted Premium Rates for each member of the family, provided at most three child dependents under age 21 for each family are taken into account. For members that use tobacco, the composite premium applicable to the member will be multiplied by the tobacco status factor applicable to the member's age.

i. Plan Adjusted Index Rate (Calibrated)

A Plan Adjusted Index Rate (Calibrated) is the estimated cost to provide coverage under a given benefit plan design for a member with a geographic rating area factor, an age factor, and a tobacco status factor of 1.00. The Plan Adjusted Index Rates (Calibrated) are provided in Exhibit 1 of Attachment 2. The actuarial value, as calculated using the CMS Actuarial Value (AV) calculator, and metal tier for each plan are also shown in this exhibit.

ii. Geographic Rating Area Factors

Individual market products will be offered in a total of 6 counties: Bartholomew, Brown, Decatur, Jackson, Jennings, and Scott. While these counties span three different rating regions, no geographic rating area factors will be applied to the products offered in the individual market.

iii. Age Factors

Age factors are based upon each member's age as of the premium rate effective date. The HHS Default Standard Age Curve is used for the age factors and is provided in Exhibit 2 of Attachment 2.

iv. Tobacco Status Factors

Tobacco status factors are based on each member's age and tobacco user status as of the premium rate effective date. Members whom do not use tobacco have a tobacco

status factor of 1.00. The tobacco status factors for members that use tobacco are provided in Exhibit 2 of Attachment 2.

3. Projected Experience with Enrollment Projection

SIHO's anticipated experience for the 2015 calendar year for individual policies under this form is provided in Table 1 below. The values reflect an estimate for the population that will enroll in these new products in January 2015.

Southeastern Indiana Health Organization
Table 1: Projected 2015 Experience

Member Months	Incurred Claims	Earned Premium	Projected Loss Ratio	Projected MLR
24,000	$9,790,000	$12,030,000	81.3%	87.0%

Note: Values have been rounded.

The projected loss ratio reflects a direct ratio of incurred claims to earned premiums. Projected medical loss ratio (MLR) was calculated consistently with the MLR methodology according to the National Associate of Insurance Commissioners as prescribed by 211 CMR 147.00, and does not reflect any credibility adjustments that may be permitted. Table 2 below contains a breakdown of the MLR calculation for SIHO's individual business.

Southeastern Indiana Health Organization
Table 2: Projected Federal Medical Loss Ratio Exhibit

Member Months	24,000
Claims PMPM	$ 462.35
Transitional Reinsurance Recoveries PMPM (Received)	$ (58.24)
Risk Adjustment Paid PMPM (Received)	$ 0.00
Risk Corridors Paid PMPM (Received)	$ 0.00
MLR Numerator	**$ 404.10**
Premium PMPM	$ 501.36
Premium-Related Retention PMPM (Taxes/Fees)	$(25.22)
Income Tax PMPM	$(11.84)
MLR Denominator	**$ 464.30**
Loss Ratio	**87.0%**

Note: Values have been rounded.

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4. Assumptions

Since this is a new product rate filing, experience data was not available for the purpose of developing premium rates for these products. As such, premium rates for this filing are the result of a manual rate development process. SIHO's small group and large group point-of-service experience for the 12 months ending December 2013, representing 125,498 member months, provided the basis for the manual rate development process.

This experience data was adjusted to reflect anticipated differences between the group and individual markets. Specific items considered in estimating these adjustments included the following:

- Benefits not included within the experience data;
- Differences in age and gender of the covered populations;
- Geography and provider network differences between the populations;
- Morbidity of the population, including the following:
    - Difference in morbidity between the individual and group markets;
    - Impact of transitional ("grandmothered") policies;
    - Health status of the previously uninsured;
    - Impact of the Medicaid spend-down population;
- Income level of the anticipated population;
- Impact of federal transitional reinsurance;

Additional Benefits not covered in the baseline experience data used include private duty nursing and Temporomandibular joint disorder. Pediatric vision services are covered under a capitation agreement effective January 2015. Please note that pediatric dental services will not be covered within the policy.

In developing estimates for the demographics of the individual market, we utilized data provided within the HHS Marketplace Enrollment report for April 2014.

The impact of morbidity was estimated as a percentage difference from the pre-ACA group market. Based on the various items outlined, the total morbidity of the individual market was estimated as being 16.5% above that of the pre-ACA group market. This morbidity assumption was developed as the product of the assumptions shown in Table 3 below. There was assumed to be no morbidity impact associated with pent-up demand for calendar year 2015. Please note that the resulting composite morbidity was rounded down to arrive at the 16.5% figure utilized for pricing purposes.

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Southeastern Indiana Health Organization
Table 3: Individual Market Morbidity

Category	Factor
Individual-Level Purchasing Decisions	1.030
Uninsured Morbidity	1.010
Impact of Transitional Policies	1.050
Medicaid Spend-Down Population	1.065
Composite Morbidity	**1.165**

Note: Values have been rounded.

The morbidity impact associated with individual-level purchasing decisions reflects the impact of consumer level purchasing relative to the experience used in the manual rate development process (SIHO small and large group business). This estimate was calculated by comparing the morbidity level of groups with 2-5 subscribers relative to that of the composite small and large group experience used in the manual rate development process.

Uninsured morbidity reflects the assumed impact of individuals entering the market in 2015 that were previously uninsured.

The impact of transitional policies reflects members in the pre-ACA individual market having the ability to renew on non-ACA compliant products in 2015. This is assumed to have an adverse impact on the morbidity of the ACA complaint risk pool, as healthier individual are more likely to renew on the non-ACA compliant products.

The morbidity impact of the Medicaid spend-down population was estimated based on information provided by the IDOI on May 15, 2014 and May 20, 2014.

Income level of the anticipated population was used in order to estimate the impact of cost share reduction (CSR) plans made available to individuals below 250% of the federal poverty level (FPL). For individuals estimated to be eligible for the 94% or 87% CSR plans, it was estimated that utilization would be 12% higher than that of the average enrollee. This assumption was based on information available within federal regulations; specifically, the HHS Notice of Benefit and Payment Parameters for 2015.

Net incurred annual trend of approximately 8.0% was applied to estimate claims experience for 2015. The 8.0% annual trend is the composite of medical trend of approximately 7.0% and prescription drug trend of approximately 14.3%. SIHO provided the medical trend estimate based upon anticipated changes in their provider contracts and a review of recent experience. The prescription drug trend estimate was developed using 2014 and 2015 projected trends from SIHO's pharmacy benefit manager for its health plan book of business and experience from 2010 to 2013 as reported by the pharmacy benefit manager for its health plan book of business and for SIHO. Prospective pharmacy trends reflect a continued higher utilization of specialty drugs, relative to historical experience.

The medical trend of approximately 7.0% and drug trend of approximately 14.3% are comprised of Allowed Trend, Cost Share Leveraging, and the impact of Non Fee for Service

expenses (Non-FFS). Cost Share Leveraging includes the impact of fixed dollar cost sharing, such as deductibles and copayments, on trend. The Medical Non-FFS Impact reflects private reinsurance trend. The Drug Non-FFS Impact reflects the trend associated with Rx rebates. A breakdown of each of these trend components is provided in Table 4 below.

Southeastern Indiana Health Organization
Table 4: 2015 Medical and Drug Trends

	Medical Trend	Drug Trend
Allowed Trend	6.0%	11.8%
Cost Share Leveraging	0.7%	1.4%
Non-FFS Impact	0.3%	1.1%
Total	**7.0%**	**14.3%**

Note: Values have been rounded.

The following table shows the estimated incurred claims, net of transitional reinsurance, for 2015 effective dates based on the manual rate development process utilized, along with an illustrated buildup to total required revenue.

Southeastern Indiana Health Organization
Table 5: 2015 Total Required Revenue

Estimated Incurred Claims PMPM for 2015	**$ 407.85**
Administrative Expense Load	$ 41.96
Profit and Risk Load	$ 30.08
Taxes and Fees	$ 21.47
Required Revenue PMPM	***$ 501.36***

Note: Values have been rounded.

The administrative expense load includes amounts for network access fees and operating expenses. SIHO's network access fees were estimated on a per member per month (PMPM) basis, based on data available within SIHO's small group block of business. Taxes and fees includes the estimated value of exchange user fees.

SIHO provided a PMPM assumption plus a percent of premium assumption for operating expenses. These estimates of 2015 operating expenses were developed by SIHO, and are illustrated in Table 6 below.

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Southeastern Indiana Health Organization
Table 6: Illustration of Administrative Expense Load

	Retention Description	PMPM	% Premium	Basis
	Administrative Expense Load			
	General Admin Expense	$ 18.50	3.69%	PMPM
	Network Access Fee	$ 2.15	0.43%	PMPM
+	Percentage Based General Admin	$ 21.31	4.25%	% of Premium
	Subtotal: Administrative Expense Load	$ 41.96	8.37%	

Note: Values have been rounded

The proposed rates reflect a combined profit and risk charge load of 6% which was converted to a PMPM for Table 5. These loads were provided by SIHO and are applied to all plans.

The following taxes and fees are reflected in Table 5:

- $3.67 PMPM for the Federal Transitional Reinsurance Program (included in incurred claims estimate);
- $0.96 Per Member Per Year for the Risk Adjustment User Fee (included in incurred claims estimate);
- $2.12 Per Member Per Year for the Patient Centered Outcomes Research Institute Fee;
- 3.5% of premium exchange user fee; and,
- 0.75% for the Health Insurer Fee.

Taxes and Fees on a PMPM basis are illustrated in Table 7 below. The impact of the Federal Transitional Reinsurance Contributions and the Risk Adjustment User Fee are excluded from the values illustrated in the figure, as they are reflected in estimated incurred claims.

Southeastern Indiana Health Organization
Table 7: Illustration of Taxes and Fees

	Retention Description	PMPM	% Premium	Basis
	Taxes and Fees			
	Patient Centered Outcomes Research Institute Fee	$ 0.18	0.04%	PMPM
	Exchange User Fee	$ 17.55	3.50%	% of Premium
+	Health Insurer Fee	$ 3.75	0.75%	% of Premium
	Subtotal: Taxes and Fees	$ 21.47	4.28%	

Note: Values have been rounded

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5. Premium Guarantee Provision

The policies are guaranteed renewable and will be sold on a guarantee of issue basis for residents of the six counties where these plans will be offered.

6. Rating Factors

a. Rate Structure

The calculation of monthly premiums and the rating factors, including geographic rating area, age, and tobacco status factors were described in Section 3 above.

b. Non-benefit Expenses

Non-benefit expenses are included in the Plan Adjusted Index Rates (Calibrated) discussed in section 3 of this memorandum. The non-benefit expenses include amounts for administrative and other expenses, sales and marketing expenses, net cost of private reinsurance, taxes, fees, risk margin, and profit.

c. Impact of Contractual Arrangement

Contractual agreements with health care providers and administrators are expected to result in medical cost and premium changes in line with market averages.

7. Company Financial Position

SIHO's risk-based capital ratio as of December 31, 2013 was 472.8%.

C. CERTIFICATION AND ATTESTATIONS

I am a Consulting Actuary with the firm of Milliman, Inc. SIHO engaged me to provide this actuarial memorandum.

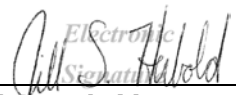
Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and I meet its qualification standards to perform the analysis and render the actuarial opinion contained herein.

I believe this rate filing is in compliance with all applicable state and federal insurance statues and regulations and with applicable actuarial standards of practice.

I attest that the same premium rate is being charged without regard to whether the plan is offered through an Exchange, or whether the plan is offered directly from SIHO or through an agent.

This memorandum should not be interpreted as a guarantee that the rates will be adequate. The rates will be adequate if the assumptions underlying their development are realized. The adequacy of the rates will be dependent on numerous factors, many of which are not subject to management control (e.g., medical care cost trends in the community, demographic characteristics of the enrollees, etc.).

In developing the rating factors and other values in this actuarial memorandum, I relied on data, other information, and assumptions provided by SIHO. I have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of the analysis may likewise be inaccurate or incomplete. I performed a limited review of the data used directly in the analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of my assignment.



Jill S. Herbold, FSA, MAAA
Consulting Actuary

June 24, 2014
Date

ATTACHMENT 1

SOUTHEASTERN INDIANA HEALTH ORGANIZATION
Exhibit: 2015 Individual Plan Designs

Benefit Category	SIHO Marketplace Bronze HSA	SIHO Marketplace Bronze	SIHO Marketplace Gold	SIHO Marketplace Silver HSA	SIHO Marketplace Silver
Annual Single Deductible	$4,500	$5,000	$750	$2,500	$2,000
Annual Family Deductible	$9,000	$10,000	$1,500	$5,000	$4,000
Annual OOP Max - Single (incl Ded)	$6,450	$6,600	$4,000	$5,000	$6,600
Annual OOP Max - Family	$12,900	$13,200	$8,000	$10,000	$13,200
PCP Office Visit	Ded, 20%	Ded, 20%	$30	Ded, 10%	$30
Specialist Office Visit	Ded, 20%	Ded, 20%	$60	Ded, 10%	$60
Preventive Care	$0	$0	$0	$0	$0
Inpatient Hospital Services	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Outpatient Hospital Services	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Professional Services (In & Out)	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Emergency Room	Ded, 20%	Ded, 20%	Ded, $200	Ded, 10%	Ded, $200
Urgent Care Facility	Ded, 20%	Ded, 20%	$60	Ded, 10%	$60
Ambulance	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
PT/OT/Speech Therapy	Ded, 20%	Ded, 20%	$60	Ded, 10%	$60
Chiropractic Services	Ded, 20%	Ded, 20%	$60	Ded, 10%	$60
DME/Orthotics & Prosthetic Devices	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Inpatient Behavioral Health	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Outpatient Behavioral Health	Ded, 20%	Ded, 20%	$30	Ded, 10%	$30
Skilled Nursing Facility/LTACH	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Acute IP Rehab	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Home Health	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Hospice	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Pharmacy:					
Generic Drug	Ded, 20%	$25	$15	Ded, 10%	$15
Brand Name Formulary	Ded, 20%	$50	$40	Ded, 10%	$40
Brand Name Non-Formulary	Ded, 20%	$100	$80	Ded, 10%	$80
Specialty Drugs *	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Mail Order	Ded, 20%	2.5x	2.5x	Ded, 10%	2.5x
Pediatric Vision Services	Eye Exam, Lenses/Frames or Contacts Once a Calendar Year				

* Specialty Drug Benefit does not apply to orally administered cancer chemotherapy drugs, which are covered at the same level as chemotherapy administered intravenously or by injection.

Milliman

ATTACHMENT 2

SOUTHEASTERN INDIANA HEALTH ORGANIZATION
Attachment 2 - Exhibit 1: Plan Adjusted Index Rates (Calibrated)

Plan Name	Actuarial Value	Metal Tier	Plan Adjusted Index Rate (Calibrated)
SIHO Marketplace Bronze HSA	60.1%	Bronze	$219.29
SIHO Marketplace Bronze	61.2%	Bronze	$240.27
SIHO Marketplace Gold	78.4%	Gold	$358.48
SIHO Marketplace Silver HSA	70.1%	Silver	$271.34
SIHO Marketplace Silver	70.3%	Silver	$316.65

Southeastern Indiana Health Organization
Attachment 2 - Exhibit 2: Age and Tobacco Status Factors

Age	Age Factor	Tobacco Factor
0-20	0.635	1.000
21	1.000	1.050
22	1.000	1.050
23	1.000	1.050
24	1.000	1.050
25	1.004	1.100
26	1.024	1.100
27	1.048	1.100
28	1.087	1.100
29	1.119	1.100
30	1.135	1.150
31	1.159	1.150
32	1.183	1.150
33	1.198	1.150
34	1.214	1.150
35	1.222	1.150
36	1.230	1.150
37	1.238	1.150
38	1.246	1.150
39	1.262	1.150
40	1.278	1.150
41	1.302	1.150
42	1.325	1.150
43	1.357	1.150
44	1.397	1.150
45	1.444	1.200
46	1.500	1.200
47	1.563	1.200
48	1.635	1.200
49	1.706	1.200
50	1.786	1.200
51	1.865	1.200
52	1.952	1.200
53	2.040	1.200
54	2.135	1.200
55	2.230	1.300
56	2.333	1.300
57	2.437	1.300
58	2.548	1.300
59	2.603	1.300
60	2.714	1.300
61	2.810	1.300
62	2.873	1.300
63	2.952	1.300
64 and Older	3.000	1.300

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July 30, 2014

Mr. Rick Kramer
Interim CFO
Southeastern Indiana Health Organization
417 Washington Street
P.O. Box 1787
Columbus, IN 47202-1787

RE: JULY 18, 2014 INDIVIDUAL QHP FILING OBJECTION QUESTIONS (SERFF TRACKING NUMBER: SEIH-129537625)

Dear Rick:

Milliman, Inc. (Milliman) was retained by Southeastern Indiana Health Organization (SIHO) to develop an individual rate filing to be filed with the Indiana Department of Insurance for effective dates beginning January 1, 2015. This correspondence responds to the first three questions about the rate filing sent by the Indiana Department of Insurance to you on July 18, 2014. We anticipate that SIHO will respond to the other questions. The first three questions from the Indiana Department of Insurance appear in bold italic font below and are followed by our responses.

LIMITATIONS

The letter is subject to the terms and conditions of the Consulting Services Agreement between SIHO and Milliman dated January 1, 2004. This letter has been prepared for the use of SIHO. We understand that this letter will be provided to the Indiana Department of Insurance and its subcontractors to assist in the review of SIHO's individual rate filing. No portion of this letter may be provided to any other party without Milliman's prior written consent. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work.

In performing this analysis, we relied on data and other information provided by SIHO. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be

uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

RESPONSES

1) I think that the factors used for the impact of transitional policies is higher than need be. At 5%, this is higher than we expect since over 80% of the current non-grandfathered business will not be transitional but moved to an ACA product.

The impact of transitional policies was intended to reflect the impact of early renewals and renewal timing changes in addition to insurers renewing non-ACA compliant policies. Morbidity assumptions were established by analyzing the aggregate impact in addition to the individual components. When comparing the aggregate morbidity impact filed of 16.5% to other publically available information, we believe the assumptions used are appropriate and potentially lower than the market average.

2) The Medicaid spend down is higher than I expect given the new data provided. Please review and see if you think this can come down further.

The morbidity impact of the Medicaid spend-down population was estimated based on information provided by the IDOI on May 15, 2014 and May 20, 2014. We have compared this estimate to information filed by other carriers in Indiana, and believe that it appropriately reflects the anticipated cost of these individuals.

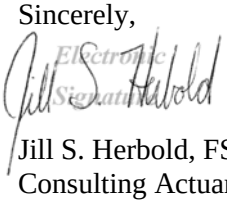
3) With the exchange fee at 3.5%, this would assume that all policies will be sold on the exchange with nothing off exchange. Is this what you anticipate?

SIHO does not intend to actively market individual products outside of the exchange. We have assumed, and anticipate, that all policies will be sold on the exchange.

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

Please contact me at (317) 524-3538 or jill.herbold@milliman.com with any questions or comments.

Sincerely,



Jill S. Herbold, FSA, MAAA
Consulting Actuary

JSH/pdn

State: Indiana **Filing Company:** Southeastern Indiana Health Organization, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Individual QHP Plans
Project Name/Number: 2015 Exhange/QHP INDV-05.2014

Supporting Document Schedules

Bypassed - Item:	10 Individual Checklist (Accident & Health)
Bypass Reason:	Individual filing only.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	12 Individual HMO Checklist (Accident & Health)
Bypass Reason:	Individual filing only.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	20(C) Out of State Association/Trust Products Checklist (Accident & Health)
Bypass Reason:	Individual filing only.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	12(A) Individual HMO Checklist (Accident & Health)
Comments:	
Attachment(s):	Individual Checklist - final.pdf
Item Status:	
Status Date:	

Bypassed - Item:	4.1 Individual New Rate/Form Requirements (Accident & Health)
Bypass Reason:	Included in actuarial memorandum and Form filing.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	7.0 Individual Rate Adjustment Requirements (Accident & Health)
Bypass Reason:	Included in actuarial memorandum and Form filing.
Attachment(s):	
Item Status:	
Status Date:	

SERFF Tracking #:	*SEIH-129537625*	***State Tracking #:***	*QHP INDV-05.2014*	***Company Tracking #:***	*QHP INDV-05.2014*

State:	*Indiana*	***Filing Company:***	*Southeastern Indiana Health Organization, Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*		
Product Name:	*Individual QHP Plans*		
Project Name/Number:	*2015 Exhange/QHP INDV-05.2014*		

Bypassed - Item:	4.1(A) QHP Individual New Rate/Form Requirements (Accident & Health)
Bypass Reason:	Included in actuarial memorandum and Form filing.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	7.0(A) QHP Individual Rate Adjustment Requirements (Accident & Health)
Bypass Reason:	Included in actuarial memorandum and Form filing.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	4.1(B) EHB Individual New Rate/Form Requirements (Accident & Health)
Comments:	Revised crosswalk form 7/11/2014.
Attachment(s):	Updated Individual Crosswalk 7.2.2014.pdf
Item Status:	
Status Date:	

Bypassed - Item:	7.0(B) EHB Individual Rate Adjustment Requirements (Accident & Health)
Bypass Reason:	Included in actuarial memorandum and Form filing.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	09 SERFF Data Field Guide (Accident & Health)
Bypass Reason:	Included in actuarial memorandum and Form filing.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Consumer Disclosure Form
Bypass Reason:	New product, no prior rates.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	04 Major Medical Experience Workbook (Accident & Health)

State: Indiana **Filing Company:** Southeastern Indiana Health Organization, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Individual QHP Plans
Project Name/Number: 2015 Exhange/QHP INDV-05.2014

Bypass Reason:	New product, no prior experience to report.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	Updated actuarial memorandum and point by point response to objections dated 5/20/14.
Attachment(s):	10-Actuarial Memorandum - 2015 - Individual.pdf DOI_Response_20140602.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Unified Rate Review Template
Comments:	Updated
Attachment(s):	UnifiedRateReviewSubmission_201406258956.xml 10-PM.QHP.Unified Rate Review Template.TMPL.v2.0.2.04152014 - Individual.xls
Item Status:	
Status Date:	

Bypassed - Item:	03 PPACA Uniform Compliance Summary
Bypass Reason:	Included in actuarial memorandum and Form filing.
Attachment(s):	
Item Status:	
Status Date:	

SERFF Tracking #:	*SEIH-129537625*	***State Tracking #:***	*QHP INDV-05.2014*	***Company Tracking #:***	*QHP INDV-05.2014*

State:	*Indiana*	***Filing Company:***	*Southeastern Indiana Health Organization, Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*		
Product Name:	*Individual QHP Plans*		
Project Name/Number:	*2015 Exhange/QHP INDV-05.2014*		

Attachment UnifiedRateReviewSubmission_201406258956.xml is not a PDF document and cannot be reproduced here.

Attachment 10-PM.QHP.Unified Rate Review Template.TMPL.v2.0.2.04152014 - Individual.xls is not a PDF document and cannot be reproduced here.

Indiana Department of Insurance
Company Filing Checklist - Policy Review Standards

12(A) Non-Grandfathered
HMO Individual Major Medical & Dental

This checklist must be submitted with any form filings for HMO Individual Major Medical or HMO Individual Dental plans that are not Grandfathered. This checklist should also be used for HMO Individual Major Medical or Dental plans that are seeking certification as a Qualified Health Plan for Health Exchange participation.

Please attach this completed checklist as a PDF to your electronic filing.

Company Name Southeastern Indiana Health Organization **NAIC #** 95812

Form number(s) QHP INDV-05.2014 **Filing date** 05/09/2014

Product Type:	☑	**Major Medical**	☐	**Pediatric Stand-Alone Dental**
Exchange Participation:	☑	**Off-Exchange**	☑	**On-Exchange**

Adult Dental: Adult Dental (all dental plans other than Pediatric Stand-Alone Dental plans) should use the Grandfathered Company Filing Checklist (either non-HMO or HMO, as appropriate). It is assumed that Adult Dental plans will not apply for Exchange participation. Contact the Indiana Department of Insurance for further clarification, if needed.

Requirements in this checklist include:

A. General Filing Requirements 2
B. Required Provisions 4
C.HMO Individual A&H Policies *must provide* 7
D. General Regulatory Issues 9
E. HMO Individual A&H must cover 10
F. ACA Must Provide 11
G. Specific Requirements for Qualified Health Plans 26
H. Specific Requirements for Exchange Certified Stand-Alone Dental Plan 28

Instructions:

This document is intended to provide a checklist for form filings of the applicable Accident and Health product. The checklist contains (1) specific requirements/provisions and (2) certifications that the Insurer has acknowledged and is in compliance with particular laws, regulations and bulletins. Additionally, this checklist is intended to provide supplementary information regarding certain laws, regulations and/or bulletins. When providing the completed checklist, the Insurer is expected to address **each** checklist line item in the column labeled "Response" as follows:

- Provide the specific location(s) in the documents provided which address the requirement; or
- Provide an affirmative statement or initial that the certification is being given; or
- Provide an explanation as to why the Insurer believes the item is not applicable for the product submitted for review.

All checklist line items require a response. Failure to provide a fully completed checklist may result in a delay of regulatory approval.

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
A. General Filing Requirements			
IC 27-1-3-15	**FILING FEES:** The fees are $35 per form plus $35 for rates or the retaliatory fees based on your state of domicile, whichever is greater. Filing fee compliance includes general compliance with SERFF user/filing fees as related to utilizing Electronic Funds Transfer (EFT) payment method.	Paid	
IC 27-1-26	**FLESCH READABILITY:** Complete a Flesch readability certification.	43.5	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**TEMPLATE:** Complete the data templates via SERFF: For Form Filings Only • Plans and Benefits Template For Rates and Forms Filing • Administrative Data • Essential Community Providers • Plans and Benefit • Prescription Drug • Network • Service Area • Rates • Business Rules • Unified Rate Review Template Templates are available at http://www.serff.com/plan_management_data_templates_2015.htm	N/A	
Bulletin 125	**RATE FILING REQUIREMENTS:** 1. All new product filings must include rates 2. Any form filing that impacts rates must be accompanied by the related rate justification 3. If rates change for any reason, they must be submitted for review. See the IDOI website for filing instructions indicating which Rate Filing Requirements document is applicable to the product being filed.	Comply	
Bulletin 125	**FILING DESCRIPTION/COVER/LETTER/NAIC TRANSMITTAL:** Each filing must contain a complete description of the filing using one of the following methods: (1) In SERFF on the General Tab - Filing Description; (2) As a note referring to an NAIC Transmittal Document. If using a Cover Letter, please attach the document to the Supporting Documentation Tab within SERFF.	Comply	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
Bulletin 125	**CONSULTING AUTHORIZATION:** If the filing is submitted by an outside consulting firm, a letter giving authorization to file on behalf of the company. If you are filing for multiple companies, you must submit an authorization from each Company, list each company separately on the cover letter by NAIC #, Company Name and form #. Separate filing/retaliatory fees for each company will be applicable.	Comply	
Bulletin 125	**ACKNOWLEDGEMENT:** All IDOI instructions, checklists and requirements for accident and health rate and/or form filings have been satisfied and are in compliance with PPACA and state requirements. *Please acknowledge.*	Acknowledge	
Bulletin 125	**ESSENTIAL HEALTH BENEFITS CROSSWALK TOOL:** Must be completed and include it in your SERFF filing under supporting documents tab for both QHP and Non-QHP filings.	Comply	
B. Required Provisions	**Policies MUST contain the following provisions, AS STATED, with the captions, or alternative appropriate captions. IF the provision does not apply, the Insurer may omit or amend WITH THE APPROVAL OF THE DEPARTMENT**		
IC 27-13-7-3(a)(1)	**THE NAME AND ADDRESS OF THE HEALTH MAINTENANCE ORGANIZATION**	Cover Page	
IC 27-13-7-3(a)(2)	**ELIGIBILITY REQUIREMENTS**	4	
IC 27-13-7-3(a)(3)	**BENEFITS AND SERVICES WITHIN THE SERVICE AREA**	57-75	
IC 27-13-7-3(a)(4) IC 27-13-36-9	**EMERGENCY CARE BENEFITS AND SERVICES**	23	
IC 27-13-7-3(a)(5)	**ANY OUT-OF-AREA BENEFITS AND SERVICES**	N/A - HMO	
IC 27-13-7-3(a)(6)	**COPAYMENTS, DEDUCTIBLES, AND OTHER OUT-OF-POCKET COSTS**	40	
IC 27-13-7-3(a)(7)	**LIMITATIONS AND EXCLUSIONS**	28	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-3(a)(8)	**ENROLLEE TERMINATION PROVISIONS**	41	
IC 27-13-7-3(a)(9)	**ANY ENROLLEE REINSTATEMENT PROVISIONS**	43	
IC 27-13-7-3(a)(10)	**CLAIMS PROCEDURES**	44	
IC 27-13-36.2	**CLEAN CLAIMS**	8	
IC 27-13-7-3(a)(11)	**ENROLLEE GRIEVANCE PROCEDURES**	46	
IC 27-13-7-3(a)(12)	**CONTINUATION OF COVERAGE PROVISIONS**	43	
IC 27-13-7-3(a)(13)	**CONVERSION PROVISIONS**	43	
IC 27-13-7-3(a)(14)	**EXTENSION OF BENEFIT PROVISIONS**	45	
IC 27-13-7-3(a)(15) 760 IAC 1-38.1	**COORDINATION OF BENEFIT PROVISIONS. NOT APPLICABLE FOR LIMITED SERVICE HEALTH MAINTENANCE ORGANIZATIONS**	34	
IC 27-13-7-3(a)(16)	**ANY SUBROGATION PROVISIONS**	34	
IC 27-13-7-3(a)(17)	**A DESCRIPTION OF THE SERVICE AREA**	57 & 60	
IC 27-13-7-3(a)(18)	**THE ENTIRE CONTRACT PROVISIONS**	4	
IC 27-13-7-3(a)(19)	**THE TERM OF THE COVERAGE PROVIDED BY THE CONTRACT**	4	
IC 27-13-7-3(a)(20)	**ANY RIGHT OF CANCELLATION OF THE GROUP OR INDIVIDUAL CONTRACT HOLDER**	42	
IC 27-13-7-3(a)(21)	**RIGHT OF RENEWAL PROVISIONS**	cover page	
IC 27-13-7-3(a)(22)	**PROVISIONS REGARDING REINSTATEMENT OF A GROUP OR AN INDIVIDUAL CONTRACT HOLDER**	43	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-3(a)(23)	**GRACE PERIOD PROVISIONS** For On-Exchange products see the section of this checklist titled "Specific Requirements for Qualified Health Plans" for grace Period requirements.	40	
IC 27-13-7-3(a)(24)	**A PROVISION ON CONFORMITY WITH STATE LAW**	13	
IC 27-13-7-3(a)(25)	**GUARANTEED RENEWABILITY:** A provision or provisions that comply with the: (A) guaranteed renewability; and (B) group portability; requirements of the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1))	cover page	
IC 27-13-7-3(a)(26) IC 27-8-5-28 Bulletin 189	**DEPENDENT AGE 26** A policy of accident and sickness insurance may not be issued, delivered, amended, or renewed unless the policy provides for coverage of a child of the policyholder or certificate holder, upon request of the policyholder or certificate holder, until the date that the child becomes twenty-six (26) years of age. Indiana Public Law 160-2011 requires Insurers and HMOs that offer dependent coverage to make the coverage available until a child reaches the age of 26. Consistent with the federal law, coverage cannot be restricted regardless of financial dependency, residency, marital status, student status, employment, eligibility for other coverage, or IRS qualification. This requirement applies to natural and adopted children, stepchildren, and children subject to legal guardianship.	7	
IC 27-13-7-4	**FREE LOOK:** 10 day "free look" provision	cover page	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-10 IC 27-13-10.1 760 IAC 1-59	**GRIEVANCE AND APPEALS PROCEDURES:** Provisions should be provided which describe a three tier process for handling (1) internal grievances, (2) internal appeals and (3) external appeals and the related time frames for each tier.	46	
Bulletin 128	**NOTICE:** Notice to policyholders regarding filing complaints with the Department of Insurance	54	
C.HMO Individual A&H Policies *must provide*			
IC 27-8-5-15.6(e)	**SUBSTANCE ABUSE PARITY**—when abuse treatment provided in conjunction with health treatment it must provide coverage in parity with other medical benefits	23 - at parity with all major medicla services	
IC 27-8-5-19(c)(17)	**HANDICAPPED CHILDREN** beyond the age of maturity. (with 120 days notice to the company)	15	
IC 27-8-5-21	**ADOPTED CHILDREN**	4	
IC 27-8-5.6-2(b)	**NEWBORNS**	4	
IC 27-8-14.5	**DIABETES TREATMENT, SUPPLIES, EQUIPMENT & EDUCATION**	24	
IC 27-8-20	**OFF-LABEL USE OF CERTAIN DRUGS**	24	
IC 27-8-24	**MINIMUM MATERNITY STAYS**	17	
IC 27-8-24.3	**VICTIMS OF ABUSE WITHOUT REGARD TO THE ABUSE**	25	
IC 27-8-24-4	**INFANT SCREENING TESTS REQUIRED BY IC 16-41-17-2**	20	
IC 27-8-26	Individuals without regard to **GENETIC TESTING**	30	
IC 27-13-7-13	**CONTINUATION OF COVERAGE STATEMENT**	43	
IC 27-13-7-15	**DENTAL ANESTHESIA/HOSPITALIZATION**	17	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-14	**BREAST RECONSTRUCTION AND PROSTHESIS FOLLOWING MASTECTOMY:**-Regardless of coverage at time of mastectomy Coverage must include: 1. Reconstruction of the breast on which the mastectomy was performed (all stages); 2. Surgery and reconstruction of the other breast to produce symmetrical appearance; 3. Prostheses; and 4. Treatment of physical complications at all stages of mastectomy PHSA §2727	21	
IC 27-13-7-14.8	**MENTAL HEALTH PARITY**; Substance abuse parity with mental health parity offered Effective January 1, 2014, plans covering mental health and substance abuse treatment services in addition to medical or surgical services may not impose financial requirements and treatment limitations that are more restrictive than the predominate requirements and limitations that apply to substantially all medical and surgical services. Annual and lifetime dollar limits only apply if mental health and substance abuse disorders are part of the Essential Health Benefits. Financial requirements and quantitative and non-quantitative limitation requirements for mental health and substance use disorder Availability of medical necessity criteria for mental health determinations 45 CFR §146.136	23 - at parity with major medical services.	
IC 27-13-37.5-2	**PRESCRIPTION DRUG:** Can't require use of specific mail order pharmacy for coverage	59	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-38-1	**PRESCRIPTION DRUG:** Allows formularies but requires process for obtaining non-formulary drug	59	
Bulletin 172	**CHEMOTHERAPY PARITY**	21	
760 IAC 1-39-7	**AIDS, HIV AND RELATED CONDITIONS**	17	
COBRA/ERISA	**OPPORTUNITY FOR COBRA COVERAGE IF EMPLOYER HAS 20 OR MORE EMPLOYEES**	N/A - Individual product	
D. General Regulatory Issues	**Under the authority provided by IC 27-4-1-4, 27-8-5-1.5 and 27-13-7-2, the Department monitors various issues that have been determined to be unjust, unfair, inequitable, misleading, deceptive, or encourage the misrepresentation of the policy or potentially constitute unfair trade practices. The following issues will be reviewed.**		
IC 27-13-7-2	**APPLICATION QUESTIONS:** 1. Questions regarding an applicant's health cannot inquire about non-specific conditions prior to the most recent five years. 2. Questions inquiring if an applicant has had signs or symptoms of a condition are not permitted.	Acknowledge	
IC 27-13-7-2	**ARBITRATION:** Mandatory and/or binding arbitration provisions are prohibited.	Acknowledge	
IC 27-13-7-2	**LARGE ENDORSEMENTS:** The Department does not allow use of large or confusing endorsements to bring contracts into compliance. In such cases the entire contract should be refiled to incorporate the multiple changes. On a similar note, Indiana specific certificates should be filed rather than file an endorsement to revise another state's certificate.	Acknowledge	
IC 27-13-7-2	**OPEN ENDORSEMENTS:** Highly flexible or "blank check" type endorsement forms that provide unlimited ability to revise forms without regulatory review are not allowed.	Acknowledge	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-2	**PROHIBITED PROVISIONS:** The policy form cannot contain provisions that are unjust, unfair, inequitable, misleading, or deceptive, or that encourage misrepresentation of the policy.	Acknowledge	
IC 27-13-7-2	**VARIOUS FEES:** Fees charged to accept or process an application are not allowed. One-time fees such as may be charged to issue a policy are acceptable providing they are clearly labeled and accompanied by a disclosure that the fee is fully refundable if the policy is not issued, not taken or returned during the "free look" period.	Acknowledge	
IC 27-8-5-19(c)(6) IC 27-8-5-2.5	**FIRST MANIFEST LANGUAGE:** Typically first manifest type language creates a permanent exclusion of coverage related to a condition present any time prior to the effective date of coverage contrary to any pre-existing condition provisions included in the form. Such inconsistencies are not permitted.	Acknowledge	
Bulletin 103	**FULL AND FINAL DISCRETION**: No full and final discretion clauses except where policy is governed by ERISA.	Acknowledge	
Bulletin 106	**FOREIGN LANGUAGE FORMS**: Foreign language forms must comply with Bulletin 106.	Acknowledge	
E. HMO Individual A&H must cover	Due to the EHB benchmark requirements, the following must be covered.		
IC 27-13-7-14.7 Bulletin 136 Bulletin 179	**AUTISM SPECTRUM DISORDERS (PREVIOUSLY PDD):** As per Bulletins 136 and 179, "Coverage for services provided as prescribed by the insured's treating physician in accordance with treatment plan." Autism Spectrum Disorders includes Asperger's Syndrome and Autism.	22	
IC 27-13-7-15.3	**MAMMOGRAPHY** (Baseline, then 1 per year after 40 unless high risk)	20	
IC 27-13-7-16	**PROSTATE CANCER SCREENING** (1 per year after 50 unless high risk)	21	
IC 27-13-7-17 IC 27-8-14.8	**COLORECTAL CANCER SCREENING**	21	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-37-4	**POINT-OF SERVICE PRODUCT**	HMO	
IC 27-13-7-18	**INHERITED METABOLIC DISEASE**	25	
F. ACA Must Provide	**All Essential Health Benefits and related Essential Health Benefit requirements are applicable for plans with effective dates on or after January 1, 2014. All other requirements are effective currently unless otherwise noted.**		
IC 27-8-5-1(c)	Category 1 Essential Health Benefit – **AMBULATORY PATIENT SERVICES** ACA §1302	23	
IC 27-8-5-1(c)	Category 2 Essential Health Benefit – **EMERGENCY SERVICES** ACA §1302	23	
IC 27-8-5-1(c)	Category 3 Essential Health Benefit – **HOSPITALIZATION** ACA §1302	17	
IC 27-8-5-1(c)	Category 4 Essential Health Benefit – **MATERNITY AND NEWBORN CARE** Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section. ACA §1302	17	
IC 27-8-5-1(c)	Category 5 Essential Health Benefit – **MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT** ACA §1302	23	
IC 27-8-5-1(c)	Category 6 Essential Health Benefit – **PRESCRIPTION DRUGS** ACA §1302	59	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	Category 7 Essential Health Benefit – **REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES** Insurer must provide sufficient documentation regarding habilitative services and devices benefits and definitions. ACA §1302	67	
IC 27-8-5-1(c)	Category 8 Essential Health Benefit – **LABORATORY SERVICES** ACA §1302	20	
IC 27-8-5-1(c)	Category 9 Essential Health Benefit – **PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT** Coverage of preventive services without cost-sharing requirements including deductibles, co-payments, and co-insurance. Covered preventive services include the current recommendations of the USPSTF http://www.uspreventiveservicestaskforce.org/recommendations.htm ACA §1302 PHSA §2713 75 Fed Reg 41726 45 CFR §147.130	27	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	Category 10 Essential Health Benefit – **PEDIATRIC SERVICES, INCLUDING ORAL AND VISION CARE** Insurer must indicate if Pediatric dental services are being included or excluded from essential health benefits in lieu of an Exchange-certified stand-alone dental plan. This applies to plans both on and off the Exchange. Pediatric vision care must be included in the essential health benefits for plans both on and off the Exchange. ACA §1302	76 - No pediatric dental	
IC 27-8-5-1(c)	**MATERIAL MODIFICATIONS** Provide 60 days advance notice to enrollees before the effective date of any material modifications including changes in preventive benefits *Please Acknowledge* PHSA §2715 75 Fed Reg 41760	Acknowledge	
IC 27-8-5-1(c)	**COVERAGE FOR DEPENDENT STUDENT ON MEDICALLY NECESSARY LEAVE OF ABSENCE ("MICHELLE'S LAW")** Issuer cannot terminate coverage due to a medically necessary leave of absence Change in benefits prohibited Eligibility for protections *Please Acknowledge* PHSA §2728 45 CFR §147.145	Acknowledge	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**LIMITATIONS ON ESSENTIAL HEALTH BENEFITS:** The plan does not include routine non-pediatric dental services, routine non-pediatric eye exam services, or long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as Essential Health Benefits. 45 CFR §156.115(d)	Acknowledge	
IC 27-8-5-1(c)	**NO LIFETIME LIMITS ON THE DOLLAR VALUE OF ESSENTIAL HEALTH BENEFITS** **NO ANNUAL LIMITS ON THE DOLLAR VALUE OF ESSENTIAL HEALTH BENEFITS** *Please Acknowledge* PHSA §2711 75 Fed Reg 37188 45 CFR §147.126	Acknowledge	
IC 27-8-5-1(c)	**ESSENTIAL HEALTH BENEFIT FORMULARY REVIEW**: The plan (1) Covers at least the greater of: (i) One drug in every United States Pharmacopeia (USP) category and class; or (ii) The same number of prescription drugs in each category and class as the Essential Health Benefit-benchmark plan; and (2) Submits its drug list to the Exchange, the State, or Office of Personnel Management (OPM). *Please Acknowledge* 45 CFR §156.122(a)	Acknowledge	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SUMMARY OF BENEFITS COVERAGE:** The Summary of Benefits Coverage must reflect the covered Essential Health Benefits, cost-sharing and Actuarial Value (metal level) that the final approved rates and forms permit. Submission of the Summary is not required as a part of this filing; however, filer must certify to the completion and conformity with regulatory requirements of the Summary. *Please Acknowledge* PHSA §2715	Acknowledge	
IC 27-8-5-1(c)	**NO PRE-EXISTING CONDITION EXCLUSIONS:** A pre-existing exclusion includes any limitation or exclusion of benefits (including denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individuals effective date of coverage. *Please Acknowledge* PHSA §§2704; 1255 75 Fed Reg 37188 45 CFR §147.108	Acknowledge	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**MARKETING:** Insurer and its officials, employees, agents and representatives comply with any applicable state laws and regulations regarding marketing by health insurance Insurers and do not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(e)	Acknowledge	
IC 27-8-5-1(c)	**PROHIBITION ON DISCRIMINATION:** The plan's benefit design, or the implementation of its benefit design, does not discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.125	Acknowledge	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**GUARANTEED AVAILABILITY OF COVERAGE:** Insurer is aware that if it offers health insurance coverage in the individual market in Indiana it must offer to any individual in Indiana all products that are approved for sale in the individual market, and must accept any individual that applies for any of those products, subject to exclusions allowed by the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(a)	Acknowledge	
IC 27-8-5-1(c)	**OPEN ENROLLMENT**: Insurer must allow an individual to purchase health insurance coverage during the initial and annual open enrollment periods and coverage effective dates consistent with the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(b)	Acknowledge	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SPECIAL ENROLLMENT:** Insurer has special enrollment periods for qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended. These special enrollment periods are in addition to any other special enrollment periods that are required under federal and state law. Enrollees must be provided 60 calendar days after the date of an event, described in this section, to elect coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(b) 45 CFR §155.410	Acknowledge	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**LIMITED OPEN ENROLLMENT:** Insurer must provide a limited open enrollment period for the events described in Section 155.420(d) of the Affordable Care Act (excluding subsections (d)(3) concerning citizenship status, (d)(8) concerning Indians and (d)(9) concerning exceptional circumstances). Additionally, the Insurer must provide, with respect to individuals enrolled in non-calendar year individual health insurance policies, a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014. Enrollees must be provided 60 calendar days after the date of an event, described in this section, to elect coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(b)	Acknowledge	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SPECIAL RULES FOR NETWORK PLANS:** (1) If Insurer offers health insurance coverage through a network plan, the Insurer may: (i) Limit the individuals who may apply for the coverage to those who live or reside in the service area for the network plan. (ii) Within the service area of the plan, deny coverage to individuals if the Insurer has demonstrated to the IDOI the following: (A) It will not have the capacity to deliver services adequately to enrollees of any additional individuals because of its obligations to enrollees. (B) It is applying this section uniformly to all individuals without regard to the claims experience of those individuals, or any health status-related factor relating to such individuals. (2) An Insurer that denies health insurance coverage to an individual in any service area may not offer coverage in the individual market within the service area to any individual for a period of 180 calendar days after the date the coverage is denied. This does not limit the Insurer's ability to renew coverage already in force or relieve the Insurer of the responsibility to renew that coverage. (3) Coverage offered within a service area after the 180-day period is subject to the same requirements. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(c)	Acknowledge	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**APPLICATION OF FINANCIAL CAPACITY LIMITS:** Insurer is aware that it may deny health insurance coverage in the individual market if it has demonstrated to IDOI limitations provided in the Affordable Care Act. An Insurer is also aware that if it denies health insurance coverage to any individual in Indiana under the financial capacity limitations, it may not offer coverage in the individual market in Indiana for at least 180 days. This limitation does not however limit the Insurer's ability to renew coverage already in force or relieve the Insurer of the responsibility to renew that coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(d)	Acknowledge	
IC 27-8-5-1(c)	**GUARANTEED RENEWABILITY OF COVERAGE:** Insurer is aware that if it offers health insurance coverage in the individual market in Indiana it must renew or continue in force the coverage at the option of the individual, subject to exclusions allowed by the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.106(a)	Acknowledge	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**GUARANTEED RENEWABILITY OF COVERAGE EXCEPTIONS:** Insurer may non-renew or discontinue health insurance coverage offered in the individual market based only on one or more of the following: (1) Nonpayment of premiums (2) Fraud (3) Violation of participation or contribution rules (4) Termination of plan (5) Enrollees' movement outside service area (6) Association membership ceases Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §147.106(b)	Acknowledge	
IC 27-8-5-1(c)	**DISCONTINUING PRODUCTS:** Insurer is aware of the requirements to discontinue a particular health insurance plan in Indiana including: (1) Notice provision (2) Requirement to offer other health insurance coverage currently offered (3) Acting without regard to claims experience or health status-related factor Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.106(c)	Acknowledge	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**DISCONTINUING ALL COVERAGE:** Insurer is aware of the requirements to discontinue all individual, group or all markets of health insurance coverage in Indiana including: (1) Notice provision (2) 5-year discontinuation period Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.106(d)	Acknowledge	
IC 27-8-5-1(c)	**COVERAGE THROUGH ASSOCIATIONS**: Any reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to the employer. Applicable for major medical plans with effective dates on or after January 1, 2014. 45 CFR §147.106(f)	Acknowledge	
IC 27-8-5-1(c)	**CLINICALLY APPROPRIATE DRUGS**: Insurer has procedures in place that allows an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.122(c)	Acknowledge	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**EMERGENCY DEPARTMENT SERVICES:** Cannot require prior authorization; Cannot be limited to only services and care for participating providers Must be covered at in-network cost-sharing level PHSA §2719A 75 Fed Reg 37188 45 CFR §147.138	Acknowledge	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**CATASTROPHIC PLANS:** If plan is a catastrophic plan, it meets the following conditions: (1) Meets all applicable requirements for health insurance coverage in the individual market and is offered only in the individual market. (2) Does not provide a bronze, silver, gold, or platinum level of coverage. (3) Provides coverage of the Essential Health Benefits once the annual limitation on cost sharing is reached as defined in the Affordable Care Act (4) Provides coverage for at least three primary care visits per year before reaching the deductible. (5) Covers only individuals who meet either of the following conditions: (i) Have not attained the age of 30 prior to the first day of the plan year. (ii) Have received a certificate of exemption in accordance with the Affordable Care Act. A catastrophic plan may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) for preventive services. For other than self-only coverage, each individual enrolled must meet the age or certificate of exemption requirements above. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.155	N/A	

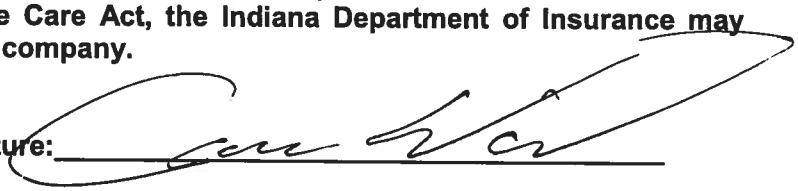
Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
G. Specific Requirements for Qualified Health Plans	**Under the authority provided by IC 27-8-5-1 the Department is responsible for determining whether the health plan submitted has met certain form requirements. Accordingly, the following items will be reviewed. All regulation references listed in this section are that of the final law or regulations of the Patient's Protection and Affordable Care Act unless otherwise indicated.** **All Qualified Health Plan requirements are applicable for plans on the Exchange with effective dates on or after January 1, 2014.**		
	NETWORK ADEQUACY: Insurer's provider network meets the following standards: (1) Includes essential community providers in accordance with the Affordable Care Act; (2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and, (3) Is consistent with the network adequacy provisions of the Affordable Care Act. 45 CFR §§156.230 (a) & (b)	Acknowledge	
	TERMINATION OF COVERAGE DUE TO NON-PAYMENT OF PREMIUM: Insurer must establish a standard policy for the termination of coverage of enrollees due to non-payment of premium. This policy for the termination of coverage: (1) Must include the grace period for enrollees receiving advance payments of the premium tax credits as described in paragraph (d) of this section; and (2) Must be applied uniformly to enrollees in similar circumstances. 45 CFR §156.270 (c)	Acknowledge	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	GRACE PERIOD FOR RECIPIENTS OF ADVANCE PAYMENTS OF THE PREMIUM TAX CREDIT: Insurer must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. During the grace period, the QHP Insurer must: (1) Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period; (2) Notify HHS of such non-payment; and, (3) Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period. 45 CFR §156.270 (d)	Acknowledge	
	SEGREGATION OF FUNDS FOR ABORTION SERVICES: Insurer must provide to the State Insurance Commissioner an annual assurance statement attesting that the plan has complied with section 1303 of the Affordable Care Act and applicable regulations. 45 CFR §156.280 (e)(5)	Acknowledge	
	NOTICE FOR ABORTION SERVICES: Insurer that provides for coverage for abortion services must provide a notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage. 45 CFR §156.280 (f)	Acknowledge	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	ENTIRE YEAR: Insurer must set rates for an entire benefit year. 45 CFR §156.255 (b)	Acknowledge	
	NOTIFICATION TO THE FFM FOR CHANGES IN ELIGIBILITY REDETERMINATIONS: QHP issuer to notify the policy holder to contact the FFM for any changes to their eligibility determination. *Please acknowledge* 45 CFR §155.330	Acknowledge	
H. Specific Requirements for Exchange Certified Stand-Alone Dental Plan	**Under the authority provided by IC 27-8-5-1 the Department is responsible for determining whether the plan submitted has met certain form requirements. Accordingly, the following items will be reviewed. All regulation references listed in this section are that of the final law or regulations of the Patient's Protection and Affordable Care Act unless otherwise indicated.** **All Exchange-Certified Stand-Alone Dental Plan requirements are applicable for plans intending to satisfy the Pediatric Dental Essential Health benefit, at a minimum, either on or off the Exchange. This type of plan has an effective date on or after January 1, 2014.**		
	EXCHANGE CERTIFIED STAND ALONE DENTAL: Insurer meets all requirements applicable to be considered Exchange-Certified. Insurer should provide the IDOI with requirements, if any, which are pending certification by the Exchange.	N/A	

By signing below, I am certifying on behalf of my company pursuant to Ind. Code 27-8-5-1.5(i)(1)(C) that our policy form(s) submitted with this checklist meets all of the applicable requirements of Indiana law and meets all the applicable requirements of federal law contained in the Patient Protection and Affordable Care Act. I understand and acknowledge, on behalf of my company, that the Indiana Department of Insurance is

relying on this certification in making its determination whether to approve or disapprove this policy filing. If any policy provision is not in compliance with Indiana law or the Patient Protection and Affordable Care Act, the Indiana Department of Insurance may take regulatory action against my company.

Signature: 

Printed Name: Cameron Wilson

Title: Director of Fully Insured

Company: Southeastern Indiana Health Organizatio

Date: 05/09/2014

Essential Health Benefits (EHB) Crosswalk and Certification Tool

The benefits included in Indiana's benchmark plan are "essential health benefits" (EHB) and must be included in all policies and plans offered in the individual and small group markets pursuant to 45 CFR §§147.150 and 156.100 et seq. Please submit a complete crosswalk and certification for each policy filed for review. This document should be submitted via SERFF into your supporting documents tab.

Benefit	Location of Benefit in Issuer's Policy			
Primary Care Visit to Treat an Injury or Illness	See Page	62	of	77
Specialist Visit	See Page	63	of	77
Other Practitioner Office Visit (Nurse, Physician Assistant)	See Page	65	of	77
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	See Page	66	of	77
Outpatient Surgery Physician/Surgical Services	See Page	66	of	77
Hospice Services	See Page	71	of	77
Private-Duty Nursing	See Page	70	of	77
Urgent Care Centers or Facilities	See Page	66	of	77
Home Health Care Services	See Page	70	of	77
Emergency Room Services	See Page	66	of	77
Emergency Transportation/Ambulance	See Page	70	of	77
Inpatient Hospital Services (e.g., Hospital Stay)	See Page	68	of	77
Inpatient Physician and Surgical Services	See Page	68	of	77
Skilled Nursing Facility	See Page	65	of	77
Prenatal and Postnatal Care	See Page	20	of	77
Delivery and All Inpatient Services for Maternity Care	See Page	17	of	77
Mental/Behavioral Health Outpatient Services	See Page	68	of	77
Mental/Behavioral Health Inpatient Services	See Page	68	of	77
Substance Abuse Disorder Outpatient Services	See Page	68	of	77
Substance Abuse Disorder Inpatient Services	See Page	68	of	77
Generic Drugs	See Page	73	of	77
Preferred Brand Drugs	See Page	73	of	77
Non-Preferred Brand Drugs	See Page	73	of	77
Specialty Drugs	See Page	73	of	77
Outpatient Rehabilitation Services	See Page	68	of	77
Habilitation Services	See Page	68	of	77
Chiropractic Care	See Page	64	of	77
Durable Medical Equipment	See Page	71	of	77
Imaging (CT/PET Scans, MRIs)	See Page	66	of	77
Preventive Care/Screening/Immunization	See Page	75	of	77

Routine Eye Exam for Children	See Page	76	of	77
Eye Glasses for Children	See Page	76	of	77
Dental Check-Up for Children	See Page	N/A	of	77
Rehabilitative Speech Therapy	See Page	67	of	77
Rehabilitative Occupational and Rehabilitative Physical Therapy	See Page	67	of	77
Well Baby Visits and Care	See Page	20	of	77
Laboratory Outpatient and Professional Services	See Page	66	of	77
X-rays and Diagnostic Imaging	See Page	66	of	77
Basic Dental Care – Child	See Page	N/A	of	77
Orthodontia – Child	See Page	N/A	of	77
Major Dental Care – Child	See Page	N/A	of	77
Transplant	See Page	18	of	77
Accidental Dental	See Page	27	of	77
Dialysis	See Page	72	of	77
Allergy Testing	See Page	63	of	77
Chemotherapy	See Page	21	of	77
Radiation	See Page	21	of	77
Diabetes Education	See Page	25	of	77
Prosthetic Devices	See Page	71	of	77
Infusion Therapy	See Page	26	of	77
Treatment for Temporomandibular Joint Disorders	See Page	28	of	77
Nutritional Counseling	See Page	26	of	77
Reconstructive Surgery	See Page	21	of	77
Clinical Trials	See Page	25	of	77
Diabetes Care Management	See Page	25	of	77
Inherited Metabolic Disorder - PKU	See Page	25	of	77
Off Label Prescription Drugs	See Page	24	of	77
Dental Anesthesia	See Page	27	of	77
Mental Health Other	See Page	23	of	77

I, on behalf of Southeastern Indiana Health C hereby certify, based on information and belief formed after reasonable inquiry, that (i) the statements and information contained herein are true, accurate and complete and (ii) all benefits included in Indiana's benchmark plan are included in the policy or policies filed by Southeaster Indiana Health Orga for review and approval.

Cameron Wilson	Director of Fully Insured	07/02/2014
Name:	Title:	Date:

Milliman

SOUTHEASTERN INDIANA HEALTH ORGANIZATION

Health Maintenance Organization Individual Product
Actuarial Memorandum
Form QHP INDV-05.2014

A. INTRODUCTION

Milliman, Inc. (Milliman) was retained by Southeastern Indiana Health Organization (SIHO) to develop an individual market rate filing with on-exchange and off-exchange plans to be filed with the Indiana Department of Insurance for 2015. This actuarial memorandum has been prepared in accordance with Indiana insurance laws and ACA Market Rating Rules. The purpose of this actuarial memorandum is to present the premium rates for SIHO's plans to be offered in the individual market in 2015. This material should not be used for any other purpose.

This actuarial memorandum has been prepared for the use of SIHO. We understand that the actuarial memorandum will be provided to the Indiana Department of Insurance and its subcontractors to assist in the review of SIHO's individual market rate filing. No portion of the actuarial memorandum may be provided to any other party without Milliman's prior written consent. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work.

The rating factors were developed from information published in the Milliman Health Cost Guidelines, and applicable state and federal regulations, as well as from information provided by SIHO. Additionally, we relied on exchange enrollment information provided within the April 2014 HHS Marketplace Enrollment report, along with information on the Medicaid spend-down population provided by the Indiana Department of Insurance (IDOI). The memorandum does not guarantee that the rates will be adequate. Rather, the filing shows that the rates will be adequate if the assumptions underlying their development are realized.

This actuarial memorandum has been updated based on information made available following the initial filing submission. We were provided with additional information related to the Medicaid spend-down population from the IDOI on May 15, 2014 and May 20, 2014. Additionally, on May 15, 2014 a Medicaid expansion plan was announced for Indiana through the Healthy Indiana Plan (HIP). If implemented, this expansion could have a significant impact to the demographics of the Marketplace population. These items were considered in updating the morbidity and demographics assumptions underlying the rate development process.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

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B. STATE OF INDIANA 4.1 (A) INDIVIDUAL RATE REQUIREMENTS

1. Benefit Structure

This is an individual medical expense service agreement offered as a health maintenance organization product. It provides for hospital, medical, and surgical expenses resulting from an eligible illness or injury. It also provides for prescription drug expenses and certain preventive care services. It is subject to various managed care provisions as described in the certificate of coverage. These are new products that will be offered beginning in 2015; SIHO does not currently offer any products in the individual market.

This policy provides for coverage of medical expenses with applicable member cost sharing, *i.e.*¸co-payments, deductibles, and coinsurance amounts. Various benefit provisions are available under this policy form. Covered benefits and copayment schedules have been included with the certificates of coverage.

Attachment 1 provides a summary of benefit provisions for the benefit plan designs that are the subject of this actuarial memorandum. Complete descriptions of covered benefits and cost sharing arrangements are contained in the certificates of coverage.

The benefit plan designs included in this rate filing will be sold to individuals in Indiana. The following qualified health plans (QHPs) will be offered both on-exchange and off-exchange:

- SIHO Marketplace Bronze;
- SIHO Marketplace Bronze HSA;
- SIHO Marketplace Silver;
- SIHO Marketplace Silver HSA; and
- SIHO Marketplace Gold.

Covered services include the Indiana essential health benefits (EHB), inclusive of state mandated benefits. The following supplemental benefits are also covered:

- Diabetes education;
- Nutrition counseling; and
- An additional 3 chiropractic visits.

2. Proposed Rates

a. <u>Premium Rate Development</u>

The proposed premium rating factors were developed based on a manual rate development process. SIHO's group experience was utilized where appropriate in developing the manual rates, and was adjusted for the following:

- Trend, i.e., medical inflation and increased utilization;
- Regional, demographical and benefit cost-sharing differences between SIHO's group experience and the projected 2015 individual market;

- The morbidity of individuals anticipated to elect to be enrolled in ACA-compliant policies during 2015, including the impact of the Medicaid spend-down population;
- Impact of federal transitional reinsurance; and
- Differences in retention components between the group and individual blocks of business.

b. Premium Rate Calculation

Consumer Adjusted Premium Rates are calculated as the product of four factors:

i. Plan Adjusted Index Rate (Calibrated);
ii. Geographic rating area factor;
iii. Age factor; and
iv. Tobacco status factor.

Monthly Premium Rates to be charged to a specific policyholder are determined by summing the Consumer Adjusted Premium Rates for each member of the family, provided at most three child dependents under age 21 for each family are taken into account. For members that use tobacco, the composite premium applicable to the member will be multiplied by the tobacco status factor applicable to the member's age.

i. Plan Adjusted Index Rate (Calibrated)

A Plan Adjusted Index Rate (Calibrated) is the estimated cost to provide coverage under a given benefit plan design for a member with a geographic rating area factor, an age factor, and a tobacco status factor of 1.00. The Plan Adjusted Index Rates (Calibrated) are provided in Exhibit 1 of Attachment 2. The actuarial value, as calculated using the CMS Actuarial Value (AV) calculator, and metal tier for each plan are also shown in this exhibit.

ii. Geographic Rating Area Factors

Individual market products will be offered in a total of 6 counties: Bartholomew, Brown, Decatur, Jackson, Jennings, and Scott. While these counties span three different rating regions, no geographic rating area factors will be applied to the products offered in the individual market.

iii. Age Factors

Age factors are based upon each member's age as of the premium rate effective date. The HHS Default Standard Age Curve is used for the age factors and is provided in Exhibit 2 of Attachment 2.

iv. Tobacco Status Factors

Tobacco status factors are based on each member's age and tobacco user status as of the premium rate effective date. Members whom do not use tobacco have a tobacco

status factor of 1.00. The tobacco status factors for members that use tobacco are provided in Exhibit 2 of Attachment 2.

3. Projected Experience with Enrollment Projection

SIHO's anticipated experience for the 2015 calendar year for individual policies under this form is provided in Table 1 below. The values reflect an estimate for the population that will enroll in these new products in January 2015.

Southeastern Indiana Health Organization
Table 1: Projected 2015 Experience

Member Months	Incurred Claims	Earned Premium	Projected Loss Ratio	Projected MLR
24,000	$9,790,000	$12,030,000	81.3%	87.0%

Note: Values have been rounded.

The projected loss ratio reflects a direct ratio of incurred claims to earned premiums. Projected medical loss ratio (MLR) was calculated consistently with the MLR methodology according to the National Associate of Insurance Commissioners as prescribed by 211 CMR 147.00, and does not reflect any credibility adjustments that may be permitted. Table 2 below contains a breakdown of the MLR calculation for SIHO's individual business.

Southeastern Indiana Health Organization
Table 2: Projected Federal Medical Loss Ratio Exhibit

Member Months	24,000
Claims PMPM	$ 462.35
Transitional Reinsurance Recoveries PMPM (Received)	$ (58.24)
Risk Adjustment Paid PMPM (Received)	$ 0.00
Risk Corridors Paid PMPM (Received)	$ 0.00
MLR Numerator	**$ 404.10**
Premium PMPM	$ 501.36
Premium-Related Retention PMPM (Taxes/Fees)	$(25.22)
Income Tax PMPM	$(11.84)
MLR Denominator	**$ 464.30**
Loss Ratio	**87.0%**

Note: Values have been rounded.

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4. Assumptions

Since this is a new product rate filing, experience data was not available for the purpose of developing premium rates for these products. As such, premium rates for this filing are the result of a manual rate development process. SIHO's small group and large group point-of-service experience for the 12 months ending December 2013, representing 125,498 member months, provided the basis for the manual rate development process.

This experience data was adjusted to reflect anticipated differences between the group and individual markets. Specific items considered in estimating these adjustments included the following:

- Benefits not included within the experience data;
- Differences in age and gender of the covered populations;
- Geography and provider network differences between the populations;
- Morbidity of the population, including the following:
    - Difference in morbidity between the individual and group markets;
    - Impact of transitional ("grandmothered") policies;
    - Health status of the previously uninsured;
    - Impact of the Medicaid spend-down population;
- Income level of the anticipated population;
- Impact of federal transitional reinsurance;

Additional Benefits not covered in the baseline experience data used include private duty nursing and Temporomandibular joint disorder. Pediatric vision services are covered under a capitation agreement effective January 2015. Please note that pediatric dental services will not be covered within the policy.

In developing estimates for the demographics of the individual market, we utilized data provided within the HHS Marketplace Enrollment report for April 2014.

The impact of morbidity was estimated as a percentage difference from the pre-ACA group market. Based on the various items outlined, the total morbidity of the individual market was estimated as being 16.5% above that of the pre-ACA group market. This morbidity assumption was developed as the product of the assumptions shown in Table 3 below. There was assumed to be no morbidity impact associated with pent-up demand for calendar year 2015. Please note that the resulting composite morbidity was rounded down to arrive at the 16.5% figure utilized for pricing purposes.

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Southeastern Indiana Health Organization
Table 3: Individual Market Morbidity

Category	Factor
Individual-Level Purchasing Decisions	1.030
Uninsured Morbidity	1.010
Impact of Transitional Policies	1.050
Medicaid Spend-Down Population	1.065
Composite Morbidity	**1.165**

Note: Values have been rounded.

The morbidity impact associated with individual-level purchasing decisions reflects the impact of consumer level purchasing relative to the experience used in the manual rate development process (SIHO small and large group business). This estimate was calculated by comparing the morbidity level of groups with 2-5 subscribers relative to that of the composite small and large group experience used in the manual rate development process.

Uninsured morbidity reflects the assumed impact of individuals entering the market in 2015 that were previously uninsured.

The impact of transitional policies reflects members in the pre-ACA individual market having the ability to renew on non-ACA compliant products in 2015. This is assumed to have an adverse impact on the morbidity of the ACA complaint risk pool, as healthier individual are more likely to renew on the non-ACA compliant products.

The morbidity impact of the Medicaid spend-down population was estimated based on information provided by the IDOI on May 15, 2014 and May 20, 2014.

Income level of the anticipated population was used in order to estimate the impact of cost share reduction (CSR) plans made available to individuals below 250% of the federal poverty level (FPL). For individuals estimated to be eligible for the 94% or 87% CSR plans, it was estimated that utilization would be 12% higher than that of the average enrollee. This assumption was based on information available within federal regulations; specifically, the HHS Notice of Benefit and Payment Parameters for 2015.

Net incurred annual trend of approximately 8.0% was applied to estimate claims experience for 2015. The 8.0% annual trend is the composite of medical trend of approximately 7.0% and prescription drug trend of approximately 14.3%. SIHO provided the medical trend estimate based upon anticipated changes in their provider contracts and a review of recent experience. The prescription drug trend estimate was developed using 2014 and 2015 projected trends from SIHO's pharmacy benefit manager for its health plan book of business and experience from 2010 to 2013 as reported by the pharmacy benefit manager for its health plan book of business and for SIHO. Prospective pharmacy trends reflect a continued higher utilization of specialty drugs, relative to historical experience.

The medical trend of approximately 7.0% and drug trend of approximately 14.3% are comprised of Allowed Trend, Cost Share Leveraging, and the impact of Non Fee for Service

expenses (Non-FFS). Cost Share Leveraging includes the impact of fixed dollar cost sharing, such as deductibles and copayments, on trend. The Medical Non-FFS Impact reflects private reinsurance trend. The Drug Non-FFS Impact reflects the trend associated with Rx rebates. A breakdown of each of these trend components is provided in Table 4 below.

Southeastern Indiana Health Organization
Table 4: 2015 Medical and Drug Trends

	Medical Trend	Drug Trend
Allowed Trend	6.0%	11.8%
Cost Share Leveraging	0.7%	1.4%
Non-FFS Impact	0.3%	1.1%
Total	**7.0%**	**14.3%**

Note: Values have been rounded.

The following table shows the estimated incurred claims, net of transitional reinsurance, for 2015 effective dates based on the manual rate development process utilized, along with an illustrated buildup to total required revenue.

Southeastern Indiana Health Organization
Table 5: 2015 Total Required Revenue

Estimated Incurred Claims PMPM for 2015	**$ 407.85**
Administrative Expense Load	$ 41.96
Profit and Risk Load	$ 30.08
Taxes and Fees	$ 21.47
Required Revenue PMPM	***$ 501.36***

Note: Values have been rounded.

The administrative expense load includes amounts for network access fees and operating expenses. SIHO's network access fees were estimated on a per member per month (PMPM) basis, based on data available within SIHO's small group block of business. Taxes and fees includes the estimated value of exchange user fees.

SIHO provided a PMPM assumption plus a percent of premium assumption for operating expenses. These estimates of 2015 operating expenses were developed by SIHO, and are illustrated in Table 6 below.

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Southeastern Indiana Health Organization
Table 6: Illustration of Administrative Expense Load

	Retention Description	PMPM	% Premium	Basis
	Administrative Expense Load			
	General Admin Expense	$ 18.50	3.69%	PMPM
	Network Access Fee	$ 2.15	0.43%	PMPM
+	Percentage Based General Admin	$ 21.31	4.25%	% of Premium
	Subtotal: Administrative Expense Load	$ 41.96	8.37%	

Note: Values have been rounded

The proposed rates reflect a combined profit and risk charge load of 6% which was converted to a PMPM for Table 5. These loads were provided by SIHO and are applied to all plans.

The following taxes and fees are reflected in Table 5:

- $3.67 PMPM for the Federal Transitional Reinsurance Program (included in incurred claims estimate);
- $0.96 Per Member Per Year for the Risk Adjustment User Fee (included in incurred claims estimate);
- $2.12 Per Member Per Year for the Patient Centered Outcomes Research Institute Fee;
- 3.5% of premium exchange user fee; and,
- 0.75% for the Health Insurer Fee.

Taxes and Fees on a PMPM basis are illustrated in Table 7 below. The impact of the Federal Transitional Reinsurance Contributions and the Risk Adjustment User Fee are excluded from the values illustrated in the figure, as they are reflected in estimated incurred claims.

Southeastern Indiana Health Organization
Table 7: Illustration of Taxes and Fees

	Retention Description	PMPM	% Premium	Basis
	Taxes and Fees			
	Patient Centered Outcomes Research Institute Fee	$ 0.18	0.04%	PMPM
	Exchange User Fee	$ 17.55	3.50%	% of Premium
+	Health Insurer Fee	$ 3.75	0.75%	% of Premium
	Subtotal: Taxes and Fees	$ 21.47	4.28%	

Note: Values have been rounded

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5. Premium Guarantee Provision

The policies are guaranteed renewable and will be sold on a guarantee of issue basis for residents of the six counties where these plans will be offered.

6. Rating Factors

a. Rate Structure

The calculation of monthly premiums and the rating factors, including geographic rating area, age, and tobacco status factors were described in Section 3 above.

b. Non-benefit Expenses

Non-benefit expenses are included in the Plan Adjusted Index Rates (Calibrated) discussed in section 3 of this memorandum. The non-benefit expenses include amounts for administrative and other expenses, sales and marketing expenses, net cost of private reinsurance, taxes, fees, risk margin, and profit.

c. Impact of Contractual Arrangement

Contractual agreements with health care providers and administrators are expected to result in medical cost and premium changes in line with market averages.

7. Company Financial Position

SIHO's risk-based capital ratio as of December 31, 2013 was 472.8%.

C. CERTIFICATION AND ATTESTATIONS

I am a Consulting Actuary with the firm of Milliman, Inc. SIHO engaged me to provide this actuarial memorandum.

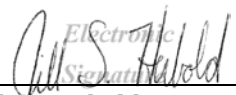
Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and I meet its qualification standards to perform the analysis and render the actuarial opinion contained herein.

I believe this rate filing is in compliance with all applicable state and federal insurance statues and regulations and with applicable actuarial standards of practice.

I attest that the same premium rate is being charged without regard to whether the plan is offered through an Exchange, or whether the plan is offered directly from SIHO or through an agent.

This memorandum should not be interpreted as a guarantee that the rates will be adequate. The rates will be adequate if the assumptions underlying their development are realized. The adequacy of the rates will be dependent on numerous factors, many of which are not subject to management control (e.g., medical care cost trends in the community, demographic characteristics of the enrollees, etc.).

In developing the rating factors and other values in this actuarial memorandum, I relied on data, other information, and assumptions provided by SIHO. I have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of the analysis may likewise be inaccurate or incomplete. I performed a limited review of the data used directly in the analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of my assignment.



Jill S. Herbold, FSA, MAAA
Consulting Actuary

June 24, 2014
Date

ATTACHMENT 1

SOUTHEASTERN INDIANA HEALTH ORGANIZATION
Exhibit: 2015 Individual Plan Designs

Benefit Category	SIHO Marketplace Bronze HSA	SIHO Marketplace Bronze	SIHO Marketplace Gold	SIHO Marketplace Silver HSA	SIHO Marketplace Silver
Annual Single Deductible	$4,500	$5,000	$750	$2,500	$2,000
Annual Family Deductible	$9,000	$10,000	$1,500	$5,000	$4,000
Annual OOP Max - Single (incl Ded)	$6,450	$6,600	$4,000	$5,000	$6,600
Annual OOP Max - Family	$12,900	$13,200	$8,000	$10,000	$13,200
PCP Office Visit	Ded, 20%	Ded, 20%	$30	Ded, 10%	$30
Specialist Office Visit	Ded, 20%	Ded, 20%	$60	Ded, 10%	$60
Preventive Care	$0	$0	$0	$0	$0
Inpatient Hospital Services	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Outpatient Hospital Services	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Professional Services (In & Out)	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Emergency Room	Ded, 20%	Ded, 20%	Ded, $200	Ded, 10%	Ded, $200
Urgent Care Facility	Ded, 20%	Ded, 20%	$60	Ded, 10%	$60
Ambulance	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
PT/OT/Speech Therapy	Ded, 20%	Ded, 20%	$60	Ded, 10%	$60
Chiropractic Services	Ded, 20%	Ded, 20%	$60	Ded, 10%	$60
DME/Orthotics & Prosthetic Devices	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Inpatient Behavioral Health	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Outpatient Behavioral Health	Ded, 20%	Ded, 20%	$30	Ded, 10%	$30
Skilled Nursing Facility/LTACH	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Acute IP Rehab	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Home Health	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Hospice	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Pharmacy:					
Generic Drug	Ded, 20%	$25	$15	Ded, 10%	$15
Brand Name Formulary	Ded, 20%	$50	$40	Ded, 10%	$40
Brand Name Non-Formulary	Ded, 20%	$100	$80	Ded, 10%	$80
Specialty Drugs *	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Mail Order	Ded, 20%	2.5x	2.5x	Ded, 10%	2.5x
Pediatric Vision Services	Eye Exam, Lenses/Frames or Contacts Once a Calendar Year				

* Specialty Drug Benefit does not apply to orally administered cancer chemotherapy drugs, which are covered at the same level as chemotherapy administered intravenously or by injection.

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ATTACHMENT 2

SOUTHEASTERN INDIANA HEALTH ORGANIZATION
Attachment 2 - Exhibit 1: Plan Adjusted Index Rates (Calibrated)

Plan Name	Actuarial Value	Metal Tier	Plan Adjusted Index Rate (Calibrated)
SIHO Marketplace Bronze HSA	60.1%	Bronze	$219.29
SIHO Marketplace Bronze	61.2%	Bronze	$240.27
SIHO Marketplace Gold	78.4%	Gold	$358.48
SIHO Marketplace Silver HSA	70.1%	Silver	$271.34
SIHO Marketplace Silver	70.3%	Silver	$316.65

Southeastern Indiana Health Organization
Attachment 2 - Exhibit 2: Age and Tobacco Status Factors

Age	Age Factor	Tobacco Factor
0-20	0.635	1.000
21	1.000	1.050
22	1.000	1.050
23	1.000	1.050
24	1.000	1.050
25	1.004	1.100
26	1.024	1.100
27	1.048	1.100
28	1.087	1.100
29	1.119	1.100
30	1.135	1.150
31	1.159	1.150
32	1.183	1.150
33	1.198	1.150
34	1.214	1.150
35	1.222	1.150
36	1.230	1.150
37	1.238	1.150
38	1.246	1.150
39	1.262	1.150
40	1.278	1.150
41	1.302	1.150
42	1.325	1.150
43	1.357	1.150
44	1.397	1.150
45	1.444	1.200
46	1.500	1.200
47	1.563	1.200
48	1.635	1.200
49	1.706	1.200
50	1.786	1.200
51	1.865	1.200
52	1.952	1.200
53	2.040	1.200
54	2.135	1.200
55	2.230	1.300
56	2.333	1.300
57	2.437	1.300
58	2.548	1.300
59	2.603	1.300
60	2.714	1.300
61	2.810	1.300
62	2.873	1.300
63	2.952	1.300
64 and Older	3.000	1.300

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June 2, 2014

Mr. Rick Kramer
Vice President and Controller
Southeastern Indiana Health Organization
417 Washington Street
P.O. Box 1787
Columbus, IN 47202-1787

RE: MAY 20, 2014 INDIVIDUAL QHP FILING OBJECTION QUESTIONS (SERFF Tracking Number: SEIH-129537625)

Dear Rick:

Milliman, Inc. (Milliman) was retained by Southeastern Indiana Health Organization (SIHO) to develop an individual rate filing to be filed with the Indiana Department of Insurance for effective dates beginning January 1, 2015. This correspondence responds to the questions about the rate filing sent by the Indiana Department of Insurance to you on May 20, 2014. The questions from the Indiana Department of Insurance appear in bold italic font below and are followed by our responses.

LIMITATIONS

The letter is subject to the terms and conditions of the Consulting Services Agreement between SIHO and Milliman dated January 1, 2004. This letter has been prepared for the use of SIHO. We understand that this letter will be provided to the Indiana Department of Insurance and its subcontractors to assist in the review of SIHO's individual rate filing. No portion of this letter may be provided to any other party without Milliman's prior written consent. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work.

In performing this analysis, we relied on data and other information provided by SIHO. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are

questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

RESPONSES

1) Please be aware that filings are considered public information when filed. If you do not intend for this to be public, please withdraw the filing

The individual rate filing and corresponding filing templates were prepared for the use of SIHO. We understand that once filed, the information is considered public. However, we do not intend to benefit or create a legal duty to any third party recipient of this work.

2) Please describe what part of the Diabetes education and Nutrition counseling is above the EHB requirements.

Information related to non-EHBs was provided to us from SIHO, and were assumed to not vary between 2014 and 2015. It was indicated that Nutrition Counseling was provided above the EHB standard in that SIHO does not impose any service limits or restrictions. For Diabetes Education, SIHO provides one education class upon diabetes diagnosis which was assumed to be different from Diabetes Management. Please note that non-EHBs were assumed to have a minimal impact on the proposed premium rates.

3) In Section 2. b. i. the plan adjusted index rates do not tie back to the URRT. Please explain.

Section 2. b. i. references to Attachment 2, Exhibit 1 of the actuarial memorandum. This exhibit contains Calibrated Plan Adjusted Index Rates. Within Worksheet 2 of the URRT, Plan Adjusted Index Rates are provided. The difference between these items is that the Attachment 2, Exhibit 1 figures are calibrated for a 1.0 age and geography factor whereas the URRT represents average rates. An explanation of the calibration factor used can be found within Section XVII. Calibration of the Part III Actuarial Memorandum submitted. The calibration factor is also discussed in question 13 below.

4) In Section 3, you show the projected MLR. Please provide a detailed demonstration of the steps in getting to the 87.2% MLR.

Figure 1 below contains a breakdown of the MLR calculation for SIHO's individual business.

Figure 1 Southeastern Indiana Health Organization, Inc. Projected Federal Medical Loss Ratio Exhibit	
Member Months	24,000
Claims PMPM	$ 518.14
Transitional Reinsurance Recoveries PMPM (Received)	$ (64.94)
Risk Adjustment Paid PMPM (Received)	$ 0.00
Risk Corridors Paid PMPM (Received)	$ 0.00
MLR Numerator	**$ 453.20**
Premium PMPM	$ 558.76
Premium-Related Retention PMPM (Taxes/Fees)	$ 27.63
Income Tax PMPM	$ 13.19
MLR Denominator	**$ 517.94**
Loss Ratio	**87.5%**

Please note that this value varies slightly from the 87.2% figure provided in the actuarial memorandum. This is a result of a modeling modification that was made while creating this figure which improved the accuracy of the MLR calculation. This adjustment was related to the treatment of income taxes in the MLR calculation, and has no impact on the premium rates filed.

5) In Section 4, you mention that the morbidity was estimated as being 25% above the pre-ACA group market. Please step through the process of this determination.

The morbidity assumption of 25% above the pre-ACA group market was developed as the product of the assumptions shown in Figure 2 below. There was assumed to be no morbidity impact associated with pent-up demand for calendar year 2015. Please note that the resulting composite morbidity was rounded down to arrive at the 25% figure utilized for pricing purposes.

Figure 2 Southeastern Indiana Health Organization, Inc. Individual Market Morbidity	
Category	**Factor**
Individual-Level Purchasing Decisions	1.03
Uninsured Morbidity	1.02
Impact of Transitional Policies	1.05
Medicaid Spend-Down Population	1.14
Composite Morbidity	**1.25**

The morbidity impact associated with individual-level purchasing decisions reflects the impact of consumer level purchasing relative to the experience used in the manual rate development process (SIHO small and large group business). This estimate was calculated by comparing the morbidity level of groups with 2-5 subscribers relative to that of the composite small and large group experience used in the manual rate development process.

Uninsured morbidity reflects the assumed impact of individuals entering the market in 2015 that were previously uninsured.

The impact of transitional policies reflects members in the pre-ACA individual marking having the ability to renew on non-ACA compliant products in 2015. This is assumed that have an adverse impact on the morbidity of the ACA complaint risk pool, as healthier individual are more likely to renew on the non-ACA compliant products.

The morbidity impact of the Medicaid spend-down population was estimated based on information provided by the IDOI on April 23, 2014. Additional information has been made available since the submission of this rate filing. We are currently reviewing this new information to determine if updates to the assumptions made would be appropriate.

6) How did you determine the 12% higher utilization for the 94% and 87% CSR plans.

The 12% induced utilization assumption for the 94% and 87% CSR plans was based on information available within federal regulations; specifically, the HHS Notice of Benefit and Payment Parameters for 2015. A link to Federal Register Vol. 79, No. 47 is provided below, and Table 5 can be found on page 64 of 101.

Link: http://www.gpo.gov/fdsys/pkg/FR-2014-03-11/pdf/2014-05052.pdf

7) I would like to see a demonstration of the trend for both medical and drugs.

A prospective trend assumption of approximately 8.0% was applied to estimate claims experience for 2015. The 8.0% annual trend is the composite of medical trend of approximately 7.0% and prescription drug trend of approximately 14.3%. SIHO provided the medical trend estimate based upon anticipated changes in their provider contracts and a review of recent experience. The prescription drug trend estimate was developed using 2014 and 2015 projected trends from SIHO's pharmacy benefit manager for its health plan book of business and experience from 2010 to 2013 as reported by the pharmacy benefit manager for its health plan book of business and for SIHO. Prospective pharmacy trends reflect a continued higher utilization of specialty drugs, relative to historical experience.

The medical trend of approximately 7.0% and drug trend of approximately 14.3% are comprised of Allowed Trend, Cost Share Leveraging, and the impact of Non Fee for Service expenses (Non-FFS). Cost Share Leveraging includes the impact of fixed dollar cost sharing, such as deductibles and copayments, on trend. The Medical Non-FFS Impact reflects private reinsurance trend. The Drug Non-FFS Impact reflects the trend associated with Rx rebates. A breakdown of each of these trend components is provided in Figure 3 below.

Figure 3 Southeastern Indiana Health Organization, Inc. 2015 Medical and Drug Trends		
	Medical Trend	**Drug Trend**
Allowed Trend	6.0%	11.8%
Cost Share Leveraging	0.7%	1.4%
Non-FFS Impact	0.3%	1.1%
Total	**7.0%**	**14.3%**

8) Please provide some additional explanations of the Benefit PMPM's as provided in Section II of Worksheet 1 in the URRT. The values are much higher than I expected.

The allowed claims PMPM provided in Worksheet 1 of the URRT were developed based on the manual rate development process outlined within the Section VII. Credibility Manual Rate Development of the Part III Actuarial Memorandum submitted. The basis of the projected allowed claims PMPM shown within the URRT was SIHO's small group and large group point-of-service experience for the 12 months ending December 2013. This experience was adjusted for the anticipated morbidity, covered services, demographics, and other items of the projected individual market population as appropriate.

SIHO's 2015 small group filing included projected allowed claims PMPM of $555.65 relative to the individual market figure of $831.23; which is a difference of just under 50%. The 50% differences is primarily comprised of higher anticipated morbidity (approximately 15% higher than post-ACA small group), age/gender differences (roughly +25%), and the assumed utilization impact of CSR plans (approximately +4.5%). The product of these three key items can be used to better understand the magnitude of the individual market figures (1.150*1.250*1.045 = 1.50).

9) I did not see a development of the Expense Load anywhere. Can you provide the detail in what makes up this value?

The administrative expense load includes amounts for network access fees and operating expenses. SIHO's network access fees were estimated on a per member per month (PMPM) basis, based on data available within SIHO's small group block of business. SIHO provided a PMPM assumption plus a percent of premium assumption for operating expenses. These estimates of 2015 operating expenses were developed by SIHO, and are illustrated in Figure 4 below.

Figure 4 Southeastern Indiana Health Organization, Inc. Illustration of Administrative Expense Load				
	Retention Description	**PMPM**	**% Premium**	**Basis**
	Administrative Expense Load			
	General Admin Expense	$ 18.50	3.3%	PMPM
	Network Access Fee	$ 2.15	0.4%	PMPM
+	Percentage Based General Admin	$ 23.75	4.3%	% of Premium
	Subtotal: Administrative Expense Load	$ 44.40	7.9%	

10) Please provide a demonstration of how the $23.90 was determined. I will need to see detail around the derivation of each piece of the taxes and fees except the Transitional Reinsurance Fee.

Taxes and Fees include estimated values of the following items.

- $2.12 Per Member Per Year for the Patient Centered Outcomes Research Institute Fee;
- 3.5% of premium exchange user fee; and,
- 0.75% for the Health Insurer Fee

Taxes and Fees on a PMPM basis are illustrated in Figure 5 below. The impact of the Federal Transitional Reinsurance Contributions and the Risk Adjustment User Fee are excluded from the values illustrated in the figure, as they are reflected in estimated incurred claims. Please note that minor differences exist due to the impact of rounding in the development of the URRT.

Figure 5
Southeastern Indiana Health Organization, Inc.
Illustration of Taxes and Fees

	Retention Description	PMPM	% Premium	Basis
	Taxes and Fees			
	Comparative Effectiveness Research Fee	$ 0.18	0.0%	PMPM
	Exchange Fee	$ 19.56	3.5%	% of Premium
+	Health Insurance Provider Fee (Excise Tax)	$ 4.15	0.7%	% of Premium
	Subtotal: Taxes and Fees	$ 23.89	4.3%	

11) I will need to see a copy of the AV calculation page for each plan.

A copy of the AV calculation page for each plan is included in Enclosure 1 of this correspondence.

12) Your attachment 2, Exhibit 1 AV does not tie back to the URRT.

This is an accurate observation. Attachment 2, Exhibit 1 included an AV of 60.1% for the Bronze HSA plan compared to a 59.9% AV for this same plan in Worksheet 2 of the URRT. All other plan designs align between these two exhibits. The value provided in Worksheet 2 of the URRT reflects an outdated version of the Bronze HSA plan design; specifically, it does not reflect the 2015 HSA maximum out of pocket requirements. Attachment 2, Exhibit 1 reflects the updated plan design with a lower maximum out of pocket, and is the correct AV for this plan.

13) Please provide a demonstration of how the calibration factor was calculated and used in determining the Plan Adjusted Index Rate. This should show the development of the age calibration, geographic calibration, and smoker calibration.

The Calibrated Plan Adjusted Index Rates shown within Attachment 2, Exhibit 1 were determined by calibrating the Plan Adjusted Index Rates for Age and Geography, as demonstrated in the figure below. The Plan Adjusted Index Rate can also be found within Worksheet 2 of the URRT.

Figure 6 Southeastern Indiana Health Organization, Inc. Plan Adjusted Index Rate Calibration					
Plan	**Plan Adjusted Index Rate**	**Age Calibration Factor**	**Geography Calibration Factor**	**Calibration Factor**	**Calibrated Plan Adjusted Index Rate**
SIHO Marketplace Bronze HSA	$418.87	1.697	1.000	1.697	$246.81
SIHO Marketplace Bronze	$458.87	1.697	1.000	1.697	$270.38
SIHO Marketplace Silver HSA	$519.28	1.697	1.000	1.697	$305.97
SIHO Marketplace Silver	$606.15	1.697	1.000	1.697	$357.16
SIHO Marketplace Gold	$687.14	1.697	1.000	1.697	$404.88

SIHO is proposing to not vary rates in the individual market for geography, which resulted in a Geography Calibration Factor of 1.00. The Age Calibration Factor provided in Figure 6 was calculated as demonstrated in Figure 7 below. Tobacco is not an allowable calibration factor adjustment, per page 19 of the Part III Actuarial Memorandum and Certification Instructions. Below you will find an excerpt from these instructions, along with a link to the document.

"Calibration factors are ONLY allowed for the age and geography factors. Calibration for tobacco-use cannot be applied at this point since it is incorporated in the actuarial value component of the plan level adjustments (see Plan Adjusted Index Rates section)."

http://www.serff.com/documents/plan_management_data_templates_2015/plan_management_data_template_2015_part3_actuarial_instructions.pdf

Figure 7 Southeastern Indiana Health Organization, Inc. Age Calibration Factor Development			
Gender	**Age Band**	**Projected Membership Distribution**	**Age Factor**
Child	0-1	0.5%	0.635
Child	2-6	1.6%	0.635
Child	7-18	5.3%	0.635
Child	19-20	2.0%	0.635
Male	21-24	2.4%	1.000
Male	25-29	4.3%	1.056
Male	30-34	4.0%	1.178
Male	35-39	3.4%	1.240
Male	40-44	4.0%	1.332
Male	45-49	4.6%	1.570
Male	50-54	4.8%	1.956
Male	55-59	6.9%	2.430
Male	60-63	4.5%	2.837
Male	64+	1.1%	3.000
Female	21-24	2.8%	1.000
Female	25-29	4.4%	1.056
Female	30-34	4.7%	1.178
Female	35-39	4.5%	1.240
Female	40-44	4.3%	1.332
Female	45-49	5.6%	1.570
Female	50-54	6.8%	1.956
Female	55-59	8.7%	2.430
Female	60-63	7.0%	2.837
Female	64+	2.0%	3.000
Composite		**100.0%**	**1.697**

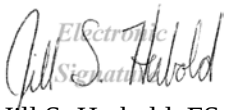
14) How was the reinsurance determined, $61.27 seems rather high.

The reinsurance value being higher than anticipated is directly correlated with benefit PMPM's provided in Section II of Worksheet 1 in the URRT, as discussed under question 8. Reinsurance was calculated using projected allowed claims by plan. These allowed claims figures were used to calibrate a claims probability distribution (CPD) for each plan design offered by SIHO. Using these calibrated CPDs, we estimated the value of 50% of allowed claims between $70,000 and $250,000. These results were weighted based on anticipated membership by plan and netted against the reinsurance contribution of $3.67 PMPM to arrive at the $61.27 PMPM figure provided in the URRT.

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

Please contact me at (317) 524-3538 or jill.herbold@milliman.com with any questions or comments.

Sincerely,



Jill S. Herbold, FSA, MAAA
Consulting Actuary

JSH/sds
Enclosure

Milliman

ENCLOSURE 1

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)	$4,500.00	$0.00	$4,500.00
Coinsurance (%, Insurer's Cost Share)	80.00%	80.00%	80.00%
OOP Maximum ($)	$6,450.00		$6,450.00
OOP Maximum if Separate ($)	$6,450.00		

Tier 2 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)	$0.00	$0.00	$0.00
Coinsurance (%, Insurer's Cost Share)	99.99%	80.00%	99.99%
OOP Maximum ($)	$0.00		$0.00
OOP Maximum if Separate ($)	$0.00	$6,350.00	

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	60.1%
Metal Tier:	Bronze

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

Tier 1 Plan Benefit Design			
	Medical	Drug	Combined
Deductible ($)	$5,000.00	$0.00	$5,000.00
Coinsurance (%, Insurer's Cost Share)	80.00%	80.00%	80.00%
OOP Maximum ($)	$6,600.00		$6,600.00
OOP Maximum if Separate ($)	$6,600.00		

Tier 2 Plan Benefit Design			
	Medical	Drug	Combined
Deductible ($)	$0.00	$0.00	$0.00
Coinsurance (%, Insurer's Cost Share)	100.00%	80.00%	100.00%
OOP Maximum ($)	$0.00		$0.00
OOP Maximum if Separate ($)	$0.00	$6,350.00	

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$25.00	☐	☐		$25.00
Preferred Brand Drugs	☐	☐		$50.00	☐	☐		$50.00
Non-Preferred Brand Drugs	☐	☐		$100.00	☐	☐		$100.00
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.2%
Metal Tier:	Bronze

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$750.00	$0.00	$750.00	$0.00	$0.00	$0.00
Coinsurance (%, Insurer's Cost Share)	90.00%	90.00%	90.00%	100.00%	90.00%	100.00%
OOP Maximum ($)	$4,000.00		$4,000.00	$0.00		$0.00
OOP Maximum if Separate ($)	$4,000.00			$0.00	$6,350.00	

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$30.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☐	☐		$60.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$60.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		$15.00
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		$40.00
Non-Preferred Brand Drugs	☐	☐		$80.00	☐	☐		$80.00
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.4%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,500.00	$0.00	$2,500.00	$0.00	$0.00	$0.00
Coinsurance (%, Insurer's Cost Share)	90.00%	90.00%	90.00%	99.99%	90.00%	99.99%
OOP Maximum ($)	$5,000.00		$5,000.00	$0.00		$0.00
OOP Maximum if Separate ($)	$5,000.00			$0.00	$6,350.00	

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.1%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$2,000.00	$0.00	$2,000.00	$0.00	$0.00	$0.00
Coinsurance (%, Insurer's Cost Share)	80.00%	80.00%	80.00%	100.00%	80.00%	100.00%
OOP Maximum ($)	$6,600.00		$6,600.00	$0.00		$0.00
OOP Maximum if Separate ($)	$6,600.00			$0.00	$6,350.00	

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$30.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☐	☐		$60.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$60.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		$15.00
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		$40.00
Non-Preferred Brand Drugs	☐	☐		$80.00	☐	☐		$80.00
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.3%
Metal Tier:	Silver

State: Indiana **Filing Company:** Southeastern Indiana Health Organization, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: Individual QHP Plans
Project Name/Number: 2015 Exhange/QHP INDV-05.2014

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
08/01/2014		Form	Certificate of Coverage	08/07/2014	SIHO FI SPD template 2014 Individual Market -7.8.14 Final.pdf (Superceded)
07/11/2014		Form	Certificate of Coverage	08/01/2014	SIHO FI SPD template 2014 Individual Market -7.8.14 Final.pdf
06/25/2014		Supporting Document	Unified Rate Review Template	07/11/2014	UnifiedRateReviewSubmission_201406258956.xml
06/25/2014		Rate	Actuarial Memorandum	08/01/2014	10-Actuarial Memorandum - 2015 - Individual.pdf
05/11/2014		Form	Certificate of Coverage	07/11/2014	SIHO FI SPD template 2014 Individual and Market draft 4a 2 - Final.pdf (Superceded)
05/11/2014		Rate	Actuarial Memorandum	06/25/2014	Actuarial Memorandum - 2015 - Individual.pdf (Superceded)
05/09/2014		Supporting Document	4.1(B) EHB Individual New Rate/Form Requirements (Accident & Health)	07/11/2014	Individual Crosswalk - Final.pdf (Superceded)
05/09/2014		Supporting Document	Actuarial Memorandum and Certifications	06/25/2014	Actuarial Memorandum - 2015 - Individual.pdf (Superceded)
05/09/2014		Supporting Document	Unified Rate Review Template	06/25/2014	PM.QHP.Unified Rate Review Template.TMPL.v2.0.2.04152014 - Individual.xlsm (Superceded)

SERFF Tracking #:	*SEIH-129537625*	***State Tracking #:***	*QHP INDV-05.2014*	***Company Tracking #:***	*QHP INDV-05.2014*

State:	*Indiana*	***Filing Company:***	*Southeastern Indiana Health Organization, Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*		
Product Name:	*Individual QHP Plans*		
Project Name/Number:	*2015 Exhange/QHP INDV-05.2014*		

Attachment PM.QHP.Unified Rate Review Template.TMPL.v2.0.2.04152014 - Individual.xlsm is not a PDF document and cannot be reproduced here.

SOUTHEASTERN INDIANA HEALTH ORGANIZATION, INC

INDIVIDUAL CERTIFICATE OF COVERAGE

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, You may return it to SIHO or the agent who sold it to you within 10 days after you receive it or have access to it electronically, whichever is earlier. Your premium will be refunded and this Contract will be void from its start.

Guaranteed Renewable: Coverage under this Contract is guaranteed renewable, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Contract by payment of the renewal premium by the end of the grace period of any Premium due date. The Exchange may refuse renewal only under certain conditions.

SIHO Insurance Services
417 Washington St.
Columbus, IN 47203

Form No. QHP INDV-05.2014

Revised May 2014

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DECLARATIONS

A. Agreement to Offer Plan

SIHO is offering this Health Plan to Individuals and their eligible Dependents.

B. Term

The term of this Agreement begins on the Effective Date of coverage.

C. Eligibility

The eligibility of the Individual and any eligible Dependents to enroll in thee Health Plan will be defined in terms of the eligibility requirements in Article II subject to the following limitations:

1. Each person making application outside of open enrollment to be a Participant is required to provide evidence of a qualifying event for coverage, excluding newborns and adopted children.

D. Effective Date of Coverage

1. Open Enrollment Period Open Enrollment periods will be held each year according to rules established by the Exchange.

2. Newborn & Adopted Child Coverage is automatic for newborn children and newly adopted children during the first 31 days of their eligibility. Coverage for newborns and newly adopted children will continue beyond the first 31 days as long as they are enrolled within 31 days of becoming eligible, the applicable enrollment fees have been paid, and other provisions of this Agreement have been met. Newborn children will be treated as Dependents from birth. Legally adopted children will be treated as Dependents from the earlier of the date of placement for the purpose of adoption; or the date of the entry of an order granting the adoptive Participant custody of the Child for purposes of adoption.

3. Special Enrollment If an individual does not enroll himself or dependents in the Health Plan during open enrollment, the individual may be eligible to enroll himself and his dependents in the Health Plan in a special enrollment if he or his dependents experience a qualifying life event, such as marriage, divorce, or involuntary loss of coverage. Events which allow a Qualified Individual or enrollee to enroll in a Qualified Health Plan or switch coverage to another QHP, outside of the Open Enrollment Period, include:

    a. Loss of Minimum Essential Coverage;

b. Enrollee gains or loses a Dependent, including situations where the enrollee becomes a Dependent on other coverage, due to marriage, birth, adoption or placement for adoption;

c. Change in citizenship status;

d. Loss of coverage in a QHP through an unintentional error or mistake;

e. A Qualified Individual demonstrates to the Exchange that their current QHP has violated its contract with the Qualified Individual;

f. A Qualified Individual becomes eligible or ineligible for Advance Payments of the Premium Tax Credit or has a change in eligibility for cost-sharing reductions, regardless of current enrollment status of the Qualified Individual;

g. A Qualified Individual loses existing coverage through an employer sponsored plan, or the employer sponsored plan will no longer be affordable or provide minimum value for the upcoming Plan Year. Such Qualified Individuals' Special Enrollment rights run through the end of their coverage under the eligible employer sponsored plan.

h. A Qualified Individual moves into or out of the Service Area.

For other examples of qualifying events that trigger special enrollment rights, please see **https://www.healthcare.gov/glossary/qualifying-life-event/**.

To qualify for this special enrollment, the individual must submit an enrollment form within 30 days after the other health coverage ends and provide sufficient information to establish that the individual lost the other health coverage involuntarily, if applicable. The effective date of coverage for special Enrollees is the eligible date of the qualifying life event. If an individual or his Dependents lose coverage under Medicaid or a state child health program the individual has 60 days after the coverage ends to enroll in the Health Plan.

4. Late Enrollment If an individual fails to enroll during an open enrollment period or within 31 days of becoming newly eligible, the individual must wait for an open enrollment period to enroll unless the individual qualifies for special enrollment.

E. Misstatement of Age

If premium fees and/or benefits are based upon age, and a misstatement of age is discovered, the corrected benefits and premium fees will be adjusted retroactively for 60 days.

F. Incontestability

The validity of the policy may not be contested, except for nonpayment of premiums, after the policy has been in force for 2 years. No statement made by a covered person, relating to the covered person, will be used in contesting the validity of the coverage unless the statement is in written form and signed by the covered person.

G. Health Insurance Portability and Accountability Act of 1996

This policy complies with the provisions of HIPAA and provides portability and guaranteed renewability as described in this federal regulation.

I. GENERAL PROVISIONS

A. Definitions

Wherever used in this document, the following words and terms, when capitalized, have the following meanings, unless a different meaning is clearly indicated by the context.

"ACA" means the Patient Protection and Affordable Care Act, as amended (including the amendments contained in the Health Care and Education Affordability Reconciliation Act of 2010), and all applicable regulations issued hereunder.

"Acute Rehabilitation Hospital" means a licensed and accredited institution which provides professional services to those needing intensive therapies to regain normal body function. Services include: physical, occupational, pulmonary and speech therapies. Services must be delivered by a licensed therapist for a minimum of 3 hours per day, and the institution must have 24 hour nursing by a licensed nurse under the direction of a full-time RN, complete medical records for each patient, utilization review and discharge plan, and a physiatrist or licensed physician overseeing the care on staff.

"Agreement" means this Certificate of Coverage, including all attachments, endorsements, amendments, and addenda.

"Appeals Hearing Committee" means a committee designated by SIHO to investigate appeals of decisions on Grievances.

"Autism Spectrum Disorder (ASD)" means a group of developmental brain disorders including: classic Autism, Asperger's disorder, Pervasive developmental disorder, Rett's disorder, and Childhood disintegrative disorder. ASD is diagnosed according to the most current guidelines listed in the Diagnostic and Statistical Manual of Mental Disorders.

"Centers of Excellence" means a specialized network of providers that have expertise in the transplantation of human organs and tissues with whom SIHO has a contract to provide transplant services to Enrollees. Networks considered to be Centers of Excellence are determined by SIHO and/or its reinsurance carrier.

"Child" or **"Children"** means any of the following individuals age 25 or under:

a. A Participant's natural born child;

b. A Participant's stepchild;

c. A Participant's legally adopted child, from the earlier of the date of placement for adoption or the date of entry of an order granting the Participant custody of the child for the purpose of adoption;

d. Any child for whom the Participant is subject to legal guardianship or legal custody

e. Any child for whom the Participant is legally responsible for Medical Care by a qualified medical child support order, as defined in ERISA.

"Claim" means any claim for benefits under the Health Plan, including Urgent Care Claims, Concurrent Care Claims, Pre-Service Claims and Post-Service Claims.

"Clean Claim" means a claim received by SIHO with all the information needed to complete the review of the claim and apply the appropriate benefit or exclusion provision. SIHO will pay or deny a clean claim within 30 days of submission if filed electronically or 45 days of submission if filed via paper.

"COBRA" means the health continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

"Coinsurance" means the percentage of covered charges for which an Enrollee is responsible under the terms of this Agreement.

"Concurrent Care Claim" means any Claim with respect to an ongoing course of treatment provided over a period of time or number of treatments that SIHO has approved.

"Consulting Provider" means any Individual Health Care Provider or Institutional Health Care Provider who or which is not a Participating Provider, but who or which has entered into a contractual arrangement with SIHO to provide services within the range of a designated specialty area of practice.

"Continuation Coverage" means Coverage provided under this Agreement in accordance with the provisions of Article XI.

"Copayment" means a specific amount as set forth in Article IV that an Enrollee must pay in connection with the receipt of services.

"Coverage" means coverage for an Enrollee under the Health Plan.

"Covered Benefits" means the Medical Care specified in this Agreement for which benefits will be provided. In order to be considered a Covered Benefit, charges for the Medical Care must be incurred while the Enrollee's Coverage is in force.

"Custodial Care" means care or service that is primarily designed to assist an Enrollee in the activities of daily living or is provided in order to maintain the Enrollee's state of health and cannot be expected to improve a medical condition. Custodial Care can be performed by individuals without professional skills. Custodial Care includes, but is not limited to:

a. Administration of medicines, dressings or therapies that can be self-administered;

b. Routine monitoring of vital signs; and

c. Help in walking, getting in and out of bed, bathing, dressing, and eating.

"Deductible" means the specified dollar amount of covered charges that an Enrollee must pay before benefits that are subject to the Deductible will be paid.

"Delegated Network" means an organization contracted with SIHO to provide a network of health care providers. Designated as "in-network" with respect to the Health Plan.

"Dependent" means a Child or spouse of a Participant who meets the Dependent eligibility requirements of this Agreement, has enrolled in the Health Plan, and has paid (and SIHO has received) the enrollment fee required by this Agreement.

"Designated Representative" means an individual who represents and acts on behalf of an Enrollee, and may be, without limitation, a provider. As used in Article XIII, Procedures for Claiming Benefits, all references to an Enrollee or claimant will also include the Enrollee's or claimant's Designated Representative.

"Eligible Charges" for services provided by a Participating Provider shall mean the lesser of billed charges or the contracted rates between the provider and SIHO for Covered Benefits. For services provided by Non-Participating Providers, eligible Charges shall mean the lesser of the providers' billed charges or the most recently published Medicare reimbursement rates for the Covered Benefits provided, except for emergency services which are calculated as described in Article IV.

"Emergency Accident" or **"Emergency Illness"** means a medical condition of such an acute nature that a prudent person, with average knowledge of medicine and health, would believe that the absence of immediate medical attention could result in serious medical complications, loss of life, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

"Enrollee" means any Participant or Dependent.

"Evidenced Based Pharmacy Plan (EBPP)" means a prescription drug benefit plan available to Enrollees with specified chronic medical conditions and who are actively participating, as determined by SIHO, in their Disease Management, Case Management, and/or other Medical Management programs.

"Experimental" or **"Investigational"** means any treatment, equipment, technology, drug, procedure or supply that does not satisfy all of the following requirements:

a. The treatment, equipment, technology, drug, procedure or supply has received final approval from the appropriate governmental regulatory bodies;

b. Scientific evidence permits conclusions concerning the effect of the treatment, equipment, technology, drug, procedure or supply on health outcomes;

c. The treatment, equipment, technology, drug, procedures or supply improves the net health outcome;

d. The improvement is attainable outside the research setting; and

e. The treatment, equipment, technology, drug, procedure or supply is generally accepted as standard medical treatment of the condition being treated.

In addition, clinical trials for which the law requires coverage are not considered "Experimental" or "Investigational."

"Grievance" means an expression of dissatisfaction, either oral or written, regarding the availability, delivery, appropriateness, or quality of Medical Care; handling or payment of claims for health care services; or matters pertaining to the contractual relationship between the Participant and the Health Plan.

"Health Plan" means the SIHO health care delivery plan as set forth in this Agreement.

"Health Plan Medical Director" means the physician(s), or his appointee, designated by SIHO to provide clinical oversight of SIHO's medical management.

"Health Plan Enrollee Services" means the SIHO office that is primarily responsible for responding to the concerns and questions of Enrollees about Health Plan Coverage and procedures and for handling Claims.

"Individual Health Care Provider" means an individual licensed to provide health services.

"Inherited Metabolic Disease" means a disease caused by inborn errors of amino acid, organic acid, or urea cycle metabolism and treatable by the dietary restriction of one or more amino acids.

"Inpatient Rehabilitation Services" means those services that are part of a separate and distinct inpatient program that provides highly skilled rehabilitation care.

"Institutional Health Care Provider" means a facility licensed to provide health services.

“Long Term Acute Care Hospital (LTACH) Services” means comprehensive inpatient services in a licensed acute care hospital for patients who require specialized, complex services, and are stable enough to move to an LTACH. These services require daily physician monitoring and intensive nursing care, generally with a length of stay of twenty-five (25) days or more. Examples include ventilator dependent patients and patients requiring wound care management, IV therapy, dialysis, and telemetry. Intensive Care Unit days are not considered LTACH Services.

"Medical Food" means a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered entirely under the direction of a physician.

"Medically Necessary" means Medical Care that is (1) consistent with the diagnosis of and prescribed course of treatment for the Enrollee's illness or injury; (2) required to treat the Enrollee's illness or injury; (3) not provided solely for the convenience of the Enrollee or provider and not required solely for Custodial Care or for comfort or maintenance reasons; (4) performed in the most cost-effective setting appropriate for the injury or illness; (5) not Experimental or Investigational; (6) appropriate treatment according to generally accepted medical standards and rendered at the frequency that is accepted in the medical community; (7) likely to be effective in treating the injury or illness; and (8) not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment to the Enrollee. The fact that a physician prescribes, orders, recommends, or approves the Medical Care does not necessarily mean that the Medical Care is Medically Necessary.

"Medical Care" means the services and supplies that Individual Health Care Providers or Institutional Health Care Providers provide within the scope of their licenses and any of the medical supplies and ancillary services listed in Article IV.

"Medicare" means the program of medical care benefits for the aged and disabled described in Title XVIII of the federal Social Security Act of 1965, as amended.

"Morbid Obesity" means (1) a body mass index of at least 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or (2) a body mass index of at least 40 kilograms per meter squared without comorbidity.

"Network Benefit" means a Covered Benefit provided by a Participating Provider or, with prior written authorization from the Health Plan Medical Director, by a Consulting Provider or Non-Participating Provider.

“Never Events” mean serious reportable adverse events as defined by the National Quality Forum (NQF), or other national bodies, including but not limited to Health and Human Services (HHS). Medical errors that should never happen.

"Non-Network Benefit" means a Covered Benefit rendered by a Consulting Provider or Non-Participating Provider, without prior written authorization from the Health Plan Medical Director.

"Non-Participating Provider" means any Individual Health Care Provider or Institutional Health Care Provider who or which is neither a Participating Provider nor a Consulting Provider.

"Participant" means an individual who has enrolled in the Health Plan, and has paid (and SIHO has received) the enrollment fee required by this Agreement.

"Participating Physician" means a doctor of medicine, osteopathy, or oral surgery who is a Participating Provider.

"Participating Provider" means an Individual Health Care Provider or an Institutional Health Care Provider who or which, at the time care is rendered to an Enrollee, has a provider agreement in effect with SIHO or its Delegated Network.

"Post-Service Claim" means any Claim for benefits under the Health Plan that is not a Pre-Service Claim, Urgent Care Claim or Concurrent Care Claim.

"Precertification" means the process used to determine that Medical Care is Medically Necessary before it is provided to the Enrollee. The description of Covered Benefits in Article IV and the Schedule of Benefits indicate the types of Medical Care that require Precertification.

"Pregnancy" means the condition of being pregnant and includes childbirth, spontaneous abortion, or miscarriage.

"Pre-Service Claim" means any Claim for benefits under the Health Plan for which the Health Plan requires Precertification.

"Prevailing Rates" means the rates generally prevailing in the Service Area for medical, surgical, hospital and related health care services.

"Preventive Health Benefits Guidelines" means the guidelines established by SIHO in accordance with the ACA that describe the schedules for receiving preventive health care services in accordance with the Agreement.

"Primary Care Physician" or **"PCP"** means a Participating Physician specializing in general practice, family practice, internal medicine, or pediatrics.

Qualified Health Plan (QHP) means a health plan that has a certification from each Exchange through which such health plan is offered.

Qualified Individual means an individual who has been determined to be eligible for enrollment in a QHP, through the Exchange, and who meets all eligibility requirements.

"Service Area" means the geographic area set forth in Attachment A.

"SIHO" means Southeastern Indiana Health Organization, Inc., an Indiana corporation operating as a health maintenance organization under Indiana Code § 27-13-1-1 et seq.

"Skilled Nursing Facility" or **"SNF"** means a licensed institution, as defined in Medicare, 42 U.S.C. § 1395x (j), that is primarily engaged in providing skilled nursing facility services and related services. "Skilled Nursing Facility" does not mean a facility that operates primarily for the aged, alcoholics, or drug addicts, for treatment of nervous disorders or mental disease, or for rest, educational, or Custodial Care purposes. It also does not include a community-based residential treatment facility or a community re-entry program.

"Urgent Care Claim" means any Claim, if processing the Claim within the Health Plan's normal time frames (1) could seriously jeopardize an Enrollee's life, health, or ability to regain maximum function; or (2) in the opinion of a physician with knowledge of the Enrollee's medical condition, would subject the Enrollee to severe pain that cannot be adequately managed without the Medical Care requested in the Claim.

B. Rules of Construction

1. Words used in the masculine gender will be construed to include the feminine gender, where appropriate, and vice versa.

2. Words used in the singular will be construed to include the plural, where appropriate, and vice versa.

3. The headings and subheadings in this Agreement are inserted for convenience of reference only and are not to be considered in the construction of any provision of the Agreement.

4. If any provision of this Agreement or the Health Plan is held to violate any state or federal law or to be invalid for any other reason, that provision will be deemed to be null and void. The invalidation of a provision will not otherwise impair or affect the remainder of the Agreement.

5. The Agreement will be construed and governed in all respects under and by the internal laws of the State of Indiana and federal laws and statutes, as applicable.

6. As an HMO, SIHO operates primarily on the basis of arranging for network services on a negotiated rate, direct service basis rather than an indemnity basis. This Agreement will be interpreted with this prepaid, direct service nature of SIHO's services in mind.

II. ELIGIBILITY

Unless SIHO and Employer agree otherwise, the following eligibility rules apply:

A. Participant Eligibility

To enroll as a Participant an individual must reside in the Service Area and must be eligible for coverage as defined under the ACA and the applicable rules of the Exchange, as set forth by the Indiana Department of Insurance. Eligibility requirements for a Qualified Individual under a Qualified Health Plan include:

1. U.S. citizenship, or be a qualified U.S. national;
2. For a non-citizen, be lawfully present in the United States for the entire coverage period;
3. Be an Indiana resident, and living within the service area covered by this contract;
4. Not institutionalized (whether in a penal institution, a mental institution, or other similar arrangements);
5. Not be covered by, nor eligible for, Medicare, whether Parts A, B or D;
6. Not covered by any other health benefit plan, whether group or individual;
7. Not receiving any SSP (State Supplementary Payments) or similar subsidies;
8. Be over 21 years of age, and have the capacity to legally enter into a contract;
    a. If under 21 years of age, a Participant must;
        i. Not be eligible for Medicaid, SSP, or similar government programs, whether federal or state;
        ii. Not be institutionalized;
        iii. Not be emancipated;
        iv. Be capable of legally entering into a contract, or be capable of having a guardian sign;
9. Willing to reveal any and all other health benefit arrangements, including any that affect coordination of benefits, both at the outset of coverage and at any time during the coverage under this contract.
10. Willing to and agree to pay the required premiums for coverage under this contract.

B. Dependent Eligibility

To enroll as a Dependent an individual must be:

1. The spouse of a Participant, except a divorced spouse; or

2. A Child

A Dependent Child's Coverage will terminate when the Child attains the age of 26, unless the Child has a mental or physical disability that manifested itself prior to the age of 26 and renders the Child incapable of self-sustaining employment and the Child depends upon the Participant for support and maintenance.

The Participant must furnish SIHO with proof of the Dependent's incapacity within 120 days of the date the Child attained the age of 26 and at each subsequent open enrollment period. SIHO may continue to require such proof at reasonable times each year except that, after the first two years, SIHO may not request proof more than once a year.

C. Other Rules of Eligibility

1. No one will be denied enrollment or re-enrollment in the Health Plan because of health status, requirements for Medical Care, or the existence of a pre-existing physical or mental condition.

2. No one may re-enroll in the Health Plan if his Coverage has been terminated under Article IX, Section A3, for failure to furnish information or furnishing incorrect or incomplete information, or under Article IX, Section A4, for misuse of identification card. Also, no one may re-enroll in the Health Plan if his Coverage has been terminated under Article IX, Section A5, for failure to pay certain amounts due unless the amounts have been fully paid subsequent to the termination and re-enrollment is approved by SIHO in its discretion.

3. A Participant may not enroll the spouse or dependent of a Child as a Dependent in the Health Plan.

D. Enrollment

Individuals and their eligible dependents who meet the requirements of this Article II may enroll by completing SIHO's enrollment applications and submitting them to SIHO. SIHO must receive the applications before applicants will be considered for enrollment.

III. MANAGED CARE

The goal of managed care is to reduce the cost of Medical Care while maintaining or improving the quality of those services. Managed care methods include, but are not limited to,

utilizing Primary Care Physicians to manage the Enrollee's health care, Precertification, case management, disease management, and utilization review.

A. Non-Network Benefits: Out-of-Plan Deductibles and Higher Coinsurance.

If an Enrollee receives Medical Care from a Consulting Provider or Non-Participating Provider without a written authorization from the Health Plan Medical Director, the Covered Benefits will be subject to higher Deductibles and Coinsurances. These provisions may not apply to coverage for Emergency Accident or Emergency Illness

B. Non-Network Benefits: Non-Participating Provider Reimbursement

If an Enrollee receives Medical Care from a Non-Participating Provider, SIHO will pay the Non-Participating Provider no more than the most recently published Medicare reimbursement rates for those services. The Non-Participating Provider may bill the enrollee for any difference between their billed charges and the Medicare reimbursement rates, if applicable. These provisions may not apply to coverage for Emergency Accident or Emergency Illness.

C. Precertification

Precertification ensures that the Medical Care an Enrollee will receive is covered by the Health Plan. The description of Covered Benefits in Article IV and the Schedule of Benefits indicate the types of Medical Care that require Precertification. If an Enrollee needs Precertification of Medical Care, the Enrollee or someone on the Enrollee's behalf (such as a family member or PCP) needs to call SIHO or their Delegated Network at the number indicated on the Enrollee's identification card. See Article XV for additional information regarding Precertification.

D. Individual Case Management

The goal of case management is to ensure that an Enrollee receives appropriate care in the most cost-effective setting. If an Enrollee has a catastrophic injury or illness or otherwise needs long-term medical care, SIHO will work with the Enrollee, the Enrollee's PCP or specialist, and the Enrollee's family members, if appropriate, to develop a treatment plan. As part of the treatment plan, SIHO may provide benefits for services that are not otherwise covered by the Health Plan. SIHO must approve and arrange for all customized services and alternative care arrangements. Coverage for alternative care is subject to the same maximums, Deductibles, Coinsurances and Copayments that apply to Medical Care being replaced.

E. Chronic Disease Management

If an Enrollee has a chronic disease, SIHO will work with the Enrollee and the Enrollee's PCP or specialist to whom the Enrollee is properly referred to develop an appropriate treatment plan in a cost-effective manner. Examples of chronic diseases include, but are not limited to, diabetes, asthma, and heart disease.

F. Medical Necessity, Experimental or Investigational Determinations and Utilization Review

The Health Plan Medical Director, or his designee, is responsible for determining whether Medical Care is Medically Necessary, Experimental or Investigational and for making all other medical benefit determinations. Whenever a benefit determination is based on a decision of whether the service is Medically Necessary, the decision is subject to utilization review by a member of a qualified panel appointed by SIHO.

G. Qualifications of Medical Provider

The Health Plan Medical Director, or his designee, has discretion to decide whether certain Medical Care must be provided by a physician or may be provided by other appropriately licensed health professionals.

IV. BENEFITS AND COVERAGE

This Article describes the Medical Care that will be covered by the Health Plan. The Schedule of Benefits attached indicates the extent of Coverage that will be provided, including any Deductible, Copayment, or Coinsurance requirements and maximum Coverage limitations. Article V lists any exclusions and limitations applicable to the services or supplies described in this Article. All Medical Care must be Medically Necessary and provided in accordance with the provisions of this Agreement. SIHO may change the benefits described in this Article IV and the Schedule of Benefits in accordance with any changes in applicable federal or state law.

A. Inpatient Hospitalization and Surgery (Requires Precertification)

Room and Board: semi-private room.

> Note: If an Enrollee chooses a private room, the Enrollee is responsible for paying any amount in excess of the Prevailing Rate for the average semi-private hospital room, unless use of a private room is Medically Necessary or the hospital only has private rooms.

Room and board: ancillary charges.

Specialty care units such as intensive care, cardiac care, and burn care units.

Surgery services including diagnostic services and therapy services directly related to the covered surgery, x-rays, assistant surgery services, and other physician or specialist fees.

Anesthesia, including local and general anesthesia.

Inpatient medical visits.

Pregnancy services and supplies, including examination and testing of newborns

Coverage for the Inpatient postpartum stay for you and your newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care. Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if your attending Physician determines further Inpatient postpartum care is not necessary for you or your newborn child, provided the following are met and the mother concurs:

- • In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:

  1. the antepartum, intrapartum, and postpartum course of the mother and infant;
  2. the gestational stage, birth weight, and clinical condition of the infant;
  3. the demonstrated ability of the mother to care for the infant after discharge; and
  4. the availability of post-discharge follow-up to verify the condition of the infant after discharge.

Hospital ancillary services, including diagnostic services.

Human organ and tissue transplants when provided by a Center of Excellence as follows:

1. Precertification Requirement for Transplant Evaluation

   Expenses incurred in connection with the evaluation of an Enrollee for any human organ or tissue transplant will be covered but only after Precertification through SIHO has occurred. The Enrollee or his physician should contact SIHO for Precertification of the evaluation process.. SIHO will assign a case manager to work with the Enrollee closely through the transplant process.

2. Precertification Requirement for Transplant Procedure

   After the evaluation by a Health Plan-designated transplant physician has occurred, the Enrollee or the transplant physician should contact the case manager. Medical information about the Enrollee's condition and the proposed transplant protocol will be requested for review. The case manager will coordinate the review of the medical information for coverage determination and to determine whether the transplant is Medically Necessary. The case manager will communicate the determination to the Enrollee and transplant physician.

3. Definitions

a. **"Covered Transplant Procedures"** means any of the following human organ and tissue transplant procedures determined to be Medically Necessary:

(1) Heart

(2) Liver

(3) Bone Marrow (related or unrelated)

(4) Lung

(5) Kidney

(6) Cornea

(7) Simultaneous Pancreas/Kidney

(8) Simultaneous Heart/Lung

(9) Intestinal

(10) Simultaneous Intestinal/Liver

(11) Simultaneous Intestinal/Pancreas

b. **"Transplant Services"** means any services directly related to a Covered Transplant Procedure and performed at a Center Of Excellence including, but not limited to, inpatient and outpatient hospital services, physician services for diagnosis, treatment, and surgery for a Covered Transplant Procedure, diagnostic services, and procurement of an organ or tissue, including services provided to a living donor of an organ or tissue for procurement of an organ or tissue, as well as surgical, storage and transportation costs incurred and directly related to the successful acquisition of an organ or tissue used in a Covered Transplant Procedure. Transplant Services also includes, but is not limited to, durable medical equipment rental outside of the hospital, prescription drugs including immunosuppressive, surgical supplies and dressings, and home health care.

Note: Transportation and lodging are covered, as approved by the Plan, up to a $10,000 benefit limit per transplant. Unrelated donor searches for bone marrow/stem cell transplants for a Covered Transplant Procedure are covered, as approved by the Plan, up to a $30,000 benefit limit.

4. Specific Exclusions for Organ/Tissue Transplants

There are no benefits for:

a. Services and supplies of any provider located outside the United States of America, except for procurement services which will be limited to those nations which share the same protocols, standards and registry with the United States.

b. Services and supplies which are eligible to be repaid under any private or public research fund, whether or not such funding was applied for or received.

c. Implant of an artificial or mechanical heart or part thereof. This does not include replacement of a heart valve.

d. Services for non-human organ transplants.

e. All other exclusions, limitations or conditions set forth in this Health Plan shall apply to Transplant Services unless otherwise provided in this Transplant Services section.

B. Physician Services and Outpatient Services

Physician office and home visits.

Physical examinations as set forth in the Preventive Health Benefits Guidelines

Well baby care, including immunizations and infant screening tests, as set forth in the Preventive Health Benefits Guidelines.

Specialist care/consultation.

Pregnancy services including prenatal and postnatal care.

X-ray, lab, and diagnostic services.

Breast cancer screening Coverage includes:

a. One mammography for female Enrollees age 35 to 39;

b. One mammography per year for female Enrollees under age 40 who are considered "at risk." An Enrollee is considered "at risk" if she meets one of the following criteria:

(1) The Enrollee has a personal history of breast cancer;

(2) The Enrollee has a personal history of breast cancer that was proven benign by biopsy;

(3) The Enrollee's mother, sister, or daughter has had breast cancer; or

(4) The Enrollee is at least 30 years old and has not given birth.

c. One mammography per year for female Enrollees age 40 or older; and

d. Any additional mammography and ultra sound services that are Medically Necessary

Breast reconstruction and prosthesis following a mastectomy

Colorectal cancer screening Coverage includes:

1. Testing for Enrollees age 50 or older; and

2. Testing for Enrollees under age 50 that is considered at high risk for colorectal cancer according to the most recent published guidelines at the American Cancer Society.

Prostate cancer screening Coverage includes:

1. One screening per year for male Enrollees age 50 or older; and

2. One screening per year for male Enrollees under age 50 who are considered at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

Outpatient surgery (Requires Precertification)

Radiation therapy for the treatment of disease by x-ray, radium or radioactive isotopes (Requires Precertification)

Chemotherapy for the treatment of disease by chemical or biological antineoplastic agents (Requires Precertification)

Dialysis treatment for acute renal failure or chronic irreversible renal insufficiency for removing waste materials from the body. Dialysis requires Precertification. Please review the Schedule of Benefits for specific limits.

Respiratory inhalation therapy for the introduction of dry or moist gases and water vapor into the lungs.

Family planning, infertility screening, diagnostic testing, and counseling to determine infertility. Covered Benefits may include treatment or surgical procedures for infertility/fertility conditions. Please refer to the Schedule of Benefits.

Chiropractic and other manipulative services to treat structural imbalance or to remove nerve interference in connection with distortion, misalignment or sublaxation of or in the vertebral column. Chiropractic and other manipulative services are subject to an annual maximum.

Routine vision screening (Snellen eye chart) by Primary Care Physician during an office visit.

Routine hearing screening (Audiometric testing) by Primary Care Physician during an office visit.

Physical medicine therapies, which include the following:

> Physical therapy, hydrotherapy, heat or similar therapies, and therapies using physical agents or bio-mechanical and neuro-physiological methods. The therapies must be designed to relieve pain, restore function, and prevent disability following disease, injury, or loss of body part.
>
> Speech therapy for speech impairment resulting from disease, surgery or injury. Speech therapy does not include language training for educational, psychological or developmental speech delays. Benefits will not be provided for speech therapy provided by schools.
>
> Occupational therapy for the treatment of physically disabled Enrollees. The therapies must be designed to restore the Enrollee's ability to perform ordinary tasks of daily living.
>
> Note: The Health Plan covers a limited number of visits for physical medicine therapies. Please review the Schedule of Benefits for specific limits.

Immunizations as set forth in the Preventive Health Benefits Guidelines.

Cardiac rehabilitation, which is an individually prescribed exercise program for cardiac patients. Cardiac rehabilitation is designed for Enrollees who have had bypass surgery, stable angina pectoris, or acute myocardial infarction within the past twelve months. Home exercise programs, on-going conditioning and maintenance are not covered.

> Note: The Health Plan covers a limited number of visits for cardiac rehabilitation. Please review the Schedule of Benefits for specific limits.

Treatment for Autism Spectrum Disorder as prescribed by a Participating Physician in a treatment plan for the Enrollee. Treatment is subject to the same Coinsurance, Copayments and Deductibles as other primary health care services and benefits.

> Note: Exclusions and limitations contained elsewhere in the Health Plan do not apply to the treatment of Autism Spectrum Disorder.

C. Mental Illness and Substance Abuse. (Requires Precertification)

Inpatient, outpatient and physician office services for treatment of mental health disorders and substance abuse. Services covered include:

- Inpatient services
- Individual psychotherapy
- Psychological testing
- Family counseling to assist in diagnosis and treatment of Enrollee
- Convulsive therapy, including electroshock treatments and convulsive drug therapy
- Partial hospitalization/intensive outpatient therapy
- Outpatient services

Please review the Schedule of Benefits for specific limits.

D. Other Benefits and Services.

Ambulance Services; Local transportation by a vehicle designed, equipped and used only to transport the sick and injured. The following services, if Medically Necessary, are covered: (1) transportation from the home of the Enrollee, the scene of the accident or the scene of the medical emergency to a hospital, (2) transportation between hospitals, (3) transportation between a hospital and a Skilled Nursing Facility, and (4) transportation from a hospital or skilled nursing facility to the home of the Enrollee. Ambulance trips must be made to the closest local facility that can give Covered Services appropriate for the condition.

Emergency care services received at a hospital or other health care provider facility for an Emergency Accident or Emergency Illness.

Note: Benefits for emergency care services performed by Non-Participating Providers will be calculated by the greater of:

- The amount negotiated with Participating Providers for emergency care services;
- The amount for emergency care services as calculated elsewhere in this Agreement for Non-Participating Providers, but substituting cost sharing provisions applicable to a Participating Provider
- Applicable Medicare reimbursement

Allergy testing and treatment.

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Benefit under this Plan. Covered Benefits are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child.
- Breast reconstruction resulting from a mastectomy.
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Prescription drugs limited to those medicines requiring a prescription under federal law (Experimental or Investigational drugs are not included), insulin, and insulin syringes. The Health Plan does not provide Coverage for vitamins. The Health Plan will provide Coverage for pre-natal vitamins if pregnancy services and supplies are otherwise covered. The Health Plan may provide Coverage for other categories of drugs. Please refer to the Schedule of Benefits for specific exclusions.

Note: Coverage is provided for "off label drug treatment" to the extent required by Indiana law.

Medical supplies received during a primary or specialty care office visit or on an inpatient basis. The supplies must be primarily and customarily used to serve a medical purpose and generally not useful to an individual in the absence of an illness or injury.

Medical aids, including prosthetic devices, durable medical equipment, and orthotic appliances. Precertification is required for all rentals of medical aids and for purchases of medical aids that cost more than $200.

Covered Benefits for prosthetic devices are limited to the initial purchase, fitting, repair and replacement of fitted devices that replace body parts or perform bodily functions. Routine maintenance is not a Covered Benefit and charges for deluxe items are limited to the cost of standard items.

Covered Benefits for durable medical equipment are limited to the rental, repair and replacement of equipment that is appropriate for home use and manufactured mainly to treat the injured or ill. Routine maintenance is not a Covered Benefit and charges for deluxe items are limited to the cost of standard items.

Covered Benefits for orthotic appliances are limited to the initial purchase, fitting, repair, and replacement of braces, splints, and other appliances, used to support or restrain a weak or deformed part of the body. Covered Benefits do not include foot support devices, such as arch supports and corrective shoes (unless they are an integral part of a leg brace), and standard elastic stockings, garter belts, and other supplies not specifically made or fitted. Routine maintenance is not a Covered Benefit and charges for deluxe items are limited to the cost of standard items.

Diabetes treatment, supplies, equipment, and self-management training.

Eyeglasses after cataract surgery. Limited to one initial pair of eyeglasses after cataract surgery is performed.

Medical Food that is Medically Necessary and prescribed for an Enrollee by a physician for treatment of the Enrollee's Inherited Metabolic Disease.

Medical Services for treatment of victims of abuse.

Covered Benefits for Clinical Trials

Routine patient care costs that are covered:

- That payer would cover for a patient not enrolled in a clinical trial
- Services required for the provision of the investigational item or service
- Services needed for reasonable and necessary care arising from the provision of the investigational item or service.

Routine patient care costs that are not covered:

- Investigational item, device, or service, itself;
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

In order to be considered a Covered Benefit the following criteria must be met:

- A physician must determine and document that the member is appropriate for a clinical trial; and
- The member must meet the eligibility criteria of the trial.

- The trial must be:
    - Conducted for the prevention, detection or treatment of cancer or other life threatening disease or condition**; and is**
    - Federally funded; or
    - Sponsored by FDA; or
    - A drug trial exempt from Investigational New Drug (IND) requirements.

A trial is considered federally funded if it is approved and funded by one or more of these agencies:

- National Institutes of Health
- Centers for Disease Control
- Agency for Healthcare Research Quality
- Centers for Medicare and Medicaid Services
- Department of Defense
- Veterans Administration; or the
- Department of Energy.

E. Alternative Care Facilities. (Requires Precertification)

Skilled Nursing Facility (SNF).

Room and board.

Note: If the Enrollee chooses a private room, the Enrollee is responsible for paying any amount in excess of the Prevailing Rate for the average semi-private SNF room unless use of a private room is Medically Necessary or the SNF has only private rooms. In those cases the private room is covered subject to the same Deductible, Copayment and Coinsurance as a semi-private room.

Note: The Health Plan covers a limited number of days in a SNF. Please review the Schedule of Benefits for the specific limits.

Ancillary services including diagnostic services.

Home Health Care for home confined Enrollees referred to a home health care agency by a Participating Physician and approved by the Health Plan Medical Director. Covered Benefits are for non-custodial medical and nursing care. Home infusion therapy will be paid only if you obtain prior approval from our home infusion therapy administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy. Covered Benefits also include nutritional counseling.

Note: The Health Plan may cover a limited number of days of Home Health Care. Please review the Schedule of Benefits for any specific limits.

Hospice Care

Note: Requires a physician's statement of life expectancy less than 6 months.

F. Acute Inpatient Rehabilitation Facility. (Requires Precertification)

Note: To be eligible for Acute Inpatient Rehabilitation Services, an Enrollee must be able to participate in a comprehensive level of rehabilitation services. The services will include a minimum of three hours of therapy treatments per day with goals that can be accomplished through hospitalization. These services must happen immediately following inpatient hospital services.

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Note: The Health Plan covers a limited number of days in an Acute Inpatient Rehabilitation Facility. Please review the Schedule of Benefits for specific limits.

G. Long Term Acute Care Hospital (LTACH) Services (Requires Precertification)

Note: The Health Plan covers a limited number of days for LTACH Services. Please review the Schedule of Benefits for specific limits.

H. Preventive Health Services

The Health Plan provides Coverage for well-baby care, regular periodic health evaluations for adults and children, periodic health screenings, and routine immunizations appropriate to the age and sex of the Enrollee. All of the preventive health services are described in the Preventative Health Benefits Guidelines, which SIHO makes available to Enrollees.

I. Treatment of Dental Conditions Caused by Accidental Injuries

The Health Plan provides Coverage for the treatment of dental conditions caused by accidental injuries. The injuries must have occurred after the effective date of the Enrollee's Coverage. Benefits will be denied if the dental condition was not caused by an accidental injury. Enrollees must report the date of the accident and may be asked to supply other information about the accident before accidental dental benefits will be provided. Covered Benefits do not include damage to teeth or gums resulting from chewing or biting in the normal course of day-to-day activity

.**Note:** The Health Plan provides an annual maximum of $3,000 dollars for the treatment of dental conditions for the repair of fractures, dislocations, and other

injuries of the mouth and jaw as related to Dental Conditions Caused by Accidental Injury.

J. Temporomandibular Joint Disorder

The Health Plan provides Coverage for Temporomandibular Joint Disorder (TMJ) if medically necessary.

K. Pediatric Vision Essential Benefit

The Health Plan provides Coverage for pediatric vision as mandated under the ACA. Pediatric vision benefits are provided until the Child attains age 19. Refer to Attachment C for the schedule of benefits.

V. EXCLUSIONS AND LIMITATIONS ON BENEFITS

A. Exclusions

SIHO's obligations under this Agreement are subject to the following exclusions. (Note: these exclusions do not apply to the treatment of Autism Spectrum Disorder, as prescribed by a Participating Physician in a treatment plan for the Enrollee.)

1. Institutional care in a hospital or other facility primarily for domiciliary, convalescent or Custodial Care purposes.

2. Court ordered services unless Medically Necessary and approved by the Health Plan Medical Director.

3. Personal comfort items such as televisions, telephones, private rooms, housekeeping services, meals or special diets, except as specifically provided in this Agreement.

4. Medical Care to treat injury or sickness caused by or related to an act of declared or undeclared war; serving in the military forces of any country, which includes serving in a non-military unit that supports such forces; the Enrollee’s committing, attempting to commit, or participating in a civil battery, illegal act, or any other crime; and taking part in a riot.

5. Medical Care for disabilities related to military service if the Enrollee is legally entitled to receive services from the Veterans Administration and adequate facilities are reasonably available to the Enrollee in SIHO's Service Area.

6. Care for conditions for which state or local law requires treatment in a public facility.

7. Hospital admission from Friday 8:00 p.m. through Monday 12:01 a.m. unless surgery is performed on that day or because of an Emergency Accident or Illness.

8. Cosmetic or plastic surgery primarily intended to improve appearance. Benefits are provided for care or treatment intended to restore bodily function or correct a deformity that results from disease, accidental injury, birth defects, or medical procedures. The medical procedure must have been a Covered Benefit. The Health Plan covers reconstructive surgery as required under the Women's Health and Cancer Rights Act of 1998.

9. Sclerotherapy, for the treatment of varicose veins of the extremities.

10. Services and supplies rendered to treat hair loss or to promote hair growth, including but not limited to hair transplants and wigs, except as mandated under the Affordable Care Act.

11. Medical, surgical or other health care procedures deemed Experimental or Investigational by the Health Plan.

12. Organ transplants deemed Experimental by the Health Plan.

13. Medical Care rendered on behalf of a donor or prospective donor when the recipient of an organ transplant is not a Health Plan Enrollee.

14. Care for mental illness, alcoholism, and drug addiction, except as provided in this Agreement.

15. Developmental treatment and education for mental retardation and mental deficiency to the extent not Medically Necessary.

16. Routine eye examinations or refraction for eyeglasses or contact lenses and furnishing, fitting, installation or use of eyeglasses or contact lenses except those pediatric essential vision benefits described in Article IV.

17. Radial keratotomy, corneal modulation, refractive keratoplasty, or any similar procedure.

18. Furnishing, fitting, installation or use of hearing aids. Surgical implantation and cochlear stimulating devices.

19. Routine injection of drugs and immunizations, except as otherwise provided in this Agreement.

20. Transportation services, unless Medically Necessary and authorized by SIHO or necessitated by an Emergency Accident or Emergency Illness.

21. Dental or oral surgical services or devices for teeth and gums. Covered Benefits include, however, oral surgical procedures related to the following: (a) excision of tumors and cysts of the jaw and mouth; (b) repair of fractures, dislocations, and other injuries of the mouth and jaw, as described in Article IV under the heading "Treatment of Dental Conditions Caused by Accidental Injuries "; (c) treatment of oral and facial cancer; (d) external incisions and drainage of cellulitis; (e) incision of accessory sinuses, salivary glands and ducts; (f) repair and treatment of congenital defects and birth abnormalities including dental treatment involved in the management of birth defects known as cleft lip and cleft palate. Covered Benefits also include anesthesia and hospital services for dental care for an Enrollee whose mental or physical condition requires dental treatment to be rendered in a hospital or an ambulatory outpatient surgical center.

22. Over-the-counter medications, except for those for which the Enrollee has a prescription and for which coverage is required under the ACA.

23. The cost of durable medical equipment, except as provided in this Agreement.

24. The cost of prosthetic devices except as provided in this Agreement.

25. The cost of medical supplies except as provided in this Agreement.

26. Transsexual surgery and related services, except in those instances when Medically Necessary due to congenital defects.

27. Reversal of voluntary sterilization.

28. Genetic counseling.

29. Sex therapy and counseling.

30. Vocational rehabilitation.

31. Family or marriage counseling.

32. Blood tests required in order to obtain a marriage license.

33. Diagnosis and treatment of:

    a. weak, strained, unstable or flat feet which includes supportive devices for the feet such as corrective shoes and arch supports; or

    b. any tarsalgia, metatarsalgia or bunion; except for surgeries which involve the exposure of bones, tendons or ligaments; or

    c. trimming of corns, calluses, or nails, other than the removal of nail matrix or roots; or

d. superficial lesions of the feet, such as corns, calluses and hyperkeratoses.

Note: Treatment will be provided to Enrollees with neurovascular conditions or diabetes to prevent foot ulcerations.

34. Acupuncture, biofeedback, hypnotherapy, sleep therapy, and behavioral training.

35. Chiropractic or manipulative services except as provided in this Agreement.

36. Speech therapy, except as provided for in this Agreement.

37. Expenses resulting from or relating to premarital exams, infertility or impotency, except as otherwise provided in the Agreement.

38. Surgical procedures performed for the purpose of correcting myopia, (nearsightedness), hyperopia (farsightedness), astigmatism and expenses related to such procedures.

39. Biomicroscopy, field charting, aniseikonic investigation, orthoptic or visual training.

40. Drugs considered Experimental or Investigational.

41. Health exams except those resulting from an accidental injury or sickness and those covered under the Preventive Health Benefits Guidelines.

42. Medical care which SIHO determines is not Medically Necessary or does not meet its medical or benefit policy guidelines.

43. Medical care required while incarcerated in a penal institution or while in custody of law enforcement authorities.

44. Charges arising out of or in the course of any employment or occupation for wage or profit if benefits are available under any Workers Compensation Act or similar law. If Workers Compensation Act benefits are not available then this Exclusion does not apply.

45. Charges in excess of SIHO's Prevailing Rates.

46. Medical care received in an emergency room which is not related to an Emergency Accident or Emergency Illness, except as specified elsewhere in this Agreement.

47. Medical costs associated with artificial or mechanical hearts and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the devices remain in place. This exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

48. Supplies, devices or medications with over the counter equivalents and any supplies, devices, or medications that are therapeutically comparable to an over the counter supply, device, or medication.

49. Human organ and tissue transplants performed by a provider not affiliated with a SIHO approved Center of Excellence.

50. Charges incurred outside the United States (a) if the Enrollee traveled to a location outside of the United States for the primary purpose of obtaining medical services, drugs or supplies or (b) if the drugs or supplies were delivered to the Enrollee from a location outside of the United States.

51. Charges arising out of any Never Events or other conditions acquired during a stay at an Institutional Health Care Provider, that are present at discharge.

52. Complications directly related to a service or treatment that is determined to be Experimental/Investigational or non-Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non-Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non-Medically Necessary service.

53. Massage Therapy care and treatment whether or not performed by a massage therapist unless part of a physical treatment plan.

54. For any services or supplies provided to a person, whether covered under this Plan or not, in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

55. Abortion services, supplies, care or treatment unless the life of the mother is endangered by the continued pregnancy or the pregnancy is the result of rape or incest.

56. [Treatment for weight loss, including but not limited to gastric bypass; gastric stapling or balloon catheterization; liposuction or reconstructive surgery; diet, health or exercise programs; health club dues; weight reduction medications; or weight reduction clinics. Nonexperimental, surgical treatment of Morbid Obesity is covered to the extent required by law. Please review Article IV for a description of Coverage provided for treatment of Morbid Obesity.]

B. Limitations.

The rights of Enrollees and obligations of SIHO and Participating Providers are subject to the following limitations:

1. Circumstances Beyond Health Plan's Control. Neither SIHO nor any Participating Provider will be responsible for providing Covered Benefits if circumstances outside SIHO's control render the provision of Covered Benefits impracticable. These circumstances include, but are not limited to, unplanned computer system or power outages, labor unrest, complete or partial destruction of facilities, major disaster, epidemic, war, riot, civil insurrection, disability of a significant part of Participating Provider's personnel, or similar causes. SIHO will make a good faith effort to arrange for alternative methods to provide the Covered Benefits.

2. Refusal of Treatment. Certain Enrollees may, for personal reasons, refuse to accept procedures or treatment recommended by Participating Providers. A Participating Provider may regard Enrollee's refusal as incompatible with continuing the provider-patient relationship and an obstruction of proper Medical Care. If an Enrollee refuses to accept treatment or procedures recommended by a Participating Provider, the Enrollee may consult with another Participating Provider of his or her choosing. If, after having adequate time to consider treatment alternatives, the Enrollee refuses to accept that Participating Provider's recommended course of treatment or procedures and both the Participating Providers and SIHO believe that no medically acceptable alternative exists, the Enrollee will be so advised. If the Enrollee still refuses to accept a recommended treatment or procedure, then neither the Participating Providers nor SIHO will have further responsibility to provide or arrange for treatment of the condition. This provision does not affect the Health Plan's obligation to provide Coverage for medically acceptable treatments for the condition otherwise covered by the Health Plan.

3. Medical Non-Compliance It is expected that the Enrollee will follow the advice of the Provider rendering or arranging services. If the Enrollee is receiving health services in a harmful or abusive quantity or manner or with harmful frequency, as determined by SIHO, the Enrollee may be required to select a single Participating Physician and a single Participating Hospital (with which the single Participating Physician is affiliated) to provide and coordinate all future health services. If the Enrollee fails to make the required selection of a Participating Physician and a single Participating Hospital within thirty-one (31) days of written notice of the need to do so, then SIHO shall designate the required single Participating Physician and Participating Hospital for the Enrollee. In the case of a medical condition which, as determined by SIHO, either requires or could benefit from special services, the Enrollee may be required to receive covered health services through a single Participating Provider designated by SIHO. Following selection or designation of a single Participating Provider, coverage is contingent upon all health services being provided by or through written referral of the designated Participating Provider.

4. Failure to Render Services. If a Participating Provider fails to or is unable to render Medical Care to an Enrollee, SIHO will arrange for another Participating Provider to provide the Medical Care.

VI. OTHER PARTY LIABILITY

A. Subrogation.

If SIHO provides benefits under this Agreement for an illness or injury caused by a third party's alleged wrongdoing and the Enrollee recovers on a claim against the third party, SIHO has a right to be reimbursed for the reasonable cash value of the benefits provided. If the Enrollee does not recover the full value of his claim, SIHO will be reimbursed out of the recovery on a pro rata basis. SIHO may take whatever legal action it sees fit against the third party to recover any benefits provided under this Agreement. SIHO's exercise of this right will not affect the Enrollee's right to pursue other forms of recovery, unless the Enrollee or his legal representative consents otherwise.

SIHO has the right to the Enrollee's full cooperation in any case involving the alleged wrongdoing of a third party. The Enrollee is obligated to provide SIHO with whatever information, assistance, and records SIHO needs to enforce its rights under this provision, including, but not limited to, any consents, releases, and assignments.

B. Coordination of the Agreement's Benefits with other Benefits (COB).

1. Applicability.

This Coordination of Benefits ("COB") section applies when an Enrollee has health care coverage under more than one "Plan," as defined below. The Order of Benefit Rules in Subsection 3 determines whether the benefits of this Health Plan are determined before or after those of another Plan. If the Order of Benefit Rules determines that this Health Plan is the "Primary Plan," as defined below, then the benefits of this Health Plan will not be reduced. If the Order of Benefit Rules determines that this Health Plan is the "Secondary Plan," as defined below, then the benefits of this Health Plan may be reduced.

2. Definitions.

The following definitions apply throughout this Article VI, Section B, but do not apply to the rest of this Agreement:

a. **"Allowable Expense"** means a necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more Plans covering the individual for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is Medically Necessary. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. When benefits are reduced under a Primary Plan because a covered individual does not comply with the plan

provisions, the amount of the reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

b. **"Claim Determination Period"** means a calendar year. However, it does not include any part of a year during which an individual does not have Coverage under this Health Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

c. **"Plan"** means this Health Plan and any of the following arrangements that provide benefits or services for, or because of, medical or dental care or treatment:

(1) Employer insurance or Employer-type coverage, whether insured or uninsured. This includes prepayment, Employer practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

(3) Coverage under an individual health or HMO policy, excluding accident only, specified disease, limited benefit plan, fixed indemnity, or Medicare supplement plans.

(4) The medical benefits coverage in group, group-type, and individual automobile "no-fault" and traditional "fault" type contracts.

(5) Any other coverage which, as defined by the Employee Retirement Income Security Act of 1974, is a union welfare plan, an employee organization plan, a labor management trustee plan, or an employee benefit organization.

(6) Medical care components of long term care contracts, such as skilled nursing care.

(7) Any other coverage provided because of membership in or sponsorship by any other union, association, or similar organization.

Each arrangement described above is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

d. **"Plan Year"** means, for the initial Plan Year, the twelve-month period commencing with the date that Employer's coverage under this Health Plan becomes effective. Thereafter, it means the twelve-month period commencing on the anniversary of Employer's Coverage under this Health Plan.

e. **"Primary"** or **"Primary Plan"** means the Plan that provides benefits for an individual before another Plan that covers the same individual. If this Health Plan is Primary to another Plan, this Health Plan's benefits will be determined before those of the other Plan without considering the other Plan's benefits.

f. **"Secondary"** or **"Secondary Plan"** means the Plan that provides benefits for an individual after another Plan that covers the same individual. If this Health Plan is Secondary to another Plan, this Health Plan's benefits will be determined after those of the other Plan and may be reduced as a result of benefits provided by the other Plan.

3. Order of Benefit Rules.

a. General. If there is a basis for benefits under this Health Plan and another Plan, this Health Plan is the Secondary Plan unless (1) the other Plan has rules coordinating its benefits with those of this Health Plan, and (2) the rules of this Health Plan and the other Plan require this Health Plan to be the Primary Plan.

b. Specific Rules. The following rules will be applied in the order they appear to determine whether this Health Plan is Primary or Secondary to another Plan:

(1) Non-Dependent/Dependent. The Plan that covers the individual as an active employee or inactive employee (i.e., laid-off or retired) rather than as a dependent is the Primary Plan except in the following situation. The Plan that covers the individual as a dependent is Primary to the Plan that covers the individual as an employee if the individual is also a Medicare beneficiary, and, as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is Secondary to the Plan covering the individual as a dependent and Primary to the Plan covering the individual as an employee.

(2) Medicare Election. For Medicare eligible individuals, the order of benefits and benefits paid will be determined presuming the eligible individual has enrolled in both Medicare Part A and Medicare Part B, irrespective of whether the individual has in fact enrolled in both parts. This provision does not apply if Medicare

coverage is Secondary to this Plan based on the size of the Employer Group.

(3) Dependent Child/Parents not Separated or Divorced. If two Plans cover the same child as a dependent of his parents, the Plan of the parent whose birthday falls earlier in a calendar year will be Primary. If both parents have the same birthday, then the Plan that has covered one parent longer will be the Primary Plan. However, if the other Plan has a rule based on gender instead of this birthday rule and, as a result, the Plans do not agree on the order of benefits, then the rule in the other Plan will determine the order of benefits.

(4) Dependent Child/Separated or Divorced. If two or more Plans cover the same child as a dependent of divorced or separated parents the following rules apply unless a qualified medical child support order ("QMCSO"), as defined in ERISA, specifies otherwise:

(a) the Plan of the parent with custody of the Child is Primary;

(b) the Plan of the spouse of the parent with custody of the child is the next Plan to be Primary; and

(c) the Plan of the parent without custody of the child is the last Plan to be Primary.

If a QMCSO states that a parent is responsible for the health care expense of a child, that parent's Plan is Primary as long as the administrator of the Plan has actual knowledge of the QMCSO. The plan of the other parent is the Secondary Plan. Until the plan administrator has actual knowledge of the QMCSO, then the rules stated in (a), (b), and (c) above apply for any Claim Determination Period or Plan Year during which benefits are paid or provided.

(5) Joint Custody. If a court order states that a child's parents have joint custody of the child but does not specify that one parent is responsible for the health care expenses of the child, the order of benefit rules in Paragraph b(3), Dependent Child/Parents not Separated or Divorced will apply.

(6) Active/Inactive Employee. A Plan that covers an individual as an active employee is Primary to a Plan that covers the individual as an inactive employee (i.e., laid-off or retired). This rule will be ignored if the other Plan does not have this rule and, as a result, the Plans do not agree on the order of benefits.

(7) Dependent of Active/Inactive Employee. A Plan that covers an individual as a dependent of an active employee is Primary to a Plan that covers an individual as a dependent of an inactive employee (i.e., laid-off or retired). This rule will be ignored if the other Plan does not have this rule and, as a result, the Plans do not agree on the order of benefits.

(8) Continuation Coverage. If an individual has Continuation Coverage under this Health Plan and also has coverage under another Plan as an employee or dependent, the other Plan is Primary to this Health Plan. This rule will be ignored if the other Plan does not have this rule and, as a result, the Plans do not agree on the order of benefits.

(9) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that has covered the individual longer will be Primary to the Plan that has covered the individual for a shorter term.

4. Effect on the Benefits of this Agreement.

a. Application. This Subsection 4 applies when the Order of Benefit Rules above determine that this Health Plan is Secondary to one or more other Plans.

b. Reduction of Health Plan's Benefits. This Health Plan's benefits will be reduced when the sum of (1) and (2) below exceeds the Allowable Expenses in a Claim Determination Period:

(1) The benefits that would be payable for the Allowable Expenses under this Health Plan in the absence of this COB provision; and

(2) The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of COB provisions like this Health Plan's COB provisions, whether or not a claim is made.

The benefits of this Health Plan will be reduced so that they and the benefits payable under the other Plans do not exceed the Allowable Expenses. Each benefit will be proportionally reduced and then charged against any applicable benefit limit of this Health Plan.

5. Facility of Payment.

If another Plan provides a benefit that should have been paid or provided under this Health Plan, SIHO may reimburse the Plan for the benefit. SIHO may then treat the amount as if it were a benefit provided under this Agreement and will not be responsible for providing that benefit again. This provision applies to the

payment of benefits as well as to providing services. If services are provided, then SIHO will reimburse the other Plan for the reasonable cash value of those services.

6. Right of Recovery.

If this Health Plan provides a benefit that exceeds the amount of benefit it should have provided under the terms of these COB provisions, SIHO may seek to recover the excess of the amount paid or the reasonable cash value of services provided from the following:

a. The individuals SIHO has paid or for whom SIHO has provided the benefit;

b. Insurance Companies; or

c. Other Organizations.

C. Worker's Compensation.

If an Enrollee is entitled to a benefit under this Health Plan that is also covered by workers' compensation laws, occupational disease laws, or other similar laws, then the benefit provided by this Health Plan will be reduced by the amounts payable under the other laws. This Health Plan will not provide benefits for services denied by the worker's compensation or other similar carrier due to the Enrollee's noncompliance with that carrier's policies, procedures, or medical provider's recommended treatment plan.

D. Right of Recovery.

If SIHO provides a benefit that, according to the terms of this Agreement, should not have been provided, SIHO may recover the reasonable cash value of the benefit provided or payment made from the recipient or other appropriate party. SIHO may recover under this Section, even if the benefit provided was the result of SIHO's error. If SIHO makes an incorrect payment to an Enrollee, SIHO may deduct the payment from future payments to be made to or on the behalf of the Enrollee.

E. Releasing or Obtaining Information.

Unless otherwise required by law, SIHO may release to or obtain from any other company, organization, or individual any information that SIHO deems necessary to apply this Article without obtaining the consent of or providing notice to the individuals involved. Any individual claiming benefits under this Health Plan must furnish SIHO with all of the information that SIHO deems necessary to implement the provisions of this Article VI.

VII. RELATIONS AMONG PARTIES AFFECTED BY THIS AGREEMENT

A. Health Plan and Participating, Consulting and Non-Participating Providers.

Participating Providers and Consulting Providers are independent contractors with respect to SIHO and the Health Plan. They are not employees or agents of SIHO. Non-Participating Providers do not have any contractual relationship with SIHO. They are not independent contractors, employees or agents of SIHO. SIHO is not liable for any act, error or omission of any Participating Provider, Consulting Provider, Non-Participating Provider, or any employee or agent thereof. Without limiting the foregoing, it is expressly understood and agreed that neither SIHO nor the Health Plan is engaged in the practice of medicine by virtue of providing for the payment of benefits hereunder, and all medical decisions are made solely by Enrollees and their medical providers.

VIII. ENROLLMENT FEES

A. Enrollment Fees.

Enrollee will pay SIHO the enrollment fees set forth in the Declarations. An Enrollee is not entitled to Coverage until SIHO receives an initial Enrollment Fee for the Enrollee. Thereafter, an Enrollee's Coverage will terminate if SIHO does not receive the monthly enrollment fee for the Enrollee by the time specified in the Declarations. If an Enrollee's Coverage is terminated for non-payment of the Enrollment Fee, the Coverage may be reinstated in accordance with the renewal application and re-enrollment provisions of this Agreement.

B. Grace Period.

1. Enrollees will have a grace period of 90 days to pay their premiums for coverage, provided that the first month's premiums are paid timely. If the first month's premiums are paid, and subsequent month's premiums are not paid timely, claims incurred in those months will be held until the premiums are paid. If premiums are not paid for 90 days, coverage will be cancelled.

C. Other Charges.

Enrollees will be required to pay Copayments, Deductibles and Coinsurance for services in the amounts indicated in the Schedule of Benefits.

D. Change in Benefits.

SIHO reserves the right to increase the benefits provided by the Health Plan without Employer's express written consent as long as the increase in benefits does not increase Employer's enrollment fees during the contract period. SIHO will notify Employer of any increase in benefits.

IX. TERMINATION OF BENEFITS

A. Termination of Benefits.

1. Loss of Eligibility.

   If an Enrollee ceases to meet the eligibility requirements of Article II, then (subject to the continuation of coverage provisions of Article X), Coverage under this Agreement for the Enrollee terminates automatically at midnight of the last day of the billing period during which SIHO receives notice of the termination. Enrollee must notify SIHO immediately if the Enrollee ceases to meet the eligibility requirements.

2. Disenrollment.

   If a Participant enrolls in an Alternative Health Benefits Plan or other benefit plan for health coverage offered through Employer, then Coverage for the Participant and Participant's Dependent(s) will terminate automatically at midnight of the last day of the billing period during which SIHO receives notice of the termination.

3. Failure to Furnish or Furnishing Incorrect or Incomplete Information.

   To enroll in the Health Plan, each Enrollee must represent to the best of his knowledge and belief that all information provided SIHO in the enrollment applications, questionnaires, forms or statements for himself and his Dependents is true, correct and complete. If an Enrollee fails to furnish SIHO with information required under this Agreement or furnishes SIHO with false or misleading information, SIHO may (1) revise the enrollment fees to the amount that SIHO would have charged had it been provided complete and accurate enrollment information and (2) if the Enrollee refuses to pay the revised rate, SIHO will pursue all legal means available to collect the owed and unpaid premium. If an Enrollee's failure to furnish SIHO with information required under this Agreement or the furnishing of false or misleading information is determined to be fraudulent or intentional misrepresentation of material fact, SIHO may also terminate all rights and benefits provided to the Enrollee and his Dependents under the Health Plan retroactive to the date the Enrollee failed to furnish the information or furnished false or misleading information. The Enrollee will be responsible for reimbursing SIHO for its cost of any benefits provided after the effective date of the termination. SIHO's costs will be based on the Prevailing Rates charged for the services in the community less any Copayments or enrollment fees paid by the Enrollee and his Dependents. SIHO will notify the Enrollee in the event SIHO terminates Coverage for the Enrollee and/or his Dependents under this Subsection.

4. Misuse of Identification Card.

Participant shall not permit another individual to use the Participant's or his Dependent's Health Plan identification card to obtain services, nor shall the Participant use an invalid identification card to obtain services. If Participant violates this provision, SIHO will terminate the Coverage of the Participant and his Dependents effective immediately upon written notice to the Participant. Any Participant involved in the misuse of a Health Plan identification card will be liable to SIHO for the Prevailing Rates of any services rendered in connection with the misuse. If a Participant's card is lost or stolen, contact SIHO immediately to obtain a new card. SIHO reserves the right to charge a fee for any replacement card.

5. Nonpayment.

If a Participant fails to pay or make satisfactory arrangements to pay SIHO or any Participating Providers any amounts due under this Agreement, including any Copayments, SIHO may terminate the Coverage of the Participant and his Dependents effective immediately upon SIHO's written notice to Participant.

6. Termination of Agreement.

If this Agreement is terminated, then the rights of all Enrollees (except any rights to continuation of benefits specifically provided by this Agreement) will terminate on the termination date of the Agreement. Notwithstanding the termination for any of the reasons described in this Section IX.A., payments for enrollment fees or other amounts due to SIHO are due for the full month during which the termination occurred without pro-rata adjustment.

B. Cancellation.

This Agreement will continue in effect for the term indicated in the Declarations subject to the following:

1. Default in Payment.

Enrollee will have a grace period of 90days to pay SIHO any enrollment fees due under the Agreement after the due date of the enrollment fees. If Enrollee fails to pay SIHO the enrollment fees by the due date or within 90 days thereafter, all benefits provided under the Health Plan will terminate at the end of the period for which the enrollment fees have been paid. SIHO may deem Enrollee's failure to pay the enrollment fees as an action by Enrollee to cancel this Agreement and will notify Enrollee of the effective date that this Agreement is canceled. If Enrollee receives services under this Agreement during the 90-day grace period and cancellation follows, the Enrollee will be liable to SIHO for the Prevailing Rates, less any Copayments made, for any services provided during that 90-day grace period. SIHO may hold Claims incurred and received within the grace period until premiums are received before the end of the grace period.

2. Fraud.

If Enrollee performs an act or practice that constitutes fraud or an intentional misrepresentation of a material fact in connection with any Coverage under the Health Plan, SIHO may terminate all rights and benefits provided to Enrollees under the Health Plan. SIHO will notify Enrollees of the effective date of the Agreement's cancellation for fraud and will return any unused enrollment fees. Notwithstanding the termination for any of the reasons described in this Section IX.B.2., payments for enrollment fees or other amounts due to SIHO are due for the full month during which the termination occurred without pro-rata adjustment.

3. Violation of Participation Rules and Participants' Movement Outside Service Area.

In accordance with the Health Insurance Portability and Accountability Act of 1996, SIHO may terminate all rights and benefits hereunder if Enrollee fails to comply with a material Agreement provision relating to the participation of Enrollees in this Agreement or if no Enrollees live, reside or work in the Service Area.

4. Discontinuance of Product.

SIHO reserves the right to discontinue offering this Health Plan in this market. If SIHO discontinues the Health Plan, SIHO will notify Enrollees in writing at least 90 days before the discontinuance and will provide Enrollee with the option to choose coverage under an alternative health care delivery product offered by SIHO in this market.

5. Discontinuance of Health Care Coverage in Market.

SIHO reserves the right to discontinue offering all health care coverage in this market. If SIHO discontinues all health care coverage, SIHO will notify Enrollees in writing at least 180 days before the discontinuance.

C. Reinstatement.

1. Enrollee.

To reinstate Coverage after termination, an Enrollee must complete a reinstatement application unless termination resulted from inadvertent clerical error. No Enrollee's Coverage shall be adversely affected due to SIHO's clerical error.

D. Continuation of Coverage After Termination by Health Plan.

Upon termination of this Health Plan, inpatient Covered Benefits provided by a hospital for an Enrollee who is hospitalized on the effective date of termination will continue until the earliest of:

1. The date the Enrollee is discharged from the Hospital;

2. The passage of 60 days after the effective date of termination;

3. The date the Enrollee acquires health care coverage from another carrier that includes the coverage provided under the Health Plan;

4. The date SIHO terminates the Enrollee's Coverage because the Enrollee knowingly provided false information to SIHO, the Enrollee failed to comply with the terms of this Agreement, or the Employer failed to pay an enrollment fee;

5. The date the Enrollee terminates Coverage.

The provisions of this Section D do not apply to the termination of Coverage as a result of the receivership of SIHO.

X. RECORDS

SIHO will keep enrollment and eligibility records of each Enrollee. Enrollee must send SIHO information, in the form requested by SIHO, reflecting any changes in an Enrollee's enrollment or eligibility by the due date for the applicable monthly enrollment fee. SIHO is not liable under this Agreement in connection with any enrollment or eligibility changes until SIHO receives accurate information about the changes. If Enrollee supplies SIHO with incorrect or incomplete information, SIHO will not be liable in connection with the information until SIHO receives correct and complete information. Enrollee and SIHO will take appropriate action to prevent SIHO from incurring any financial loss as a result of incorrect or incomplete information supplied by an Enrollee. If SIHO incurs a financial loss as a result of such incorrect or incomplete information, then SIHO has the right to seek reimbursement for the loss from the Enrollee.

SIHO will comply with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and it's implementing regulations applicable to SIHO in handling health information protected by HIPAA. SIHO will not use or disclose an Enrollee's health information without authorization, except to the extent permitted or required under HIPAA. SIHO will not disclose health information protected by HIPAA to the Employer except to the extent required or permitted by law or authorized by the Enrollee.

XI. PROCEDURES FOR CLAIMING BENEFITS

A. Claim Filing.

If an Enrollee receives a bill directly from a provider, is required to pay for services at the time they are provided, or assigns his or her right to reimbursement to a provider with the consent of SIHO, the Claim may be submitted to SIHO for payment. In order to be

eligible for payment, the Claim must be submitted with receipts within 90 days of the date the services were rendered or, in the case of a Consulting or Participating Provider, within the timeframe for submitting claims set forth in the provider agreement in effect between the Consulting or Participating Provider and SIHO. Non-Participating Providers must submit claims to SIHO within 90 days of the date services were provided to be eligible for payment. If SIHO approves the Claim, SIHO will reimburse the Enrollee or provider, as appropriate, for Covered Benefits less any applicable Copayments, Deductible, Coinsurance, penalty, and any amounts that SIHO has already paid to the Enrollee or the provider prior to receiving the Claim. The Claim should describe the occurrence, character, and extent of the Medical Care provided by the provider. Notwithstanding anything herein to the contrary, Enrollees may not assign any claims or other rights to receive Benefits hereunder to any Non-Participating Provider without the prior approval of SIHO. In the absence of such prior approval, SIHO reserves the right to pay Claims or other Benefits directly to the Enrollee, and such payment shall fully discharge SIHO's obligation under this Agreement with respect to such Claims or other Benefits. In such a case, the Enrollee is responsible for all payments that may be due to the Non-Participating Provider.

1. Claim Forms. Submission of claims by an Enrollee must be accompanied by a claim form. These forms can be obtained from SIHO via mail, email or website.

B. Claim Determination.

1. Pre-Service Claims. With respect to a Pre-Service Claim, SIHO will notify the claimant of its decision within 15 days of receipt of the Claim.

    a. This 15-day period may be extended for an additional 10 days if SIHO determines that an extension is necessary due to matters beyond the Health Plan's control and notifies the claimant of the circumstances requiring the extension of time and the date by which SIHO expects to render a decision.

    b. If an extension is necessary because the claimant has not submitted information necessary to decide the Claim, SIHO will provide the claimant with a notice of extension which will specifically describe the additional information required. If the extension is necessary because the Claim does not properly identify the individual requesting a benefit, specify the medical condition or symptom, and the specific treatment, service, or product for which approval is requested, SIHO will provide the notice of extension and an explanation of the proper procedures to be followed in filing a Claim. Any notice of extension may be oral, unless the claimant requests a notice in writing. The claimant will have at least 45 days to provide any requested information.

2. Precertification of Urgent Care Claims. In the case of a request for Precertification of an Urgent Care Claim, SIHO will notify the claimant of its determination by the

earlier of seventy-two hours or two business days after its receipt of the request and all information necessary to make a determination.

If the claimant has not provided sufficient information for SIHO to determine the request for Precertification of an Urgent Care Claim, SIHO will notify the claimant within 24 hours after receiving the request of the specific information that must be submitted for SIHO to complete the processing of the Claim. The claimant will have at least 48 hours in which to provide the additional information. SIHO will notify the claimant of its decision within 24 hours after it receives the additional information, or, if the claimant does not provide the requested information, 24 hours after the end of the period of time that the claimant was given to provide the information.

3. Concurrent Care Claims. With respect to a Concurrent Care Claim, if SIHO reduces or terminates benefits for a course of treatment (for reasons other than amendment or termination of the Health Plan) before the end of the period of time or number of treatments, the claimant must be notified sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of SIHO's decision before it becomes effective. The claimant may request the Health Plan to extend the course of treatment beyond the already approved time or number of treatments. SIHO will notify the claimant of its decision within 24 hours of its receipt of the request, provided that the claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, and within 72 hours of its receipt if the request is received less than 24 hours prior to the expiration of the prescribed period or number of treatments.

C. Grievances.

An Enrollee may initiate a Grievance procedure by contacting us verbally or in writing. Enrollees have the right to appoint a Designated Representative to act on their behalf with respect to the Grievance by filing a signed form that may be obtained from SIHO upon request; provided, that if a provider files a Grievance relating to precertification of an Urgent Care Claim, then SIHO will treat such provider as a Designated Representative with respect to that matter even without the submission of a signed form.

SIHO will accept oral or written comments, documents or other information relating to the Grievance from the Enrollee or his/her Designated Representative by telephone, mail or other reasonable means. Enrollees are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Grievance.

Enrollees may obtain information regarding SIHO’s Grievance procedures by calling the toll-free number on the back of the Enrollee’s identification card during normal business hours.

Once a Grievance has been initiated by an Enrollee, SIHO will respond within 3 business days to acknowledge its receipt of the Grievance. Such response will be in writing, unless the Grievance was received orally, in which case the response may be oral. Grievances will be resolved within 20 business days after they are filed if all information needed to complete a review is available. If additional information is needed and the Grievance does not involve Precertification matters, SIHO may notify you before the 19th business day of its election to take an additional 10 business days to receive information and address the Grievance.

If an Enrollee's Grievance is denied in whole or in part, SIHO will notify the claimant, in writing or electronically, and the notice will include the following:

1. the specific reason or reasons for the denial;

2. reference to specific Health Plan provisions on which the denial is based;

3. a description of any internal rule, guideline, protocol or similar criterion relied on in making the adverse determination (or a statement that the information will be provided free of charge upon request);

4. an explanation of any scientific or clinical judgment on which the denial is based (or a statement that the explanation will be provided free of charge upon request);

5. a description of any additional material or information that the claimant may need to provide with an explanation as to why the material or information is necessary;

6. an explanation of the claimant's right to appeal under the Health Plan's appeal procedures, and the claimant's right to bring a civil action in federal court; and

7. the name, address, and phone number of a SIHO representative who can provide the claimant with more information about the decision and the right to appeal.

SIHO may provide the above information to the claimant orally, provided that a written notice is furnished to the claimant within 3 days after the oral notification.

D. Appeal Procedures.

If SIHO's Grievance decision is satisfactory to the Enrollee, then the matter is concluded. If, however, the Enrollee is unsatisfied with SIHO's decision, the Enrollee may initiate an appeal of the Grievance in accordance with this Section.

1. General.

   a. The claimant will have 180 days from the receipt of SIHO's decision to appeal.

b. The claimant may submit an appeal verbally or in writing. Any SIHO employee who has been unable to resolve the Grievance may take the appeal information.

c. All written notices requesting an appeal will be forwarded to an appeals coordinator.

d. All verbal requests must be documented by the SIHO associate who is assisting the claimant. Upon request, the notice will be forwarded to the appeals coordinator.

e. An acknowledgement notice will be sent to the claimant within 3 business days of receipt of the written or verbal appeal request.

2. Claimant's Rights on Appeal.

a. The claimant will have the opportunity to submit written comments, documents, or other information relating to the Grievance. All such information must be submitted by the enrollee or provider within 180 days of receipt.

b. Upon request and free of charge, the claimant will be provided with reasonable access to and copies ofall documents, records and other information relevant to the Grievance.

c. The review will take into account all comments, documents, records and other information the claimant submits, whether or not presented or considered in the initial determination.

d. No deference will be afforded to the initial determination.

e. The review will be conducted by a person or persons different from the person who made the initial determination and who is not the original decision-maker's subordinate.

f. If the decision is made on the grounds of a medical judgment, SIHO will consult with a health care professional with appropriate training and experience. The health care professional will not be the individual who was consulted during the initial determination or that person's subordinate.

g. SIHO will provide the claimant with the name of any medical or vocational expert who advised SIHO with regard to the Grievance.

3. Appeals Hearing Committee.

a. The appeals coordinator will investigate the issue and gather the data needed to review the circumstances surrounding the appeal.

b. The appeals coordinator will convene an Appeals Hearing Committee consisting of at least one person. None of the Committee will have been involved in any of the previous determinations, or involved in a direct business relationship with the Enrollee or health care provider whose care is at issue.

c. The appeals coordinator will send notice of the hearing date, time, and location to the claimant, at least 72 hours in advance of the hearing. The hearing process will make any reasonable accommodations to convenience the claimant, including arranging for a teleconference in situations where the claimant is unable to attend.

d. If the claimant attends the appeal hearing or participates via teleconference, the claimant may present his case. The hearing provides an opportunity for the claimant to explain his position as well as allow the Appeals Hearing Committee members to ask the claimant any pertinent questions they may have.

E. Notification of Resolution of Appeal.

1. Pre-Service Grievances. In the case of a Grievance not involving urgent care, SIHO will notify the claimant of its decision within 30 days after it receives the request for review and sufficient information to make its determination.

2. Urgent Care Grievances. In the case of a Grievance that relates to an Urgent Care matter, SIHO will notify the claimant of its decision within 48 hours after it receives the request for review and sufficient information to make its determination.

3. Other Grievances. In the case of all other Grievances, SIHO will notify the claimant within 30 days after it receives the written request for review and sufficient information to make its determination.

F. Expedited Appeals.

1. A claimant may request an expedited appeal or SIHO may independently determine that the process should be expedited. The expedited process is considered a stand-alone procedure and is in lieu of the standard appeal procedure.

2. The claimant may request an expedited appeal orally or in writing. All information, including SIHO's decision, may be transmitted between the claimant and SIHO by telephone, facsimile, or other available similar method.

3. Resolution of the expedited appeal will be made as expeditiously as the appellant's health warrants but will occur no later than 48 hours after the filing of the appeal.

G. Notice of Decision on Appeal.

If an appeal is denied, SIHO will notify the claimant, in writing or electronically. The notice will contain the following information:

1. the specific reason(s) for SIHO's denial;

2. a reference to the specific Health Plan provision(s) on which the denial is based;

3. a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse determination;

4. an explanation of any scientific or clinical judgment on which the denial is based;

5. a statement that the claimant is entitled to receive, upon request and without charge, reasonable access to and copies of all documents, records or other information relevant to the appeal;

6. a statement describing the voluntary appeal procedures via the external review offered by the Health Plan and the claimant's right to obtain information about the procedures;

7. the statement that "You or your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency";

8. a statement describing the claimant's right to bring a civil suit under federal law; and

9. the name, address and telephone number of the appeals coordinator whom the claimant may contact for more information.

H. External Review of Appeals Process.

1. If the claimant is dissatisfied with the Appeal Hearing Committee's resolution, and the matter involves (i) an adverse determination of appropriateness, (ii) an adverse determination of Medical Necessity, (iii) a determination that the proposed service is Experimental or Investigational, or (iv) a rescission of coverage by SIHO, he or she may file a written request to initiate an External Review Appeal. This request must be filed no later than 120 days after the claimant is notified of the resolution of the Appeal Hearing Committee’s decision. External Review Appeal is not available for matters other than those specified in this paragraph.

2. The claimant may not file more than one (1) External Review Appeal request on the same appeal.

3. Upon receipt of the request for External Review Appeal, the appeals coordinator will select an independent review organization that is certified to perform external review in the State of Indiana.

4. The external review organization will assign a medical review professional who is board certified in the applicable specialty for resolution of the appeal.

5. The external review organization and the medical review professional conducting the external review may not have a material professional, familial, or financial, or other affiliation with SIHO; any officer, director, or management employee of SIHO; the physician or the physician's medical group that is proposing the service; the facility at which the service would be provided; or the development or manufacture of the principal drug, device, procedure, or other therapy that is proposed by the treating physician. However, the medical review professional may have an affiliation under which the medical review professional provides health care services to Enrollees of SIHO and may have an affiliation that is limited to staff privileges at the health facility if the affiliation is disclosed to the claimant and to SIHO before commencing the review and neither the claimant nor SIHO objects to the affiliation.

6. A claimant who files an appeal under this final alternative is not subject to retaliation for exercising his or her right to an appeal by an external review organization. The claimant may be permitted to utilize the assistance of other individuals, including physicians, attorneys, friends, and family members throughout the external review process. The claimant shall be permitted to submit additional information relating to the proposed service throughout the review process and may cooperate with the external review organization by providing any requested medical information or authorizing the release of necessary medical information.

7. SIHO shall cooperate with the external review organization by promptly providing any information requested by the external review organization.

8. The external review organization shall make a determination to uphold or reverse SIHO's appeal resolution based on information gathered from the claimant, SIHO, the treating physician, or any additional information that the external review organization considers necessary and appropriate. For standard appeals, the determination shall be made within 15 business days from the filing date of the request for external review. For expedited appeals, the determination shall be made within 72 hours after the external review request is filed.

9. When making the determination of the resolution of the appeal, the external review organization shall apply the standards of decision making that are based on objective clinical evidence and the terms of the appellant's benefit contract.

10. The external review organization shall notify SIHO and the claimant of the determination made under this section within 72 hours after making the determination. For expedited appeals, the notification will occur within 24 hours of the determination. The result of the determination is binding on SIHO.

11. If at any time during the external review process the claimant submits information to SIHO that is relevant to SIHO's previous appeal resolution and was not considered by SIHO during the appeals hearing phase, SIHO shall reconsider the previous resolution under the appeals hearing process. The external review organization shall cease the external review process until the reconsideration by SIHO is completed.

12. If additional information from the claimant results in SIHO's reconsideration of the appeal at the hearing level, SIHO will notify the claimant of its decision within 15 days after the information is received. If the appeal is related to an Urgent Care Claim, SIHO will make a determination within 72 hours of receipt of the additional information.

13. If the reconsideration determination made by SIHO is adverse to the claimant, the claimant may request that the external review organization resume the external review.

XII. MISCELLANEOUS

A. Agreement Generally.

All Enrollees or their legal representatives (if the Enrollees are incapable of contracting) must agree to all the terms, conditions and provisions of this Agreement.

B. Applications, Questionnaires, Forms and Statements.

1. Enrollees and applicants for enrollment in the Health Plan must complete all applications, medical review questionnaires, and other forms or statements that SIHO reasonably requests. Enrollees must represent to the best of their knowledge and belief that all information contained in the applications, questionnaires, forms, or statements submitted to SIHO are true, correct, and complete. All rights to benefits under the Health Plan are subject to the truth and accuracy of an Enrollee's representations. Any misrepresentation may cause SIHO to terminate the Enrollee's Coverage. If an Enrollee is eligible for Medicare and fails to submit the documents requested under this Agreement, the Enrollee must pay for services received at Prevailing Rates.

2. If this Agreement is provided in electronic format, the Enrollee may request a paper copy.

C. Identification Cards.

The identification cards that SIHO issues to Enrollees are for identification only. Possession of a Health Plan identification card confers no rights to services or other benefits under this Agreement. To be entitled to benefits under the Health Plan, the holder of the card must, in fact, be an Enrollee on whose behalf all applicable enrollment fees, Copayments, Deductibles and Coinsurance amounts have been paid. SIHO will charge any individual who receives benefits under the Health Plan to which the individual is not entitled the Prevailing Rates for the services.

D. Policies, Procedures, Rules and Interpretations.

SIHO may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Agreement.

E. Liability Prior to Effective Date.

SIHO will not be liable for fees and bills for Medical Care received by an Enrollee prior to the effective date of the Enrollee's Coverage.

F. Authority to Change Agreement on Behalf of SIHO.

No agent or other person, except an officer of SIHO, has the authority to waive any conditions or restrictions of this Agreement; to extend the time for making payment; or to bind SIHO by making any promise or representation, or by giving or receiving information. No change to this Agreement will be valid unless Enrollee and SIHO agree to a written amendment and an officer of SIHO signs the amendment.

G. Mailing of Notices.

Any notice under this Agreement must be sent by United States mail, first class, postage prepaid, addressed as follows:

1. If to SIHO, to the address appearing on page one of this Agreement;

2. If to an Enrollee, to the Enrollee's last address known to SIHO.

H. Department of Insurance

Questions regarding your policy or coverage should be directed to:

SIHO Insurance Services
(812) 378-7070

If you need the assistance of the governmental agency that regulates insurance; or have a complaint you have been unable to resolve with your insurer, you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461
Complaints can be filed electronically at www.in.gov/idoi

I. Dissemination of Notices.

SIHO agrees to disseminate all notices regarding matters material to this Agreement to Participants in the next regular communication to Enrollees or in a special communication to Participants within 30 days after SIHO receives the material information.

J. Entire Agreement.

This Agreement and the individual enrollment applications of Enrollees constitute the entire agreement between the parties and, as of the effective date of this Agreement, supersede all other agreements between the parties.

K. Invalid Provisions.

If any provision of this Agreement is held to violate Indiana law or applicable federal law or be illegal or invalid for any other reason, that provision will be deemed to be void, but the invalidation of that provision will not otherwise impair or affect the rest of the Agreement.

L. Legal Actions.

No legal action may be filed to recover under the policy before 60 days after a claim is filed, and not later than 3 years after the claim is required to be filed.

M. Examination

SIHO reserves the right to have an Enrollee examined (including by autopsy) by a medical provider of SIHO's choice to assist in the evaluation of the appropriateness of a Claim, Precertification request, appeal or any other matter related to this agreement.

XIII. NETWORK AND NON-NETWORK SERVICES

A. Network Services.

An Enrollee is entitled to receive Network Services in the Service Area subject to the Deductibles, Coinsurance and Copayments described in Article IV. It is the Enrollee's

responsibility to secure proper Precertification of such services, if required under this Agreement.

[Coverage for Network Services may vary based on whether the treating Provider participates in the Tier 1 or Tier 2 provider network. The applicable Deductibles, Coinsurance, and Copayments for each Tier are described in Attachment B, Schedule of Benefits. SIHO will make available to all enrollees a provider directory that specifies which Participating Providers participate in the Tier 1 or Tier 2 network.]

B. Emergency Accident or Emergency Illness Services.

1. An Enrollee who is temporarily outside of the Service Area and who cannot access a Participating Provider, may receive treatment of an Emergency Accident or Emergency Illness from a Non-Participating Provider, subject to the Deductibles, Coinsurance and Copayments described in Article IV.

2. If the Enrollee is admitted to a Non-Participating Provider hospital as the result of an Emergency Accident or Emergency Illness, Enrollee or his representative must contact SIHO or their Delegated Network within 48 hours of admission to obtain Precertification of any further inpatient services.

C. Non-Network Services.

A Non-Network Benefit is a Covered Benefit (other than treatment for an Emergency Accident or Emergency Illness) provided by a Non-Participating Provider, without the prior written approval of the Health Plan Medical Director. Non-Network Benefits are subject to the Deductible, Coinsurance and Copayments described in Article IV and to the Precertification requirements described in this Section C, below. Non-Participating Providers will be paid no more than the most recently published Medicare reimbursement rates and may bill the enrollee for any difference between their billed charges and the Medicare reimbursement rates if applicable.

D. Precertification.

The Health Plan Medical Director or his designee must precertify all inpatient care, outpatient surgery, and durable medical equipment, and other services identified in the Health Plan and the Schedule of Benefits.

1. <u>Procedures to Request Precertification</u>.

   a. For elective care an Enrollee or his physician must send a Precertification request to SIHO by mail, at least 14 working days before the services/equipment are provided. If the need for services/equipment is unforeseen, the Enrollee or his physician must call SIHO (812-378-7050 or 800-553-6027) at least one working day before the services/equipment is provided to request Precertification.

b. For maternity admissions the Enrollee or her physician should call SIHO to request Precertification on the second or fourth day after admission, respectively, if the inpatient admission is expected to exceed two days for a vaginal delivery or four days for a cesarean section. If the maternity admission is for reasons other than delivery, then the Enrollee or physician must call SIHO within one working day of the admission.

c. For other Precertification requests, the Enrollee or his physician should call SIHO or their Delegated Network at the number indicated on the Enrollee's identification card.

2. Precertification Decisions. If SIHO or their Delegated Network finds that proposed Medical Care is Medically Necessary and the setting is appropriate, SIHO or their Delegated Network will precertify the quantity and character of the Medical Care. SIHO will not precertify any extra inpatient days for tests that can be obtained on an outpatient basis before the Enrollee is admitted. If Precertification is obtained, SIHO will pay the benefits for the services as described in Article IV.

3. If Precertification has not been obtained, SIHO will reduce the benefits paid for the Medical Care as follows:

   a. Medical Care that is not Medically Necessary. SIHO will not provide benefits for any Medical Care that is not Medically Necessary. Charges for such Medical Care will not apply toward any Health Plan Deductible or stop-loss limitations. If Precertification is denied, a Enrollee or his Participating Physician may request a review of the denial and may submit evidence to support Precertification as provided in the Health Plan's Claim Procedures.

   b. Precertification not Requested. If Precertification is not obtained for Medical Care that is Medically Necessary and requires Precertification, SIHO will reduce the amount of benefits it will pay for the Medical Care to the lesser of 50% of the Prevailing Rates for the Medical Care or the applicable Medicare reimbursement rate for the Medical Care. This 50% reduction will not apply toward any plan Deductible or stop-loss limitations.

4. Precertification does not guarantee coverage for or payment of the service or procedure reviewed. For benefits to be paid, the Enrollee must be and remain eligible for benefits, all enrollment fees owed must be paid, and the service or procedure must be a Covered Benefit and not subject to an exclusion or limitation.

ATTACHMENT A

The following Indiana counties are part of Southeastern Indiana Health Organization's (SIHO) Service Area:

Bartholomew
Brown
Decatur
Jackson
Jennings
Scott

ATTACHMENT B

SCHEDULE OF BENEFITS

PRE-ADMISSION CERTIFICATION

[If precertification is not requested and obtained prior to receiving Medical Services that require precertification, the benefits paid by SIHO will be reduced by a penalty of 30% of the Prevailing Rate for the services provided. The penalty will not be applied toward any Deductible . It is important to note that this Agreement does not cover weekend admissions and any associated Medical Services unless they are Medically Necessary. To use the Pre-Admission Certification program, contact the Health Plan Medical Director of the designee at:_____.

[If precertification is not requested and obtained prior to receiving Medical Services that require precertification, the benefits paid by SIHO will be reduced by a penalty of [%] of the Prevailing Rate for the services provided [, to a maximum of [$500-$5,000] per confinement]. The penalty will not be applied toward any Deductible limitations. It is important to note that this Agreement does not cover weekend admissions and any associated Medical Services unless they are Medically Necessary. To use this Pre-Admission Certification program, contact the Health Plan Medical Director of the designee at:_____]

ADMINISTRATOR:_____
ADDRESS:_____
PHONE NUMBER:(_____)-_____-_____

[Many individual services and benefits also require precertification in order to be included as Covered Services. Those services are identified in the Provider and Service Schedule portion of this Schedule of Benefits.]

ADDITIONAL FEATURES

Some additional general terms and limitations will have impact upon the Covered Services under this Agreement and need to be highlighted below. If the YES box next to the specific feature is checked, it will apply to this Agreement. If the NO box is checked, it will not apply to this Agreement. Read the Provider and Service Coverage portion of the Schedule of Benefits for a detailed explanation of all individual benefits and features, and how they are impacted by the following:

YES	NO	
[___]	[___]	Medicare Reimbursement Rates [plus an additional ____%] will be used as the limit for the Non-Network Service charges.
[___]	[___]	Network and Non-Network Service charges/payments combined for limitations.
[___]	[___]	[Tier 1 and Tier 2 charges/payments combined for limitations.]
[___]	[___]	In instances of Copayments, the *lesser* of the Copayment or billed charges will

apply.

[PRESCRIPTION DRUG BENEFITS:

[Eligible charges for prescription drug benefits will be limited to the cost of generic prescription drugs, wherever available.] [The following Prescription Drug Deductible will apply to coverage for Prescription Drugs]
[Combined Network and Non-Network Deductible per year:
Individual: $0 to $1,000
Family: $0 to $3,000]

[The following Copayments will apply to Coverage for prescription drugs:

Network	[$0-$50] per Generic Rx, [After Prescription Drug Deductible] [$0-$75] per Brand Rx [plus the difference between available Generic and chosen Brand] [After Prescription Drug Deductible]
Non-Network	[$0-$100] per Generic Rx, [After Prescription Drug Deductible] [$0-$100] per Brand Rx [plus the difference between available Generic and chosen Brand] [After Prescription Drug Deductible]
[Formulary	[$0-$75] per non-Formulary compliance Rx [After Prescription Drug Deductible] [plus the minimum difference, not to be less than $__, between formulary Rx and non-formulary Rx chosen] [After Prescription Drug Deductible]

[Biotech or Specialty Injectable Drugs other than insulin and anti neoplasm drugs
[10% to 40%] Coinsurance up to a maximum of [$100 to 500] per Rx. Coinsurance does [not] apply to the annual out-of-pocket maximum. Annual Benefit Maximum of [$50,000 to Unlimited].]

[Annual Maximum $5,000, $10,000, $15,000, Unlimited]
[Rx defined as 1 to 30 day supply]

[**Evidence Based Pharmacy Plan (EBPP)**
The Deductible, Coinsurance, or Copayment for selected maintenance medications will be waived or reduced for Enrollees identified with specific chronic conditions and who are actively participating, as determined by SIHO, in their Disease Management, Case Management, and/or other Medical Management programs.]

[**Step Therapy Programs**
Use of a Generic drug in a given Class may be required before a Non-Preferred Brand Drug is Covered. Affected Enrollees will be notified of the Step Therapy Program prior to it's effective date so that they can contact their physician and discuss a new prescription. Medical exceptions to the program may be granted based on clinical justification supplied by the Enrollee's physician.]

[Orally Administered Cancer Chemotherapy
As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.]

[PRIMARY CARE PHYSICIAN:

An Enrollee must get approval from his Primary Care Physician to receive Network Services. Covered Services must be accessed through the Enrollee's current Primary Care Physician in order to obtain any Coverage. Any Medical Services that are not provided, arranged, authorized, or approved by the Enrollee's Primary Care Physician or the Health Plan Medical Director is excluded. This limitation does not apply to Medically Necessary emergency services.]

GEOGRAPHIC SERVICE AREA:

The geographic Service Area includes [the following counties:_____.] [the area represented by the following zip codes:_____.] [the area within a [25-60] mile radius of:_____.]

All Covered Services are subject to calendar year Deductible amounts UNLESS STATED OTHERWISE. All calendar year deductibles are applied [after, before] the applicable service Copayments. All plan payments accrue towards annual maximums.

	NETWORK SERVICES [LEVEL 1] [TIERS 1 AND 2]		**NON-NETWORK SERVICES** [LEVEL II] [TIER 3]	
	[Level I benefits apply to Medical Care received from a Participating Provider or from a Non-Participating Provider with written authorization from the Health Plan Medical Director.] [Tier 1 and 2 benefits apply to Medical Care received from a Participating Provider or from a Non-Participating Provider with written authorization from the Health Plan Medical Director.]		[Level II benefits apply to Medical Care received from a Non-Participating Provider without a written authorization from the Health Plan Medical Director] [Tier 3 benefits apply to Medical Care received from a Non-Participating Provider without a written authorization from the Health Plan Medical Director.]	
	[TIER 1] [TIER 2]		[TIER 3]	
General Services	**Enrollee Pays**	**Health Plan Pays**	**Enrollee Pays**	**Health Plan Pays**
All covered services are subject to these conditions unless otherwise provided	**Network Deductible per year:** Individual : [0-$5,000] Family: [0-$15,000] [The Individual Deductible applies only to Enrollees with self-only coverage. If an individual has family coverage, the Family Deductible applies. Except for Preventive Health Benefits, the Health Plan will not pay benefits for any Enrollee with family coverage until the eligible medical charges incurred by the Enrollee's family exceed the Family Deductible.] **Coinsurance:** Individual [0-40%] Family [0-40%] **Network Out-of-Pocket Maximum per year:** Individual: [$0-unlimited] Family [$0-unlimited] **General Services Copayment:** [None] or [$0-60].	[60-100]% of eligible charges after Enrollee Pays: [General Services Copayment] [Network Deductible] [After the Enrollee's Network Out-of-Pocket Maximum is reached, the Health Plan will pay 100% of the Enrollee's expenses.] [The Health Plan's payments are subject to the following limits: Annual maximum: $[0 - Unlimited] Lifetime maximum: $[0-Unlimited]]	**Non-Network Deductible per year:** Individual: [$0-$10,000] Family: [$0-$30,000] [The Individual Deductible applies only to Enrollees with self-only coverage. If an individual has family coverage, the Family Deductible applies. Except for Preventive Health Benefits, the Health Plan will not pay benefits for any Enrollee with family coverage until the eligible medical charges incurred by the Enrollee's family exceed the Family Deductible.] **Coinsurance:** Individual: [0-50%] Family: [0-50%] **Non-Network Out-of-Pocket Maximum per year:** Individual: [$0-unlimited] Family: [$0-unlimited] **General Services Copayment:** [None] or [$0-60]	[50-100]% of Medicare Reimbursement Rates after Enrollee pays: [General Services Copayment] [Network Deductible] [Non-Network Deductible] [After the Enrollee's Network Out-of-Pocket Maximum is reached, the Health Plan will pay 100% of the Enrollee's expenses.] [The Health Plan's payments are limited to following: Annual maximum: $[0 - Unlimited] Lifetime maximum: $[0-Unlimited]]

Primary Health Care Physician Services	Enrollee Pays	Health Plan Pays	Enrollee Pays	Health Plan Pays
One Copayment will apply per [visit, service]. ** Indicates that the Non-Network Deductible applies [before, after] applicable Copayments.				
Office Visit	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [$0-$60] [**] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Home Visit	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [$0-$60] [**] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Immunizations	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or [$0-$60] [**] Coinsurance: [None] or [0-50]%	[Not Covered], [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Health Education	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or [$0-$60] [**] Coinsurance: [None] or [0-50]%	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Wellness Education [Per the SIHO schedule]	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or [$0-$60] [**] Coinsurance: [None] or [0-50]%	[Not Covered] [50-100]% of eligible charges after the Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Hearing and Vision Screening	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or [$0-$60] [**] Coinsurance: [None] or [0-50]%	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]

Specialty Health Care (Physician Services)	Enrollee Pays	Health Plan Pays	Enrollee Pays	Health Plan Pays
One Copayment will apply per [visit, service]. ** Indicates that Non-Network deductible applies [before, after] applicable Copayments.				
Office Visit	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]%	[Not covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Home Visit	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]%	[Not covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Consultations, In-Patient	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]%	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Consultations, non in-Patient	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]%	[Not covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Allergy	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]%	[Not covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]

Chiropractor, Manipulative Services [Requires Precertification] Annual Maximum: 12 Visits	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Lifetime Maximum is reached.]	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Lifetime Maximum is reached.]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Lifetime Maximum is reached.]	[Not covered] [Limited to [ ] visits per month] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Lifetime Maximum is reached.]
Dermatology	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]%	[Not covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
[Family Planning/ Infertility]	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Lifetime Maximum is reached.]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Lifetime Maximum is reached.]	[Not covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Lifetime Maximum is reached.]
Podiatry Excludes routine foot care	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Network Deductible] [Copayment]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]%	[Not covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Temporomandibular Joint Disorder	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]%	[Not covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]

Psychologist or Psychiatrist Mental Health Treatment: Outpatient [Requires Precertification]	Copayment: [None] or [$0-$60] Coinsurance: [None] or [percentage listed for general services]%	[60-100]% of all eligible charges after Enrollee pays: [Network Deductible] [Copayment]	[Not covered] Copayment: [None] or $[0-400] [**] Coinsurance: [None] or [percentage listed for general services]%	[Not covered] [50-100]% of covered service charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Substance Abuse Treatment: Outpatient [Requires Precertification]	Copayment: [None] or [$0-$60] Coinsurance: [None] or [percentage listed for general services]%	[60-100]% of all eligible charges after Enrollee pays: [Network Deductible] [Copayment]	[Not covered] Copayment: [None] or $[0-400] [**] Coinsurance: [None] or [percentage listed for general services]%	[Not covered] [50-100]% of covered service charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Surgery and Hospital (Physician Services)	**Enrollee Pays**	**Health Plan Pays**	**Enrollee Pays**	**Health Plan Pays**
One Copayment will apply per [day, visit].				
Anesthesia	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Network Deductible] [Copayment]	Copayment: [None] or [$0-$80] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Medical Visits in Hospital, Primary Physician	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Network Deductible] [Copayment]	Copayment: [None] or [$0-$80] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Medical Visits in Hospital, Specialty Physician	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Network Deductible] [Copayment]	Copayment: [None] or [$0-$80] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Medical Visits in SNF, Primary Physician	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Network Deductible] [Copayment]	Copayment: [None] or [$0-$80] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]

Medical Visits in SNF, Specialty Physicians	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Network Deductible] [Copayment]	Copayment: [None] or [$0-$80] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Surgery	Copayment: [None] or [$0-$100] per procedure Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Network Deductible] [Copayment]	Copayment: [None] or [$0-$200] per procedure Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Institutional Health Care: Outpatient	**Enrollee Pays**	**Health Plan Pays**	**Enrollee Pays**	**Health Plan Pays**
[Copayment applies per visit.] [Copayment applies in addition to any other Copayments for each service]				
Outpatient Diagnostic [MRIs and CT Scans Require Precertification]	Copayment: [None], [$0-$500] or [$0-$150] per test whenever there is no accompanying facility charge [Facility Charge] Coinsurance: [None] or [0-40]% [80% Coinsurance will apply for Procedures greater than [$250-$1,000]	[60-100]% of eligible charges after Enrollee pays: [Network Deductible] [Copayment] [Facility Charge]	Copayment: [None] or [$0-$250] Coinsurance: [None] or [0-50]% [Facility Charge]	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [Facility Charge]
Emergency Department	Copayment: [None] or [$0-$500] [Facility Charge] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after the Enrollee pays: [Network Deductible] [Copayment] [Facility Charge]	Copayment: [None] or [$0-$500] Coinsurance: [None] or [0-50]% [Facility Charge]	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [Facility Charge]
Urgent Care Facility	Copayment: [None] or [$0-$500] [Facility Charge] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after the Enrollee pays: [Network Deductible] [Copayment] [Facility Charge]	Copayment: [None] or [$0-$500] Coinsurance: [None] or [0-50]% [Facility Charge]	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [Facility Charge]
Outpatient Mental Health Services [Requires Precertification]	Copayment: [None] or $[0-400] Coinsurance: [None] or [percentage listed for General Services	[60-100]% of all eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or $[0-400] Coinsurance: [None] or [percentage listed for General Services]	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]

Outpatient Substance Abuse Services [Requires Precertification]	Copayment: [None] or $[0-400] Coinsurance: [None] or [percentage listed for General Services	[60-100]% of all eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or $[0-400] Coinsurance: [None] or [percentage listed for General Services]	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Outpatient Surgery [Requires Precertification]	Copayment: [None] or [$0-$500] per procedure Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after the Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [$0-$750] per procedure Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Outpatient Hospital Ancillaries	Copayment: [None] or [O/P Copayment] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after the Enrollee pays: [O/P Copayment] [Network Deductible]	Copayment: [None] or [O/P Copayment] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [O/P Copayment] [Network Deductible] [Non-Network Deductible]
Outpatient Therapy [Requires Precertification] Annual Maximum: [20] visits each for physical, pulmonary, occupational, and speech therapies. Separate limits between Outpatient Rehabilitation Services and Habilitation Services. Annual Maximum: 36 visits for Cardiac Rehabilitation.	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]% An Enrollee is responsible for 100% of the cost after the number of treatment visits reaches the Annual or Lifetime Maximum.	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] The Health Plan will not pay any amounts after the number of treatment visits reaches the Annual or Lifetime Maximum.	[Not Covered] Copayment: [None] or [$0-$80] Coinsurance: [None] or [0-50]% An Enrollee is responsible for 100% of the cost after the number of treatment visits reaches the Annual or Lifetime Maximum.	[Not Covered], [Limited to [15] visits per month] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] The Health Plan will not pay any amounts after the number of treatment visits reaches the Annual or Lifetime Maximum.

Outpatient Therapy Facility [Therapy Program Requires Precertification] Annual Maximum: [20] visits each for physical, pulmonary, occupational, and speech therapies. Separate limits between Outpatient Rehabilitation Services and Habilitation Services. Annual Maximum: 36 visits for Cardiac Rehabilitation.	Copayment: [None] or [$0-$250] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or [$0-$250] Coinsurance: [None] or [0-50]%	[Not covered], [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Institutional Health Care: Inpatient	**Enrollee Pays**	**Health Plan Pays**	**Enrollee Pays**	**Health Plan Pays**
Hospital Room and Board [Requires Precertification]	Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Specialty Care	Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Pregnancy Services [Requires Precertification]	[Not Covered] Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [0-50]%	[Not Covered], [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [0-50]%	[Not covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Mental Health Services [Requires Precertification]	Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [percentage listed for General Services]	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [percentage listed for General Services]	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]

Substance Abuse Services [Requires Precertification]	Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [percentage listed for General Services]	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [percentage listed for General Services]	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Hospital; Ancillaries	Copayment: [None] or [I/P Copayment] Coinsurance: [None] or [0-40]% [Deductible: I/P Deductible]	[60-100]% of eligible charges after Enrollee pays: [Copayment] [I/P Deductible] [Network Deductible]	Copayment: [None] or [I/P Copayment] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Acute Inpatient Rehabilitation Services [Requires Precertification Annual Maximum: 60 days	Copayment: [None] or $[0-1,000] per [Day, admission] Coinsurance: [None] or [0-40]% [Includes days in Non-Network facility]	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] The Health Plan will not pay any amounts after the number of treatment days reaches the Annual or Lifetime Maximum	[Not Covered] Copayment: [None] or $[0-1,000] per [Day, Admission] . Coinsurance: [None] or [0-50]% An enrollee is responsible for 100% of the cost after the number of treatment days reaches the Annual or Lifetime Maximum. [Includes days in Network facility]	[Not Covered] [50-100]% of eligible charges up to a maximum of $750 per day after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] The Health Plan will not pay any amounts after the number of treatment days reaches the Annual or Lifetime Maximum
SNF Room and Board and Ancillaries [Requires Precertification] Annual Maximum: 90 days	Copayment: [None] or [$0-$30] per SNF day if it immediately followed a Hospital Confinement [plus a [$0-$1,000] per SNF [day, confinement] if admitted directly to an SNF without a hospital Confinement] Coinsurance: [None] or [0-40]% The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual Maximum is reached.	[60-100]% of the eligible charges [up to a maximum of $500 per day] after Enrollee pays: [Copayment] [Network Deductible] The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.	Copayment: [None] or [$0-$60] per SNF day if it immediately followed a Hospital Confinement [plus a [$0-$1,000] per SNF [day, confinement] if admitted directly to an SNF without a hospital Confinement]] Coinsurance: [None] or [0-40]% The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual Maximum is reached.	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.

Long Term Acute Care Hospital (LTACH) Services [Requires Precertification and Referral] Annual Maximum: 90 days	Copayment: [None] or $[0-1,000] per [Day, admission] Coinsurance: [None] or [0-40]% An Enrollee is responsible for 100% of the cost after the number of treatment days reaches the Annual or Lifetime Maximum. [Includes days in Non-Network facility]	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] The Health Plan will not pay any amounts after the number of treatment days reaches the Annual or Lifetime Maximum	[Not Covered] Copayment: [None] or $[0-1,000] per [Day, Admission] . Coinsurance: [None] or [0-50]% An enrollee is responsible for 100% of the cost after the number of treatment days reaches the Annual or Lifetime Maximum. [Includes days in Network facility]	[Not Covered] [50-100]% of eligible charges up to a maximum of $750 per day after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] The Health Plan will not pay any amounts after the number of treatment days reaches the Annual or Lifetime Maximum
Medical Supplies and Ancillary Services	**Enrollee Pays**	**Health Plan Pays**	**Enrollee Pays**	**Health Plan Pays**
Ambulance, medically necessary	Copayment: [None] or [$0-$250] per service Coinsurance: [None] or [0-40]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual Maximum is reached.]	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.]	Copayment: [None] or [$0-$250] per service Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual Maximum is reached.]	[50-100]% of eligible charges Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.]
Blood	[Included within the corresponding Individual Health Care Provider/Institutional Copayment] or [Copayment: [None] or [$0-$200] per service] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [$0-$200] per service Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Home Health Care [Requires Precertification] Annual Maximum: 90] days] Note: Maximum does not include Private Duty Nursing rendered in home. Private Duty Nursing: Annual Maximum [82 visits] Lifetime Maximum [164 visits]	Copayment: [None] or [$0-$50] per [day, provider service] of a prescribed continuous period of care Coinsurance: [None] or [0-40]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual or Lifetime Maximum is reached.]	[60-100]% of eligible charges [up to a maximum of $500 per day] after Enrollee pays: [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual or Lifetime Maximum is reached.]	Copayment: [None] or [$0-$50] per [day, provider service] of a prescribed continuous period of care Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual or Lifetime Maximum is reached.]	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] Maximum Charges: [$500 per day] [The Health Plan will not pay any amounts for this Specific Service after the Annual or Lifetime Maximum is reached.]

Hospice, Facility [Requires Precertification]	Copayment: [None] or [$0-$50] per day Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges [up to a maximum of $500 per day] after Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [$0-$50] per day Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Hospice, Home Care [Requires Precertification]	Copayment: [None] or [$0-$50] per [day, provider service] Coinsurance: [None] or [0-40]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Lifetime Maximum is reached.]	[60-100]% of eligible charges [up to a maximum of $500 per day] after Enrollee pays: [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Lifetime Maximum is reached.]	Copayment: [None] or [$0-$50] per [day, provider service] Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Lifetime Maximum is reached.]	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Lifetime Maximum is reached.]
Medical Aids: Prosthetic Devices [Requires Precertification]	[Not Covered] Copayment: [None] or [$0-$50] per device Coinsurance: [None] or [0-40]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual or Lifetime Combined Maximum is reached.]	[Not Covered] [60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual or Lifetime Combined Maximum is reached.]	[Not Covered] Copayment: [None] or [$0-$100] per device Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual or Lifetime Combined Maximum is reached.]	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual or Lifetime Combined Maximum is reached.]
Medical Aids: Durable Medical Equipment [Requires Precertification]	[Not Covered] Copayment: [None] or [$0-$50] per device Coinsurance: [None] or [0-40]% [Subject to combined maximums for Medical Aids.]	[Not Covered] [60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Subject to combined maximums for Medical Aids.]	[Not Covered] Copayment: [None] or [$0-$100] per device Coinsurance: [None] or [0-40]% [Subject to combined maximums for Medical Aids.]	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [Subject to combined maximums for Medical Aids.]

Medical Aids: Orthotic Appliances [Requires Precertification]	[Not Covered] Copayment: [None] or [$0-$50] per device Coinsurance: [None] or [0-40]% [Subject to combined maximums for Medical Aids.]	[Not Covered] [60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Subject to combined maximums for Medical Aids.]	[Not Covered] Copayment: [None] or [$0-$100] per device Coinsurance: [None] or [0-50]% [Subject to combined maximums for Medical Aids.]	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [Subject to combined maximums for Medical Aids.]
Medical Supplies	Copayment: [None] or [amount set by Health Care Provider] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [amount set by Health Care Provider] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Renal Dialysis Annual Maximum [90 days	Copayment: [None] or [amount set by Health Care Provider] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [amount set by Health Care Provider] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]

Prescription Drugs Biotech or Specialty Injectable Drugs other than insulin and anti neoplasm drugs Annual Benefit Maximum of $50,000 to Unlimited The Health Plan does not provide coverage for oral contraceptives.	[Prescription Drug Deductible: Individual: $0-$1,000 Family: $0-$3,000 Deductibles cross apply Network and Non-Network] Copayment: Generic: [None] or [$0-$50] [Brand Name: [None] or [$0-$75] [plus the difference between the brand and available generic drugs] [$30 to $100 benefit allowance] [Non-Formulary: [None] or [$0-$75] [plus the positive difference between the formulary and the non-compliant drugs] [$10 to $100 benefit allowance]] [Biotech or Specialty Injectable Drugs other than insulin and anti neoplasm drugs coinsurance [10% to 40%] to a maximum of [$100 to $500] per Rx] Coinsurance: [None] or [0-40]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual Maximum is reached.]	[Not Covered] [60-100]% of eligible charges after Enrollee pays: [Prescription Drug Deductible] [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.]	[Prescription Drug Deductible: Individual: $0-$1,000 Family: $0-$3,000 Deductibles cross apply Network and Non-Network] Copayment: Generic: [None] or [$0-$50] [Brand Name: [None] or [$0-$75] [plus the difference between the brand and available generic drugs] Non-Formulary: [None] or [$0-$75] [plus the positive difference between the formulary and the non-compliant drugs] Coinsurance: [None] or [0-50]% [Biotech or Specialty Injectable Drugs other than insulin and anti neoplasm drugs not covered] [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual Maximum is reached.]	[Not Covered], [50-100]% of eligible charges after Enrollee pays: [Prescription Drug Deductible] [Copayment] [Network Deductible] [Non-Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.]
[Evidenced Based Pharmacy Plan] The Health Plan does not provide coverage for oral contraceptives.	[Not Covered] [60-100]% of eligible charges after Enrollee pays: [Prescription Drug Deductible] [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.]	[Prescription Drug Deductible: Individual: $0-$1,000 Family: $0-$3,000 Deductibles cross apply Network and Non-Network] Copayment: Generic: [None] or [$0-$50] Brand Name: [None] or [$0-$75] [plus the difference between the brand and available generic drugs] Non-Formulary: [None] or [$0-$75] [plus the positive difference between the formulary and the non-compliant drugs] Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual Maximum is reached.]	[Not Covered], [50-100]% of eligible charges after Enrollee pays: [Prescription Drug Deductible] [Copayment] [Network Deductible] [Non-Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.]

Specified Health Care Benefit Services	Enrollee Pays	Health Plan Pays	Enrollee Pays	Health Plan Pays
Donor Organ Procurement [I/P stay Requires Precertification] Lifetime Maximum: [$20,000-Unlimited	Copayment: [None] or [I/P Copayment] Coinsurance: [None] or [0-40]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Lifetime Maximum is reached.]	[60-100]% of eligible charges Enrollee pays: [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Lifetime Maximum is reached.]	Copayment: [None] or [I/P Copayment] Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Lifetime Maximum is reached.]	[50-100]% of eligible charges Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Lifetime Maximum is reached.]
Pre-Admission Testing	Copayment: [None] or [amount set by Health Care Provider] Coinsurance: [0-40]% [Deductible: set by Health Care Provider]	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Health Care Provider Deductible] [Network Deductible]	Copayment: [None] [$0-$75 per test] or [amount set by Health Care Provider] Coinsurance: [0-50]% [Deductible: set by Health Care Provider]	[50-100]% of eligible charges Enrollee pays: [Copayment] [Health Care Provider Deductible] [Network Deductible] [Non-Network Deductible]
Special Routine Care-Mammography-Pap Smear	Copayment: [None] or [amount set by Health Care Provider] Coinsurance: [0-40]% [Deductible: set by Health Care Provider]	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Health Care Provider Deductible] [Network Deductible]	Copayment: [None] or [$0-$200 per test] or [amount set by Health Care Provider] Coinsurance: [0-50]% [Deductible: set by Health Care Provider]	[50-100]% of eligible charges Enrollee pays: [Copayment] [Health Care Provider Deductible] [Network Deductible] [Non-Network Deductible]
Supplemental Emergency Accident	Copayment: [None] or [$0-$250] Coinsurance: [None] or [0-40]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual Maximum is reached.]	100% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.]	Copayment: [None] or [$0-$500] Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual Maximum is reached.]	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.]

[Surgical Treatment of Morbid Obesity, including Complications [Requires Precertification] Annual Maximum: $10,000 – Unlimited	Copayment: [None] or [$0-$5,000] per procedure Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after the Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [$0-$5,000] per procedure Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]]
Preventative Health Benefit	**Enrollee Pays**	**Health Plan Pays**	**Enrollee Pays**	**Health Plan Pays**
Physical Medicine Therapies	Copayment: [None] or [$0-$30] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [$0-$40] Coinsurance: [None] or [0-50]%	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]

ATTACHMENT C

SCHEDULE OF BENEFITS
PEDIATRIC VISION ESSENTIAL BENEFIT

GENERAL
This Schedule list the vision care services and vision care materials to which Enrollees under the age of 19 are entitled, subject to any conditions, limitations and/or exclusions stated herein or in the Certificate of Coverage to which this is attached. Vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, who are Participating Providers.

Participating Provider are those doctors who have agreed to participate in VSP's Choice Network, available at www.vsp.com.

When Covered Benefits are received from Participating Providers, benefits are applicable as stated below.

COVERED BENEFIT	PARTICIPATING PROVIDER BENEFIT
VISION CARE SERVICES	
Vision Examination	Covered in Full
VISION CARE MATERIALS	
Lenses	
Single Vision	Covered in Full*
Bifocal	Covered in Full*
Trifocal	Covered in Full*
Lenticular	Covered in Full*

Frames	Covered in Full from a Pediatric Exchange Collection
CONTACT LENSES	
Necessary	
Professional Fees and Materials	Covered in Full
Elective	
Professional Fees**	Covered in Full
Materials	Covered in full with the following service limitations: Standard (one pair annually) = 1 contact lens per eye (total 2 lenses) Monthly (six-month supply) = 6 lenses per eye (total 12 lenses) Bi-weekly (3 month supply) = 6 lenses per eye (total 12 lenses) Dailies (one month supply) = 30 lenses per eye (total 60 lenses)

Necessary Contact Lenses are a Covered Benefit when specific benefit criteria are satisfied and when prescribed by a Participating Provider or Non-Participating Provider. Prior review and approval by VSP are not required to be eligible for Necessary Contact Lenses.

*Coverage includes lenses in polycarbonate, plastic or glass, scratch resistant or UV coatings also covered.

**15% discount applies to Participating Provider's usual and customary professional fees for contact lens evaluation and fitting.

COPAYMENT
There shall be no Copayment for the examination or materials payable to the Participating Provider at the time services are rendered.

SOUTHEASTERN INDIANA HEALTH ORGANIZATION, INC

INDIVIDUAL CERTIFICATE OF COVERAGE

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, You may return it to SIHO or the agent who sold it to you within 10 days after you receive it or have access to it electronically, whichever is earlier. Your premium will be refunded and this Contract will be void from its start.

Guaranteed Renewable: Coverage under this Contract is guaranteed renewable, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Contract by payment of the renewal premium by the end of the grace period of any Premium due date. The Exchange may refuse renewal only under certain conditions.

SIHO Insurance Services
417 Washington St.
Columbus, IN 47203

Form No. QHP INDV-05.2014

Revised May 2014

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DECLARATIONS

A. Agreement to Offer Plan

SIHO is offering this Health Plan to Individuals and their eligible Dependents.

B. Term

The term of this Agreement begins on the Effective Date of coverage.

C. Eligibility

The eligibility of the Individual and any eligible Dependents to enroll in thee Health Plan will be defined in terms of the eligibility requirements in Article II subject to the following limitations:

1. Each person making application outside of open enrollment to be a Participant is required to provide evidence of a qualifying event for coverage, excluding newborns and adopted children.

D. Effective Date of Coverage

1. Open Enrollment Period Open Enrollment periods will be held each year according to rules established by the Exchange.

2. Newborn & Adopted Child Coverage is automatic for newborn children and newly adopted children during the first 31 days of their eligibility. Coverage for newborns and newly adopted children will continue beyond the first 31 days as long as they are enrolled within 31 days of becoming eligible, the applicable enrollment fees have been paid, and other provisions of this Agreement have been met. Newborn children will be treated as Dependents from birth. Legally adopted children will be treated as Dependents from the earlier of the date of placement for the purpose of adoption; or the date of the entry of an order granting the adoptive Participant custody of the Child for purposes of adoption.

3. Special Enrollment If an individual does not enroll himself or dependents in the Health Plan during open enrollment, the individual may be eligible to enroll himself and his dependents in the Health Plan in a special enrollment if he or his dependents experience a qualifying life event, such as marriage, divorce, or involuntary loss of coverage. Events which allow a Qualified Individual or enrollee to enroll in a Qualified Health Plan or switch coverage to another QHP, outside of the Open Enrollment Period, include:

    a. Loss of Minimum Essential Coverage;

b. Enrollee gains or loses a Dependent, including situations where the enrollee becomes a Dependent on other coverage, due to marriage, birth, adoption or placement for adoption;

c. Change in citizenship status;

d. Loss of coverage in a QHP through an unintentional error or mistake;

e. A Qualified Individual demonstrates to the Exchange that their current QHP has violated its contract with the Qualified Individual;

f. A Qualified Individual becomes eligible or ineligible for Advance Payments of the Premium Tax Credit or has a change in eligibility for cost-sharing reductions, regardless of current enrollment status of the Qualified Individual;

g. A Qualified Individual loses existing coverage through an employer sponsored plan, or the employer sponsored plan will no longer be affordable or provide minimum value for the upcoming Plan Year. Such Qualified Individuals' Special Enrollment rights run through the end of their coverage under the eligible employer sponsored plan.

h. A Qualified Individual moves into or out of the Service Area.

For other examples of qualifying events that trigger special enrollment rights, please see **https://www.healthcare.gov/glossary/qualifying-life-event/**.

To qualify for this special enrollment, the individual must submit an enrollment form within 30 days after the other health coverage ends and provide sufficient information to establish that the individual lost the other health coverage involuntarily, if applicable. The effective date of coverage for special Enrollees is the eligible date of the qualifying life event. If an individual or his Dependents lose coverage under Medicaid or a state child health program the individual has 60 days after the coverage ends to enroll in the Health Plan.

4. Late Enrollment If an individual fails to enroll during an open enrollment period or within 31 days of becoming newly eligible, the individual must wait for an open enrollment period to enroll unless the individual qualifies for special enrollment.

E. Misstatement of Age

If premium fees and/or benefits are based upon age, and a misstatement of age is discovered, the corrected benefits and premium fees will be adjusted retroactively for 60 days.

F. Incontestability

The validity of the policy may not be contested, except for nonpayment of premiums, after the policy has been in force for 2 years. No statement made by a covered person, relating to the covered person, will be used in contesting the validity of the coverage unless the statement is in written form and signed by the covered person.

G. Health Insurance Portability and Accountability Act of 1996

This policy complies with the provisions of HIPAA and provides portability and guaranteed renewability as described in this federal regulation.

I. GENERAL PROVISIONS

A. Definitions

Wherever used in this document, the following words and terms, when capitalized, have the following meanings, unless a different meaning is clearly indicated by the context.

"ACA" means the Patient Protection and Affordable Care Act, as amended (including the amendments contained in the Health Care and Education Affordability Reconciliation Act of 2010), and all applicable regulations issued hereunder.

"Acute Rehabilitation Hospital" means a licensed and accredited institution which provides professional services to those needing intensive therapies to regain normal body function. Services include: physical, occupational, pulmonary and speech therapies. Services must be delivered by a licensed therapist for a minimum of 3 hours per day, and the institution must have 24 hour nursing by a licensed nurse under the direction of a full-time RN, complete medical records for each patient, utilization review and discharge plan, and a physiatrist or licensed physician overseeing the care on staff.

"Agreement" means this Certificate of Coverage, including all attachments, endorsements, amendments, and addenda.

"Appeals Hearing Committee" means a committee designated by SIHO to investigate appeals of decisions on Grievances.

"Autism Spectrum Disorder (ASD)" means a group of developmental brain disorders including: classic Autism, Asperger's disorder, Pervasive developmental disorder, Rett's disorder, and Childhood disintegrative disorder. ASD is diagnosed according to the most current guidelines listed in the Diagnostic and Statistical Manual of Mental Disorders.

"Centers of Excellence" means a specialized network of providers that have expertise in the transplantation of human organs and tissues with whom SIHO has a contract to provide transplant services to Enrollees. Networks considered to be Centers of Excellence are determined by SIHO and/or its reinsurance carrier.

"Child" or **"Children"** means any of the following individuals age 25 or under:

a. A Participant's natural born child;

b. A Participant's stepchild;

c. A Participant's legally adopted child, from the earlier of the date of placement for adoption or the date of entry of an order granting the Participant custody of the child for the purpose of adoption;

d. Any child for whom the Participant is subject to legal guardianship or legal custody

e. Any child for whom the Participant is legally responsible for Medical Care by a qualified medical child support order, as defined in ERISA.

"Claim" means any claim for benefits under the Health Plan, including Urgent Care Claims, Concurrent Care Claims, Pre-Service Claims and Post-Service Claims.

"Clean Claim" means a claim received by SIHO with all the information needed to complete the review of the claim and apply the appropriate benefit or exclusion provision. SIHO will pay or deny a clean claim within 30 days of submission if filed electronically or 45 days of submission if filed via paper.

"COBRA" means the health continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

"Coinsurance" means the percentage of covered charges for which an Enrollee is responsible under the terms of this Agreement.

"Concurrent Care Claim" means any Claim with respect to an ongoing course of treatment provided over a period of time or number of treatments that SIHO has approved.

"Consulting Provider" means any Individual Health Care Provider or Institutional Health Care Provider who or which is not a Participating Provider, but who or which has entered into a contractual arrangement with SIHO to provide services within the range of a designated specialty area of practice.

"Continuation Coverage" means Coverage provided under this Agreement in accordance with the provisions of Article XI.

"Copayment" means a specific amount as set forth in Article IV that an Enrollee must pay in connection with the receipt of services.

"Coverage" means coverage for an Enrollee under the Health Plan.

"Covered Benefits" means the Medical Care specified in this Agreement for which benefits will be provided. In order to be considered a Covered Benefit, charges for the Medical Care must be incurred while the Enrollee's Coverage is in force.

"Custodial Care" means care or service that is primarily designed to assist an Enrollee in the activities of daily living or is provided in order to maintain the Enrollee's state of health and cannot be expected to improve a medical condition. Custodial Care can be performed by individuals without professional skills. Custodial Care includes, but is not limited to:

a. Administration of medicines, dressings or therapies that can be self-administered;

b. Routine monitoring of vital signs; and

c. Help in walking, getting in and out of bed, bathing, dressing, and eating.

"Deductible" means the specified dollar amount of covered charges that an Enrollee must pay before benefits that are subject to the Deductible will be paid.

"Delegated Network" means an organization contracted with SIHO to provide a network of health care providers. Designated as "in-network" with respect to the Health Plan.

"Dependent" means a Child or spouse of a Participant who meets the Dependent eligibility requirements of this Agreement, has enrolled in the Health Plan, and has paid (and SIHO has received) the enrollment fee required by this Agreement.

"Designated Representative" means an individual who represents and acts on behalf of an Enrollee, and may be, without limitation, a provider. As used in Article XIII, Procedures for Claiming Benefits, all references to an Enrollee or claimant will also include the Enrollee's or claimant's Designated Representative.

"Eligible Charges" for services provided by a Participating Provider shall mean the lesser of billed charges or the contracted rates between the provider and SIHO for Covered Benefits. For services provided by Non-Participating Providers, eligible Charges shall mean the lesser of the providers' billed charges or the most recently published Medicare reimbursement rates for the Covered Benefits provided, except for emergency services which are calculated as described in Article IV.

"Emergency Accident" or **"Emergency Illness"** means a medical condition of such an acute nature that a prudent person, with average knowledge of medicine and health, would believe that the absence of immediate medical attention could result in serious medical complications, loss of life, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

"Enrollee" means any Participant or Dependent.

"Evidenced Based Pharmacy Plan (EBPP)" means a prescription drug benefit plan available to Enrollees with specified chronic medical conditions and who are actively participating, as determined by SIHO, in their Disease Management, Case Management, and/or other Medical Management programs.

"Experimental" or **"Investigational"** means any treatment, equipment, technology, drug, procedure or supply that does not satisfy all of the following requirements:

a. The treatment, equipment, technology, drug, procedure or supply has received final approval from the appropriate governmental regulatory bodies;

b. Scientific evidence permits conclusions concerning the effect of the treatment, equipment, technology, drug, procedure or supply on health outcomes;

c. The treatment, equipment, technology, drug, procedures or supply improves the net health outcome;

d. The improvement is attainable outside the research setting; and

e. The treatment, equipment, technology, drug, procedure or supply is generally accepted as standard medical treatment of the condition being treated.

In addition, clinical trials for which the law requires coverage are not considered "Experimental" or "Investigational."

"Grievance" means an expression of dissatisfaction, either oral or written, regarding the availability, delivery, appropriateness, or quality of Medical Care; handling or payment of claims for health care services; or matters pertaining to the contractual relationship between the Participant and the Health Plan.

"Health Plan" means the SIHO health care delivery plan as set forth in this Agreement.

"Health Plan Medical Director" means the physician(s), or his appointee, designated by SIHO to provide clinical oversight of SIHO's medical management.

"Health Plan Enrollee Services" means the SIHO office that is primarily responsible for responding to the concerns and questions of Enrollees about Health Plan Coverage and procedures and for handling Claims.

"Individual Health Care Provider" means an individual licensed to provide health services.

"Inherited Metabolic Disease" means a disease caused by inborn errors of amino acid, organic acid, or urea cycle metabolism and treatable by the dietary restriction of one or more amino acids.

"Inpatient Rehabilitation Services" means those services that are part of a separate and distinct inpatient program that provides highly skilled rehabilitation care.

"Institutional Health Care Provider" means a facility licensed to provide health services.

“Long Term Acute Care Hospital (LTACH) Services” means comprehensive inpatient services in a licensed acute care hospital for patients who require specialized, complex services, and are stable enough to move to an LTACH. These services require daily physician monitoring and intensive nursing care, generally with a length of stay of twenty-five (25) days or more. Examples include ventilator dependent patients and patients requiring wound care management, IV therapy, dialysis, and telemetry. Intensive Care Unit days are not considered LTACH Services.

"Medical Food" means a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered entirely under the direction of a physician.

"Medically Necessary" means Medical Care that is (1) consistent with the diagnosis of and prescribed course of treatment for the Enrollee's illness or injury; (2) required to treat the Enrollee's illness or injury; (3) not provided solely for the convenience of the Enrollee or provider and not required solely for Custodial Care or for comfort or maintenance reasons; (4) performed in the most cost-effective setting appropriate for the injury or illness; (5) not Experimental or Investigational; (6) appropriate treatment according to generally accepted medical standards and rendered at the frequency that is accepted in the medical community; (7) likely to be effective in treating the injury or illness; and (8) not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment to the Enrollee. The fact that a physician prescribes, orders, recommends, or approves the Medical Care does not necessarily mean that the Medical Care is Medically Necessary.

"Medical Care" means the services and supplies that Individual Health Care Providers or Institutional Health Care Providers provide within the scope of their licenses and any of the medical supplies and ancillary services listed in Article IV.

"Medicare" means the program of medical care benefits for the aged and disabled described in Title XVIII of the federal Social Security Act of 1965, as amended.

"Morbid Obesity" means (1) a body mass index of at least 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or (2) a body mass index of at least 40 kilograms per meter squared without comorbidity.

"Network Benefit" means a Covered Benefit provided by a Participating Provider or, with prior written authorization from the Health Plan Medical Director, by a Consulting Provider or Non-Participating Provider.

“Never Events” mean serious reportable adverse events as defined by the National Quality Forum (NQF), or other national bodies, including but not limited to Health and Human Services (HHS). Medical errors that should never happen.

"Non-Network Benefit" means a Covered Benefit rendered by a Consulting Provider or Non-Participating Provider, without prior written authorization from the Health Plan Medical Director.

"Non-Participating Provider" means any Individual Health Care Provider or Institutional Health Care Provider who or which is neither a Participating Provider nor a Consulting Provider.

"Participant" means an individual who has enrolled in the Health Plan, and has paid (and SIHO has received) the enrollment fee required by this Agreement.

"Participating Physician" means a doctor of medicine, osteopathy, or oral surgery who is a Participating Provider.

"Participating Provider" means an Individual Health Care Provider or an Institutional Health Care Provider who or which, at the time care is rendered to an Enrollee, has a provider agreement in effect with SIHO or its Delegated Network.

"Post-Service Claim" means any Claim for benefits under the Health Plan that is not a Pre-Service Claim, Urgent Care Claim or Concurrent Care Claim.

"Precertification" means the process used to determine that Medical Care is Medically Necessary before it is provided to the Enrollee. The description of Covered Benefits in Article IV and the Schedule of Benefits indicate the types of Medical Care that require Precertification.

"Pregnancy" means the condition of being pregnant and includes childbirth, spontaneous abortion, or miscarriage.

"Pre-Service Claim" means any Claim for benefits under the Health Plan for which the Health Plan requires Precertification.

"Prevailing Rates" means the rates generally prevailing in the Service Area for medical, surgical, hospital and related health care services.

"Preventive Health Benefits Guidelines" means the guidelines established by SIHO in accordance with the ACA that describe the schedules for receiving preventive health care services in accordance with the Agreement.

"Primary Care Physician" or **"PCP"** means a Participating Physician specializing in general practice, family practice, internal medicine, or pediatrics.

Qualified Health Plan (QHP) means a health plan that has a certification from each Exchange through which such health plan is offered.

Qualified Individual means an individual who has been determined to be eligible for enrollment in a QHP, through the Exchange, and who meets all eligibility requirements.

"Service Area" means the geographic area set forth in Attachment A.

"SIHO" means Southeastern Indiana Health Organization, Inc., an Indiana corporation operating as a health maintenance organization under Indiana Code § 27-13-1-1 et seq.

"Skilled Nursing Facility" or **"SNF"** means a licensed institution, as defined in Medicare, 42 U.S.C. § 1395x (j), that is primarily engaged in providing skilled nursing facility services and related services. "Skilled Nursing Facility" does not mean a facility that operates primarily for the aged, alcoholics, or drug addicts, for treatment of nervous disorders or mental disease, or for rest, educational, or Custodial Care purposes. It also does not include a community-based residential treatment facility or a community re-entry program.

"Urgent Care Claim" means any Claim, if processing the Claim within the Health Plan's normal time frames (1) could seriously jeopardize an Enrollee's life, health, or ability to regain maximum function; or (2) in the opinion of a physician with knowledge of the Enrollee's medical condition, would subject the Enrollee to severe pain that cannot be adequately managed without the Medical Care requested in the Claim.

B. Rules of Construction

1. Words used in the masculine gender will be construed to include the feminine gender, where appropriate, and vice versa.

2. Words used in the singular will be construed to include the plural, where appropriate, and vice versa.

3. The headings and subheadings in this Agreement are inserted for convenience of reference only and are not to be considered in the construction of any provision of the Agreement.

4. If any provision of this Agreement or the Health Plan is held to violate any state or federal law or to be invalid for any other reason, that provision will be deemed to be null and void. The invalidation of a provision will not otherwise impair or affect the remainder of the Agreement.

5. The Agreement will be construed and governed in all respects under and by the internal laws of the State of Indiana and federal laws and statutes, as applicable.

6. As an HMO, SIHO operates primarily on the basis of arranging for network services on a negotiated rate, direct service basis rather than an indemnity basis. This Agreement will be interpreted with this prepaid, direct service nature of SIHO's services in mind.

II. ELIGIBILITY

Unless SIHO and Employer agree otherwise, the following eligibility rules apply:

A. Participant Eligibility

To enroll as a Participant an individual must reside in the Service Area and must be eligible for coverage as defined under the ACA and the applicable rules of the Exchange, as set forth by the Indiana Department of Insurance. Eligibility requirements for a Qualified Individual under a Qualified Health Plan include:

1. U.S. citizenship, or be a qualified U.S. national;
2. For a non-citizen, be lawfully present in the United States for the entire coverage period;
3. Be an Indiana resident, and living within the service area covered by this contract;
4. Not institutionalized (whether in a penal institution, a mental institution, or other similar arrangements);
5. Not be covered by, nor eligible for, Medicare, whether Parts A, B or D;
6. Not covered by any other health benefit plan, whether group or individual;
7. Not receiving any SSP (State Supplementary Payments) or similar subsidies;
8. Be over 21 years of age, and have the capacity to legally enter into a contract;
    a. If under 21 years of age, a Participant must;
        i. Not be eligible for Medicaid, SSP, or similar government programs, whether federal or state;
        ii. Not be institutionalized;
        iii. Not be emancipated;
        iv. Be capable of legally entering into a contract, or be capable of having a guardian sign;
9. Willing to reveal any and all other health benefit arrangements, including any that affect coordination of benefits, both at the outset of coverage and at any time during the coverage under this contract.
10. Willing to and agree to pay the required premiums for coverage under this contract.

B. Dependent Eligibility

To enroll as a Dependent an individual must be:

1. The spouse of a Participant, except a divorced spouse; or

2. A Child

A Dependent Child's Coverage will terminate when the Child attains the age of 26, unless the Child has a mental or physical disability that manifested itself prior to the age of 26 and renders the Child incapable of self-sustaining employment and the Child depends upon the Participant for support and maintenance.

The Participant must furnish SIHO with proof of the Dependent's incapacity within 120 days of the date the Child attained the age of 26 and at each subsequent open enrollment period. SIHO may continue to require such proof at reasonable times each year except that, after the first two years, SIHO may not request proof more than once a year.

C. Other Rules of Eligibility

1. No one will be denied enrollment or re-enrollment in the Health Plan because of health status, requirements for Medical Care, or the existence of a pre-existing physical or mental condition.

2. No one may re-enroll in the Health Plan if his Coverage has been terminated under Article IX, Section A3, for failure to furnish information or furnishing incorrect or incomplete information, or under Article IX, Section A4, for misuse of identification card. Also, no one may re-enroll in the Health Plan if his Coverage has been terminated under Article IX, Section A5, for failure to pay certain amounts due unless the amounts have been fully paid subsequent to the termination and re-enrollment is approved by SIHO in its discretion.

3. A Participant may not enroll the spouse or dependent of a Child as a Dependent in the Health Plan.

D. Enrollment

Individuals and their eligible dependents who meet the requirements of this Article II may enroll by completing SIHO's enrollment applications and submitting them to SIHO. SIHO must receive the applications before applicants will be considered for enrollment.

III. MANAGED CARE

The goal of managed care is to reduce the cost of Medical Care while maintaining or improving the quality of those services. Managed care methods include, but are not limited to,

utilizing Primary Care Physicians to manage the Enrollee's health care, Precertification, case management, disease management, and utilization review.

A. Non-Network Benefits: Out-of-Plan Deductibles and Higher Coinsurance.

If an Enrollee receives Medical Care from a Consulting Provider or Non-Participating Provider without a written authorization from the Health Plan Medical Director, the Covered Benefits will be subject to higher Deductibles and Coinsurances. These provisions may not apply to coverage for Emergency Accident or Emergency Illness

B. Non-Network Benefits: Non-Participating Provider Reimbursement

If an Enrollee receives Medical Care from a Non-Participating Provider, SIHO will pay the Non-Participating Provider no more than the most recently published Medicare reimbursement rates for those services. The Non-Participating Provider may bill the enrollee for any difference between their billed charges and the Medicare reimbursement rates, if applicable. These provisions may not apply to coverage for Emergency Accident or Emergency Illness.

C. Precertification

Precertification ensures that the Medical Care an Enrollee will receive is covered by the Health Plan. The description of Covered Benefits in Article IV and the Schedule of Benefits indicate the types of Medical Care that require Precertification. If an Enrollee needs Precertification of Medical Care, the Enrollee or someone on the Enrollee's behalf (such as a family member or PCP) needs to call SIHO or their Delegated Network at the number indicated on the Enrollee's identification card. See Article XV for additional information regarding Precertification.

D. Individual Case Management

The goal of case management is to ensure that an Enrollee receives appropriate care in the most cost-effective setting. If an Enrollee has a catastrophic injury or illness or otherwise needs long-term medical care, SIHO will work with the Enrollee, the Enrollee's PCP or specialist, and the Enrollee's family members, if appropriate, to develop a treatment plan. As part of the treatment plan, SIHO may provide benefits for services that are not otherwise covered by the Health Plan. SIHO must approve and arrange for all customized services and alternative care arrangements. Coverage for alternative care is subject to the same maximums, Deductibles, Coinsurances and Copayments that apply to Medical Care being replaced.

E. Chronic Disease Management

If an Enrollee has a chronic disease, SIHO will work with the Enrollee and the Enrollee's PCP or specialist to whom the Enrollee is properly referred to develop an appropriate treatment plan in a cost-effective manner. Examples of chronic diseases include, but are not limited to, diabetes, asthma, and heart disease.

F. Medical Necessity, Experimental or Investigational Determinations and Utilization Review

The Health Plan Medical Director, or his designee, is responsible for determining whether Medical Care is Medically Necessary, Experimental or Investigational and for making all other medical benefit determinations. Whenever a benefit determination is based on a decision of whether the service is Medically Necessary, the decision is subject to utilization review by a member of a qualified panel appointed by SIHO.

G. Qualifications of Medical Provider

The Health Plan Medical Director, or his designee, has discretion to decide whether certain Medical Care must be provided by a physician or may be provided by other appropriately licensed health professionals.

IV. BENEFITS AND COVERAGE

This Article describes the Medical Care that will be covered by the Health Plan. The Schedule of Benefits attached indicates the extent of Coverage that will be provided, including any Deductible, Copayment, or Coinsurance requirements and maximum Coverage limitations. Article V lists any exclusions and limitations applicable to the services or supplies described in this Article. All Medical Care must be Medically Necessary and provided in accordance with the provisions of this Agreement. SIHO may change the benefits described in this Article IV and the Schedule of Benefits in accordance with any changes in applicable federal or state law.

A. Inpatient Hospitalization and Surgery (Requires Precertification)

Room and Board: semi-private room.

> Note: If an Enrollee chooses a private room, the Enrollee is responsible for paying any amount in excess of the Prevailing Rate for the average semi-private hospital room, unless use of a private room is Medically Necessary or the hospital only has private rooms.

Room and board: ancillary charges.

Specialty care units such as intensive care, cardiac care, and burn care units.

Surgery services including diagnostic services and therapy services directly related to the covered surgery, x-rays, assistant surgery services, and other physician or specialist fees.

Anesthesia, including local and general anesthesia.

Inpatient medical visits.

Pregnancy services and supplies, including examination and testing of newborns

Coverage for the Inpatient postpartum stay for you and your newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care. Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if your attending Physician determines further Inpatient postpartum care is not necessary for you or your newborn child, provided the following are met and the mother concurs:

- In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:

  1. the antepartum, intrapartum, and postpartum course of the mother and infant;
  2. the gestational stage, birth weight, and clinical condition of the infant;
  3. the demonstrated ability of the mother to care for the infant after discharge; and
  4. the availability of post-discharge follow-up to verify the condition of the infant after discharge.

Hospital ancillary services, including diagnostic services.

Human organ and tissue transplants when provided by a Center of Excellence as follows:

1. Precertification Requirement for Transplant Evaluation

   Expenses incurred in connection with the evaluation of an Enrollee for any human organ or tissue transplant will be covered but only after Precertification through SIHO has occurred. The Enrollee or his physician should contact SIHO for Precertification of the evaluation process.. SIHO will assign a case manager to work with the Enrollee closely through the transplant process.

2. Precertification Requirement for Transplant Procedure

   After the evaluation by a Health Plan-designated transplant physician has occurred, the Enrollee or the transplant physician should contact the case manager. Medical information about the Enrollee's condition and the proposed transplant protocol will be requested for review. The case manager will coordinate the review of the medical information for coverage determination and to determine whether the transplant is Medically Necessary. The case manager will communicate the determination to the Enrollee and transplant physician.

3. Definitions

a. **"Covered Transplant Procedures"** means any of the following human organ and tissue transplant procedures determined to be Medically Necessary:

(1) Heart

(2) Liver

(3) Bone Marrow (related or unrelated)

(4) Lung

(5) Kidney

(6) Cornea

(7) Simultaneous Pancreas/Kidney

(8) Simultaneous Heart/Lung

(9) Intestinal

(10) Simultaneous Intestinal/Liver

(11) Simultaneous Intestinal/Pancreas

b. **"Transplant Services"** means any services directly related to a Covered Transplant Procedure and performed at a Center Of Excellence including, but not limited to, inpatient and outpatient hospital services, physician services for diagnosis, treatment, and surgery for a Covered Transplant Procedure, diagnostic services, and procurement of an organ or tissue, including services provided to a living donor of an organ or tissue for procurement of an organ or tissue, as well as surgical, storage and transportation costs incurred and directly related to the successful acquisition of an organ or tissue used in a Covered Transplant Procedure. Transplant Services also includes, but is not limited to, durable medical equipment rental outside of the hospital, prescription drugs including immunosuppressive, surgical supplies and dressings, and home health care.

Note: Transportation and lodging are covered, as approved by the Plan, up to a $10,000 benefit limit per transplant. Unrelated donor searches for bone marrow/stem cell transplants for a Covered Transplant Procedure are covered, as approved by the Plan, up to a $30,000 benefit limit.

4. Specific Exclusions for Organ/Tissue Transplants

There are no benefits for:

a. Services and supplies of any provider located outside the United States of America, except for procurement services which will be limited to those nations which share the same protocols, standards and registry with the United States.

b. Services and supplies which are eligible to be repaid under any private or public research fund, whether or not such funding was applied for or received.

c. Implant of an artificial or mechanical heart or part thereof. This does not include replacement of a heart valve.

d. Services for non-human organ transplants.

e. All other exclusions, limitations or conditions set forth in this Health Plan shall apply to Transplant Services unless otherwise provided in this Transplant Services section.

B. Physician Services and Outpatient Services

Physician office and home visits.

Physical examinations as set forth in the Preventive Health Benefits Guidelines

Well baby care, including immunizations and infant screening tests, as set forth in the Preventive Health Benefits Guidelines.

Specialist care/consultation.

Pregnancy services including prenatal and postnatal care.

X-ray, lab, and diagnostic services.

Breast cancer screening Coverage includes:

a. One mammography for female Enrollees age 35 to 39;

b. One mammography per year for female Enrollees under age 40 who are considered "at risk." An Enrollee is considered "at risk" if she meets one of the following criteria:

(1) The Enrollee has a personal history of breast cancer;

(2) The Enrollee has a personal history of breast cancer that was proven benign by biopsy;

(3) The Enrollee's mother, sister, or daughter has had breast cancer; or

(4) The Enrollee is at least 30 years old and has not given birth.

c. One mammography per year for female Enrollees age 40 or older; and

d. Any additional mammography and ultra sound services that are Medically Necessary

Breast reconstruction and prosthesis following a mastectomy

Colorectal cancer screening Coverage includes:

1. Testing for Enrollees age 50 or older; and

2. Testing for Enrollees under age 50 that is considered at high risk for colorectal cancer according to the most recent published guidelines at the American Cancer Society.

Prostate cancer screening Coverage includes:

1. One screening per year for male Enrollees age 50 or older; and

2. One screening per year for male Enrollees under age 50 who are considered at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

Outpatient surgery (Requires Precertification)

Radiation therapy for the treatment of disease by x-ray, radium or radioactive isotopes (Requires Precertification)

Chemotherapy for the treatment of disease by chemical or biological antineoplastic agents (Requires Precertification)

Dialysis treatment for acute renal failure or chronic irreversible renal insufficiency for removing waste materials from the body. Dialysis requires Precertification. Please review the Schedule of Benefits for specific limits.

Respiratory inhalation therapy for the introduction of dry or moist gases and water vapor into the lungs.

Family planning, infertility screening, diagnostic testing, and counseling to determine infertility. Covered Benefits may include treatment or surgical procedures for infertility/fertility conditions. Please refer to the Schedule of Benefits.

Chiropractic and other manipulative services to treat structural imbalance or to remove nerve interference in connection with distortion, misalignment or sublaxation of or in the vertebral column. Chiropractic and other manipulative services are subject to an annual maximum.

Routine vision screening (Snellen eye chart) by Primary Care Physician during an office visit.

Routine hearing screening (Audiometric testing) by Primary Care Physician during an office visit.

Physical medicine therapies, which include the following:

> Physical therapy, hydrotherapy, heat or similar therapies, and therapies using physical agents or bio-mechanical and neuro-physiological methods. The therapies must be designed to relieve pain, restore function, and prevent disability following disease, injury, or loss of body part.
>
> Speech therapy for speech impairment resulting from disease, surgery or injury. Speech therapy does not include language training for educational, psychological or developmental speech delays. Benefits will not be provided for speech therapy provided by schools.
>
> Occupational therapy for the treatment of physically disabled Enrollees. The therapies must be designed to restore the Enrollee's ability to perform ordinary tasks of daily living.
>
> Note: The Health Plan covers a limited number of visits for physical medicine therapies. Please review the Schedule of Benefits for specific limits.

Immunizations as set forth in the Preventive Health Benefits Guidelines.

Cardiac rehabilitation, which is an individually prescribed exercise program for cardiac patients. Cardiac rehabilitation is designed for Enrollees who have had bypass surgery, stable angina pectoris, or acute myocardial infarction within the past twelve months. Home exercise programs, on-going conditioning and maintenance are not covered.

> Note: The Health Plan covers a limited number of visits for cardiac rehabilitation. Please review the Schedule of Benefits for specific limits.

Treatment for Autism Spectrum Disorder as prescribed by a Participating Physician in a treatment plan for the Enrollee. Treatment is subject to the same Coinsurance, Copayments and Deductibles as other primary health care services and benefits.

> Note: Exclusions and limitations contained elsewhere in the Health Plan do not apply to the treatment of Autism Spectrum Disorder.

C. Mental Illness and Substance Abuse. (Requires Precertification)

Inpatient, outpatient and physician office services for treatment of mental health disorders and substance abuse. Services covered include:

- Inpatient services
- Individual psychotherapy
- Psychological testing
- Family counseling to assist in diagnosis and treatment of Enrollee
- Convulsive therapy, including electroshock treatments and convulsive drug therapy
- Partial hospitalization/intensive outpatient therapy
- Outpatient services

Please review the Schedule of Benefits for specific limits.

D. Other Benefits and Services.

Ambulance Services; Local transportation by a vehicle designed, equipped and used only to transport the sick and injured. The following services, if Medically Necessary, are covered: (1) transportation from the home of the Enrollee, the scene of the accident or the scene of the medical emergency to a hospital, (2) transportation between hospitals, (3) transportation between a hospital and a Skilled Nursing Facility, and (4) transportation from a hospital or skilled nursing facility to the home of the Enrollee. Ambulance trips must be made to the closest local facility that can give Covered Services appropriate for the condition.

Emergency care services received at a hospital or other health care provider facility for an Emergency Accident or Emergency Illness.

Note: Benefits for emergency care services performed by Non-Participating Providers will be calculated by the greater of:

- The amount negotiated with Participating Providers for emergency care services;
- The amount for emergency care services as calculated elsewhere in this Agreement for Non-Participating Providers, but substituting cost sharing provisions applicable to a Participating Provider
- Applicable Medicare reimbursement

Allergy testing and treatment.

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Benefit under this Plan. Covered Benefits are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child.
- Breast reconstruction resulting from a mastectomy.
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Prescription drugs limited to those medicines requiring a prescription under federal law (Experimental or Investigational drugs are not included), insulin, and insulin syringes. The Health Plan does not provide Coverage for vitamins. The Health Plan will provide Coverage for pre-natal vitamins if pregnancy services and supplies are otherwise covered. The Health Plan may provide Coverage for other categories of drugs. Please refer to the Schedule of Benefits for specific exclusions.

Note: Coverage is provided for "off label drug treatment" to the extent required by Indiana law.

Medical supplies received during a primary or specialty care office visit or on an inpatient basis. The supplies must be primarily and customarily used to serve a medical purpose and generally not useful to an individual in the absence of an illness or injury.

Medical aids, including prosthetic devices, durable medical equipment, and orthotic appliances. Precertification is required for all rentals of medical aids and for purchases of medical aids that cost more than $200.

Covered Benefits for prosthetic devices are limited to the initial purchase, fitting, repair and replacement of fitted devices that replace body parts or perform bodily functions. Routine maintenance is not a Covered Benefit and charges for deluxe items are limited to the cost of standard items.

Covered Benefits for durable medical equipment are limited to the rental, repair and replacement of equipment that is appropriate for home use and manufactured mainly to treat the injured or ill. Routine maintenance is not a Covered Benefit and charges for deluxe items are limited to the cost of standard items.

Covered Benefits for orthotic appliances are limited to the initial purchase, fitting, repair, and replacement of braces, splints, and other appliances, used to support or restrain a weak or deformed part of the body. Covered Benefits do not include foot support devices, such as arch supports and corrective shoes (unless they are an integral part of a leg brace), and standard elastic stockings, garter belts, and other supplies not specifically made or fitted. Routine maintenance is not a Covered Benefit and charges for deluxe items are limited to the cost of standard items.

Diabetes treatment, supplies, equipment, and self-management training.

Eyeglasses after cataract surgery. Limited to one initial pair of eyeglasses after cataract surgery is performed.

Medical Food that is Medically Necessary and prescribed for an Enrollee by a physician for treatment of the Enrollee's Inherited Metabolic Disease.

Medical Services for treatment of victims of abuse.

Covered Benefits for Clinical Trials

Routine patient care costs that are covered:

- That payer would cover for a patient not enrolled in a clinical trial
- Services required for the provision of the investigational item or service
- Services needed for reasonable and necessary care arising from the provision of the investigational item or service.

Routine patient care costs that are not covered:

- Investigational item, device, or service, itself;
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

In order to be considered a Covered Benefit the following criteria must be met:

- A physician must determine and document that the member is appropriate for a clinical trial; and
- The member must meet the eligibility criteria of the trial.

- The trial must be:
    - Conducted for the prevention, detection or treatment of cancer or other life threatening disease or condition**; and is**
    - Federally funded; or
    - Sponsored by FDA; or
    - A drug trial exempt from Investigational New Drug (IND) requirements.

A trial is considered federally funded if it is approved and funded by one or more of these agencies:

- National Institutes of Health
- Centers for Disease Control
- Agency for Healthcare Research Quality
- Centers for Medicare and Medicaid Services
- Department of Defense
- Veterans Administration; or the
- Department of Energy.

E. Alternative Care Facilities. (Requires Precertification)

Skilled Nursing Facility (SNF).

Room and board.

Note: If the Enrollee chooses a private room, the Enrollee is responsible for paying any amount in excess of the Prevailing Rate for the average semi-private SNF room unless use of a private room is Medically Necessary or the SNF has only private rooms. In those cases the private room is covered subject to the same Deductible, Copayment and Coinsurance as a semi-private room.

Note: The Health Plan covers a limited number of days in a SNF. Please review the Schedule of Benefits for the specific limits.

Ancillary services including diagnostic services.

Home Health Care for home confined Enrollees referred to a home health care agency by a Participating Physician and approved by the Health Plan Medical Director. Covered Benefits are for non-custodial medical and nursing care. Home infusion therapy will be paid only if you obtain prior approval from our home infusion therapy administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy. Covered Benefits also include nutritional counseling.

Note: The Health Plan may cover a limited number of days of Home Health Care. Please review the Schedule of Benefits for any specific limits.

Hospice Care

Note: Requires a physician's statement of life expectancy less than 6 months.

F. Acute Inpatient Rehabilitation Facility. (Requires Precertification)

Note: To be eligible for Acute Inpatient Rehabilitation Services, an Enrollee must be able to participate in a comprehensive level of rehabilitation services. The services will include a minimum of three hours of therapy treatments per day with goals that can be accomplished through hospitalization. These services must happen immediately following inpatient hospital services.

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Note: The Health Plan covers a limited number of days in an Acute Inpatient Rehabilitation Facility. Please review the Schedule of Benefits for specific limits.

G. Long Term Acute Care Hospital (LTACH) Services (Requires Precertification)

Note: The Health Plan covers a limited number of days for LTACH Services. Please review the Schedule of Benefits for specific limits.

H. Preventive Health Services

The Health Plan provides Coverage for well-baby care, regular periodic health evaluations for adults and children, periodic health screenings, and routine immunizations appropriate to the age and sex of the Enrollee. All of the preventive health services are described in the Preventative Health Benefits Guidelines, which SIHO makes available to Enrollees.

I. Treatment of Dental Conditions Caused by Accidental Injuries

The Health Plan provides Coverage for the treatment of dental conditions caused by accidental injuries. The injuries must have occurred after the effective date of the Enrollee's Coverage. Benefits will be denied if the dental condition was not caused by an accidental injury. Enrollees must report the date of the accident and may be asked to supply other information about the accident before accidental dental benefits will be provided. Covered Benefits do not include damage to teeth or gums resulting from chewing or biting in the normal course of day-to-day activity

.**Note:** The Health Plan provides an annual maximum of $3,000 dollars for the treatment of dental conditions for the repair of fractures, dislocations, and other

injuries of the mouth and jaw as related to Dental Conditions Caused by Accidental Injury.

J. Temporomandibular Joint Disorder

The Health Plan provides Coverage for Temporomandibular Joint Disorder (TMJ) if medically necessary.

K. Pediatric Vision Essential Benefit

The Health Plan provides Coverage for pediatric vision as mandated under the ACA. Pediatric vision benefits are provided until the Child attains age 19. Refer to Attachment C for the schedule of benefits.

V. EXCLUSIONS AND LIMITATIONS ON BENEFITS

A. Exclusions

SIHO's obligations under this Agreement are subject to the following exclusions. (Note: these exclusions do not apply to the treatment of Autism Spectrum Disorder, as prescribed by a Participating Physician in a treatment plan for the Enrollee.)

1. Institutional care in a hospital or other facility primarily for domiciliary, convalescent or Custodial Care purposes.

2. Court ordered services unless Medically Necessary and approved by the Health Plan Medical Director.

3. Personal comfort items such as televisions, telephones, private rooms, housekeeping services, meals or special diets, except as specifically provided in this Agreement.

4. Medical Care to treat injury or sickness caused by or related to an act of declared or undeclared war; serving in the military forces of any country, which includes serving in a non-military unit that supports such forces; the Enrollee’s committing, attempting to commit, or participating in a civil battery, illegal act, or any other crime; and taking part in a riot.

5. Medical Care for disabilities related to military service if the Enrollee is legally entitled to receive services from the Veterans Administration and adequate facilities are reasonably available to the Enrollee in SIHO's Service Area.

6. Care for conditions for which state or local law requires treatment in a public facility.

7. Hospital admission from Friday 8:00 p.m. through Monday 12:01 a.m. unless surgery is performed on that day or because of an Emergency Accident or Illness.

8. Cosmetic or plastic surgery primarily intended to improve appearance. Benefits are provided for care or treatment intended to restore bodily function or correct a deformity that results from disease, accidental injury, birth defects, or medical procedures. The medical procedure must have been a Covered Benefit. The Health Plan covers reconstructive surgery as required under the Women's Health and Cancer Rights Act of 1998.

9. Sclerotherapy, for the treatment of varicose veins of the extremities.

10. Services and supplies rendered to treat hair loss or to promote hair growth, including but not limited to hair transplants and wigs, except as mandated under the Affordable Care Act.

11. Medical, surgical or other health care procedures deemed Experimental or Investigational by the Health Plan.

12. Organ transplants deemed Experimental by the Health Plan.

13. Medical Care rendered on behalf of a donor or prospective donor when the recipient of an organ transplant is not a Health Plan Enrollee.

14. Care for mental illness, alcoholism, and drug addiction, except as provided in this Agreement.

15. Developmental treatment and education for mental retardation and mental deficiency to the extent not Medically Necessary.

16. Routine eye examinations or refraction for eyeglasses or contact lenses and furnishing, fitting, installation or use of eyeglasses or contact lenses except those pediatric essential vision benefits described in Article IV.

17. Radial keratotomy, corneal modulation, refractive keratoplasty, or any similar procedure.

18. Furnishing, fitting, installation or use of hearing aids. Surgical implantation and cochlear stimulating devices.

19. Routine injection of drugs and immunizations, except as otherwise provided in this Agreement.

20. Transportation services, unless Medically Necessary and authorized by SIHO or necessitated by an Emergency Accident or Emergency Illness.

21. Dental or oral surgical services or devices for teeth and gums. Covered Benefits include, however, oral surgical procedures related to the following: (a) excision of tumors and cysts of the jaw and mouth; (b) repair of fractures, dislocations, and other injuries of the mouth and jaw, as described in Article IV under the heading "Treatment of Dental Conditions Caused by Accidental Injuries "; (c) treatment of oral and facial cancer; (d) external incisions and drainage of cellulitis; (e) incision of accessory sinuses, salivary glands and ducts; (f) repair and treatment of congenital defects and birth abnormalities including dental treatment involved in the management of birth defects known as cleft lip and cleft palate. Covered Benefits also include anesthesia and hospital services for dental care for an Enrollee whose mental or physical condition requires dental treatment to be rendered in a hospital or an ambulatory outpatient surgical center.

22. Over-the-counter medications, except for those for which the Enrollee has a prescription and for which coverage is required under the ACA.

23. The cost of durable medical equipment, except as provided in this Agreement.

24. The cost of prosthetic devices except as provided in this Agreement.

25. The cost of medical supplies except as provided in this Agreement.

26. Transsexual surgery and related services, except in those instances when Medically Necessary due to congenital defects.

27. Reversal of voluntary sterilization.

28. Genetic counseling.

29. Sex therapy and counseling.

30. Vocational rehabilitation.

31. Family or marriage counseling.

32. Blood tests required in order to obtain a marriage license.

33. Diagnosis and treatment of:

    a. weak, strained, unstable or flat feet which includes supportive devices for the feet such as corrective shoes and arch supports; or

    b. any tarsalgia, metatarsalgia or bunion; except for surgeries which involve the exposure of bones, tendons or ligaments; or

    c. trimming of corns, calluses, or nails, other than the removal of nail matrix or roots; or

d. superficial lesions of the feet, such as corns, calluses and hyperkeratoses.

Note: Treatment will be provided to Enrollees with neurovascular conditions or diabetes to prevent foot ulcerations.

34. Acupuncture, biofeedback, hypnotherapy, sleep therapy, and behavioral training.

35. Chiropractic or manipulative services except as provided in this Agreement.

36. Speech therapy, except as provided for in this Agreement.

37. Expenses resulting from or relating to premarital exams, infertility or impotency, except as otherwise provided in the Agreement.

38. Surgical procedures performed for the purpose of correcting myopia, (nearsightedness), hyperopia (farsightedness), astigmatism and expenses related to such procedures.

39. Biomicroscopy, field charting, aniseikonic investigation, orthoptic or visual training.

40. Drugs considered Experimental or Investigational.

41. Health exams except those resulting from an accidental injury or sickness and those covered under the Preventive Health Benefits Guidelines.

42. Medical care which SIHO determines is not Medically Necessary or does not meet its medical or benefit policy guidelines.

43. Medical care required while incarcerated in a penal institution or while in custody of law enforcement authorities.

44. Charges arising out of or in the course of any employment or occupation for wage or profit if benefits are available under any Workers Compensation Act or similar law. If Workers Compensation Act benefits are not available then this Exclusion does not apply.

45. Charges in excess of SIHO's Prevailing Rates.

46. Medical care received in an emergency room which is not related to an Emergency Accident or Emergency Illness, except as specified elsewhere in this Agreement.

47. Medical costs associated with artificial or mechanical hearts and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the devices remain in place. This exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

48. Supplies, devices or medications with over the counter equivalents and any supplies, devices, or medications that are therapeutically comparable to an over the counter supply, device, or medication.

49. Human organ and tissue transplants performed by a provider not affiliated with a SIHO approved Center of Excellence.

50. Charges incurred outside the United States (a) if the Enrollee traveled to a location outside of the United States for the primary purpose of obtaining medical services, drugs or supplies or (b) if the drugs or supplies were delivered to the Enrollee from a location outside of the United States.

51. Charges arising out of any Never Events or other conditions acquired during a stay at an Institutional Health Care Provider, that are present at discharge.

52. Complications directly related to a service or treatment that is determined to be Experimental/Investigational or non-Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non-Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non-Medically Necessary service.

53. Massage Therapy care and treatment whether or not performed by a massage therapist unless part of a physical treatment plan.

54. For any services or supplies provided to a person, whether covered under this Plan or not, in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

55. Abortion services, supplies, care or treatment unless the life of the mother is endangered by the continued pregnancy or the pregnancy is the result of rape or incest.

56. [Treatment for weight loss, including but not limited to gastric bypass; gastric stapling or balloon catheterization; liposuction or reconstructive surgery; diet, health or exercise programs; health club dues; weight reduction medications; or weight reduction clinics. Nonexperimental, surgical treatment of Morbid Obesity is covered to the extent required by law. Please review Article IV for a description of Coverage provided for treatment of Morbid Obesity.]

B. Limitations.

The rights of Enrollees and obligations of SIHO and Participating Providers are subject to the following limitations:

1. Circumstances Beyond Health Plan's Control. Neither SIHO nor any Participating Provider will be responsible for providing Covered Benefits if circumstances outside SIHO's control render the provision of Covered Benefits impracticable. These circumstances include, but are not limited to, unplanned computer system or power outages, labor unrest, complete or partial destruction of facilities, major disaster, epidemic, war, riot, civil insurrection, disability of a significant part of Participating Provider's personnel, or similar causes. SIHO will make a good faith effort to arrange for alternative methods to provide the Covered Benefits.

2. Refusal of Treatment. Certain Enrollees may, for personal reasons, refuse to accept procedures or treatment recommended by Participating Providers. A Participating Provider may regard Enrollee's refusal as incompatible with continuing the provider-patient relationship and an obstruction of proper Medical Care. If an Enrollee refuses to accept treatment or procedures recommended by a Participating Provider, the Enrollee may consult with another Participating Provider of his or her choosing. If, after having adequate time to consider treatment alternatives, the Enrollee refuses to accept that Participating Provider's recommended course of treatment or procedures and both the Participating Providers and SIHO believe that no medically acceptable alternative exists, the Enrollee will be so advised. If the Enrollee still refuses to accept a recommended treatment or procedure, then neither the Participating Providers nor SIHO will have further responsibility to provide or arrange for treatment of the condition. This provision does not affect the Health Plan's obligation to provide Coverage for medically acceptable treatments for the condition otherwise covered by the Health Plan.

3. Medical Non-Compliance It is expected that the Enrollee will follow the advice of the Provider rendering or arranging services. If the Enrollee is receiving health services in a harmful or abusive quantity or manner or with harmful frequency, as determined by SIHO, the Enrollee may be required to select a single Participating Physician and a single Participating Hospital (with which the single Participating Physician is affiliated) to provide and coordinate all future health services. If the Enrollee fails to make the required selection of a Participating Physician and a single Participating Hospital within thirty-one (31) days of written notice of the need to do so, then SIHO shall designate the required single Participating Physician and Participating Hospital for the Enrollee. In the case of a medical condition which, as determined by SIHO, either requires or could benefit from special services, the Enrollee may be required to receive covered health services through a single Participating Provider designated by SIHO. Following selection or designation of a single Participating Provider, coverage is contingent upon all health services being provided by or through written referral of the designated Participating Provider.

4. Failure to Render Services. If a Participating Provider fails to or is unable to render Medical Care to an Enrollee, SIHO will arrange for another Participating Provider to provide the Medical Care.

VI. OTHER PARTY LIABILITY

A. Subrogation.

If SIHO provides benefits under this Agreement for an illness or injury caused by a third party's alleged wrongdoing and the Enrollee recovers on a claim against the third party, SIHO has a right to be reimbursed for the reasonable cash value of the benefits provided. If the Enrollee does not recover the full value of his claim, SIHO will be reimbursed out of the recovery on a pro rata basis. SIHO may take whatever legal action it sees fit against the third party to recover any benefits provided under this Agreement. SIHO's exercise of this right will not affect the Enrollee's right to pursue other forms of recovery, unless the Enrollee or his legal representative consents otherwise.

SIHO has the right to the Enrollee's full cooperation in any case involving the alleged wrongdoing of a third party. The Enrollee is obligated to provide SIHO with whatever information, assistance, and records SIHO needs to enforce its rights under this provision, including, but not limited to, any consents, releases, and assignments.

B. Coordination of the Agreement's Benefits with other Benefits (COB).

1. Applicability.

This Coordination of Benefits ("COB") section applies when an Enrollee has health care coverage under more than one "Plan," as defined below. The Order of Benefit Rules in Subsection 3 determines whether the benefits of this Health Plan are determined before or after those of another Plan. If the Order of Benefit Rules determines that this Health Plan is the "Primary Plan," as defined below, then the benefits of this Health Plan will not be reduced. If the Order of Benefit Rules determines that this Health Plan is the "Secondary Plan," as defined below, then the benefits of this Health Plan may be reduced.

2. Definitions.

The following definitions apply throughout this Article VI, Section B, but do not apply to the rest of this Agreement:

a. **"Allowable Expense"** means a necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more Plans covering the individual for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is Medically Necessary. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. When benefits are reduced under a Primary Plan because a covered individual does not comply with the plan

provisions, the amount of the reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

b. **"Claim Determination Period"** means a calendar year. However, it does not include any part of a year during which an individual does not have Coverage under this Health Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

c. **"Plan"** means this Health Plan and any of the following arrangements that provide benefits or services for, or because of, medical or dental care or treatment:

(1) Employer insurance or Employer-type coverage, whether insured or uninsured. This includes prepayment, Employer practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

(3) Coverage under an individual health or HMO policy, excluding accident only, specified disease, limited benefit plan, fixed indemnity, or Medicare supplement plans.

(4) The medical benefits coverage in group, group-type, and individual automobile “no-fault” and traditional “fault” type contracts.

(5) Any other coverage which, as defined by the Employee Retirement Income Security Act of 1974, is a union welfare plan, an employee organization plan, a labor management trustee plan, or an employee benefit organization.

(6) Medical care components of long term care contracts, such as skilled nursing care.

(7) Any other coverage provided because of membership in or sponsorship by any other union, association, or similar organization.

Each arrangement described above is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

d. **"Plan Year"** means, for the initial Plan Year, the twelve-month period commencing with the date that Employer's coverage under this Health Plan becomes effective. Thereafter, it means the twelve-month period commencing on the anniversary of Employer's Coverage under this Health Plan.

e. **"Primary"** or **"Primary Plan"** means the Plan that provides benefits for an individual before another Plan that covers the same individual. If this Health Plan is Primary to another Plan, this Health Plan's benefits will be determined before those of the other Plan without considering the other Plan's benefits.

f. **"Secondary"** or **"Secondary Plan"** means the Plan that provides benefits for an individual after another Plan that covers the same individual. If this Health Plan is Secondary to another Plan, this Health Plan's benefits will be determined after those of the other Plan and may be reduced as a result of benefits provided by the other Plan.

3. Order of Benefit Rules.

a. General. If there is a basis for benefits under this Health Plan and another Plan, this Health Plan is the Secondary Plan unless (1) the other Plan has rules coordinating its benefits with those of this Health Plan, and (2) the rules of this Health Plan and the other Plan require this Health Plan to be the Primary Plan.

b. Specific Rules. The following rules will be applied in the order they appear to determine whether this Health Plan is Primary or Secondary to another Plan:

(1) Non-Dependent/Dependent. The Plan that covers the individual as an active employee or inactive employee (i.e., laid-off or retired) rather than as a dependent is the Primary Plan except in the following situation. The Plan that covers the individual as a dependent is Primary to the Plan that covers the individual as an employee if the individual is also a Medicare beneficiary, and, as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is Secondary to the Plan covering the individual as a dependent and Primary to the Plan covering the individual as an employee.

(2) Medicare Election. For Medicare eligible individuals, the order of benefits and benefits paid will be determined presuming the eligible individual has enrolled in both Medicare Part A and Medicare Part B, irrespective of whether the individual has in fact enrolled in both parts. This provision does not apply if Medicare

coverage is Secondary to this Plan based on the size of the Employer Group.

(3) Dependent Child/Parents not Separated or Divorced. If two Plans cover the same child as a dependent of his parents, the Plan of the parent whose birthday falls earlier in a calendar year will be Primary. If both parents have the same birthday, then the Plan that has covered one parent longer will be the Primary Plan. However, if the other Plan has a rule based on gender instead of this birthday rule and, as a result, the Plans do not agree on the order of benefits, then the rule in the other Plan will determine the order of benefits.

(4) Dependent Child/Separated or Divorced. If two or more Plans cover the same child as a dependent of divorced or separated parents the following rules apply unless a qualified medical child support order ("QMCSO"), as defined in ERISA, specifies otherwise:

(a) the Plan of the parent with custody of the Child is Primary;

(b) the Plan of the spouse of the parent with custody of the child is the next Plan to be Primary; and

(c) the Plan of the parent without custody of the child is the last Plan to be Primary.

If a QMCSO states that a parent is responsible for the health care expense of a child, that parent's Plan is Primary as long as the administrator of the Plan has actual knowledge of the QMCSO. The plan of the other parent is the Secondary Plan. Until the plan administrator has actual knowledge of the QMCSO, then the rules stated in (a), (b), and (c) above apply for any Claim Determination Period or Plan Year during which benefits are paid or provided.

(5) Joint Custody. If a court order states that a child's parents have joint custody of the child but does not specify that one parent is responsible for the health care expenses of the child, the order of benefit rules in Paragraph b(3), Dependent Child/Parents not Separated or Divorced will apply.

(6) Active/Inactive Employee. A Plan that covers an individual as an active employee is Primary to a Plan that covers the individual as an inactive employee (i.e., laid-off or retired). This rule will be ignored if the other Plan does not have this rule and, as a result, the Plans do not agree on the order of benefits.

(7) Dependent of Active/Inactive Employee. A Plan that covers an individual as a dependent of an active employee is Primary to a Plan that covers an individual as a dependent of an inactive employee (i.e., laid-off or retired). This rule will be ignored if the other Plan does not have this rule and, as a result, the Plans do not agree on the order of benefits.

(8) Continuation Coverage. If an individual has Continuation Coverage under this Health Plan and also has coverage under another Plan as an employee or dependent, the other Plan is Primary to this Health Plan. This rule will be ignored if the other Plan does not have this rule and, as a result, the Plans do not agree on the order of benefits.

(9) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that has covered the individual longer will be Primary to the Plan that has covered the individual for a shorter term.

4. Effect on the Benefits of this Agreement.

a. Application. This Subsection 4 applies when the Order of Benefit Rules above determine that this Health Plan is Secondary to one or more other Plans.

b. Reduction of Health Plan's Benefits. This Health Plan's benefits will be reduced when the sum of (1) and (2) below exceeds the Allowable Expenses in a Claim Determination Period:

(1) The benefits that would be payable for the Allowable Expenses under this Health Plan in the absence of this COB provision; and

(2) The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of COB provisions like this Health Plan's COB provisions, whether or not a claim is made.

The benefits of this Health Plan will be reduced so that they and the benefits payable under the other Plans do not exceed the Allowable Expenses. Each benefit will be proportionally reduced and then charged against any applicable benefit limit of this Health Plan.

5. Facility of Payment.

If another Plan provides a benefit that should have been paid or provided under this Health Plan, SIHO may reimburse the Plan for the benefit. SIHO may then treat the amount as if it were a benefit provided under this Agreement and will not be responsible for providing that benefit again. This provision applies to the

payment of benefits as well as to providing services. If services are provided, then SIHO will reimburse the other Plan for the reasonable cash value of those services.

6. Right of Recovery.

If this Health Plan provides a benefit that exceeds the amount of benefit it should have provided under the terms of these COB provisions, SIHO may seek to recover the excess of the amount paid or the reasonable cash value of services provided from the following:

a. The individuals SIHO has paid or for whom SIHO has provided the benefit;

b. Insurance Companies; or

c. Other Organizations.

C. Worker's Compensation.

If an Enrollee is entitled to a benefit under this Health Plan that is also covered by workers' compensation laws, occupational disease laws, or other similar laws, then the benefit provided by this Health Plan will be reduced by the amounts payable under the other laws. This Health Plan will not provide benefits for services denied by the worker's compensation or other similar carrier due to the Enrollee's noncompliance with that carrier's policies, procedures, or medical provider's recommended treatment plan.

D. Right of Recovery.

If SIHO provides a benefit that, according to the terms of this Agreement, should not have been provided, SIHO may recover the reasonable cash value of the benefit provided or payment made from the recipient or other appropriate party. SIHO may recover under this Section, even if the benefit provided was the result of SIHO's error. If SIHO makes an incorrect payment to an Enrollee, SIHO may deduct the payment from future payments to be made to or on the behalf of the Enrollee.

E. Releasing or Obtaining Information.

Unless otherwise required by law, SIHO may release to or obtain from any other company, organization, or individual any information that SIHO deems necessary to apply this Article without obtaining the consent of or providing notice to the individuals involved. Any individual claiming benefits under this Health Plan must furnish SIHO with all of the information that SIHO deems necessary to implement the provisions of this Article VI.

VII. RELATIONS AMONG PARTIES AFFECTED BY THIS AGREEMENT

A. Health Plan and Participating, Consulting and Non-Participating Providers.

Participating Providers and Consulting Providers are independent contractors with respect to SIHO and the Health Plan. They are not employees or agents of SIHO. Non-Participating Providers do not have any contractual relationship with SIHO. They are not independent contractors, employees or agents of SIHO. SIHO is not liable for any act, error or omission of any Participating Provider, Consulting Provider, Non-Participating Provider, or any employee or agent thereof. Without limiting the foregoing, it is expressly understood and agreed that neither SIHO nor the Health Plan is engaged in the practice of medicine by virtue of providing for the payment of benefits hereunder, and all medical decisions are made solely by Enrollees and their medical providers.

VIII. ENROLLMENT FEES

A. Enrollment Fees.

Enrollee will pay SIHO the enrollment fees set forth in the Declarations. An Enrollee is not entitled to Coverage until SIHO receives an initial Enrollment Fee for the Enrollee. Thereafter, an Enrollee's Coverage will terminate if SIHO does not receive the monthly enrollment fee for the Enrollee by the time specified in the Declarations. If an Enrollee's Coverage is terminated for non-payment of the Enrollment Fee, the Coverage may be reinstated in accordance with the renewal application and re-enrollment provisions of this Agreement.

B. Grace Period.

1. Enrollees will have a grace period of 90 days to pay their premiums for coverage, provided that the first month’s premiums are paid timely. If the first month’s premiums are paid, and subsequent month’s premiums are not paid timely, claims incurred in those months will be held until the premiums are paid. If premiums are not paid for 90 days, coverage will be cancelled.

C. Other Charges.

Enrollees will be required to pay Copayments, Deductibles and Coinsurance for services in the amounts indicated in the Schedule of Benefits.

D. Change in Benefits.

SIHO reserves the right to increase the benefits provided by the Health Plan without Employer's express written consent as long as the increase in benefits does not increase Employer's enrollment fees during the contract period. SIHO will notify Employer of any increase in benefits.

IX. TERMINATION OF BENEFITS

A. Termination of Benefits.

1. Loss of Eligibility.

   If an Enrollee ceases to meet the eligibility requirements of Article II, then (subject to the continuation of coverage provisions of Article X), Coverage under this Agreement for the Enrollee terminates automatically at midnight of the last day of the billing period during which SIHO receives notice of the termination. Enrollee must notify SIHO immediately if the Enrollee ceases to meet the eligibility requirements.

2. Disenrollment.

   If a Participant enrolls in an Alternative Health Benefits Plan or other benefit plan for health coverage offered through Employer, then Coverage for the Participant and Participant's Dependent(s) will terminate automatically at midnight of the last day of the billing period during which SIHO receives notice of the termination.

3. Failure to Furnish or Furnishing Incorrect or Incomplete Information.

   To enroll in the Health Plan, each Enrollee must represent to the best of his knowledge and belief that all information provided SIHO in the enrollment applications, questionnaires, forms or statements for himself and his Dependents is true, correct and complete. If an Enrollee fails to furnish SIHO with information required under this Agreement or furnishes SIHO with false or misleading information, SIHO may (1) revise the enrollment fees to the amount that SIHO would have charged had it been provided complete and accurate enrollment information and (2) if the Enrollee refuses to pay the revised rate, SIHO will pursue all legal means available to collect the owed and unpaid premium. If an Enrollee's failure to furnish SIHO with information required under this Agreement or the furnishing of false or misleading information is determined to be fraudulent or intentional misrepresentation of material fact, SIHO may also terminate all rights and benefits provided to the Enrollee and his Dependents under the Health Plan retroactive to the date the Enrollee failed to furnish the information or furnished false or misleading information. The Enrollee will be responsible for reimbursing SIHO for its cost of any benefits provided after the effective date of the termination. SIHO's costs will be based on the Prevailing Rates charged for the services in the community less any Copayments or enrollment fees paid by the Enrollee and his Dependents. SIHO will notify the Enrollee in the event SIHO terminates Coverage for the Enrollee and/or his Dependents under this Subsection.

4. Misuse of Identification Card.

Participant shall not permit another individual to use the Participant's or his Dependent's Health Plan identification card to obtain services, nor shall the Participant use an invalid identification card to obtain services. If Participant violates this provision, SIHO will terminate the Coverage of the Participant and his Dependents effective immediately upon written notice to the Participant. Any Participant involved in the misuse of a Health Plan identification card will be liable to SIHO for the Prevailing Rates of any services rendered in connection with the misuse. If a Participant's card is lost or stolen, contact SIHO immediately to obtain a new card. SIHO reserves the right to charge a fee for any replacement card.

5. Nonpayment.

If a Participant fails to pay or make satisfactory arrangements to pay SIHO or any Participating Providers any amounts due under this Agreement, including any Copayments, SIHO may terminate the Coverage of the Participant and his Dependents effective immediately upon SIHO's written notice to Participant.

6. Termination of Agreement.

If this Agreement is terminated, then the rights of all Enrollees (except any rights to continuation of benefits specifically provided by this Agreement) will terminate on the termination date of the Agreement. Notwithstanding the termination for any of the reasons described in this Section IX.A., payments for enrollment fees or other amounts due to SIHO are due for the full month during which the termination occurred without pro-rata adjustment.

B. Cancellation.

This Agreement will continue in effect for the term indicated in the Declarations subject to the following:

1. Default in Payment.

Enrollee will have a grace period of 90days to pay SIHO any enrollment fees due under the Agreement after the due date of the enrollment fees. If Enrollee fails to pay SIHO the enrollment fees by the due date or within 90 days thereafter, all benefits provided under the Health Plan will terminate at the end of the period for which the enrollment fees have been paid. SIHO may deem Enrollee's failure to pay the enrollment fees as an action by Enrollee to cancel this Agreement and will notify Enrollee of the effective date that this Agreement is canceled. If Enrollee receives services under this Agreement during the 90-day grace period and cancellation follows, the Enrollee will be liable to SIHO for the Prevailing Rates, less any Copayments made, for any services provided during that 90-day grace period. SIHO may hold Claims incurred and received within the grace period until premiums are received before the end of the grace period.

2. Fraud.

If Enrollee performs an act or practice that constitutes fraud or an intentional misrepresentation of a material fact in connection with any Coverage under the Health Plan, SIHO may terminate all rights and benefits provided to Enrollees under the Health Plan. SIHO will notify Enrollees of the effective date of the Agreement's cancellation for fraud and will return any unused enrollment fees. Notwithstanding the termination for any of the reasons described in this Section IX.B.2., payments for enrollment fees or other amounts due to SIHO are due for the full month during which the termination occurred without pro-rata adjustment.

3. Violation of Participation Rules and Participants' Movement Outside Service Area.

In accordance with the Health Insurance Portability and Accountability Act of 1996, SIHO may terminate all rights and benefits hereunder if Enrollee fails to comply with a material Agreement provision relating to the participation of Enrollees in this Agreement or if no Enrollees live, reside or work in the Service Area.

4. Discontinuance of Product.

SIHO reserves the right to discontinue offering this Health Plan in this market. If SIHO discontinues the Health Plan, SIHO will notify Enrollees in writing at least 90 days before the discontinuance and will provide Enrollee with the option to choose coverage under an alternative health care delivery product offered by SIHO in this market.

5. Discontinuance of Health Care Coverage in Market.

SIHO reserves the right to discontinue offering all health care coverage in this market. If SIHO discontinues all health care coverage, SIHO will notify Enrollees in writing at least 180 days before the discontinuance.

C. Reinstatement.

1. Enrollee.

To reinstate Coverage after termination, an Enrollee must complete a reinstatement application unless termination resulted from inadvertent clerical error. No Enrollee's Coverage shall be adversely affected due to SIHO's clerical error.

D. Continuation of Coverage After Termination by Health Plan.

Upon termination of this Health Plan, inpatient Covered Benefits provided by a hospital for an Enrollee who is hospitalized on the effective date of termination will continue until the earliest of:

1. The date the Enrollee is discharged from the Hospital;

2. The passage of 60 days after the effective date of termination;

3. The date the Enrollee acquires health care coverage from another carrier that includes the coverage provided under the Health Plan;

4. The date SIHO terminates the Enrollee's Coverage because the Enrollee knowingly provided false information to SIHO, the Enrollee failed to comply with the terms of this Agreement, or the Employer failed to pay an enrollment fee;

5. The date the Enrollee terminates Coverage.

The provisions of this Section D do not apply to the termination of Coverage as a result of the receivership of SIHO.

X. RECORDS

SIHO will keep enrollment and eligibility records of each Enrollee. Enrollee must send SIHO information, in the form requested by SIHO, reflecting any changes in an Enrollee's enrollment or eligibility by the due date for the applicable monthly enrollment fee. SIHO is not liable under this Agreement in connection with any enrollment or eligibility changes until SIHO receives accurate information about the changes. If Enrollee supplies SIHO with incorrect or incomplete information, SIHO will not be liable in connection with the information until SIHO receives correct and complete information. Enrollee and SIHO will take appropriate action to prevent SIHO from incurring any financial loss as a result of incorrect or incomplete information supplied by an Enrollee. If SIHO incurs a financial loss as a result of such incorrect or incomplete information, then SIHO has the right to seek reimbursement for the loss from the Enrollee.

SIHO will comply with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and it's implementing regulations applicable to SIHO in handling health information protected by HIPAA. SIHO will not use or disclose an Enrollee's health information without authorization, except to the extent permitted or required under HIPAA. SIHO will not disclose health information protected by HIPAA to the Employer except to the extent required or permitted by law or authorized by the Enrollee.

XI. PROCEDURES FOR CLAIMING BENEFITS

A. Claim Filing.

If an Enrollee receives a bill directly from a provider, is required to pay for services at the time they are provided, or assigns his or her right to reimbursement to a provider with the consent of SIHO, the Claim may be submitted to SIHO for payment. In order to be

eligible for payment, the Claim must be submitted with receipts within 90 days of the date the services were rendered or, in the case of a Consulting or Participating Provider, within the timeframe for submitting claims set forth in the provider agreement in effect between the Consulting or Participating Provider and SIHO. Non-Participating Providers must submit claims to SIHO within 90 days of the date services were provided to be eligible for payment. If SIHO approves the Claim, SIHO will reimburse the Enrollee or provider, as appropriate, for Covered Benefits less any applicable Copayments, Deductible, Coinsurance, penalty, and any amounts that SIHO has already paid to the Enrollee or the provider prior to receiving the Claim. The Claim should describe the occurrence, character, and extent of the Medical Care provided by the provider. Notwithstanding anything herein to the contrary, Enrollees may not assign any claims or other rights to receive Benefits hereunder to any Non-Participating Provider without the prior approval of SIHO. In the absence of such prior approval, SIHO reserves the right to pay Claims or other Benefits directly to the Enrollee, and such payment shall fully discharge SIHO's obligation under this Agreement with respect to such Claims or other Benefits. In such a case, the Enrollee is responsible for all payments that may be due to the Non-Participating Provider.

1. Claim Forms. Submission of claims by an Enrollee must be accompanied by a claim form. These forms can be obtained from SIHO via mail, email or website.

B. Claim Determination.

1. Pre-Service Claims. With respect to a Pre-Service Claim, SIHO will notify the claimant of its decision within 15 days of receipt of the Claim.

    a. This 15-day period may be extended for an additional 10 days if SIHO determines that an extension is necessary due to matters beyond the Health Plan's control and notifies the claimant of the circumstances requiring the extension of time and the date by which SIHO expects to render a decision.

    b. If an extension is necessary because the claimant has not submitted information necessary to decide the Claim, SIHO will provide the claimant with a notice of extension which will specifically describe the additional information required. If the extension is necessary because the Claim does not properly identify the individual requesting a benefit, specify the medical condition or symptom, and the specific treatment, service, or product for which approval is requested, SIHO will provide the notice of extension and an explanation of the proper procedures to be followed in filing a Claim. Any notice of extension may be oral, unless the claimant requests a notice in writing. The claimant will have at least 45 days to provide any requested information.

2. Precertification of Urgent Care Claims. In the case of a request for Precertification of an Urgent Care Claim, SIHO will notify the claimant of its determination by the

earlier of seventy-two hours or two business days after its receipt of the request and all information necessary to make a determination.

If the claimant has not provided sufficient information for SIHO to determine the request for Precertification of an Urgent Care Claim, SIHO will notify the claimant within 24 hours after receiving the request of the specific information that must be submitted for SIHO to complete the processing of the Claim. The claimant will have at least 48 hours in which to provide the additional information. SIHO will notify the claimant of its decision within 24 hours after it receives the additional information, or, if the claimant does not provide the requested information, 24 hours after the end of the period of time that the claimant was given to provide the information.

3. Concurrent Care Claims. With respect to a Concurrent Care Claim, if SIHO reduces or terminates benefits for a course of treatment (for reasons other than amendment or termination of the Health Plan) before the end of the period of time or number of treatments, the claimant must be notified sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of SIHO's decision before it becomes effective. The claimant may request the Health Plan to extend the course of treatment beyond the already approved time or number of treatments. SIHO will notify the claimant of its decision within 24 hours of its receipt of the request, provided that the claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, and within 72 hours of its receipt if the request is received less than 24 hours prior to the expiration of the prescribed period or number of treatments.

C. Grievances.

An Enrollee may initiate a Grievance procedure by contacting us verbally or in writing. Enrollees have the right to appoint a Designated Representative to act on their behalf with respect to the Grievance by filing a signed form that may be obtained from SIHO upon request; provided, that if a provider files a Grievance relating to precertification of an Urgent Care Claim, then SIHO will treat such provider as a Designated Representative with respect to that matter even without the submission of a signed form.

SIHO will accept oral or written comments, documents or other information relating to the Grievance from the Enrollee or his/her Designated Representative by telephone, mail or other reasonable means. Enrollees are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Grievance.

Enrollees may obtain information regarding SIHO’s Grievance procedures by calling the toll-free number on the back of the Enrollee’s identification card during normal business hours.

Once a Grievance has been initiated by an Enrollee, SIHO will respond within 3 business days to acknowledge its receipt of the Grievance. Such response will be in writing, unless the Grievance was received orally, in which case the response may be oral. Grievances will be resolved within 20 business days after they are filed if all information needed to complete a review is available. If additional information is needed and the Grievance does not involve Precertification matters, SIHO may notify you before the 19th business day of its election to take an additional 10 business days to receive information and address the Grievance.

If an Enrollee's Grievance is denied in whole or in part, SIHO will notify the claimant, in writing or electronically, and the notice will include the following:

1. the specific reason or reasons for the denial;

2. reference to specific Health Plan provisions on which the denial is based;

3. a description of any internal rule, guideline, protocol or similar criterion relied on in making the adverse determination (or a statement that the information will be provided free of charge upon request);

4. an explanation of any scientific or clinical judgment on which the denial is based (or a statement that the explanation will be provided free of charge upon request);

5. a description of any additional material or information that the claimant may need to provide with an explanation as to why the material or information is necessary;

6. an explanation of the claimant's right to appeal under the Health Plan's appeal procedures, and the claimant's right to bring a civil action in federal court; and

7. the name, address, and phone number of a SIHO representative who can provide the claimant with more information about the decision and the right to appeal.

SIHO may provide the above information to the claimant orally, provided that a written notice is furnished to the claimant within 3 days after the oral notification.

D. Appeal Procedures.

If SIHO's Grievance decision is satisfactory to the Enrollee, then the matter is concluded. If, however, the Enrollee is unsatisfied with SIHO's decision, the Enrollee may initiate an appeal of the Grievance in accordance with this Section.

1. General.

   a. The claimant will have 180 days from the receipt of SIHO's decision to appeal.

b. The claimant may submit an appeal verbally or in writing. Any SIHO employee who has been unable to resolve the Grievance may take the appeal information.

c. All written notices requesting an appeal will be forwarded to an appeals coordinator.

d. All verbal requests must be documented by the SIHO associate who is assisting the claimant. Upon request, the notice will be forwarded to the appeals coordinator.

e. An acknowledgement notice will be sent to the claimant within 3 business days of receipt of the written or verbal appeal request.

2. Claimant's Rights on Appeal.

a. The claimant will have the opportunity to submit written comments, documents, or other information relating to the Grievance. All such information must be submitted by the enrollee or provider within 180 days of receipt.

b. Upon request and free of charge, the claimant will be provided with reasonable access to and copies ofall documents, records and other information relevant to the Grievance.

c. The review will take into account all comments, documents, records and other information the claimant submits, whether or not presented or considered in the initial determination.

d. No deference will be afforded to the initial determination.

e. The review will be conducted by a person or persons different from the person who made the initial determination and who is not the original decision-maker's subordinate.

f. If the decision is made on the grounds of a medical judgment, SIHO will consult with a health care professional with appropriate training and experience. The health care professional will not be the individual who was consulted during the initial determination or that person's subordinate.

g. SIHO will provide the claimant with the name of any medical or vocational expert who advised SIHO with regard to the Grievance.

3. Appeals Hearing Committee.

a. The appeals coordinator will investigate the issue and gather the data needed to review the circumstances surrounding the appeal.

b. The appeals coordinator will convene an Appeals Hearing Committee consisting of at least one person. None of the Committee will have been involved in any of the previous determinations, or involved in a direct business relationship with the Enrollee or health care provider whose care is at issue.

c. The appeals coordinator will send notice of the hearing date, time, and location to the claimant, at least 72 hours in advance of the hearing. The hearing process will make any reasonable accommodations to convenience the claimant, including arranging for a teleconference in situations where the claimant is unable to attend.

d. If the claimant attends the appeal hearing or participates via teleconference, the claimant may present his case. The hearing provides an opportunity for the claimant to explain his position as well as allow the Appeals Hearing Committee members to ask the claimant any pertinent questions they may have.

E. Notification of Resolution of Appeal.

1. Pre-Service Grievances. In the case of a Grievance not involving urgent care, SIHO will notify the claimant of its decision within 30 days after it receives the request for review and sufficient information to make its determination.

2. Urgent Care Grievances. In the case of a Grievance that relates to an Urgent Care matter, SIHO will notify the claimant of its decision within 48 hours after it receives the request for review and sufficient information to make its determination.

3. Other Grievances. In the case of all other Grievances, SIHO will notify the claimant within 30 days after it receives the written request for review and sufficient information to make its determination.

F. Expedited Appeals.

1. A claimant may request an expedited appeal or SIHO may independently determine that the process should be expedited. The expedited process is considered a stand-alone procedure and is in lieu of the standard appeal procedure.

2. The claimant may request an expedited appeal orally or in writing. All information, including SIHO's decision, may be transmitted between the claimant and SIHO by telephone, facsimile, or other available similar method.

3. Resolution of the expedited appeal will be made as expeditiously as the appellant's health warrants but will occur no later than 48 hours after the filing of the appeal.

G. Notice of Decision on Appeal.

If an appeal is denied, SIHO will notify the claimant, in writing or electronically. The notice will contain the following information:

1. the specific reason(s) for SIHO's denial;

2. a reference to the specific Health Plan provision(s) on which the denial is based;

3. a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse determination;

4. an explanation of any scientific or clinical judgment on which the denial is based;

5. a statement that the claimant is entitled to receive, upon request and without charge, reasonable access to and copies of all documents, records or other information relevant to the appeal;

6. a statement describing the voluntary appeal procedures via the external review offered by the Health Plan and the claimant's right to obtain information about the procedures;

7. the statement that "You or your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency";

8. a statement describing the claimant's right to bring a civil suit under federal law; and

9. the name, address and telephone number of the appeals coordinator whom the claimant may contact for more information.

H. External Review of Appeals Process.

1. If the claimant is dissatisfied with the Appeal Hearing Committee's resolution, and the matter involves (i) an adverse determination of appropriateness, (ii) an adverse determination of Medical Necessity, (iii) a determination that the proposed service is Experimental or Investigational, or (iv) a rescission of coverage by SIHO, he or she may file a written request to initiate an External Review Appeal. This request must be filed no later than 120 days after the claimant is notified of the resolution of the Appeal Hearing Committee’s decision. External Review Appeal is not available for matters other than those specified in this paragraph.

2. The claimant may not file more than one (1) External Review Appeal request on the same appeal.

3. Upon receipt of the request for External Review Appeal, the appeals coordinator will select an independent review organization that is certified to perform external review in the State of Indiana.

4. The external review organization will assign a medical review professional who is board certified in the applicable specialty for resolution of the appeal.

5. The external review organization and the medical review professional conducting the external review may not have a material professional, familial, or financial, or other affiliation with SIHO; any officer, director, or management employee of SIHO; the physician or the physician's medical group that is proposing the service; the facility at which the service would be provided; or the development or manufacture of the principal drug, device, procedure, or other therapy that is proposed by the treating physician. However, the medical review professional may have an affiliation under which the medical review professional provides health care services to Enrollees of SIHO and may have an affiliation that is limited to staff privileges at the health facility if the affiliation is disclosed to the claimant and to SIHO before commencing the review and neither the claimant nor SIHO objects to the affiliation.

6. A claimant who files an appeal under this final alternative is not subject to retaliation for exercising his or her right to an appeal by an external review organization. The claimant may be permitted to utilize the assistance of other individuals, including physicians, attorneys, friends, and family members throughout the external review process. The claimant shall be permitted to submit additional information relating to the proposed service throughout the review process and may cooperate with the external review organization by providing any requested medical information or authorizing the release of necessary medical information.

7. SIHO shall cooperate with the external review organization by promptly providing any information requested by the external review organization.

8. The external review organization shall make a determination to uphold or reverse SIHO's appeal resolution based on information gathered from the claimant, SIHO, the treating physician, or any additional information that the external review organization considers necessary and appropriate. For standard appeals, the determination shall be made within 15 business days from the filing date of the request for external review. For expedited appeals, the determination shall be made within 72 hours after the external review request is filed.

9. When making the determination of the resolution of the appeal, the external review organization shall apply the standards of decision making that are based on objective clinical evidence and the terms of the appellant's benefit contract.

10. The external review organization shall notify SIHO and the claimant of the determination made under this section within 72 hours after making the determination. For expedited appeals, the notification will occur within 24 hours of the determination. The result of the determination is binding on SIHO.

11. If at any time during the external review process the claimant submits information to SIHO that is relevant to SIHO's previous appeal resolution and was not considered by SIHO during the appeals hearing phase, SIHO shall reconsider the previous resolution under the appeals hearing process. The external review organization shall cease the external review process until the reconsideration by SIHO is completed.

12. If additional information from the claimant results in SIHO's reconsideration of the appeal at the hearing level, SIHO will notify the claimant of its decision within 15 days after the information is received. If the appeal is related to an Urgent Care Claim, SIHO will make a determination within 72 hours of receipt of the additional information.

13. If the reconsideration determination made by SIHO is adverse to the claimant, the claimant may request that the external review organization resume the external review.

XII. MISCELLANEOUS

A. Agreement Generally.

All Enrollees or their legal representatives (if the Enrollees are incapable of contracting) must agree to all the terms, conditions and provisions of this Agreement.

B. Applications, Questionnaires, Forms and Statements.

1. Enrollees and applicants for enrollment in the Health Plan must complete all applications, medical review questionnaires, and other forms or statements that SIHO reasonably requests. Enrollees must represent to the best of their knowledge and belief that all information contained in the applications, questionnaires, forms, or statements submitted to SIHO are true, correct, and complete. All rights to benefits under the Health Plan are subject to the truth and accuracy of an Enrollee's representations. Any misrepresentation may cause SIHO to terminate the Enrollee's Coverage. If an Enrollee is eligible for Medicare and fails to submit the documents requested under this Agreement, the Enrollee must pay for services received at Prevailing Rates.

2. If this Agreement is provided in electronic format, the Enrollee may request a paper copy.

C. Identification Cards.

The identification cards that SIHO issues to Enrollees are for identification only. Possession of a Health Plan identification card confers no rights to services or other benefits under this Agreement. To be entitled to benefits under the Health Plan, the holder of the card must, in fact, be an Enrollee on whose behalf all applicable enrollment fees, Copayments, Deductibles and Coinsurance amounts have been paid. SIHO will charge any individual who receives benefits under the Health Plan to which the individual is not entitled the Prevailing Rates for the services.

D. Policies, Procedures, Rules and Interpretations.

SIHO may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Agreement.

E. Liability Prior to Effective Date.

SIHO will not be liable for fees and bills for Medical Care received by an Enrollee prior to the effective date of the Enrollee's Coverage.

F. Authority to Change Agreement on Behalf of SIHO.

No agent or other person, except an officer of SIHO, has the authority to waive any conditions or restrictions of this Agreement; to extend the time for making payment; or to bind SIHO by making any promise or representation, or by giving or receiving information. No change to this Agreement will be valid unless Enrollee and SIHO agree to a written amendment and an officer of SIHO signs the amendment.

G. Mailing of Notices.

Any notice under this Agreement must be sent by United States mail, first class, postage prepaid, addressed as follows:

1. If to SIHO, to the address appearing on page one of this Agreement;

2. If to an Enrollee, to the Enrollee's last address known to SIHO.

H. Department of Insurance

Questions regarding your policy or coverage should be directed to:

SIHO Insurance Services
(812) 378-7070

If you need the assistance of the governmental agency that regulates insurance; or have a complaint you have been unable to resolve with your insurer, you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461
Complaints can be filed electronically at www.in.gov/idoi

I. Dissemination of Notices.

SIHO agrees to disseminate all notices regarding matters material to this Agreement to Participants in the next regular communication to Enrollees or in a special communication to Participants within 30 days after SIHO receives the material information.

J. Entire Agreement.

This Agreement and the individual enrollment applications of Enrollees constitute the entire agreement between the parties and, as of the effective date of this Agreement, supersede all other agreements between the parties.

K. Invalid Provisions.

If any provision of this Agreement is held to violate Indiana law or applicable federal law or be illegal or invalid for any other reason, that provision will be deemed to be void, but the invalidation of that provision will not otherwise impair or affect the rest of the Agreement.

L. Legal Actions.

No legal action may be filed to recover under the policy before 60 days after a claim is filed, and not later than 3 years after the claim is required to be filed.

M. Examination

SIHO reserves the right to have an Enrollee examined (including by autopsy) by a medical provider of SIHO's choice to assist in the evaluation of the appropriateness of a Claim, Precertification request, appeal or any other matter related to this agreement.

XIII. NETWORK AND NON-NETWORK SERVICES

A. Network Services.

An Enrollee is entitled to receive Network Services in the Service Area subject to the Deductibles, Coinsurance and Copayments described in Article IV. It is the Enrollee's

responsibility to secure proper Precertification of such services, if required under this Agreement.

[Coverage for Network Services may vary based on whether the treating Provider participates in the Tier 1 or Tier 2 provider network. The applicable Deductibles, Coinsurance, and Copayments for each Tier are described in Attachment B, Schedule of Benefits. SIHO will make available to all enrollees a provider directory that specifies which Participating Providers participate in the Tier 1 or Tier 2 network.]

B. Emergency Accident or Emergency Illness Services.

1. An Enrollee who is temporarily outside of the Service Area and who cannot access a Participating Provider, may receive treatment of an Emergency Accident or Emergency Illness from a Non-Participating Provider, subject to the Deductibles, Coinsurance and Copayments described in Article IV.

2. If the Enrollee is admitted to a Non-Participating Provider hospital as the result of an Emergency Accident or Emergency Illness, Enrollee or his representative must contact SIHO or their Delegated Network within 48 hours of admission to obtain Precertification of any further inpatient services.

C. Non-Network Services.

A Non-Network Benefit is a Covered Benefit (other than treatment for an Emergency Accident or Emergency Illness) provided by a Non-Participating Provider, without the prior written approval of the Health Plan Medical Director. Non-Network Benefits are subject to the Deductible, Coinsurance and Copayments described in Article IV and to the Precertification requirements described in this Section C, below. Non-Participating Providers will be paid no more than the most recently published Medicare reimbursement rates and may bill the enrollee for any difference between their billed charges and the Medicare reimbursement rates if applicable.

D. Precertification.

The Health Plan Medical Director or his designee must precertify all inpatient care, outpatient surgery, and durable medical equipment, and other services identified in the Health Plan and the Schedule of Benefits.

1. <u>Procedures to Request Precertification</u>.

   a. For elective care an Enrollee or his physician must send a Precertification request to SIHO by mail, at least 14 working days before the services/equipment are provided. If the need for services/equipment is unforeseen, the Enrollee or his physician must call SIHO (812-378-7050 or 800-553-6027) at least one working day before the services/equipment is provided to request Precertification.

b. For maternity admissions the Enrollee or her physician should call SIHO to request Precertification on the second or fourth day after admission, respectively, if the inpatient admission is expected to exceed two days for a vaginal delivery or four days for a cesarean section. If the maternity admission is for reasons other than delivery, then the Enrollee or physician must call SIHO within one working day of the admission.

c. For other Precertification requests, the Enrollee or his physician should call SIHO or their Delegated Network at the number indicated on the Enrollee's identification card.

2. Precertification Decisions. If SIHO or their Delegated Network finds that proposed Medical Care is Medically Necessary and the setting is appropriate, SIHO or their Delegated Network will precertify the quantity and character of the Medical Care. SIHO will not precertify any extra inpatient days for tests that can be obtained on an outpatient basis before the Enrollee is admitted. If Precertification is obtained, SIHO will pay the benefits for the services as described in Article IV.

3. If Precertification has not been obtained, SIHO will reduce the benefits paid for the Medical Care as follows:

   a. Medical Care that is not Medically Necessary. SIHO will not provide benefits for any Medical Care that is not Medically Necessary. Charges for such Medical Care will not apply toward any Health Plan Deductible or stop-loss limitations. If Precertification is denied, a Enrollee or his Participating Physician may request a review of the denial and may submit evidence to support Precertification as provided in the Health Plan's Claim Procedures.

   b. Precertification not Requested. If Precertification is not obtained for Medical Care that is Medically Necessary and requires Precertification, SIHO will reduce the amount of benefits it will pay for the Medical Care to the lesser of 50% of the Prevailing Rates for the Medical Care or the applicable Medicare reimbursement rate for the Medical Care. This 50% reduction will not apply toward any plan Deductible or stop-loss limitations.

4. Precertification does not guarantee coverage for or payment of the service or procedure reviewed. For benefits to be paid, the Enrollee must be and remain eligible for benefits, all enrollment fees owed must be paid, and the service or procedure must be a Covered Benefit and not subject to an exclusion or limitation.

ATTACHMENT A

The following Indiana counties are part of Southeastern Indiana Health Organization's (SIHO) Service Area:

Bartholomew
Brown
Decatur
Jackson
Jennings
Scott

ATTACHMENT B

SCHEDULE OF BENEFITS

PRE-ADMISSION CERTIFICATION

[If precertification is not requested and obtained prior to receiving Medical Services that require precertification, the benefits paid by SIHO will be reduced by a penalty of 30% of the Prevailing Rate for the services provided. The penalty will not be applied toward any Deductible . It is important to note that this Agreement does not cover weekend admissions and any associated Medical Services unless they are Medically Necessary. To use the Pre-Admission Certification program, contact the Health Plan Medical Director of the designee at:_____.

[If precertification is not requested and obtained prior to receiving Medical Services that require precertification, the benefits paid by SIHO will be reduced by a penalty of [%] of the Prevailing Rate for the services provided [, to a maximum of [$500-$5,000] per confinement]. The penalty will not be applied toward any Deductible limitations. It is important to note that this Agreement does not cover weekend admissions and any associated Medical Services unless they are Medically Necessary. To use this Pre-Admission Certification program, contact the Health Plan Medical Director of the designee at:_____]

ADMINISTRATOR:_____
ADDRESS:_____
PHONE NUMBER:(_____)-_____-_____

[Many individual services and benefits also require precertification in order to be included as Covered Services. Those services are identified in the Provider and Service Schedule portion of this Schedule of Benefits.]

ADDITIONAL FEATURES

Some additional general terms and limitations will have impact upon the Covered Services under this Agreement and need to be highlighted below. If the YES box next to the specific feature is checked, it will apply to this Agreement. If the NO box is checked, it will not apply to this Agreement. Read the Provider and Service Coverage portion of the Schedule of Benefits for a detailed explanation of all individual benefits and features, and how they are impacted by the following:

YES	NO	
[___]	[___]	Medicare Reimbursement Rates [plus an additional ____%] will be used as the limit for the Non-Network Service charges.
[___]	[___]	Network and Non-Network Service charges/payments combined for limitations.
[___]	[___]	[Tier 1 and Tier 2 charges/payments combined for limitations.]
[___]	[___]	In instances of Copayments, the *lesser* of the Copayment or billed charges will

apply.

[PRESCRIPTION DRUG BENEFITS:

[Eligible charges for prescription drug benefits will be limited to the cost of generic prescription drugs, wherever available.] [The following Prescription Drug Deductible will apply to coverage for Prescription Drugs]
[Combined Network and Non-Network Deductible per year:
Individual: $0 to $1,000
Family: $0 to $3,000]

[The following Copayments will apply to Coverage for prescription drugs:

Network	[$0-$50] per Generic Rx, [After Prescription Drug Deductible] [$0-$75] per Brand Rx [plus the difference between available Generic and chosen Brand] [After Prescription Drug Deductible]
Non-Network	[$0-$100] per Generic Rx, [After Prescription Drug Deductible] [$0-$100] per Brand Rx [plus the difference between available Generic and chosen Brand] [After Prescription Drug Deductible]
[Formulary	[$0-$75] per non-Formulary compliance Rx [After Prescription Drug Deductible] [plus the minimum difference, not to be less than $__, between formulary Rx and non-formulary Rx chosen] [After Prescription Drug Deductible]

[Biotech or Specialty Injectable Drugs other than insulin and anti neoplasm drugs
[10% to 40%] Coinsurance up to a maximum of [$100 to 500] per Rx. Coinsurance does [not] apply to the annual out-of-pocket maximum. Annual Benefit Maximum of [$50,000 to Unlimited].]

[Annual Maximum $5,000, $10,000, $15,000, Unlimited]
[Rx defined as 1 to 30 day supply]

[**Evidence Based Pharmacy Plan (EBPP)**
The Deductible, Coinsurance, or Copayment for selected maintenance medications will be waived or reduced for Enrollees identified with specific chronic conditions and who are actively participating, as determined by SIHO, in their Disease Management, Case Management, and/or other Medical Management programs.]

[**Step Therapy Programs**
Use of a Generic drug in a given Class may be required before a Non-Preferred Brand Drug is Covered. Affected Enrollees will be notified of the Step Therapy Program prior to it's effective date so that they can contact their physician and discuss a new prescription. Medical exceptions to the program may be granted based on clinical justification supplied by the Enrollee's physician.]

[Orally Administered Cancer Chemotherapy
As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.]

[PRIMARY CARE PHYSICIAN:

An Enrollee must get approval from his Primary Care Physician to receive Network Services. Covered Services must be accessed through the Enrollee's current Primary Care Physician in order to obtain any Coverage. Any Medical Services that are not provided, arranged, authorized, or approved by the Enrollee's Primary Care Physician or the Health Plan Medical Director is excluded. This limitation does not apply to Medically Necessary emergency services.]

GEOGRAPHIC SERVICE AREA:

The geographic Service Area includes [the following counties:_____.] [the area represented by the following zip codes:_____.] [the area within a [25-60] mile radius of:_____.]

All Covered Services are subject to calendar year Deductible amounts UNLESS STATED OTHERWISE. All calendar year deductibles are applied [after, before] the applicable service Copayments. All plan payments accrue towards annual maximums.

	NETWORK SERVICES [LEVEL 1] [TIERS 1 AND 2]		**NON-NETWORK SERVICES** [LEVEL II] [TIER 3]	
	[Level I benefits apply to Medical Care received from a Participating Provider or from a Non-Participating Provider with written authorization from the Health Plan Medical Director.] [Tier 1 and 2 benefits apply to Medical Care received from a Participating Provider or from a Non-Participating Provider with written authorization from the Health Plan Medical Director.]		[Level II benefits apply to Medical Care received from a Non-Participating Provider without a written authorization from the Health Plan Medical Director] [Tier 3 benefits apply to Medical Care received from a Non-Participating Provider without a written authorization from the Health Plan Medical Director.]	
	[TIER 1] [TIER 2]		[TIER 3]	
General Services	**Enrollee Pays**	**Health Plan Pays**	**Enrollee Pays**	**Health Plan Pays**
All covered services are subject to these conditions unless otherwise provided	**Network Deductible per year:** Individual : [0-$5,000] Family: [0-$15,000] [The Individual Deductible applies only to Enrollees with self-only coverage. If an individual has family coverage, the Family Deductible applies. Except for Preventive Health Benefits, the Health Plan will not pay benefits for any Enrollee with family coverage until the eligible medical charges incurred by the Enrollee's family exceed the Family Deductible.] **Coinsurance:** Individual [0-40%] Family [0-40%] **Network Out-of-Pocket Maximum per year:** Individual: [$0-unlimited] Family [$0-unlimited] **General Services Copayment:** [None] or [$0-60].	[60-100]% of eligible charges after Enrollee Pays: [General Services Copayment] [Network Deductible] [After the Enrollee's Network Out-of-Pocket Maximum is reached, the Health Plan will pay 100% of the Enrollee's expenses.] [The Health Plan's payments are subject to the following limits: Annual maximum: $[0 - Unlimited] Lifetime maximum: $[0-Unlimited]]	**Non-Network Deductible per year:** Individual: [$0-$10,000] Family: [$0-$30,000] [The Individual Deductible applies only to Enrollees with self-only coverage. If an individual has family coverage, the Family Deductible applies. Except for Preventive Health Benefits, the Health Plan will not pay benefits for any Enrollee with family coverage until the eligible medical charges incurred by the Enrollee's family exceed the Family Deductible.] **Coinsurance:** Individual: [0-50%] Family: [0-50%] **Non-Network Out-of-Pocket Maximum per year:** Individual: [$0-unlimited] Family: [$0-unlimited] **General Services Copayment:** [None] or [$0-60]	[50-100]% of Medicare Reimbursement Rates after Enrollee pays: [General Services Copayment] [Network Deductible] [Non-Network Deductible] [After the Enrollee's Network Out-of-Pocket Maximum is reached, the Health Plan will pay 100% of the Enrollee's expenses.] [The Health Plan's payments are limited to following: Annual maximum: $[0 - Unlimited] Lifetime maximum: $[0-Unlimited]]

Primary Health Care Physician Services	Enrollee Pays	Health Plan Pays	Enrollee Pays	Health Plan Pays
One Copayment will apply per [visit, service]. ** Indicates that the Non-Network Deductible applies [before, after] applicable Copayments.				
Office Visit	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [$0-$60] [**] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Home Visit	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [$0-$60] [**] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Immunizations	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or [$0-$60] [**] Coinsurance: [None] or [0-50]%	[Not Covered], [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Health Education	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or [$0-$60] [**] Coinsurance: [None] or [0-50]%	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Wellness Education [Per the SIHO schedule]	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or [$0-$60] [**] Coinsurance: [None] or [0-50]%	[Not Covered] [50-100]% of eligible charges after the Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Hearing and Vision Screening	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or [$0-$60] [**] Coinsurance: [None] or [0-50]%	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]

Specialty Health Care (Physician Services)	Enrollee Pays	Health Plan Pays	Enrollee Pays	Health Plan Pays
One Copayment will apply per [visit, service]. ** Indicates that Non-Network deductible applies [before, after] applicable Copayments.				
Office Visit	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]%	[Not covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Home Visit	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]%	[Not covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Consultations, In-Patient	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]%	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Consultations, non in-Patient	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]%	[Not covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Allergy	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]%	[Not covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]

[Chiropractor, Manipulative Services] [Requires Precertification] [Annual Maximum: 12 Visits]	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Lifetime Maximum is reached.]	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Lifetime Maximum is reached.]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Lifetime Maximum is reached.]	[Not covered] [Limited to [ ] visits per month] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Lifetime Maximum is reached.]
Dermatology	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]%	[Not covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
[Family Planning/ Infertility]	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Lifetime Maximum is reached.]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Lifetime Maximum is reached.]	[Not covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Lifetime Maximum is reached.]
Podiatry Excludes routine foot care	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Network Deductible] [Copayment]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]%	[Not covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Temporomandibular Joint Disorder	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not covered] Copayment: [None] or [$0-$80] [**] Coinsurance: [None] or [0-50]%	[Not covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]

Psychologist or Psychiatrist Mental Health Treatment: Outpatient [Requires Precertification]	Copayment: [None] or [$0-$60] Coinsurance: [None] or [percentage listed for general services]%	[60-100]% of all eligible charges after Enrollee pays: [Network Deductible] [Copayment]	[Not covered] Copayment: [None] or $[0-400] [**] Coinsurance: [None] or [percentage listed for general services]%	[Not covered] [50-100]% of covered service charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Substance Abuse Treatment: Outpatient [Requires Precertification]	Copayment: [None] or [$0-$60] Coinsurance: [None] or [percentage listed for general services]%	[60-100]% of all eligible charges after Enrollee pays: [Network Deductible] [Copayment]	[Not covered] Copayment: [None] or $[0-400] [**] Coinsurance: [None] or [percentage listed for general services]%	[Not covered] [50-100]% of covered service charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Surgery and Hospital (Physician Services)	**Enrollee Pays**	**Health Plan Pays**	**Enrollee Pays**	**Health Plan Pays**
One Copayment will apply per [day, visit].				
Anesthesia	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Network Deductible] [Copayment]	Copayment: [None] or [$0-$80] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Medical Visits in Hospital, Primary Physician	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Network Deductible] [Copayment]	Copayment: [None] or [$0-$80] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Medical Visits in Hospital, Specialty Physician	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Network Deductible] [Copayment]	Copayment: [None] or [$0-$80] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Medical Visits in SNF, Primary Physician	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Network Deductible] [Copayment]	Copayment: [None] or [$0-$80] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]

Medical Visits in SNF, Specialty Physicians	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Network Deductible] [Copayment]	Copayment: [None] or [$0-$80] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Surgery	Copayment: [None] or [$0-$100] per procedure Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Network Deductible] [Copayment]	Copayment: [None] or [$0-$200] per procedure Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Institutional Health Care: Outpatient	**Enrollee Pays**	**Health Plan Pays**	**Enrollee Pays**	**Health Plan Pays**
[Copayment applies per visit.] [Copayment applies in addition to any other Copayments for each service]				
Outpatient Diagnostic [MRIs and CT Scans Require Precertification] Annual Benefit Maximum [$500 to Unlimited]	Copayment: [None], [$0-$500] or [$0-$150] per test whenever there is no accompanying facility charge [Facility Charge] Coinsurance: [None] or [0-40]% [80% Coinsurance will apply for Procedures greater than [$250-$1,000]	[60-100]% of eligible charges after Enrollee pays: [Network Deductible] [Copayment] [Facility Charge]	Copayment: [None] or [$0-$250] Coinsurance: [None] or [0-50]% [Facility Charge]	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [Facility Charge]
Emergency Department	Copayment: [None] or [$0-$500] [Facility Charge] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after the Enrollee pays: [Network Deductible] [Copayment] [Facility Charge]	Copayment: [None] or [$0-$500] Coinsurance: [None] or [0-50]% [Facility Charge]	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [Facility Charge]
Urgent Care Facility	Copayment: [None] or [$0-$500] [Facility Charge] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after the Enrollee pays: [Network Deductible] [Copayment] [Facility Charge]	Copayment: [None] or [$0-$500] Coinsurance: [None] or [0-50]% [Facility Charge]	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [Facility Charge]
Outpatient Mental Health Services [Requires Precertification]	Copayment: [None] or $[0-400] Coinsurance: [None] or [percentage listed for General Services	[60-100]% of all eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or $[0-400] Coinsurance: [None] or [percentage listed for General Services]	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]

Outpatient Substance Abuse Services [Requires Precertification]	Copayment: [None] or $[0-400] Coinsurance: [None] or [percentage listed for General Services	[60-100]% of all eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or $[0-400] Coinsurance: [None] or [percentage listed for General Services]	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Outpatient Surgery [Requires Precertification]	Copayment: [None] or [$0-$500] per procedure Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after the Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [$0-$750] per procedure Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Outpatient Hospital Ancillaries	Copayment: [None] or [O/P Copayment] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after the Enrollee pays: [O/P Copayment] [Network Deductible]	Copayment: [None] or [O/P Copayment] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [O/P Copayment] [Network Deductible] [Non-Network Deductible]
Outpatient Therapy [Requires Precertification] Annual Maximum: [20] visits each for physical, pulmonary, occupational, and speech therapies. Separate limits between Outpatient Rehabilitation Services and Habilitation Services. Annual Maximum: 36 visits for Cardiac Rehabilitation.	Copayment: [None] or [$0-$60] Coinsurance: [None] or [0-50]% An Enrollee is responsible for 100% of the cost after the number of treatment visits reaches the Annual or Lifetime Maximum.	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] The Health Plan will not pay any amounts after the number of treatment visits reaches the Annual or Lifetime Maximum.	[Not Covered] Copayment: [None] or [$0-$80] Coinsurance: [None] or [0-50]% An Enrollee is responsible for 100% of the cost after the number of treatment visits reaches the Annual or Lifetime Maximum.	[Not Covered], [Limited to [15] visits per month] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] The Health Plan will not pay any amounts after the number of treatment visits reaches the Annual or Lifetime Maximum.

Outpatient Therapy Facility [Therapy Program Requires Precertification] Annual Maximum: [20] visits each for physical, pulmonary, occupational, and speech therapies. Separate limits between Outpatient Rehabilitation Services and Habilitation Services. Annual Maximum: 36 visits for Cardiac Rehabilitation.	Copayment: [None] or [$0-$250] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or [$0-$250] Coinsurance: [None] or [0-50]%	[Not covered], [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Institutional Health Care: Inpatient	**Enrollee Pays**	**Health Plan Pays**	**Enrollee Pays**	**Health Plan Pays**
Hospital Room and Board [Requires Precertification]	Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Specialty Care	Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Pregnancy Services [Requires Precertification]	[Not Covered] Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [0-50]%	[Not Covered], [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [0-50]%	[Not covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Mental Health Services [Requires Precertification]	Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [percentage listed for General Services]	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [percentage listed for General Services]	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]

Substance Abuse Services [Requires Precertification]	Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [percentage listed for General Services]	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	[Not Covered] Copayment: [None] or [$0-$1,000] per I/P [Day, Admission] Coinsurance: [None] or [percentage listed for General Services]	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Hospital; Ancillaries	Copayment: [None] or [I/P Copayment] Coinsurance: [None] or [0-40]% [Deductible: I/P Deductible]	[60-100]% of eligible charges after Enrollee pays: [Copayment] [I/P Deductible] [Network Deductible]	Copayment: [None] or [I/P Copayment] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Acute Inpatient Rehabilitation Services [Requires Precertification Annual Maximum: 60 days	Copayment: [None] or $[0-1,000] per [Day, admission] Coinsurance: [None] or [0-40]% [Includes days in Non-Network facility]	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] The Health Plan will not pay any amounts after the number of treatment days reaches the Annual or Lifetime Maximum	[Not Covered] Copayment: [None] or $[0-1,000] per [Day, Admission] . Coinsurance: [None] or [0-50]% An enrollee is responsible for 100% of the cost after the number of treatment days reaches the Annual or Lifetime Maximum. [Includes days in Network facility]	[Not Covered] [50-100]% of eligible charges up to a maximum of $750 per day after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] The Health Plan will not pay any amounts after the number of treatment days reaches the Annual or Lifetime Maximum
SNF Room and Board and Ancillaries [Requires Precertification] Annual Maximum: 90 days	Copayment: [None] or [$0-$30] per SNF day if it immediately followed a Hospital Confinement [plus a [$0-$1,000] per SNF [day, confinement] if admitted directly to an SNF without a hospital Confinement] Coinsurance: [None] or [0-40]% The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual Maximum is reached.	[60-100]% of the eligible charges [up to a maximum of $500 per day] after Enrollee pays: [Copayment] [Network Deductible] The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.	Copayment: [None] or [$0-$60] per SNF day if it immediately followed a Hospital Confinement [plus a [$0-$1,000] per SNF [day, confinement] if admitted directly to an SNF without a hospital Confinement]] Coinsurance: [None] or [0-40]% The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual Maximum is reached.	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.

Long Term Acute Care Hospital (LTACH) Services [Requires Precertification and Referral] Annual Maximum: 90 days	Copayment: [None] or $[0-1,000] per [Day, admission] Coinsurance: [None] or [0-40]% An Enrollee is responsible for 100% of the cost after the number of treatment days reaches the Annual or Lifetime Maximum. [Includes days in Non-Network facility]	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] The Health Plan will not pay any amounts after the number of treatment days reaches the Annual or Lifetime Maximum	[Not Covered] Copayment: [None] or $[0-1,000] per [Day, Admission] . Coinsurance: [None] or [0-50]% An enrollee is responsible for 100% of the cost after the number of treatment days reaches the Annual or Lifetime Maximum. [Includes days in Network facility]	[Not Covered] [50-100]% of eligible charges up to a maximum of $750 per day after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] The Health Plan will not pay any amounts after the number of treatment days reaches the Annual or Lifetime Maximum
Medical Supplies and Ancillary Services	**Enrollee Pays**	**Health Plan Pays**	**Enrollee Pays**	**Health Plan Pays**
Ambulance, medically necessary Annual Maximum: [$0-unlimited]	Copayment: [None] or [$0-$250] per service Coinsurance: [None] or [0-40]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual Maximum is reached.]	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.]	Copayment: [None] or [$0-$250] per service Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual Maximum is reached.]	[50-100]% of eligible charges Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.]
Blood	[Included within the corresponding Individual Health Care Provider/Institutional Copayment] or [Copayment: [None] or [$0-$200] per service] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [$0-$200] per service Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Home Health Care [Requires Precertification] Annual Maximum: 90] days] Note: Maximum does not include Private Duty Nursing rendered in home. Private Duty Nursing: Annual Maximum [82 visits] Lifetime Maximum [164 visits]	Copayment: [None] or [$0-$50] per [day, provider service] of a prescribed continuous period of care Coinsurance: [None] or [0-40]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual or Lifetime Maximum is reached.]	[60-100]% of eligible charges [up to a maximum of $500 per day] after Enrollee pays: [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual or Lifetime Maximum is reached.]	Copayment: [None] or [$0-$50] per [day, provider service] of a prescribed continuous period of care Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual or Lifetime Maximum is reached.]	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] Maximum Charges: [$500 per day] [The Health Plan will not pay any amounts for this Specific Service after the Annual or Lifetime Maximum is reached.]

Hospice, Facility [Requires Precertification]	Copayment: [None] or [$0-$50] per day Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges [up to a maximum of $500 per day] after Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [$0-$50] per day Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Hospice, Home Care [Requires Precertification]	Copayment: [None] or [$0-$50] per [day, provider service] Coinsurance: [None] or [0-40]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Lifetime Maximum is reached.]	[60-100]% of eligible charges [up to a maximum of $500 per day] after Enrollee pays: [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Lifetime Maximum is reached.]	Copayment: [None] or [$0-$50] per [day, provider service] Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Lifetime Maximum is reached.]	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Lifetime Maximum is reached.]
[Medical Aids: Prosthetic Devices [Requires Precertification]	[Not Covered] Copayment: [None] or [$0-$50] per device Coinsurance: [None] or [0-40]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual or Lifetime Combined Maximum is reached.]	[Not Covered] [60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual or Lifetime Combined Maximum is reached.]	[Not Covered] Copayment: [None] or [$0-$100] per device Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual or Lifetime Combined Maximum is reached.]	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual or Lifetime Combined Maximum is reached.]
[Medical Aids: Durable Medical Equipment [Requires Precertification]	[Not Covered] Copayment: [None] or [$0-$50] per device Coinsurance: [None] or [0-40]% [Subject to combined maximums for Medical Aids.]	[Not Covered] [60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Subject to combined maximums for Medical Aids.]	[Not Covered] Copayment: [None] or [$0-$100] per device Coinsurance: [None] or [0-40]% [Subject to combined maximums for Medical Aids.]	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [Subject to combined maximums for Medical Aids.]

[Medical Aids: Orthotic Appliances [Requires Precertification]	[Not Covered] Copayment: [None] or [$0-$50] per device Coinsurance: [None] or [0-40]% [Subject to combined maximums for Medical Aids.]	[Not Covered] [60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Subject to combined maximums for Medical Aids.]	[Not Covered] Copayment: [None] or [$0-$100] per device Coinsurance: [None] or [0-50]% [Subject to combined maximums for Medical Aids.]	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [Subject to combined maximums for Medical Aids.]
Medical Supplies	Copayment: [None] or [amount set by Health Care Provider] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [amount set by Health Care Provider] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]
Renal Dialysis Annual Maximum [90 days	Copayment: [None] or [amount set by Health Care Provider] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [amount set by Health Care Provider] Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]

Prescription Drugs [Annual Maximum: $5,000/ $10,000/ $15,000] [Biotech or Specialty Injectable Drugs other than insulin and anti neoplasm drugs Annual Benefit Maximum of $50,000 to Unlimited [The Health Plan does not provide coverage for oral contraceptives.]	[Prescription Drug Deductible: Individual: $0-$1,000 Family: $0-$3,000 Deductibles cross apply Network and Non-Network] Copayment: Generic: [None] or [$0-$50] [Brand Name: [None] or [$0-$75] [plus the difference between the brand and available generic drugs] [$30 to $100 benefit allowance] [Non-Formulary: [None] or [$0-$75] [plus the positive difference between the formulary and the non-compliant drugs] [$10 to $100 benefit allowance]] [Biotech or Specialty Injectable Drugs other than insulin and anti neoplasm drugs coinsurance [10% to 40%] to a maximum of [$100 to $500] per Rx] Coinsurance: [None] or [0-40]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual Maximum is reached.]	[Not Covered] [60-100]% of eligible charges after Enrollee pays: [Prescription Drug Deductible] [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.]	[Prescription Drug Deductible: Individual: $0-$1,000 Family: $0-$3,000 Deductibles cross apply Network and Non-Network] Copayment: Generic: [None] or [$0-$50] [Brand Name: [None] or [$0-$75] [plus the difference between the brand and available generic drugs] Non-Formulary: [None] or [$0-$75] [plus the positive difference between the formulary and the non-compliant drugs] Coinsurance: [None] or [0-50]% [Biotech or Specialty Injectable Drugs other than insulin and anti neoplasm drugs not covered] [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual Maximum is reached.]	[Not Covered], [50-100]% of eligible charges after Enrollee pays: [Prescription Drug Deductible] [Copayment] [Network Deductible] [Non-Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.]
[Evidenced Based Pharmacy Plan] [Annual Maximum: $5,000/ $10,000/ $15,000, Unlimited] [The Health Plan does not provide coverage for oral contraceptives.]	[Not Covered] [60-100]% of eligible charges after Enrollee pays: [Prescription Drug Deductible] [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.]	[Prescription Drug Deductible: Individual: $0-$1,000 Family: $0-$3,000 Deductibles cross apply Network and Non-Network] Copayment: Generic: [None] or [$0-$50] Brand Name: [None] or [$0-$75] [plus the difference between the brand and available generic drugs] Non-Formulary: [None] or [$0-$75] [plus the positive difference between the formulary and the non-compliant drugs] Coinsurance: [None] or [0-40]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual Maximum is reached.]	[Not Covered], [50-100]% of eligible charges after Enrollee pays: [Prescription Drug Deductible] [Copayment] [Network Deductible] [Non-Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.]

Specified Health Care Benefit Services	Enrollee Pays	Health Plan Pays	Enrollee Pays	Health Plan Pays
Donor Organ Procurement [I/P stay Requires Precertification] Lifetime Maximum: [$20,000-Unlimited	Copayment: [None] or [I/P Copayment] Coinsurance: [None] or [0-40]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Lifetime Maximum is reached.]	[60-100]% of eligible charges Enrollee pays: [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Lifetime Maximum is reached.]	Copayment: [None] or [I/P Copayment] Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Lifetime Maximum is reached.]	[50-100]% of eligible charges Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Lifetime Maximum is reached.]
Pre-Admission Testing	Copayment: [None] or [amount set by Health Care Provider] Coinsurance: [0-40]% [Deductible: set by Health Care Provider]	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Health Care Provider Deductible] [Network Deductible]	Copayment: [None] [$0-$75 per test] or [amount set by Health Care Provider] Coinsurance: [0-50]% [Deductible: set by Health Care Provider]	[50-100]% of eligible charges Enrollee pays: [Copayment] [Health Care Provider Deductible] [Network Deductible] [Non-Network Deductible]
[Special Routine Care-Mammography-Pap Smear]	Copayment: [None] or [amount set by Health Care Provider] Coinsurance: [0-40]% [Deductible: set by Health Care Provider]	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Health Care Provider Deductible] [Network Deductible]	Copayment: [None] or [$0-$200 per test] or [amount set by Health Care Provider] Coinsurance: [0-50]% [Deductible: set by Health Care Provider]	[50-100]% of eligible charges Enrollee pays: [Copayment] [Health Care Provider Deductible] [Network Deductible] [Non-Network Deductible]
Supplemental Emergency Accident [Annual Maximum: [$0-unlimited] per accident]	Copayment: [None] or [$0-$250] Coinsurance: [None] or [0-40]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual Maximum is reached.]	100% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.]	Copayment: [None] or [$0-$500] Coinsurance: [None] or [0-50]% [The Enrollee is responsible for 100% of the cost for this Specific Service after the Annual Maximum is reached.]	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible] [The Health Plan will not pay any amounts for this Specific Service after the Annual Maximum is reached.]

[Surgical Treatment of Morbid Obesity, including Complications [Requires Precertification] Annual Maximum: $10,000 – Unlimited	Copayment: [None] or [$0-$5,000] per procedure Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after the Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [$0-$5,000] per procedure Coinsurance: [None] or [0-50]%	[50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]]
Preventative Health Benefit	**Enrollee Pays**	**Health Plan Pays**	**Enrollee Pays**	**Health Plan Pays**
Physical Medicine Therapies	Copayment: [None] or [$0-$30] Coinsurance: [None] or [0-40]%	[60-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible]	Copayment: [None] or [$0-$40] Coinsurance: [None] or [0-50]%	[Not Covered] [50-100]% of eligible charges after Enrollee pays: [Copayment] [Network Deductible] [Non-Network Deductible]

ATTACHMENT C

SCHEDULE OF BENEFITS
PEDIATRIC VISION ESSENTIAL BENEFIT

GENERAL
This Schedule list the vision care services and vision care materials to which Enrollees under the age of 19 are entitled, subject to any conditions, limitations and/or exclusions stated herein or in the Certificate of Coverage to which this is attached. Vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, who are Participating Providers.

Participating Provider are those doctors who have agreed to participate in VSP's Choice Network, available at www.vsp.com.

When Covered Benefits are received from Participating Providers, benefits are applicable as stated below.

COVERED BENEFIT	PARTICIPATING PROVIDER BENEFIT
VISION CARE SERVICES	
Vision Examination	Covered in Full
VISION CARE MATERIALS	
Lenses	
Single Vision	Covered in Full*
Bifocal	Covered in Full*
Trifocal	Covered in Full*
Lenticular	Covered in Full*

Frames	Covered in Full from a Pediatric Exchange Collection
CONTACT LENSES	
Necessary	
Professional Fees and Materials	Covered in Full
Elective	
Professional Fees**	Covered in Full
Materials	Covered in full with the following service limitations: Standard (one pair annually) = 1 contact lens per eye (total 2 lenses) Monthly (six-month supply) = 6 lenses per eye (total 12 lenses) Bi-weekly (3 month supply) = 6 lenses per eye (total 12 lenses) Dailies (one month supply) = 30 lenses per eye (total 60 lenses)

Necessary Contact Lenses are a Covered Benefit when specific benefit criteria are satisfied and when prescribed by a Participating Provider or Non-Participating Provider. Prior review and approval by VSP are not required to be eligible for Necessary Contact Lenses.

*Coverage includes lenses in polycarbonate, plastic or glass, scratch resistant or UV coatings also covered.

**15% discount applies to Participating Provider’s usual and customary professional fees for contact lens evaluation and fitting.

COPAYMENT
There shall be no Copayment for the examination or materials payable to the Participating Provider at the time services are rendered.

SOUTHEASTERN INDIANA HEALTH ORGANIZATION

Health Maintenance Organization Individual Product
Actuarial Memorandum
Form QHP INDV-05.2014

A. INTRODUCTION

Milliman, Inc. (Milliman) was retained by Southeastern Indiana Health Organization (SIHO) to develop an individual market rate filing with on-exchange and off-exchange plans to be filed with the Indiana Department of Insurance for 2015. This actuarial memorandum has been prepared in accordance with Indiana insurance laws and ACA Market Rating Rules. The purpose of this actuarial memorandum is to present the premium rates for SIHO's plans to be offered in the individual market in 2015. This material should not be used for any other purpose.

This actuarial memorandum has been prepared for the use of SIHO. We understand that the actuarial memorandum will be provided to the Indiana Department of Insurance and its subcontractors to assist in the review of SIHO's individual market rate filing. No portion of the actuarial memorandum may be provided to any other party without Milliman's prior written consent. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work.

The rating factors were developed from information published in the Milliman Health Cost Guidelines, and applicable state and federal regulations, as well as from information provided by SIHO. Additionally, we relied on exchange enrollment information provided within the April 2014 HHS Marketplace Enrollment report, along with information on the Medicaid spend-down population provided by the Indiana Department of Insurance (IDOI). The memorandum does not guarantee that the rates will be adequate. Rather, the filing shows that the rates will be adequate if the assumptions underlying their development are realized.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

B. STATE OF INDIANA 4.1 (A) INDIVIDUAL RATE REQUIREMENTS

1. Benefit Structure

This is an individual medical expense service agreement offered as a health maintenance organization product. It provides for hospital, medical, and surgical expenses resulting from an eligible illness or injury. It also provides for prescription drug expenses and certain preventive care services. It is subject to various managed care provisions as described in the certificate of coverage. These are new products that will be offered beginning in 2015; SIHO does not currently offer any products in the individual market.

This policy provides for coverage of medical expenses with applicable member cost sharing, *i.e.*, co-payments, deductibles, and coinsurance amounts. Various benefit provisions are available under this policy form. Covered benefits and copayment schedules have been included with the certificates of coverage.

Attachment 1 provides a summary of benefit provisions for the benefit plan designs that are the subject of this actuarial memorandum. Complete descriptions of covered benefits and cost sharing arrangements are contained in the certificates of coverage.

The benefit plan designs included in this rate filing will be sold to individuals in Indiana. The following qualified health plans (QHPs) will be offered both on-exchange and off-exchange:

- SIHO Marketplace Bronze;
- SIHO Marketplace Bronze HSA;
- SIHO Marketplace Silver;
- SIHO Marketplace Silver HSA; and
- SIHO Marketplace Gold.

Covered services include the Indiana essential health benefits (EHB), inclusive of state mandated benefits. The following supplemental benefits are also covered:

- Diabetes education;
- Nutrition counseling; and
- An additional 3 chiropractic visits.

2. Proposed Rates

a. Premium Rate Development

The proposed premium rating factors were developed based on a manual rate development process. SIHO's group experience was utilized where appropriate in developing the manual rates, and was adjusted for the following:

- Trend, i.e., medical inflation and increased utilization;
- Regional, demographical and benefit cost-sharing differences between SIHO's group experience and the projected 2015 individual market;
- The morbidity of individuals anticipated to elect to be enrolled in ACA-compliant policies during 2015, including the impact of the Medicaid spend-down population;
- Impact of federal transitional reinsurance; and
- Differences in retention components between the group and individual blocks of business.

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b. Premium Rate Calculation

Consumer Adjusted Premium Rates are calculated as the product of four factors:

i. Plan Adjusted Index Rate (Calibrated);
ii. Geographic rating area factor;
iii. Age factor; and
iv. Tobacco status factor.

Monthly Premium Rates to be charged to a specific policyholder are determined by summing the Consumer Adjusted Premium Rates for each member of the family, provided at most three child dependents under age 21 for each family are taken into account. For members that use tobacco, the composite premium applicable to the member will be multiplied by the tobacco status factor applicable to the member's age.

i. Plan Adjusted Index Rate (Calibrated)

A Plan Adjusted Index Rate (Calibrated) is the estimated cost to provide coverage under a given benefit plan design for a member with a geographic rating area factor, an age factor, and a tobacco status factor of 1.00. The Plan Adjusted Index Rates (Calibrated) are provided in Exhibit 1 of Attachment 2. The actuarial value, as calculated using the CMS Actuarial Value (AV) calculator, and metal tier for each plan are also shown in this exhibit.

ii. Geographic Rating Area Factors

Individual market products will be offered in a total of 6 counties: Bartholomew, Brown, Decatur, Jackson, Jennings, and Scott. While these counties span three different rating regions, no geographic rating area factors will be applied to the products offered in the individual market.

iii. Age Factors

Age factors are based upon each member's age as of the premium rate effective date. The HHS Default Standard Age Curve is used for the age factors and is provided in Exhibit 2 of Attachment 2.

iv. Tobacco Status Factors

Tobacco status factors are based on each member's age and tobacco user status as of the premium rate effective date. Members whom do not use tobacco have a tobacco status factor of 1.00. The tobacco status factors for members that use tobacco are provided in Exhibit 2 of Attachment 2.

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3. Projected Experience with Enrollment Projection

SIHO's anticipated experience for the 2015 calendar year for individual policies under this form is provided in Table 1 below. The values reflect an estimate for the population that will enroll in these new products in January 2015.

Southeastern Indiana Health Organization
Table 1: Projected 2015 Experience

Member Months	Incurred Claims	Earned Premium	Projected Loss Ratio	Projected MLR
24,000	$ 10,960,000	$ 13,400,000	81.8%	87.2%

Note: Values have been rounded.

The projected loss ratio reflects a direct ratio of incurred claims to earned premiums. Projected medical loss ratio (MLR) was calculated consistently with the MLR methodology according to the National Associate of Insurance Commissioners as prescribed by 211 CMR 147.00, and does not reflect any credibility adjustments that may be permitted.

4. Assumptions

Since this is a new product rate filing, experience data was not available for the purpose of developing premium rates for these products. As such, premium rates for this filing are the result of a manual rate development process. SIHO's small group and large group point-of-service experience for the 12 months ending December 2013, representing 125,498 member months, provided the basis for the manual rate development process.

This experience data was adjusted to reflect anticipated differences between the group and individual markets. Specific items considered in estimating these adjustments included the following:

- Benefits not included within the experience data;
- Differences in age and gender of the covered populations;
- Geography and provider network differences between the populations;
- Morbidity of the population, including the following:
    - Difference in morbidity between the individual and group markets;
    - Impact of transitional ("grandmothered") policies;
    - Health status of the previously uninsured;
    - Impact of the Medicaid spend-down population;
- Income level of the anticipated population;
- Impact of federal transitional reinsurance;

Additional Benefits not covered in the baseline experience data used include private duty nursing and Temporomandibular joint disorder. Pediatric vision services are covered under a

capitation agreement effective January 2015. Please note that pediatric dental services will not be covered within the policy.

In developing estimates for the demographics of the individual market, we utilized data provided within the HHS Marketplace Enrollment report for April 2014.

The impact of morbidity was estimated as a percentage difference from the pre-ACA group market. Based on the various items outlined, the total morbidity of the individual market was estimated as being 25% above that of the pre-ACA group market.

Income level of the anticipated population was used in order to estimate the impact of cost share reduction (CSR) plans made available to individuals below 250% of the federal poverty level (FPL). For individuals estimated to be eligible for the 94% or 87% CSR plans, it was estimated that utilization would be 12% higher than that of the average enrollee.

Net incurred annual trend of approximately 8.0% was applied to estimate claims experience for 2015. The 8.0% annual trend is the composite of medical trend of approximately 7.0% and prescription drug trend of approximately 14.3%. SIHO provided the medical trend estimate based upon anticipated changes in their provider contracts and a review of recent experience. The prescription drug trend estimate was developed using 2014 and 2015 projected trends from SIHO's pharmacy benefit manager for its health plan book of business and experience from 2010 to 2013 as reported by the pharmacy benefit manager for its health plan book of business and for SIHO.

The following table shows the estimated incurred claims, net of transitional reinsurance, for 2015 effective dates based on the manual rate development process utilized, along with an illustrated buildup to total required revenue.

Estimated Incurred Claims PMPM for 2015	**$456.67**
Administrative Expense Load	$44.40
Profit and Risk Load	$33.51
Taxes and Fees	$23.90
Required Revenue PMPM	***$558.48***

The administrative expense load includes amounts for network access fees and operating expenses. SIHO's network access fees were estimated on a per member per month (PMPM) basis, based on data available within SIHO's small group block of business. Taxes and fees includes the estimated value of exchange user fees.

SIHO provided a PMPM assumption plus a percent of premium assumption for operating expenses. These estimates of 2015 operating expenses were developed by SIHO.

The proposed rates reflect a combined profit and risk charge load of 6% converted to a PMPM for the table above. These loads were provided by SIHO and are applied to all plans.

The following taxes and fees are reflected in the table above:

- $3.67 PMPM for the Federal Transitional Reinsurance Program (included in incurred claims estimate);
- $0.96 Per Member Per Year for the Risk Adjustment User Fee (included in incurred claims estimate);
- $2.12 Per Member Per Year for the Patient Centered Outcomes Research Institute Fee;
- 3.5% of premium exchange user fee; and,
- 0.75% for the Health Insurer Fee.

5. Premium Guarantee Provision

The policies are guaranteed renewable and will be sold on a guarantee of issue basis for residents of the six counties where these plans will be offered.

6. Rating Factors

a. Rate Structure

The calculation of monthly premiums and the rating factors, including geographic rating area, age, and tobacco status factors were described in Section 3 above.

b. Non-benefit Expenses

Non-benefit expenses are included in the Plan Adjusted Index Rates (Calibrated) discussed in section 3 of this memorandum. The non-benefit expenses include amounts for administrative and other expenses, sales and marketing expenses, net cost of private reinsurance, taxes, fees, risk margin, and profit.

c. Impact of Contractual Arrangement

Contractual agreements with health care providers and administrators are expected to result in medical cost and premium changes in line with market averages.

7. Company Financial Position

SIHO's risk-based capital ratio as of December 31, 2013 was 472.8%.

C. CERTIFICATION AND ATTESTATIONS

I am a Consulting Actuary with the firm of Milliman, Inc. SIHO engaged me to provide this actuarial memorandum.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and I meet its qualification standards to perform the analysis and render the actuarial opinion contained herein.

I believe this rate filing is in compliance with all applicable state and federal insurance statues and regulations and with applicable actuarial standards of practice.

I attest that the same premium rate is being charged without regard to whether the plan is offered through an Exchange, or whether the plan is offered directly from SIHO or through an agent.

This memorandum should not be interpreted as a guarantee that the rates will be adequate. The rates will be adequate if the assumptions underlying their development are realized. The adequacy of the rates will be dependent on numerous factors, many of which are not subject to management control (e.g., medical care cost trends in the community, demographic characteristics of the enrollees, etc.).

In developing the rating factors and other values in this actuarial memorandum, I relied on data, other information, and assumptions provided by SIHO. I have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of the analysis may likewise be inaccurate or incomplete. I performed a limited review of the data used directly in the analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of my assignment.

Jill S. Herbold, FSA, MAAA
Consulting Actuary

May 8, 2014
Date

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ATTACHMENT 1

SOUTHEASTERN INDIANA HEALTH ORGANIZATION
Exhibit: 2015 Individual Plan Designs

Benefit Category	SIHO Marketplace Bronze HSA	SIHO Marketplace Bronze	SIHO Marketplace Gold	SIHO Marketplace Silver HSA	SIHO Marketplace Silver
Annual Single Deductible	$4,500	$5,000	$750	$2,500	$2,000
Annual Family Deductible	$9,000	$10,000	$1,500	$5,000	$4,000
Annual OOP Max - Single (incl Ded)	$6,450	$6,600	$4,000	$5,000	$6,600
Annual OOP Max - Family	$12,900	$13,200	$8,000	$10,000	$13,200
PCP Office Visit	Ded, 20%	Ded, 20%	$30	Ded, 10%	$30
Specialist Office Visit	Ded, 20%	Ded, 20%	$60	Ded, 10%	$60
Preventive Care	$0	$0	$0	$0	$0
Inpatient Hospital Services	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Outpatient Hospital Services	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Professional Services (In & Out)	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Emergency Room	Ded, 20%	Ded, 20%	Ded, $200	Ded, 10%	Ded, $200
Urgent Care Facility	Ded, 20%	Ded, 20%	$60	Ded, 10%	$60
Ambulance	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
PT/OT/Speech Therapy	Ded, 20%	Ded, 20%	$60	Ded, 10%	$60
Chiropractic Services	Ded, 20%	Ded, 20%	$60	Ded, 10%	$60
DME/Orthotics & Prosthetic Devices	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Inpatient Behavioral Health	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Outpatient Behavioral Health	Ded, 20%	Ded, 20%	$30	Ded, 10%	$30
Skilled Nursing Facility/LTACH	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Acute IP Rehab	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Home Health	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Hospice	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Pharmacy:					
Generic Drug	Ded, 20%	$25	$15	Ded, 10%	$15
Brand Name Formulary	Ded, 20%	$50	$40	Ded, 10%	$40
Brand Name Non-Formulary	Ded, 20%	$100	$80	Ded, 10%	$80
Specialty Drugs *	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Mail Order	Ded, 20%	2.5x	2.5x	Ded, 10%	2.5x
Pediatric Vision Services	Eye Exam, Lenses/Frames or Contacts Once a Calendar Year				

* Specialty Drug Benefit does not apply to orally administered cancer chemotherapy drugs, which are covered at the same level as chemotherapy administered intravenously or by injection.

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ATTACHMENT 2

SOUTHEASTERN INDIANA HEALTH ORGANIZATION
Attachment 2 - Exhibit 1: Plan Adjusted Index Rates (Calibrated)

Plan Name	Actuarial Value	Metal Tier	Plan Adjusted Index Rate (Calibrated)
SIHO Marketplace Bronze HSA	60.1%	Bronze	$246.81
SIHO Marketplace Bronze	61.2%	Bronze	$270.38
SIHO Marketplace Gold	78.4%	Gold	$404.88
SIHO Marketplace Silver HSA	70.1%	Silver	$305.97
SIHO Marketplace Silver	70.3%	Silver	$357.16

Southeastern Indiana Health Organization
Attachment 2 - Exhibit 2: Age and Tobacco Status Factors

Age	Age Factor	Tobacco Factor
0-20	0.635	1.000
21	1.000	1.050
22	1.000	1.050
23	1.000	1.050
24	1.000	1.050
25	1.004	1.100
26	1.024	1.100
27	1.048	1.100
28	1.087	1.100
29	1.119	1.100
30	1.135	1.150
31	1.159	1.150
32	1.183	1.150
33	1.198	1.150
34	1.214	1.150
35	1.222	1.150
36	1.230	1.150
37	1.238	1.150
38	1.246	1.150
39	1.262	1.150
40	1.278	1.150
41	1.302	1.150
42	1.325	1.150
43	1.357	1.150
44	1.397	1.150
45	1.444	1.200
46	1.500	1.200
47	1.563	1.200
48	1.635	1.200
49	1.706	1.200
50	1.786	1.200
51	1.865	1.200
52	1.952	1.200
53	2.040	1.200
54	2.135	1.200
55	2.230	1.300
56	2.333	1.300
57	2.437	1.300
58	2.548	1.300
59	2.603	1.300
60	2.714	1.300
61	2.810	1.300
62	2.873	1.300
63	2.952	1.300
64 and Older	3.000	1.300

Essential Health Benefits (EHB) Crosswalk and Certification Tool

The benefits included in Indiana's benchmark plan are "essential health benefits" (EHB) and must be included in all policies and plans offered in the individual and small group markets pursuant to 45 CFR §§147.150 and 156.100 et seq. Please submit a complete crosswalk and certification for each policy filed for review. This document should be submitted via SERFF into your supporting documents tab.

Benefit	Location of Benefit in Issuer's Policy			
Primary Care Visit to Treat an Injury or Illness	See Page	62	of	77
Specialist Visit	See Page	63	of	77
Other Practitioner Office Visit (Nurse, Physician Assistant)	See Page	65	of	77
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	See Page	66	of	77
Outpatient Surgery Physician/Surgical Services	See Page	66	of	77
Hospice Services	See Page	71	of	77
Private-Duty Nursing	See Page	70	of	77
Urgent Care Centers or Facilities	See Page	66	of	77
Home Health Care Services	See Page	70	of	77
Emergency Room Services	See Page	66	of	77
Emergency Transportation/Ambulance	See Page	70	of	77
Inpatient Hospital Services (e.g., Hospital Stay)	See Page	68	of	77
Inpatient Physician and Surgical Services	See Page	68	of	77
Skilled Nursing Facility	See Page	65	of	77
Prenatal and Postnatal Care	See Page	20	of	77
Delivery and All Inpatient Services for Maternity Care	See Page	17	of	77
Mental/Behavioral Health Outpatient Services	See Page	68	of	77
Mental/Behavioral Health Inpatient Services	See Page	68	of	77
Substance Abuse Disorder Outpatient Services	See Page	68	of	77
Substance Abuse Disorder Inpatient Services	See Page	68	of	77
Generic Drugs	See Page	73	of	77
Preferred Brand Drugs	See Page	73	of	77
Non-Preferred Brand Drugs	See Page	73	of	77
Specialty Drugs	See Page	73	of	77
Outpatient Rehabilitation Services	See Page	68	of	77
Habilitation Services	See Page	68	of	77
Chiropractic Care	See Page	64	of	77
Durable Medical Equipment	See Page	71	of	77
Imaging (CT/PET Scans, MRIs)	See Page	66	of	77
Preventive Care/Screening/Immunization	See Page	75	of	77

Routine Eye Exam for Children	See Page	76	of	77
Eye Glasses for Children	See Page	76	of	77
Dental Check-Up for Children	See Page	N/A	of	NA
Rehabilitative Speech Therapy	See Page	67	of	77
Rehabilitative Occupational and Rehabilitative Physical Therapy	See Page	67	of	77
Well Baby Visits and Care	See Page	20	of	77
Laboratory Outpatient and Professional Services	See Page	66	of	77
X-rays and Diagnostic Imaging	See Page	N/A	of	N/A
Basic Dental Care – Child	See Page	N/A	of	N/A
Orthodontia – Child	See Page	N/A	of	N/A
Major Dental Care – Child	See Page	N/A	of	N/A
Transplant	See Page	18	of	77
Accidental Dental	See Page	27	of	77
Dialysis	See Page	72	of	77
Allergy Testing	See Page	63	of	77
Chemotherapy	See Page	21	of	77
Radiation	See Page	21	of	77
Diabetes Education	See Page	25	of	77
Prosthetic Devices	See Page	71	of	77
Infusion Therapy	See Page	26	of	77
Treatment for Temporomandibular Joint Disorders	See Page	28	of	77
Nutritional Counseling	See Page	26	of	77
Reconstructive Surgery	See Page	21	of	77
Clinical Trials	See Page	25	of	77
Diabetes Care Management	See Page	25	of	77
Inherited Metabolic Disorder - PKU	See Page	25	of	77
Off Label Prescription Drugs	See Page	24	of	77
Dental Anesthesia	See Page	27	of	77
Mental Health Other	See Page	23	of	77

I, on behalf of Southeastern Indiana Health C hereby certify, based on information and belief formed after reasonable inquiry, that (i) the statements and information contained herein are true, accurate and complete and (ii) all benefits included in Indiana's benchmark plan are included in the policy or policies filed by Southeastern Indiana Health Org for review and approval.

Cameron Wilson	Director of Fully Insured	05/09/2014
Name:	Title:	Date:

SOUTHEASTERN INDIANA HEALTH ORGANIZATION

Health Maintenance Organization Individual Product
Actuarial Memorandum
Form QHP INDV-05.2014

A. INTRODUCTION

Milliman, Inc. (Milliman) was retained by Southeastern Indiana Health Organization (SIHO) to develop an individual market rate filing with on-exchange and off-exchange plans to be filed with the Indiana Department of Insurance for 2015. This actuarial memorandum has been prepared in accordance with Indiana insurance laws and ACA Market Rating Rules. The purpose of this actuarial memorandum is to present the premium rates for SIHO's plans to be offered in the individual market in 2015. This material should not be used for any other purpose.

This actuarial memorandum has been prepared for the use of SIHO. We understand that the actuarial memorandum will be provided to the Indiana Department of Insurance and its subcontractors to assist in the review of SIHO's individual market rate filing. No portion of the actuarial memorandum may be provided to any other party without Milliman's prior written consent. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work.

The rating factors were developed from information published in the Milliman Health Cost Guidelines, and applicable state and federal regulations, as well as from information provided by SIHO. Additionally, we relied on exchange enrollment information provided within the April 2014 HHS Marketplace Enrollment report, along with information on the Medicaid spend-down population provided by the Indiana Department of Insurance (IDOI). The memorandum does not guarantee that the rates will be adequate. Rather, the filing shows that the rates will be adequate if the assumptions underlying their development are realized.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

B. STATE OF INDIANA 4.1 (A) INDIVIDUAL RATE REQUIREMENTS

1. Benefit Structure

This is an individual medical expense service agreement offered as a health maintenance organization product. It provides for hospital, medical, and surgical expenses resulting from an eligible illness or injury. It also provides for prescription drug expenses and certain preventive care services. It is subject to various managed care provisions as described in the certificate of coverage. These are new products that will be offered beginning in 2015; SIHO does not currently offer any products in the individual market.

This policy provides for coverage of medical expenses with applicable member cost sharing, *i.e.*, co-payments, deductibles, and coinsurance amounts. Various benefit provisions are available under this policy form. Covered benefits and copayment schedules have been included with the certificates of coverage.

Attachment 1 provides a summary of benefit provisions for the benefit plan designs that are the subject of this actuarial memorandum. Complete descriptions of covered benefits and cost sharing arrangements are contained in the certificates of coverage.

The benefit plan designs included in this rate filing will be sold to individuals in Indiana. The following qualified health plans (QHPs) will be offered both on-exchange and off-exchange:

- SIHO Marketplace Bronze;
- SIHO Marketplace Bronze HSA;
- SIHO Marketplace Silver;
- SIHO Marketplace Silver HSA; and
- SIHO Marketplace Gold.

Covered services include the Indiana essential health benefits (EHB), inclusive of state mandated benefits. The following supplemental benefits are also covered:

- Diabetes education;
- Nutrition counseling; and
- An additional 3 chiropractic visits.

2. Proposed Rates

a. Premium Rate Development

The proposed premium rating factors were developed based on a manual rate development process. SIHO's group experience was utilized where appropriate in developing the manual rates, and was adjusted for the following:

- Trend, i.e., medical inflation and increased utilization;
- Regional, demographical and benefit cost-sharing differences between SIHO's group experience and the projected 2015 individual market;
- The morbidity of individuals anticipated to elect to be enrolled in ACA-compliant policies during 2015, including the impact of the Medicaid spend-down population;
- Impact of federal transitional reinsurance; and
- Differences in retention components between the group and individual blocks of business.

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b. Premium Rate Calculation

Consumer Adjusted Premium Rates are calculated as the product of four factors:

i. Plan Adjusted Index Rate (Calibrated);
ii. Geographic rating area factor;
iii. Age factor; and
iv. Tobacco status factor.

Monthly Premium Rates to be charged to a specific policyholder are determined by summing the Consumer Adjusted Premium Rates for each member of the family, provided at most three child dependents under age 21 for each family are taken into account. For members that use tobacco, the composite premium applicable to the member will be multiplied by the tobacco status factor applicable to the member's age.

i. Plan Adjusted Index Rate (Calibrated)

A Plan Adjusted Index Rate (Calibrated) is the estimated cost to provide coverage under a given benefit plan design for a member with a geographic rating area factor, an age factor, and a tobacco status factor of 1.00. The Plan Adjusted Index Rates (Calibrated) are provided in Exhibit 1 of Attachment 2. The actuarial value, as calculated using the CMS Actuarial Value (AV) calculator, and metal tier for each plan are also shown in this exhibit.

ii. Geographic Rating Area Factors

Individual market products will be offered in a total of 6 counties: Bartholomew, Brown, Decatur, Jackson, Jennings, and Scott. While these counties span three different rating regions, no geographic rating area factors will be applied to the products offered in the individual market.

iii. Age Factors

Age factors are based upon each member's age as of the premium rate effective date. The HHS Default Standard Age Curve is used for the age factors and is provided in Exhibit 2 of Attachment 2.

iv. Tobacco Status Factors

Tobacco status factors are based on each member's age and tobacco user status as of the premium rate effective date. Members whom do not use tobacco have a tobacco status factor of 1.00. The tobacco status factors for members that use tobacco are provided in Exhibit 2 of Attachment 2.

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3. Projected Experience with Enrollment Projection

SIHO's anticipated experience for the 2015 calendar year for individual policies under this form is provided in Table 1 below. The values reflect an estimate for the population that will enroll in these new products in January 2015.

Southeastern Indiana Health Organization
Table 1: Projected 2015 Experience

Member Months	Incurred Claims	Earned Premium	Projected Loss Ratio	Projected MLR
24,000	$ 10,960,000	$ 13,400,000	81.8%	87.2%

Note: Values have been rounded.

The projected loss ratio reflects a direct ratio of incurred claims to earned premiums. Projected medical loss ratio (MLR) was calculated consistently with the MLR methodology according to the National Associate of Insurance Commissioners as prescribed by 211 CMR 147.00, and does not reflect any credibility adjustments that may be permitted.

4. Assumptions

Since this is a new product rate filing, experience data was not available for the purpose of developing premium rates for these products. As such, premium rates for this filing are the result of a manual rate development process. SIHO's small group and large group point-of-service experience for the 12 months ending December 2013, representing 125,498 member months, provided the basis for the manual rate development process.

This experience data was adjusted to reflect anticipated differences between the group and individual markets. Specific items considered in estimating these adjustments included the following:

- Benefits not included within the experience data;
- Differences in age and gender of the covered populations;
- Geography and provider network differences between the populations;
- Morbidity of the population, including the following:
    - Difference in morbidity between the individual and group markets;
    - Impact of transitional ("grandmothered") policies;
    - Health status of the previously uninsured;
    - Impact of the Medicaid spend-down population;
- Income level of the anticipated population;
- Impact of federal transitional reinsurance;

Additional Benefits not covered in the baseline experience data used include private duty nursing and Temporomandibular joint disorder. Pediatric vision services are covered under a

capitation agreement effective January 2015. Please note that pediatric dental services will not be covered within the policy.

In developing estimates for the demographics of the individual market, we utilized data provided within the HHS Marketplace Enrollment report for April 2014.

The impact of morbidity was estimated as a percentage difference from the pre-ACA group market. Based on the various items outlined, the total morbidity of the individual market was estimated as being 25% above that of the pre-ACA group market.

Income level of the anticipated population was used in order to estimate the impact of cost share reduction (CSR) plans made available to individuals below 250% of the federal poverty level (FPL). For individuals estimated to be eligible for the 94% or 87% CSR plans, it was estimated that utilization would be 12% higher than that of the average enrollee.

Net incurred annual trend of approximately 8.0% was applied to estimate claims experience for 2015. The 8.0% annual trend is the composite of medical trend of approximately 7.0% and prescription drug trend of approximately 14.3%. SIHO provided the medical trend estimate based upon anticipated changes in their provider contracts and a review of recent experience. The prescription drug trend estimate was developed using 2014 and 2015 projected trends from SIHO's pharmacy benefit manager for its health plan book of business and experience from 2010 to 2013 as reported by the pharmacy benefit manager for its health plan book of business and for SIHO.

The following table shows the estimated incurred claims, net of transitional reinsurance, for 2015 effective dates based on the manual rate development process utilized, along with an illustrated buildup to total required revenue.

Estimated Incurred Claims PMPM for 2015	**$456.67**
Administrative Expense Load	$44.40
Profit and Risk Load	$33.51
Taxes and Fees	$23.90
Required Revenue PMPM	***$558.48***

The administrative expense load includes amounts for network access fees and operating expenses. SIHO's network access fees were estimated on a per member per month (PMPM) basis, based on data available within SIHO's small group block of business. Taxes and fees includes the estimated value of exchange user fees.

SIHO provided a PMPM assumption plus a percent of premium assumption for operating expenses. These estimates of 2015 operating expenses were developed by SIHO.

The proposed rates reflect a combined profit and risk charge load of 6% converted to a PMPM for the table above. These loads were provided by SIHO and are applied to all plans.

The following taxes and fees are reflected in the table above:

- $3.67 PMPM for the Federal Transitional Reinsurance Program (included in incurred claims estimate);
- $0.96 Per Member Per Year for the Risk Adjustment User Fee (included in incurred claims estimate);
- $2.12 Per Member Per Year for the Patient Centered Outcomes Research Institute Fee;
- 3.5% of premium exchange user fee; and,
- 0.75% for the Health Insurer Fee.

5. Premium Guarantee Provision

The policies are guaranteed renewable and will be sold on a guarantee of issue basis for residents of the six counties where these plans will be offered.

6. Rating Factors

a. Rate Structure

The calculation of monthly premiums and the rating factors, including geographic rating area, age, and tobacco status factors were described in Section 3 above.

b. Non-benefit Expenses

Non-benefit expenses are included in the Plan Adjusted Index Rates (Calibrated) discussed in section 3 of this memorandum. The non-benefit expenses include amounts for administrative and other expenses, sales and marketing expenses, net cost of private reinsurance, taxes, fees, risk margin, and profit.

c. Impact of Contractual Arrangement

Contractual agreements with health care providers and administrators are expected to result in medical cost and premium changes in line with market averages.

7. Company Financial Position

SIHO's risk-based capital ratio as of December 31, 2013 was 472.8%.

C. CERTIFICATION AND ATTESTATIONS

I am a Consulting Actuary with the firm of Milliman, Inc. SIHO engaged me to provide this actuarial memorandum.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and I meet its qualification standards to perform the analysis and render the actuarial opinion contained herein.

I believe this rate filing is in compliance with all applicable state and federal insurance statues and regulations and with applicable actuarial standards of practice.

I attest that the same premium rate is being charged without regard to whether the plan is offered through an Exchange, or whether the plan is offered directly from SIHO or through an agent.

This memorandum should not be interpreted as a guarantee that the rates will be adequate. The rates will be adequate if the assumptions underlying their development are realized. The adequacy of the rates will be dependent on numerous factors, many of which are not subject to management control (e.g., medical care cost trends in the community, demographic characteristics of the enrollees, etc.).

In developing the rating factors and other values in this actuarial memorandum, I relied on data, other information, and assumptions provided by SIHO. I have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of the analysis may likewise be inaccurate or incomplete. I performed a limited review of the data used directly in the analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of my assignment.

Jill S. Herbold, FSA, MAAA
Consulting Actuary

May 8, 2014
Date

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ATTACHMENT 1

SOUTHEASTERN INDIANA HEALTH ORGANIZATION
Exhibit: 2015 Individual Plan Designs

Benefit Category	SIHO Marketplace Bronze HSA	SIHO Marketplace Bronze	SIHO Marketplace Gold	SIHO Marketplace Silver HSA	SIHO Marketplace Silver
Annual Single Deductible	$4,500	$5,000	$750	$2,500	$2,000
Annual Family Deductible	$9,000	$10,000	$1,500	$5,000	$4,000
Annual OOP Max - Single (incl Ded)	$6,450	$6,600	$4,000	$5,000	$6,600
Annual OOP Max - Family	$12,900	$13,200	$8,000	$10,000	$13,200
PCP Office Visit	Ded, 20%	Ded, 20%	$30	Ded, 10%	$30
Specialist Office Visit	Ded, 20%	Ded, 20%	$60	Ded, 10%	$60
Preventive Care	$0	$0	$0	$0	$0
Inpatient Hospital Services	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Outpatient Hospital Services	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Professional Services (In & Out)	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Emergency Room	Ded, 20%	Ded, 20%	Ded, $200	Ded, 10%	Ded, $200
Urgent Care Facility	Ded, 20%	Ded, 20%	$60	Ded, 10%	$60
Ambulance	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
PT/OT/Speech Therapy	Ded, 20%	Ded, 20%	$60	Ded, 10%	$60
Chiropractic Services	Ded, 20%	Ded, 20%	$60	Ded, 10%	$60
DME/Orthotics & Prosthetic Devices	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Inpatient Behavioral Health	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Outpatient Behavioral Health	Ded, 20%	Ded, 20%	$30	Ded, 10%	$30
Skilled Nursing Facility/LTACH	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Acute IP Rehab	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Home Health	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Hospice	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Pharmacy:					
Generic Drug	Ded, 20%	$25	$15	Ded, 10%	$15
Brand Name Formulary	Ded, 20%	$50	$40	Ded, 10%	$40
Brand Name Non-Formulary	Ded, 20%	$100	$80	Ded, 10%	$80
Specialty Drugs *	Ded, 20%	Ded, 20%	Ded, 10%	Ded, 10%	Ded, 20%
Mail Order	Ded, 20%	2.5x	2.5x	Ded, 10%	2.5x
Pediatric Vision Services	Eye Exam, Lenses/Frames or Contacts Once a Calendar Year				

* Specialty Drug Benefit does not apply to orally administered cancer chemotherapy drugs, which are covered at the same level as chemotherapy administered intravenously or by injection.

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ATTACHMENT 2

SOUTHEASTERN INDIANA HEALTH ORGANIZATION
Attachment 2 - Exhibit 1: Plan Adjusted Index Rates (Calibrated)

Plan Name	Actuarial Value	Metal Tier	Plan Adjusted Index Rate (Calibrated)
SIHO Marketplace Bronze HSA	60.1%	Bronze	$246.81
SIHO Marketplace Bronze	61.2%	Bronze	$270.38
SIHO Marketplace Gold	78.4%	Gold	$404.88
SIHO Marketplace Silver HSA	70.1%	Silver	$305.97
SIHO Marketplace Silver	70.3%	Silver	$357.16

Southeastern Indiana Health Organization
Attachment 2 - Exhibit 2: Age and Tobacco Status Factors

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29	1.119	1.100
30	1.135	1.150
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32	1.183	1.150
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52	1.952	1.200
53	2.040	1.200
54	2.135	1.200
55	2.230	1.300
56	2.333	1.300
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