A 2014 ANALYSIS OF 88 MICHIGAN INDIVIDUAL HEALTH INSURANCE POLICIES FOR COMPLIANCE WITH MENTAL HEALTH PARITY

MENTAL HEALTH ASSOCIATION IN MICHIGAN

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EXECUTIVE SUMMARY

In 2014, under federal law and policy, Michigan became a mental health insurance parity state.

With individual and small-group policies, as well as the Obamacare health insurance exchanges, newly required to provide parity coverage, this investigation sought to compare and contrast behavioral health and other medical care among 88 individual coverage policies in Michigan for 2014. Seventy percent of these plans were from the federal health insurance exchange marketplace; thirty percent were off-exchange.

Relying primarily on electronic summative postings from the federal marketplace as well as insurers who also offered off-exchange plans, we were able to compare and contrast plan offerings with respect to inpatient care (in-network and out-of-network) and outpatient services (in-network and out-of-network). Relying on insurance company drug formularies, we also analyzed the way plans handled three mental health products that did not have generic equivalents in 2014.

Substantive intra-plan differences, often disadvantageous to behavioral health, were found when comparing in-network behavioral health outpatient coverage to the coverage for in-network outpatient primary care. Among the 88 plans, coverage differences were noted 45 times (51%). In 24 of those instances (27% of all plans), enough information was available to conclude that the differences negatively affected behavioral health.

Whether these differences represented technical violations of federal parity law and policy would be partly dependent on how the federal government defines “office visits,” as federal parity rules state that such visits (undefined) are in effect a parity category unto themselves. An appointment with a primary care physician would undoubtedly be an “office visit” to the federal government, and we believe (but cannot guarantee) an outpatient appointment for mental health or substance use would be as well.

Either way, what we found represents a violation of at least the spirit of federal parity law and policy, if not legally technical non-compliance.

Regarding prescriptions, we found an array of differing approaches and procedures among the involved insurers for the three products examined. A confounding factor here was (and is) the flexibility that federal rules and guidance give to insurers regarding mental health medication coverage, even though prescriptions are a “priority” area under federal parity rules and an “essential health benefit” under federal Obamacare guidance.

Among recommendations made were: (1) the provision of more information for consumers in plan summations; (2) federal rules definition of what is and is not an “office visit” for purposes of parity comparisons; (3) better monitoring of plans’ parity compliance by the federal government and state insurance commissioners; and (4) reexamination and readjustment of how prescriptions are handled under related federal rules and guidance.

INTRODUCTION

Although Michigan has never enacted a private sector mental health insurance parity law, it became a parity state in January 2014 via a combination of federal legislation (Domenici-Wellstone Mental Health & Parity Act of 2008 and Patient Protection & Affordable Care Act of 2010) and follow-up policy.

Under Domenici-Wellstone, all businesses with more than 50 employees (excepting a minuscule percentage of companies with exemptions) have had to cover mental health and other medical care equally, if they in fact offer health insurance and have elected to include mental health within that offering.

Under the Affordable Care Act (ACA) and its federal policy follow-up, small-group and individual policies (unless exemptions were obtained), as well as the new Obamacare insurance exchanges, were required beginning in 2014 to cover mental health and substance use disorder service ("including behavioral health treatment") as one of ten "essential health benefits,"[1] and to insure mental health and substance disorders (MH/SA) in a manner comparable to other medical care coverage, according to the final federal rules for Domenici-Wellstone (issued late 2013).

With Michigan entering new territory for small-group and individual polices, as well as those offered through the ACA health insurance exchanges (operated in Michigan by the federal government), we endeavored to determine what individual policies offered in 2014 for behavioral health and how that compared to other medical care under the policies.[2]

Our interest focused on six behavioral health areas highlighted by the Domenici-Wellstone final rules as "priorities": (1) Inpatient, in-network; (2) Inpatient, out-of-network; (3) Outpatient, in-network; (4) Outpatient, out-of-network; (5) Emergency care; (6) Prescription drugs.

We were also interested in how plans slotted what the rules call "intermediate" benefits into the framework of their policies. Examples of such benefits for MH/SA were listed per the rules as residential care, partial hospitalization and intensive outpatient treatment. For other medical care, listed examples were skilled nursing facilities, rehabilitation hospitals and home health care.

[1] The other essential health benefits which took effect in 2014 were: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

[2] This report deals with 2014 offerings only. Policies can be changed by sponsoring companies for 2015, and some companies that didn't participate in the health insurance exchanges for 2014 are doing so for '15.

INITIAL STUDY APPROACH

We visited the federal health insurance exchange marketplace (www.healthcare.gov) and the websites of all insurers offering 2014 plans under the federal exchange program, as well as the websites of selected companies offering off-exchange individual policies. A total of 12 insurers, offering 88 different plans for individual coverage – 62 within the health insurance exchange marketplace and 26 outside it – were reviewed (see Appendices A and B) for summative information posted about coverage benefits and consumer cost-sharing. Our goal was to compare the plans where possible for behavioral health and other medical care, respectively. We also desired to use the final federal parity rules for guidance in assessing such comparisons. This proved a difficult task, as will be explained later.

CATEGORIES FOR EXAMINATION VIA THE ELECTRONIC POSTINGS

The postings provided information on several categories of interest that could be subjected to examination. These were (using the insurers'/plans' headings, not ours):

*Emergency room services and emergency transportation

*Mental health outpatient (including substance abuse)

*Primary care

*Specialist (services)

*Lab/Outpatient professional

*Chiropractic/Rehabilitation

*Mental health inpatient (including substance abuse)

*General hospital inpatient

*Prescriptions

Both in-network and out-of-network information was available for each of these. (In the case of prescriptions, the prescribing doctor, not the filling pharmacy, was the network focal point.)

Nothing in the emergency services realm differentiated MH/SA from other medical conditions. There was no mention of MH/SA in these descriptions as being handled differently compared to other types of medical emergencies.

Additionally, the postings did not provide information on specific prescription drugs covered, with the reader directed to companies' drug formularies.

Further, all exchange-posted descriptions, as well as several off-exchange plans, lacked any information on what the federal parity rules termed "intermediate" benefits, whether applied to MH/SA or other medical care.

APPLICATION OF FEDERAL PARITY RULES TO ANY COMPARISONS

Comparing mental health inpatient to general hospital inpatient was a relatively simple, straightforward task.

Doing comparisons in the outpatient domain was much more confounding. Although the federal parity rules have formulas that can be computed for technical compliance, applying them would require more specific information on each plan than what was posted. Additionally, the rules say that an "office visit" does not have to follow the same procedures as other outpatient services. Unfortunately, the rules don't define what is and is not an "office visit."[3]

One would presume seeing a primary care doctor is such a visit. But what about going in for "mental health outpatient" service? A consult from a specialist? A trip to a chiropractor?

The federal rules for prescriptions are also confounding, as plans are clearly allowed to have their own mental health formularies.[4] Additionally, federal guidance for the Obamacare exchanges offers considerable medication flexibility for those plans. They must simply offer the same number of medications (not the exact same types) per drug category as are covered by the model plan selected in a state for prescription purposes. (In other words, if a state's model plan makes three antipsychotics available, the exchange plans in that state should each make at least three antipsychotics available.

[3] In the federal government's preamble to the rules, the term "office visit" is amplified by the parenthetical words "such as physician or psychological visits," and the term "all other outpatient services" is amplified by the parenthetical words "such as oupatient surgery." In the actual rules, "office visit" is amplified with the parenthetical words "such as physician visits."

[4] The rules state, "If a plan (or health insurance coverage) applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors determined in accordance with [other relevant rules' portions] and without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits, the plan (or health insurance coverage) satisfies the parity requirements of this paragraph (c) with respect to prescription drug benefits. Reasonable facors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up."

Which particular antipsychotics make up the minimum three could vary from plan-to-plan.) Further, under this guidance, offering or covering a drug does not mean the health plan is prohibited from using administrative mechanisms that delay consumer receipt of the particular product prescribed.

REVISED STUDY APPROACH

Given the previously described limiting factors, we were able to use the electronic posting information for attention to the following "priority" areas from the federal parity rules:

*Inpatient care (both in-network and out-of-network)

*Outpatient care (both in-network and out-of-network)

Given the complications of the federal rules and compliance formulas and the lack of definition for "office visits," we have assessed outpatient MH/SA in terms of the following comparisons:

~Outpatient MH/SA versus outpatient primary care (outpatient MH/SA is presumed to be the closest category in plan descriptions to a primary care office visit).

~Outpatient MH/SA in comparison to specialist services (as the latter could potentially be considered an "office visit").

~Outpatient MH/SA compared to chiropractic/rehabilitative care (once again, it is unknown to us if the latter would represent an "office visit" to the federal government).[5]

The federal "priority" of emergency care could not be analyzed further in light of information that was electronically posted. There was no evidence of mental health discrimination here. Conversely, there was also no proof of equal treatment for MH/SA regarding emergencies.

For the federal "priority" of prescriptions, we turned to the sponsoring companies' formularies. But given the huge mental health (and other) prescription flexibility allowed by the federal government, it would have been a futile exercise attempting to compare what was available for mental health and other medical care, respectively. Rather, we undertook two tasks: a focus on three mental health products that did not have generic equivalents in 2014; and a comparison of Blue Cross formularies to the state's model plan for prescriptions (Priority Health Commercial) for the number of products available in certain mental health categories.

[5] We did not deem it advisable or productive to compare MH/SA outpatient to laboratory services.

Finally, for the "intermediate" benefits under federal rules, because so often there wasn't related information available through the electronic postings, we did a limited partial check by examining plan documents elsewhere on company websites, reviewing provider panel composition, or directly asking the sponsoring companies, via e-mail or telephone, if their plans offered coverage for behavioral health residential and partial hospitalization.

RESULTS

Inpatient In-Network

There were no intra-plan differences in stated benefits and consumer cost-sharing for any of the plans regarding in-network MH/SA inpatient versus general inpatient. What the involved companies posted for their plans was the same for MH/SA as for other medical care.

Inpatient Out-of-Network

There were no intra-plan differences in stated benefits and consumer cost-sharing for any of the plans regarding out-of-network MH/SA inpatient vs. general inpatient. What the involved companies posted for their plans was the same for MH/SA as for other medical care.

Outpatient Out-of Network

A number of plans did not offer out-of-network coverage for Chiropractic/Rehabilitation (or several other areas of care). Among those that did, there were typically limits on the number of annual visits, something not seen in other outpatient categories. Beyond those factors, there were only a few instances of intra-plan differences in stated benefits and consumer cost-sharing regarding out-of-network MH/SA Outpatient versus Primary Care, Specialist Service and Chiropractic/Rehabilitation.

Outpatient In-Network

There were several differences between MH/SA and other outpatient care under this category. Many of these, most especially in comparison with Primary Care, were comparatively disadvantageous for the receipt of MH/SA service.

A. Outpatient In-Network: MH/SA vs. Primary Care
Of 88 plans, there were 45 instances in which MH/SA Outpatient consumer cost-sharing was different than for Primary Care. In 21 of these instances, it was not possible without additional informatiuon from plans to determine whether MH/SA or Primary Care had the more advantageous arrangements for the consumer. In the remaining 24 instances, MH/SA Outpatient service procedures were more burdensome (expensive) for the consumer than was the case with Primary Care. (See

Appendix C.) There were also 14 instances where plan postings said prior authorization was required for MH/SA Outpatient (but not Primary Care).[6]

B. *Outpatient In-Network: MH/SA vs. Specialist Service*[7]
Bringing Specialist Service into the mix, there were 43 differences between this category and MH/SA Outpatient. In 20 instances, it was not possible without additional plan information to determine which category had more adantageous arrangements for the consumer. In the other 23 cases, Specialist Service had greater consumer cost-sharing than did MH/SA Outpatient (Appendix D). Each category had a similar number of prior authorization (or referral) requirements.

C. *Outpatient In-Network: MH/SA vs. Chiropractic/Rehabilitation*[8]
In the vast majority of instances (over 70), there were limits on the number of annual visits for Chiropractic/Rehabilitation, whereas there were none stated for MH/SA outpatient. There were also several references to prior authorization for chiropractic/rehabilitative. Regarding consumer cost-sharing, there were 38 differences between the two categories where one would need more information; five instances where cost-sharing was greater for MH/SA than for Chiropractic/Rehabilitation; four cases where the opposite was in effect; and one instance with a mixed result, depending on whether rehabilitative or chiropractic care was the specific service involved (Appendix E).

<u>Prescriptions</u>

We went to the drug formularies of the involved insurance companies.[9] We concentrated on three mental health medications that did not have generic equivalents in 2014: Abilify, Seroquel-XR and Strattera. As can be seen in Appendix F, the formularies were quite diverse regarding these products. Four (out of 12) covered Abilify as “preferred”; four (not necessarily the same ones) also did so for Seroquel-XR; and Strattera was “preferred” for four.

Abilify required prior approval on four formularies; Seroquel-XR on six; and Strattera on four.

Step-therapy (“fail-first” on other products) was required for Abilify by four insurers; for Seroquel-XR by three; and for Strattera by four.

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[6] We further encountered one company (with seven plans) stating under in-network MH/SA Outpatient that “some services” require prior authorization. To determine which services, we conducted further, more detailed website investigation of that company and these plans. We could find no documentation of prior authorization applying to any in-network MH/SA Outpatient services, and our tabular presentations of these plans did not include prior authorization as applicable to MH/SA.
[7] Within the Specialist Service category, plan postings made no mention of Specialist Services for MH/SA in one way or another.
[8] Within the Chiropractic/Rehabilitation category, plan postings made no mention of MH/SA in any way.
[9] Companies’ formularies for 2015 will not necessarily be the same as for ’14 in all aspects.

There was a quantity limit on Abilify in five instances; on Seroquel-XR in six cases; and on Strattera in six formularies.

We reemphasize that existing federal guidance to exchange plans and the final federal parity rules allow such flexibility and diversity for medication coverage.

To further examine the issue of federal guidance to exchange plans, we compared Michigan's model plan for prescriptions (Priority Health Commercial) to the formulary used by Blue Cross/Blue Shield and Blue Care Network. We looked at "psychotherapeutics" and anti-anxiety products. In both categories, the respective formularies appeared to offer the same number of generic products. However, Priority Commercial also included as non-preferred (available at higher consumer cost-sharing with some insurer support) certain brand-name drugs that had generic equivalents. The Blues did not have these products listed in any manner, suggesting a consumer would have to pay 100% on his/her own to access them. Does this mean the Blues matched the number of products available through Priority Commercial? Perhaps the federal government or the courts would have to answer that question.

"Intermediate" Benefits

We attempted additional website investigation of or personal contact with all of the involved insurance companies to see if they covered MH/SA residential and partial hospitalization. We could obtain no relevant information on one of the companies. Of the remaining eleven, nine claimed to cover residential, and seven reported covering partial hospitalization.

DISCUSSION

This investigation was able to compare and contrast the 2014 behavioral health and other medical coverage of 88 Michigan insurance plans (including the Obamacare exchange plans) for inpatient and outpatient services. The limited information provided through the plans' electronic summative postings prevented similar comparisons regarding emergency services and "intermediate" benefits.[10] A comparison of all plans on medication coverage for behavioral health vs. other medical care was also not practical, given existing federal policies on this subject.

Our study found no evidence of MH/SA services being singled out for lesser benefits in any category we attempted to examine. Conversely, our review provided no assurance that all behavioral benefits were comparable to those available for other medical care.

The main conclusions we could draw were:

[10] In a recent review of public documents on 20 plans in five states, Mental Health America raised the following question: "Can plans standardize their provider search functions, make them consistently more user-friendly, and enhance those functions…?"

*The intra-plan MH/SA descriptions we encountered for psychiatric inpatient service (in-network and out-of-network) matched those which existed for other hospital care.

*Medication formularies from the involved insurers were highly disparate when it came to three single-source (no generic equivalent) mental health drugs we examined. A consumer would be unable to know this from the plans' summative postings. (Only a review of insurers' formularies, to which the summative postings directed readers, would answer the question, and a consumer would likely need some familiarity with formularies and their terminologies to completely comprehend them.[11]) One has to wonder if the huge flexibility accorded to exchange and off-exchange plans by federal rules and guidance is inconsistent with the concept of parity and not in the best interest of consumers.

*The intra-plan MH/SA descriptions we encountered for in-network outpatient service were frequently different (and often discriminatory to MH/SA, most especially vis-à-vis Primary Care) than were descriptions for other types of outpatient care.

Outpatient differences were found in each of three comparisons of MH/SA vs. other outpatient categories: MH/SA vs. Primary Care; MH/SA vs. Specialist Service; and MH/SA vs. Chiropractic/Rehabilitation.

The comparison that was most disadvantageous to MH/SA involved Primary Care. For 27% of all plans, consumer cost-sharing was greater for MH/SA than for Primary Care. (For another 24% of plans, there were cost-sharing differences that couldn't be judged more favorable for one category or the other). And for at least 14 plans – and perhaps as many as 21 – prior authorization approval was uniquely required in some way for MH/SA service.

The MH/SA vs. Primary Care disparities were troubling, given that federal parity rules state "office visits" (undefined) are a category unto themselves, and Primary Care would be the closest oupatient classification to MH/SA. In fact, the preamble to the federal parity rules lists both physician and "psychological" visits as examples of "office visits." (In the actual rules sections, a physician appointment is the one "office visit" example given.) Although only the federal government or the courts could legally answer what constitutues an "office visit," it is highly unlikely that a distinction would be drawn here between MH/SA Outpatient and Primary Care. Such an interpretation yields a situation where several Michigan plans in 2014 were violating the spirit, if not the letter, of federal parity law and policy.

The other two outpatient comparisons conducted did not yield the same level of observable unfavorability toward MH/SA.

[11] A national coalition, I AM (Still) ESSENTIAL, has been pressing the federal government for new rules on better access, transparency and user-friendliness regarding drug formulary information from Affordable Care Act insurance plans.

The comparison of MH/SA to Chiropractic/Rehabilitation was a mixed bag. Cost-sharing differences favoring one category over the other evinced relatively small numbers of almost equal frequency. (It's important to remember that this comparison involved more indeterminable differences – 38, or 43 % – than any other.) The vast majority of plans had annual limits on Chiropractic/Rehabilitation that weren't stated for MH/SA. Both categories had several instances of prior authorization requirements. Assuming that MH/SA Outpatient would be an "office visit," it is not known whether Chiropractic/Rehabilitation would also be such to the federal government.

The comparison of MH/SA to Specialist Service indicated that in instances where enough information for judgment was available, intra-plan differences were generally more favorable to MH/SA. Once again, it is not known if the federal government would consider Specialist Service to represent "office visits," as the work of a specialist could easily involve a records consult as opposed to an actual consumer appointment with the specialist.

In sum regarding in-network outpatient service, MH/SA often fared unfavorably compared to Primary Care. If one interprets both MH/SA and Primary Care appointments as "office visits" (which we believe should and would be the case), this investigation found troubling results regarding parity compliance in Michigan for the year 2014.

RECOMMENDATIONS

1. The federal government should take steps to see that more information about behavioral health coverage, including prescriptions, is provided in summative plan information available electronically for Obamacare exchanges. For off-exchange electronic summaries, private insurers should do the same. What we encountered through this investigation was not sufficient.

2. Federal parity rules must definitively and clearly define what is and isn't an "office visit" since that is allowed by the federal government to be a parity outpatient category unto itself – not comparable to other outpatient service.

3. The federal government and state insurance commissioners must be more vigilant about monitoring plans for parity compliance and assuring corrective action for instances of non-compliance. The federal government especially must re-double its efforts in this regard.[12]

4. The federally allowed practice of prescription variability among insurers should be reexamined and adjusted. (This applies to both the federal parity rules and the federal

[12] According to the New York Times December 22, 2014, "The Obama administration said (today) that it would investigate prescription drug coverage and other benefits offered by health insurance companies to see if they discriminated against people with AIDS, mental illness, diabetes or other costly chronic conditions."

guidance for exchange plans.) If insurers are permitted under federal rules to take "reasonable" steps based on evidentiary factors, what we found regarding three examined products is that there is no precise consensus on those steps and factors for at least some mental health drugs. If there was such consensus, the insurers' formularies wouldn't have had so many differences in the way those three products were handled. It is extremely confounding to have prescriptions as a priority area for parity under federal rules and yet have those same rules say, in effect, this really doesn't apply. Additionally, the federal guidance to exchange plans (offering the same number of products in each category as a state-selected model plan) has no clinical rationale whatsoever as its underpinning, and our partial mental health comparison of Michigan's model prescription plan to Blue Cross/Blue Shield and Blue Care Network found the model plan offering more products if one counts brand-name drugs that possess generic equivalents.

5. Analysis of parity implementation and compliance in Michigan should now move from what is stated on paper to what consumers' actual experiences have been. The Mental Health Association in Michigan intends to undertake such a project in 2015.

Appendix A - Insurers Included in the Study

(includes those offering exchange and/or off-exchange plans)

Aetna
Blue Cross-Blue Shield
Blue Care Network
Consumers Mutual
HAP Personal Alliance
Humana
Meridian
McLaren
Molina
Priority
Totally You
United Health Care

Appendix B - Plans Included in the Study

Plans for individuals available through the exchange: healthcare.gov

Plan	Total Individual Deductible
Blue Care Network Partnered- Bronze	$5,950
Blue Care Network Partnered - Silver	$1,650
Blue Care Network Partnered- Gold	$250
Blue Care Network Select- Bronze	$5,950
Blue Care Network Select - Silver	$1,650
Blue Care Network Select - Gold	$250
Blue Care Network Preferred - Bronze	$5,950
Blue Care Network Preferred - Silver	$1,650
Blue Care Network Preferred - Gold	$250
BC/BS Premier Bronze	$6,350
BC/BS Premier Silver	$1,400
BC/BS Premier Gold	$150
BC/BS Multi-State Silver	$1,400
BC/BS Multi-State Gold	$150
Consumers Mutual Basic - High Deductible	$6,000
Consumers Mutual Choice - Medium Deductible	$2,000
Consumers Mutual Choice - Low Deductible	$1,000
Consumers Mutual Premier - No Deductible	$0
HAP Personal Alliance 5000 H S A	$5,000
HAP Personal Alliance 5000	$5,000
HAP Personal Alliance 500	$500
HAP Personal Alliance 3000	$3,000
HAP Personal Alliance 2500	$2,500
HAP Personal Alliance 1500	$1,500
HAP Personal Alliance 1000	$1,000
Humana Bronze	$6,300
Humana Silver	$4,600
Humana Gold	$2,500
Humana Platinum	$1,000
McLaren Silver	$2,000
McLaren Gold	$1,000
McLaren Platinum	$500
Meridian Bronze	$4,700
Meridian Bronze	$4,250
Meridian Silver	$1,750
Meridian Gold	$1,500
Molina Bronze	$4,000
Molina Silver 250	$1,700

Molina Silver 200	$1,500
Molina Silver 150	$0
Molina Silver 100	$0
Molina Gold	$250
Priority Health MyHealth Bronze	$5,000
Priority Health MyHealth Silver	$1,500
Priority Health MyHealth Silver	$2,000
Priority Health MyHealth Silver	$2,500
Priority Health MyHealth Gold	$1,000
Priority Health MyHealth Gold	$1,500
Priority Health MyHealth ACCESS Bronze	$5,000
Priority Health MyHealth ACCESS Silver	$1,500
Priority Health MyHealth ACCESS Silver	$2,000
Priority Health MyHealth ACCESS Silver	$2,500
Priority Health MyHealth ACCESS Gold	$1,000
Priority Health MyHealth ACCESS Gold	$1,500
Priority Health HSA Bronze	$6,000
Priority Health HSA Silver	$2,000
Priority Health HSA Gold	$1,250
Priority Health HSA ACCESS Bronze	$6,000
Priority Health HSA ACCESS Silver	$2,000
Priority Health HSA ACCESS Gold	$1,250
Totally You Total Health Care Silver	$3,000
Total HMO Standard	$1,000

Individual plans available off-exchange

Plan	Total Individual Deductible
Aetna Advantage Plus PD Bronze	$5,500
Aetna Advantage 6350 PD Bronze	$6,350
Aetna Advantage 5750 PD Bronze	$5,750
MI Aetna Classic 5000 PD	$5,000
Consumers Mutual Premier - Low Deductible	$1,000
HAP Champion PPO 30/60	$5,000
HAP Champion PPO QHDHP	$6,000
HAP Guide HMO 25/50	$3,750
HAP Guide HMO 30/60	$4,500
HAP Guide HMO QHDHP	$5,000
HAP Pathfinder POS 30/60	$5,000
HAP Pathfinder POS QHDHP	$3,000
HAP Champion PPO	$2,000
HAP Champion PPO 25/50	$2,250
HAP Pathfinder POS QHDHP	$2,250
HAP Pathfinder POS	$3,150
HAP Pathfinder POS 20/40	$800

United Health Care - Bronze HSA	$6,350
United Health Care - Bronze Co-Pay Select	$5,500
United Health Care - Silver HSA	$3,650
United Health Care - Silver Co-Pay Select 1	$5,000
United Health Care - Silver Co-Pay Select 2	$2,500
United Health Care - Silver Co-Pay Select 3	$3,500
United Health Care - Gold Co-Pay Select 1	$1,000
United Health Care - Gold Co-Pay Select 2	$1,500
United Health Care - Platinum Co-Pay Select	$750

Appendix C - Plan Comparisons
Outpatient MH/SA and Primary Care

Unless specified, no visit or dollar limits were noted
Plans are presented in random order

Individual Plans Available Through the Exchange

Plan		Outpatient MH/SA	Primary Care
1	**In Network**	$40 copay	$40 copay
	Out of Network	no coverage	no coverage
2	**In Network**	30% copay after deductible, prior authorization required	no charge for three visits, then $25 copay after deductible
	Out of Network	no coverage	no coverage
3	**In Network**	$30 after deductible	$30 before deductible
	Out of Network	no coverage	no coverage
4	**In Network**	$20 for 4 visits before deductible, 10% after deductible	$20 for 4 visits before deductible, 10% after deductible
	Out of Network	no coverage	no coverage
5	**In Network**	20% after deductible in network, no coverage out of network	20% after deductible
	Out of Network	no coverage	no coverage
6	**In Network**	$30 after deductible	$30 before deductible
	Out of Network	no coverage	no coverage
7	**In Network**	20% copay after deductible	$30 after deductible
	Out of Network	40% copay after deductible	no coverage
8	**In Network**	$60 before deductible in network tier 1, $85 tier 2	$60 before deductible tier 1, $85 tier 2
	Out of Network	50% after deductible	50% after deductible
9	**In Network**	$40 copay, prior authorization required	$15 copay
	Out of Network	no coverage	no coverage
10	**In Network**	20% after deductible	20% after deductible
	Out of Network	40% after deductible	40% after deductible
11	**In Network**	$30 co-pay after deductible, prior authorization required	$30 before deductible

	Out of Network	no coverage	no coverage
12	**In Network**	40% co-pay after deductible, prior authorization required	$30 before deductible
	Out of Network	no coverage	no coverage
13	**In Network**	$20 for 4 visits before deductible, 10% after deductible	$20 for 4 visits before deductible, 10% after deductible
	Out of Network	30% after deductible	30% after deductible

14	**In Network**	$60 copay	$30 copay
	Out of Network	no coverage	no coverage
15	**In Network**	$20 for 4 visits before deductible, 30% after deductible	$20 for 4 visits before deductible, 30% after deductible
	Out of Network	no coverage	no coverage
16	**In Network**	20% copay after deductible	$25 copay
	Out of Network	no coverage	no coverage
17	**In Network**	$30 co-pay after deductible, prior authorization required	$30 before deductible
	Out of Network	no coverage	no coverage
18	**In Network**	$35 copay	$35 copay
	Out of Network	50% copay after deductible	50% copay after deductible
19	**In Network**	$10 copay, prior authorization required	no charge
	Out of Network	no coverage	no coverage
20	**In Network**	no charge after deductible	no charge after deductible
	Out of Network	no charge after deductible	no charge after deductible
21	**In Network**	$50 copay	$50 copay
	Out of Network	no coverage	no coverage
22	**In Network**	$50 before deductible tier 1, $75 tier 2	$50 before deductible tier 1, $75 tier 2
	Out of Network	50% after deductible	50% after deductible
23	**In Network**	20% copay after deductible	$30 after deductible
	Out of Network	40% copay after deductible	no coverage
24	**In Network**	50% copay after deductible, prior authorization required	no charge for three visits, then 50% copay after deductible
	Out of Network	no coverage	no coverage

25	**In Network**	$20 for 4 visits before deductible, 20% after deductible	$20 for 4 visits before deductible, 20% after deductible
	Out of Network	no coverage	no coverage
26	**In Network**	20% copay after deductible	$30 after deductible
	Out of Network	40% copay after deductible	no coverage
27	**In Network**	$20 copay	$20 copay
	Out of Network	no coverage	no coverage
28	**In Network**	$65 copay, prior authorization required	$40 copay
	Out of Network	no coverage	no coverage
29	**In Network**	$20 before deductible first 4 visits, then 30% co-pay	$20 before deductible first 4 visits, then 30% co-pay
	Out of Network	50% copay after deductible	50% copay after deductible
30	**In Network**	$40 before deductible in network tier 1, $65 tier 2	$40 before deductible tier 1, $65 tier 2
	Out of Network	50% after deductible	50% after deductible

31	**In Network**	$30 after deductible	$30 before deductible
	Out of Network	$30 after deductible	$30 before deductible
32	**In Network**	$15 copay	$15 copay
	Out of Network	50% copay after deductible	50% copay after deductible
33	**In Network**	$75 copay, prior authorization required	$45 copay
	Out of Network	no coverage	no coverage
34	**In Network**	$20 for 4 visits before deductible, 10% after deductible	$20 for 4 visits before deductible, 10% after deductible
	Out of Network	no coverage	no coverage
35	**In Network**	$40 copay	$20 copay
	Out of Network	no coverage	no coverage
36	**In Network**	$25 copay	$25 copay
	Out of Network	no coverage	no coverage
37	**In Network**	$30 co-pay after deductible, prior authorization required	$30 before deductible
	Out of Network	no coverage	no coverage

38	**In Network**	$30 copay	$30 copay
	Out of Network	no coverage	no coverage
39	**In Network**	20% copay after deductible	$25 copay
	Out of Network	no coverage	no coverage
40	**In Network**	$30 copay after deductible, prior authorization required	no charge for three visits, then $30 copay after deductible
	Out of Network	no coverage	no coverage
41	**In Network**	$20 for 4 visits before deductible, 20% after deductible	$20 for 4 visits before deductible, 20% after deductible
	Out of Network	40% after deductible	40% after deductible
42	**In Network**	10% after deductible	10% after deductible
	Out of Network	30% after deductible	30% after deductible
43	**In Network**	20% copay after deductible	$25 copay
	Out of Network	no coverage	no coverage
44	**In Network**	$20 for 4 visits before deductible, 20% after deductible	$20 for 4 visits before deductible, 20% after deductible
	Out of Network	40% after deductible	40% after deductible
45	**In Network**	50% copay after deductible, prior authorization required	no charge for three visits, then 50% copay after deductible
	Out of Network	no coverage	no coverage
46	**In Network**	no charge after deductible	no charge after deductible
	Out of Network	no charge after deductible	no charge after deductible
47	**In Network**	no charge after deductible	no charge after deductible
	Out of Network	no coverage	no coverage
48	**In Network**	$50 copay, prior authorization required	$20 copay
	Out of Network	no coverage	no coverage
49	**In Network**	20% before deductible tier 1, 30% tier 2	$40 before deductible tier 1, $65 tier 2
	Out of Network	50% after deductible	50% after deductible
50	**In Network**	$20 for 4 visits before deductible, 30% after deductible	$20 for 4 visits before deductible, 30% after deductible
	Out of Network	no coverage	no coverage
51	**In Network**	10% after deductible	10% after deductible

	Out of Network	no coverage	no coverage
52	**In Network**	40% co-pay after deductible	$30 after deductible
	Out of Network	no coverage	no coverage
53	**In Network**	20% copay after deductible	20% copay after deductible
	Out of Network	50% copay after deductible	50% copay after deductible
54	**In Network**	$20 for 4 visits before deductible, 10% after deductible	$20 for 4 visits before deductible, 10% after deductible
	Out of Network	30% after deductible	30% after deductible
55	**In Network**	$40 copay	$40 copay
	Out of Network	no coverage	no coverage
56	**In Network**	$60 copay, prior authorization required	$30 copay
	Out of Network	no coverage	no coverage
57	**In Network**	$20 before deductible first 4 visits then 30% co-pay	$20 before deductible first 4 visits then 30% co-pay
	Out of Network	50% copay after deductible	50% copay after deductible
58	**In Network**	no charge after deductible	no charge after deductible
	Out of Network	no coverage	no coverage
59	**In Network**	20% copay after deductible	$30 after deductible
	Out of Network	40% copay after deductible	no coverage
60	**In Network**	$10 copay	$10 copay
	Out of Network	no coverage	no coverage
61	**In Network**	$20 for 4 visits before deductible, 20% after deductible	$20 for 4 visits before deductible, 20% after deductible
	Out of Network	no coverage	no coverage
62	**In Network**	40% co-pay after deductible	$30 after deductible
	Out of Network	40% co-pay after deductible	$30 after deductible

Additional Individual Plans Available Off-Exchange

Plan		**Outpatient MH/SA**	**Primary Care**
1	**In Network**	25% after deductible	25% after deductible
	Out of Network	no coverage	no coverage

2	**In Network**	$40 after deductible	$20 after deductible
	Out of Network	40% after deductible	40% after deductible
3	**In Network**	$40 after deductible	$20 deductible waived
	Out of Network	50% copay after deductible	50% copay after deductible
4	**In Network**	20% after deductible	$50, no deductible for 4 visits, then $50 after deductible
	Out of Network	no coverage	no coverage
5	**In Network**	no charge after deductible	no charge after deductible
	Out of Network	50% after deductible	50% after deductible
6	**In Network**	10% before deductible tier 1, 20% tier 2	$15 after deductible tier 1, $40 tier 2
	Out of Network	40% after deductible	40% after deductible
7	**In Network**	$80 after deductible	$40 after deductible
	Out of Network	60% after deductible	60% after deductible
8	**In Network**	20% after deductible	$25, no deductible
	Out of Network	no coverage	no coverage
9	**In Network**	no charge after deductible	no charge before deductible
	Out of Network	no coverage	no coverage
10	**In Network**	$30 after deductible	$30 after deductible
	Out of Network	no coverage	no coverage
11	**In Network**	no charge after deductible	$20 with deductible waived for three visits, then no charge after deductible
	Out of Network	50% copay after deductible	50% copay after deductible
12	**In Network**	20% after deductible	$35, no deductible
	Out of Network	no coverage	no coverage
13	**In Network**	$30 after deductible	$30 after deductible
	Out of Network	50% after deductible	50% after deductible
14	**In Network**	10% after deductible	10% after deductible
	Out of Network	50% copay after deductible	50% copay after deductible
15	**In Network**	50% after deductible	50% after deductible
	Out of Network	50% after deductible	50% after deductible
16	**In Network**	no charge after deductible	no charge before deductible
	Out of Network	no coverage	no coverage

17	**In Network**	50% after deductible	50% after deductible
	Out of Network	50% after deductible	50% after deductible
18	**In Network**	20% after deductible	$35, no deductible for 4 visits, then $50 after deductible
	Out of Network	no coverage	no coverage
19	**In Network**	$50 after deductible	$25 after deductible
	Out of Network	40% after deductible	40% after deductible
20	**In Network**	30% after deductible	$35, no deductible for 4 visits, then $50 after deductible
	Out of Network	no coverage	no coverage
21	**In Network**	10% after deductible	$15, no deductible
	Out of Network	no coverage	no coverage
22	**In Network**	$25 after deductible	$25 after deductible
	Out of Network	no coverage	no coverage
23	**In Network**	$30 after deductible	$30 after deductible
	Out of Network	50% after deductible	50% after deductible
24	**In Network**	$60 after deductible	$30 deductible waived
	Out of Network	50% copay after deductible	50% copay after deductible
25	**In Network**	10% after deductible	$15, no deductible
	Out of Network	no coverage	no coverage
26	**In Network**	15% after deductible	15% after deductible
	Out of Network	50% after deductible	50% after deductible

Appendix D - Plan Comparisons
Outpatient MH/SA and Specialist

Unless specified, no visit or dollar limits were noted
Plans are presented in random order

Individual Plans Available Through the Exchange

Plan		Outpatient MH/SA	Specialist
1	**In Network**	$40 copay	$60 copay
	Out of Network	no coverage	no coverage
2	**In Network**	30% copay after deductible, prior authorization required	$50 copay after deductible, prior authorization required
	Out of Network	no coverage	no coverage
3	**In Network**	$30 after deductible	$50 after deductible
	Out of Network	no coverage	no coverage
4	**In Network**	$20 for 4 visits before deductible, 10% after deductible	$20 for 4 visits before deductible, 10% after deductible
	Out of Network	no coverage	no coverage
5	**In Network**	20% after deductible in network, no coverage out of network	20% after deductible
	Out of Network	no coverage	no coverage
6	**In Network**	$30 after deductible	$50 after deductible
	Out of Network	no coverage	no coverage
7	**In Network**	20% copay after deductible	$50 after deductible
	Out of Network	40% copay after deductible	no coverage
8	**In Network**	$60 before deductible in network tier 1, $85 tier 2	$85 before deductible tier 1, $110 tier 2
	Out of Network	50% after deductible	50% after deductible
9	**In Network**	$40 copay, prior authorization required	$40 copay, prior authorization may be required
	Out of Network	no coverage	no coverage
10	**In Network**	20% after deductible	20% after deductible
	Out of Network	40% after deductible	40% after deductible
11	**In Network**	$30 co-pay after deductible, prior authorization required	$50 after deductible, referral required

	Out of Network	no coverage	no coverage
12	**In Network**	40% co-pay after deductible, prior authorization required	$50 after deductible, referral required
	Out of Network	no coverage	no coverage
13	**In Network**	$20 for 4 visits before deductible, 10% after deductible	$20 for 4 visits before deductible, 10% after deductible
	Out of Network	30% after deductible	30% after deductible

14	**In Network**	$60 copay	$60 copay
	Out of Network	no coverage	no coverage
15	**In Network**	$20 for 4 visits before deductible, 30% after deductible	$20 for 4 visits before deductible, 30% after deductible
	Out of Network	no coverage	no coverage
16	**In Network**	20% copay after deductible	$35 copay
	Out of Network	no coverage	no coverage
17	**In Network**	$30 co-pay after deductible, prior authorization required	$50 after deductible, referral required
	Out of Network	no coverage	no coverage
18	**In Network**	$35 copay	$50 copay
	Out of Network	50% copay after deductible	50% copay after deductible
19	**In Network**	$10 copay, prior authorization required	$10 copay, prior authorization may be required
	Out of Network	no coverage	no coverage
20	**In Network**	no charge after deductible	no charge after deductible
	Out of Network	no charge after deductible	no charge after deductible
21	**In Network**	$50 copay	$80 copay
	Out of Network	no coverage	no coverage
22	**In Network**	$50 before deductible tier 1, $75 tier 2	$75 before deductible tier 1, $100 tier 2
	Out of Network	50% after deductible	50% after deductible
23	**In Network**	20% copay after deductible	$50 after deductible
	Out of Network	40% copay after deductible	no coverage
24	**In Network**	50% copay after deductible, prior authorization required	50% copay after deductible, prior authorization required
	Out of Network	no coverage	no coverage

25	**In Network**	$20 for 4 visits before deductible, 20% after deductible	$20 for 4 visits before deductible, 20% after deductible
	Out of Network	no coverage	no coverage
26	**In Network**	20% copay after deductible	$50 after deductible
	Out of Network	40% copay after deductible	no coverage
27	**In Network**	$20 copay	$30 copay
	Out of Network	no coverage	no coverage
28	**In Network**	$65 copay, prior authorization required	$65 copay, prior authorization may be required
	Out of Network	no coverage	no coverage
29	**In Network**	$20 before deductible first 4 visits, then 30% co-pay	$20 before deductible first 4 visits, then 30% co-pay
	Out of Network	50% copay after deductible	50% copay after deductible
30	**In Network**	$40 before deductible in network tier 1, $65 tier 2	$60 before deductible tier 1, $85 tier 2
	Out of Network	50% after deductible	50% after deductible

31	**In Network**	$30 after deductible	$50 after deductible
	Out of Network	$30 after deductible	$50 after deductible
32	**In Network**	$15 copay	$30 copay
	Out of Network	50% copay after deductible	50% copay after deductible
33	**In Network**	$75 copay, prior authorization required	$75 copay, prior authorization may be required
	Out of Network	no coverage	no coverage
34	**In Network**	$20 for 4 visits before deductible, 10% after deductible	$20 for 4 visits before deductible, 10% after deductible
	Out of Network	no coverage	no coverage
35	**In Network**	$40 copay	$40 copay
	Out of Network	no coverage	no coverage
36	**In Network**	$25 copay	$50 copay
	Out of Network	no coverage	no coverage
37	**In Network**	$30 co-pay after deductible, prior authorization required	$50 after deductible, referral required
	Out of Network	no coverage	no coverage
38	**In Network**	$30 copay	$50 copay

	Out of Network	no coverage	no coverage
39	**In Network**	20% copay after deductible	$35 copay
	Out of Network	no coverage	no coverage
40	**In Network**	$30 copay after deductible, prior authorization required	$50 copay after deductible, prior authorization required
	Out of Network	no coverage	no coverage
41	**In Network**	$20 for 4 visits before deductible, 20% after deductible	$20 for 4 visits before deductible, 20% after deductible
	Out of Network	40% after deductible	40% after deductible
42	**In Network**	10% after deductible	10% after deductible
	Out of Network	30% after deductible	30% after deductible
43	**In Network**	20% copay after deductible	$35 copay
	Out of Network	no coverage	no coverage
44	**In Network**	$20 for 4 visits before deductible, 20% after deductible	$20 for 4 visits before deductible, 20% after deductible
	Out of Network	40% after deductible	40% after deductible
45	**In Network**	50% copay after deductible, prior authorization required	50% copay after deductible, prior authorization required
	Out of Network	no coverage	no coverage
46	**In Network**	no charge after deductible	no charge after deductible
	Out of Network	no charge after deductible	no charge after deductible

47	**In Network**	no charge after deductible	no charge after deductible
	Out of Network	no coverage	no coverage
48	**In Network**	$50 copay, prior authorization required	$50 copay, prior authorization may be required
	Out of Network	no coverage	no coverage
49	**In Network**	20% before deductible tier 1, 30% tier 2	$65 before deductible tier 1, $90 tier 2
	Out of Network	50% after deductible	50% after deductible
50	**In Network**	$20 for 4 visits before deductible 30% after deductible	$20 for 4 visits before deductible 30% after deductible
	Out of Network	no coverage	no coverage
51	**In Network**	10% after deductible	10% after deductible
	Out of Network	no coverage	no coverage

52	**In Network**	40% co-pay after deductible	$50 after deductible
	Out of Network	no coverage	no coverage
53	**In Network**	20% copay after deductible	20% copay after deductible
	Out of Network	50% copay after deductible	50% copay after deductible
54	**In Network**	$20 for 4 visits before deductible, 10% after deductible	$20 for 4 visits before deductible, 10% after deductible
	Out of Network	30% after deductible	30% after deductible
55	**In Network**	$40 copay	$60 copay
	Out of Network	no coverage	no coverage
56	**In Network**	$60 copay, prior authorization required	$60 copay, prior authorization may be required
	Out of Network	no coverage	no coverage
57	**In Network**	$20 before deductible first 4 visits, then 30% co-pay	$20 before deductible first 4 visits, then 30% co-pay
	Out of Network	50% copay after deductible	50% copay after deductible
58	**In Network**	no charge after deductible	no charge after deductible
	Out of Network	no coverage	no coverage
59	**In Network**	20% copay after deductible	$50 after deductible
	Out of Network	40% copay after deductible	no coverage
60	**In Network**	$10 copay	$30 copay
	Out of Network	no coverage	no coverage
61	**In Network**	$20 for 4 visits before deductible, 20% after deductible	$20 for 4 visits before deductible, 20% after deductible
	Out of Network	no coverage	no coverage
62	**In Network**	40% co-pay after deductible	$50 after deductible
	Out of Network	40% co-pay after deductible	$50 after deductible

Additional Individual Plans Available Off-Exchange

Plan		**Outpatient MH/SA**	**Specialist**
1	**In Network**	25% after deductible	25% after deductible
	Out of Network	no coverage	no coverage
2	**In Network**	$40 after deductible	$40 after deductible

	Out of Network	40% after deductible	40% after deductible
3	**In Network**	$40 after deductible	$40 after deductible
	Out of Network	50% copay after deductible	50% copay after deductible
4	**In Network**	20% after deductible	$100, no deductible, primary care referral required
	Out of Network	no coverage	no coverage
5	**In Network**	no charge after deductible	no charge after deductible
	Out of Network	50% after deductible	50% after deductible
6	**In Network**	10% before deductible tier 1, 20% tier 2	$35 after deductible tier 1, $60 tier 2
	Out of Network	40% after deductible	40% after deductible
7	**In Network**	$80 after deductible	$80 after deductible
	Out of Network	60% after deductible	60% after deductible
8	**In Network**	20% after deductible	$30, no deductible, primary care referral required
	Out of Network	no coverage	no coverage
9	**In Network**	no charge after deductible	no charge after deductible, primary care referral required
	Out of Network	no coverage	no coverage
10	**In Network**	$30 after deductible	$60 after deductible
	Out of Network	no coverage	no coverage
11	**In Network**	no charge after deductible	no charge after deductible
	Out of Network	50% copay after deductible	50% copay after deductible
12	**In Network**	20% after deductible	$60, no deductible, primary care referral required
	Out of Network	no coverage	no coverage
13	**In Network**	$30 after deductible	$60 after deductible
	Out of Network	50% after deductible	50% after deductible
14	**In Network**	10% after deductible	10% after deductible
	Out of Network	50% copay after deductible	50% copay after deductible
15	**In Network**	50% after deductible	50% after deductible
	Out of Network	50% after deductible	50% after deductible
16	**In Network**	no charge after deductible	no charge after deductible, primary care referral required

	Out of Network	no coverage	no coverage

17	**In Network**	50% after deductible	50% after deductible
	Out of Network	50% after deductible	50% after deductible
18	**In Network**	20% after deductible	$70, no deductible, primary care referral required
	Out of Network	no coverage	no coverage
19	**In Network**	$50 after deductible	$50 after deductible
	Out of Network	40% after deductible	40% after deductible
20	**In Network**	30% after deductible	$70, no deductible, primary care referral required
	Out of Network	no coverage	no coverage
21	**In Network**	10% after deductible	$30, no deductible, primary care referral required
	Out of Network	no coverage	no coverage
22	**In Network**	$25 after deductible	$50 after deductible
	Out of Network	no coverage	no coverage
23	**In Network**	$30 after deductible	$60 after deductible
	Out of Network	50% after deductible	50% after deductible
24	**In Network**	$60 after deductible	$60 after deductible
	Out of Network	50% copay after deductible	50% copay after deductible
25	**In Network**	10% after deductible	$30, no deductible, primary care referral required
	Out of Network	no coverage	no coverage
26	**In Network**	15% after deductible	15% after deductible
	Out of Network	50% after deductible	50% after deductible

Appendix E - Plan Comparisons
Outpatient MH/SA and Chiropractic/Rehabilitation

Unless specified, no visit or dollar limits were noted
Plans are presented in random order

Individual Plans Available Through the Exchange

Plan		Outpatient MH/SA	Chiropractic/Rehabilitation
1	**In Network**	$40 copay	Chiropractic is $30 copay. Rehabilitation is $40 copay. Annual visit limits: chiropractic 20, occupational and physical therapy 30 combined, speech therapy 30.
	Out of Network	no coverage	no coverage
2	**In Network**	30% copay after deductible, prior authorization required	30% copay after deductible, prior authorization required, 30 visit annual limit per therapy
	Out of Network	no coverage	no coverage
3	**In Network**	$30 after deductible	20% co-pay after deductible, 30 visit per year limit
	Out of Network	no coverage	no coverage
4	**In Network**	$20 for 4 visits before deductible, 10% after deductible	10% after deductible, no coverage out of network, 30 visit annual limit for chiropractic combined with physical and occupational therapy, 90 visit annual limit for rehabilitation
	Out of Network	no coverage	no coverage
5	**In Network**	20% after deductible in network, no coverage out of network	20% after deductible, visit limits apply as for the MyHealth policies
	Out of Network	no coverage	no coverage
6	**In Network**	$30 after deductible	30% co-pay after deductible, 30 visit per year limit
	Out of Network	no coverage	no coverage
7	**In Network**	20% copay after deductible	20% copay after deductible, 30 visit limit per year
	Out of Network	40% copay after deductible	40% copay after deductible, 30 visit limit per year
8	**In Network**	$60 before deductible in network tier 1, $85 tier 2	$60 before deductible tier 1, $85 tier 2, quantity limit set at EHB benchmark
	Out of Network	50% after deductible	50% after deductible, quantity limit set at EHB benchmark

9	**In Network**	$40 copay, prior authorization required	25% copay after deductible, prior authorization required, 30 visit annual limit combined
	Out of Network	no coverage	no coverage
10	**In Network**	20% after deductible	20% after deductible, 30 combined visit annual limit
	Out of Network	40% after deductible	40% after deductible, 30 combined visit annual limit

11	**In Network**	$30 co-pay after deductible, prior authorization required	20% co-pay after deductible, prior authorization may be required, 30 visit per year limit
	Out of Network	no coverage	no coverage
12	**In Network**	40% co-pay after deductible, prior authorization required	40 % co-pay after deductible, prior authorization may be required, 30 visit per year limit
	Out of Network	no coverage	no coverage
13	**In Network**	$20 for 4 visits before deductible, 10% after deductible	10% after deductible, 30 visit annual limit for chiropractic combined with physical and occupational therapy
	Out of Network	30% after deductible	30% after deductible, 30 visit annual limit for chiropractic combined with physical and occupational therapy
14	**In Network**	$60 copay	no charge after deductible, 30 visit annual limit
	Out of Network	no coverage	no coverage
15	**In Network**	$20 for 4 visits before deductible, 30% after deductible	30% after deductible, 30 visit annual limit for chiropractic combined with physical and occupational therapy, 90 visit annual limit for rehabilitation
	Out of Network	no coverage	no coverage
16	**In Network**	20% copay after deductible	no charge after deductible, 30 visit annual limit for chiropractic combined with physical and occupational therapy, prior authorization required
	Out of Network	no coverage	no coverage
17	**In Network**	$30 co-pay after deductible, prior authorization required	20% co-pay after deductible, prior authorization may be required, 30 visit per year limit
	Out of Network	no coverage	no coverage

18	**In Network**	$35 copay	Chiropractic is $30 copay. Rehabilitation is $50 copay. Annual visit limits: chiropractic 20, occupational and physical therapy 30 combined, speech therapy 30.
	Out of Network	50% copay after deductible	50% copay after deductible. Annual visit limits: chiropractic 20. occupational and physical therapy 30 combined, speech therapy 30.
19	**In Network**	$10 copay, prior authorization required	10% copay after deductible, prior authorization required, 30 visit annual limit combined
	Out of Network	no coverage	no coverage
20	**In Network**	no charge after deductible	no charge after deductible, 30 combined visit limit per year
	Out of Network	no charge after deductible	no charge after deductible, 30 combined visit limit per year
21	**In Network**	$50 copay	40% copay after deductible
	Out of Network	no coverage	no coverage

22	**In Network**	$50 before deductible tier 1, $75 tier 2	$50 before deductible tier 1, $75 tier 2, quantity limit set at EHB benchmark
	Out of Network	50% after deductible	50% after deductible, quantity limit set at EHB benchmark
23	**In Network**	20% copay after deductible	20% copay after deductible, 30 visit limit per year
	Out of Network	40% copay after deductible	40% copay after deductible, 30 visit limit per year
24	**In Network**	50% copay after deductible, prior authorization required	50% copay after deductible, prior authorization required, 30 visit annual limit per therapy
	Out of Network	no coverage	no coverage
25	**In Network**	$20 for 4 visits before deductible, 20% after deductible	20% after deductible, 30 visit annual limit for chiropractic combined with physical and occupational therapy, 90 visit annual limit for rehabilitation
	Out of Network	no coverage	no coverage
26	**In Network**	20% copay after deductible	20% copay after deductible, 30 visit limit per year
	Out of Network	40% copay after deductible	40% copay after deductible, 30 visit limit per year
27	**In Network**	$20 copay	Chiropractic is $30 copay. Rehabilitation is $20 copay. Annual visit limits: chiropractic 20, occupational and physical therapy 30 combined, speech therapy 30

	Out of Network	no coverage	no coverage
28	**In Network**	$65 copay, prior authorization required	30% copay after deductible, prior authorization required, 30 visit annual limit combined
	Out of Network	no coverage	no coverage
29	**In Network**	$20 before deductible first 4 visits then 30% co-pay	30% copay after deductible, 30 combined visit limit per year
	Out of Network	50% copay after deductible	50% copay after deductible
30	**In Network**	$40 before deductible in network tier 1, $65 tier 2	$40 before deductible tier 1, $65 tier 2, quantity limit set at EHB benchmark
	Out of Network	50% after deductible	50% after deductible, quantity limit set at EHB benchmark
31	**In Network**	$30 after deductible	$30 after deductible, 30 visit per year limit
	Out of Network	$30 after deductible	$30 after deductible, 30 visit per year limit
32	**In Network**	$15 copay	Chiropractic is $30 copay. Rehabilitation is $50 copay. Annual visit limits: chiropractic 20, occupational and physical therapy 30 combined, speech therapy 30
	Out of Network	50% copay after deductible	50% copay after deductible. Annual visit limits: chiropractic 20, occupational and physical therapy 30 combined, speech therapy 30
33	**In Network**	$75 copay, prior authorization required	40% copay after deductible, prior authorization required, 30 visit annual limit combined
	Out of Network	no coverage	no coverage

34	**In Network**	$20 for 4 visits before deductible, 10% after deductible	10% after deductible, no coverage out of network, 30 visit annual limit for chiropractic combined with physical and occupational therapy
	Out of Network	no coverage	no coverage
35	**In Network**	$40 copay	20% after deductible, 30 visit annual limit
	Out of Network	no coverage	no coverage
36	**In Network**	$25 copay	10% copay after deductible
	Out of Network	no coverage	no coverage
37	**In Network**	$30 copay after deductible, prior authorization required	30% copay after deductible, prior authorization may be required, 30 visit per year limit
	Out of Network	no coverage	no coverage

38	**In Network**	$30 copay	Chiropractic is $30 copay. Rehabilitation is $50 copay. Annual visit limits: chiropractic 20, occupational and physical therapy 30 combined, speech therapy 30
	Out of Network	no coverage	no coverage
39	**In Network**	20% copay after deductible	no charge after deductible, 30 visit annual limit for chiropractic combined with physical and occupational therapy, prior authorization required
	Out of Network	no coverage	no coverage
40	**In Network**	$30 copay after deductible, prior authorization required	40% copay after deductible, prior authorization required, 30 visit annual limit per therapy
	Out of Network	no coverage	no coverage
41	**In Network**	$20 for 4 visits before deductible, 20% after deductible	20% after deductible, 30 visit annual limit for chiropractic combined with physical and occupational therapy
	Out of Network	40% after deductible	40% after deductible, 30 visit annual limit for chiropractic combined with physical and occupational therapy
42	**In Network**	10% after deductible	10% after deductible, 30 combined visit annual limit
	Out of Network	30% after deductible	30% after deductible, 30 combined visit annual limit
43	**In Network**	20% copay after deductible	no charge after deductible, 30 visit annual limit for chiropractic combined with physical and occupational therapy, prior authorization required
	Out of Network	no coverage	no coverage
44	**In Network**	$20 for 4 visits before deductible, 20% after deductible	20% after deductible, 30 visit annual limit for chiropractic combined with physical and occupational therapy
	Out of Network	40% after deductible	40% after deductible, 30 visit annual limit for chiropractic combined with physical and occupational therapy

45	**In Network**	50% copay after deductible, prior authorization required	50% copay after deductible, prior authorization required, 30 visit annual limit per therapy
	Out of Network	no coverage	no coverage
46	**In Network**	no charge after deductible	no charge after deductible, 30 visit per year limit

	Out of Network	no charge after deductible	no charge after deductible, 30 visit per year limit
47	**In Network**	no charge after deductible	no charge after deductible, visit limits apply as for the MyHealth policies
	Out of Network	no coverage	no coverage
48	**In Network**	$50 copay, prior authorization required	20% copay after deductible, prior authorization required, 30 visit annual limit combined
	Out of Network	no coverage	no coverage
49	**In Network**	20% before deductible tier 1, 30% tier 2	$40 before deductible tier 1, $65 tier 2, quantity limit set at EHB benchmark
	Out of Network	50% after deductible	50% after deductible, quantity limit set at EHB benchmark
50	**In Network**	$20 for 4 visits before deductible 30% after deductible	30% after deductible, 30 visit annual limit for chiropractic combined with physical and occupational therapy, 90 visit annual limit for rehabilitation
	Out of Network	no coverage	no coverage
51	**In Network**	10% after deductible	10% after deductible, visit limits apply as for the MyHealth policies
	Out of Network	no coverage	no coverage
52	**In Network**	40% co-pay after deductible	40% co-pay after deductible, 30 visit per year limit
	Out of Network	no coverage	no coverage
53	**In Network**	20% copay after deductible	20% copay after deductible. Annual visit limits: chiropractic 20, occupational and physical therapy 30 combined, speech therapy 30
	Out of Network	50% copay after deductible	50% copay after deductible. Annual visit limits: chiropractic 20, occupational and physical therapy 30 combined, speech therapy 30
54	**In Network**	$20 for 4 visits before deductible, 10% after deductible	10% after deductible, 30 visit annual limit for chiropractic combined with physical and occupational therapy
	Out of Network	30% after deductible	30% after deductible, 30 visit annual limit for chiropractic combined with physical and occupational therapy
55	**In Network**	$40 copay	25% copay after deductible
	Out of Network	no coverage	no coverage

56	**In Network**	$60 copay, prior authorization required	30% copay after deductible, prior authorization required, 30 visit annual limit combined
	Out of Network	no coverage	no coverage
57	**In Network**	$20 before deductible first 4 visits, then 30% co-pay	30% copay after deductible, 30 combined visit limit per year
	Out of Network	50% copay after deductible	50% copay after deductible
58	**In Network**	no charge after deductible	no charge after deductible, 30 visit annual limit for chiropractic combined with physical and occupational therapy, prior authorization required
	Out of Network	no coverage	no coverage
59	**In Network**	20% copay after deductible	20% copay after deductible, 30 visit limit per year
	Out of Network	40% copay after deductible	40% copay after deductible, 30 visit limit per year
60	**In Network**	$10 copay	Chiropractic is $30 copay. Rehabilitation is $10 copay. Annual visit limits: chiropractic 20, occupational and physical therapy 30 combined, speech therapy 30
	Out of Network	no coverage	no coverage
61	**In Network**	$20 for 4 visits before deductible, 20% after deductible	20% after deductible, 30 visit annual limit for chiropractic combined with physical and occupational therapy, 90 visit annual limit for rehabilitation
	Out of Network	no coverage	no coverage
62	**In Network**	40% co-pay after deductible	40% co-pay after deductible, 30 visit per year limit
	Out of Network	40% co-pay after deductible	40% co-pay after deductible, 30 visit per year limit

Additional Individual Plans Available Off-Exchange

Plan		**Outpatient MH/SA**	**Chiropractic/Rehabilitation**
1	**In Network**	25% after deductible	25% after deductible, limit of 60 visits per year for each condition
	Out of Network	no coverage	no coverage
2	**In Network**	$40 after deductible	20% after deductible, limit of 60 visits per year for each condition

	Out of Network	40% after deductible	40% after deductible, limit of 60 visits per year for each condition
3	**In Network**	$40 after deductible	$40 after deductible, 30 visit per year limit
	Out of Network	50% copay after deductible	50% copay after deductible, 30 visit per year limit
4	**In Network**	20% after deductible	20% after deductible, 30 visit per year limit
	Out of Network	no coverage	no coverage
5	**In Network**	no charge after deductible	no charge after deductible, limit of 60 visits per year for each condition
	Out of Network	50% after deductible	50% after deductible, limit of 60 visits per year for each condition
6	**In Network**	10% before deductible tier 1, 20% tier 2	$15 before deductible tier 1, $40 tier 2, limit 30 visits per year
	Out of Network	40% after deductible	40% after deductible
7	**In Network**	$80 after deductible	40% after deductible, limit of 60 visits per year for each condition
	Out of Network	60% after deductible	60% after deductible, limit of 60 visits per year for each condition
8	**In Network**	20% after deductible	20% after deductible, 30 visit per year limit
	Out of Network	no coverage	no coverage
9	**In Network**	no charge after deductible	no charge after deductible, 30 visit per year limit
	Out of Network	no coverage	no coverage
10	**In Network**	$30 after deductible	25% after deductible, limit of 60 visits per year for each condition
	Out of Network	no coverage	no coverage
11	**In Network**	no charge after deductible	no charge after deductible
	Out of Network	50% copay after deductible	50% copay after deductible
12	**In Network**	20% after deductible	20% after deductible, 30 visit per year limit
	Out of Network	no coverage	no coverage
13	**In Network**	$30 after deductible	30% after deductible, limit of 60 visits per year for each condition
	Out of Network	50% after deductible	50% after deductible, limit of 60 visits per year for each condition
14	**In Network**	10% after deductible	10% after deductible
	Out of Network	50% copay after deductible	50% copay after deductible, 30 visit per year limit

15	**In Network**	50% after deductible	50% after deductible, limit of 60 visits per year for each condition
	Out of Network	50% after deductible	50% after deductible, limit of 60 visits per year for each condition

16	**In Network**	no charge after deductible	no charge after deductible, 30 visit per year limit
	Out of Network	no coverage	no coverage
17	**In Network**	50% after deductible	50% after deductible, limit of 60 visits per year for each condition
	Out of Network	50% after deductible	50% after deductible, limit of 60 visits per year for each condition
18	**In Network**	20% after deductible	20% after deductible, 30 visit per year limit
	Out of Network	no coverage	no coverage
19	**In Network**	$50 after deductible	30% after deductible, limit of 60 visits per year for each condition
	Out of Network	40% after deductible	40% after deductible, limit of 60 visits per year for each condition
20	**In Network**	30% after deductible	30% after deductible, 30 visit per year limit
	Out of Network	no coverage	no coverage
21	**In Network**	10% after deductible	10% after deductible, 30 visit per year limit
	Out of Network	no coverage	no coverage
22	**In Network**	$25 after deductible	30% after deductible, limit of 60 visits per year for each condition
	Out of Network	no coverage	no coverage
23	**In Network**	$30 after deductible	30% after deductible, limit of 60 visits per year for each condition
	Out of Network	50% after deductible	50% after deductible, limit of 60 visits per year for each condition
24	**In Network**	$60 after deductible	$30 after deductible, 30 visit per year limit
	Out of Network	50% copay after deductible	50% copay after deductible
25	**In Network**	10% after deductible	10% after deductible, 30 visit per year limit
	Out of Network	no coverage	no coverage
26	**In Network**	15% after deductible	15% after deductible, limit of 60 visits per year for each condition

	Out of Network	50% after deductible	50% after deductible, limit of 60 visits per year for each condition

Appendix F - Medication Coverage

Drug	Carrier	Covered As preferred	non-preferred	prior approval	step therapy	quantity limit
Abilify	Aetna		X	X		X
	BCBS	X			X	
	Blue Care Network	X			X	
	Consumers Mutual	X				
	HAP Personal Alliance		X	X		X
	Humana		X	X		X
	Meridian	X				
	McLaren		X			X
	Molina		X		X	
	Priority		X		X	
	Totally You		X	X		
	United Health Care		X			X
Seroquel XR	Aetna		X	X	X	X
	BCBS		X	X		
	Blue Care Network		X	X		
	Consumers Mutual	X				
	HAP Personal Alliance		X	X		X
	Humana		X	X		X
	Meridian	X				
	McLaren		X			X
	Molina		X		X	
	Priority	X			X	X
	Totally You		X	X		
	United Health Care	X				X
Strattera	Aetna		X		X	X
	BCBS		X			
	Blue Care Network		X		X	X
	Consumers Mutual	X			X	X
	HAP Personal Alliance		X	X		X
	Humana		X	X		X
	Meridian	X				
	McLaren		X	X		
	Molina	X				
	Priority	X				X
	Totally You		X	X		
	United Health Care		X		X	