Health Reform: **Beyond the Basics**

healthreformbeyondthebasics.org

Part III:

Plan Design

Coverage Year 2019

Center on Budget and Policy Priorities

September 20, 2018

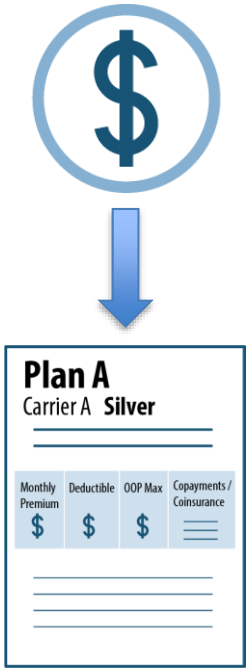
Center on Budget and Policy Priorities

Elements of Plan Design

Premiums vs Cost-Sharing Charges

Premiums

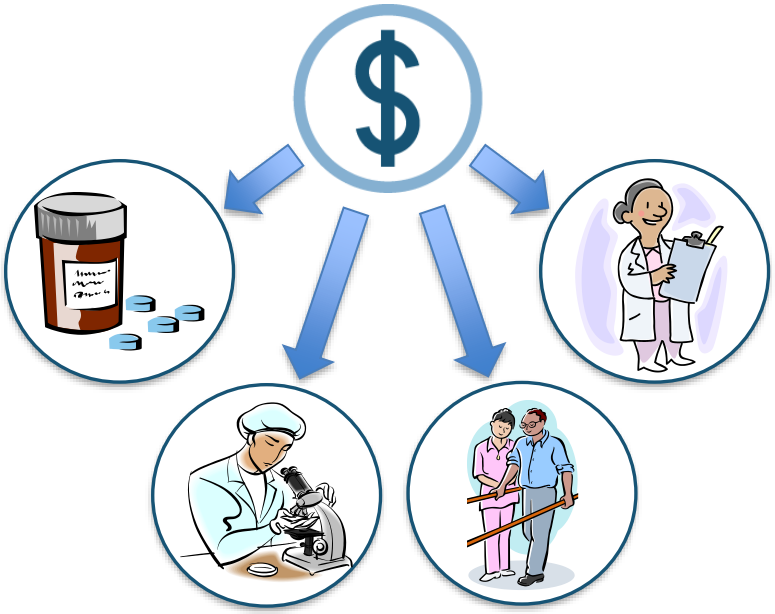
The monthly cost a person pays for a health plan



VS

Cost-Sharing Charges

The charges a person pays as he or she uses benefits covered by a health plan



Basic Elements of Marketplace Plans

- Covered Benefits
  - → Essential Health Benefits, including preventive services
  - → Additional benefits possible

- Provider Network
  - → Insurers contract with physicians, hospitals, and other professionals to provide services to plan enrollees
  - → May be broad (with a greater number of providers) or narrow
  - → Plan may or may not provide coverage outside its network

Essential Health Benefits (EHBs)

10 "Essential Health Benefits" All Qualified Health Plans Must Provide	
 Ambulatory Patient Services	 Preventive and Wellness Services and Chronic Disease Management
 Emergency Services	 Laboratory Services
 Maternity and Newborn Care	 Prescription Drugs
 Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment	 Rehabilitative and Habilitative Services and Devices
 Hospitalization	 Pediatric Services, including Oral and Vision Care

Types of Cost-Sharing Charges

Deductible	Copayments	Coinsurance
• Enrollee must pay the deductible before the plan begins to pay for most benefits • Set on a yearly basis	• Dollar amount for an item or service that enrollees must pay • Many copayments are applicable before the deductible is met	• Percentage of the cost of an item or service that enrollees must pay

Maximum Out-of-Pocket Limit (OOP)

- Puts a cap on the amount an enrollee can pay in cost-sharing charges each year
  - → Set on a yearly basis
  - → Applies to in-network services, not out-of-network care
- OOP limit is not the amount that an enrollee must spend each year

Maximum OOP Limit for 2019 Coverage	
Individual OOP Limit *(NOTE: applies to each individual in a family plan as well)*	$7,900
Family OOP Limit	$15,800

Lower Maximum OOP Limits for Cost-Sharing Reduction Plans (2019 Coverage)			
Household Income	**Up to 150% FPL**	**151 –200% FPL**	**201–250% FPL**
Individual OOP Limit	$2,600	$2,600	$6,300
Family OOP Limit	$5,200	$5,200	$12,600

More to Know about Cost-Sharing Charges

- Some services may be exempt from the deductible (sometimes referred to as "first dollar coverage")
  - → *Examples:* Coverage of 2 physician visits for a copayment, or coverage of generic drugs with a copayment – even when enrollee has not reached the deductible

- Some benefits may have a separate deductible
  - → *Example:* Prescription drugs

Cost Sharing and the Metal Tiers

Costs covered by a plan

Premiums paid by consumer

METAL LEVEL PLAN TIERS

QHPs must provide plan designs consistent with actuarial values

Platinum	90% actuarial value
Gold	80% actuarial value
Silver	70% actuarial value
Bronze	60% actuarial value
Catastrophic coverage	High deductible health plan available for individuals up to age 30 or those 30 and older who are granted a hardship exemption (PTC do not apply to these plans)

Actuarial value is a measure of the percentage of expected health care costs a health plan will cover and is considered a general summary measure of health plan generosity. It represents an average for a population and does not necessarily reflect the actual cost-sharing experience of an individual.

What is Actuarial Value?

- A way to estimate and compare the overall generosity of plans

Calculating Actuarial Value:

- Assume entire typical population enrolls
- Estimate the percentage of costs the plan pays for their covered services
- Plan pays 70% of the costs of covered benefits → Silver plan

Typical population

NOTE: AV does not represent what the plan would pay for a particular individual enrolled in the plan

→ Enrollee OOP costs depend on the medical care a person uses

→ AV does not determine what benefits or prescription drugs are covered nor does it impact the provider network

Actuarial Value Guides Cost-Sharing Charges

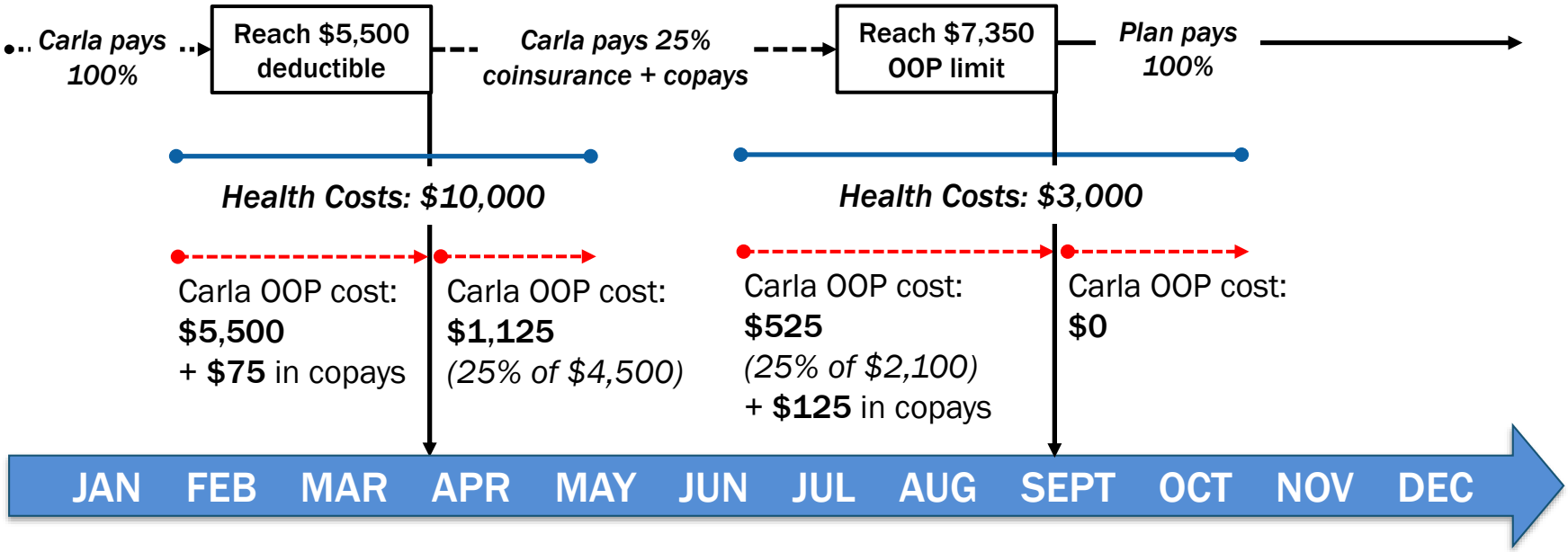
	Plan A Cigna Health **Bronze**	**Plan B** Kaiser Permanente **Bronze**	**Plan C** Cigna Health **Silver**	**Plan D** CareFirst BlueChoice **Silver**	**Plan E** Kaiser Permanente **Gold**
Metal tier	Bronze	Bronze	Silver	Silver	Gold
Actuarial value	60% AV	60% AV	70% AV	70% AV	80% AV
Deductible	$6,400	$5,500	$6,500	$3,500	$0
OOP limit	$7,350	$7,350	$7,350	$7,350	$6,850
Inpatient hospital	50% (after deductible)	35% (after deductible)	30% (after deductible)	$500 per day (after deductible)	30%
Primary care visit	50% (after deductible)	$50 (2 visits) + $50 (after deductible)	$15	$30	$20
Specialist visit	50% (after deductible)	$70 (after deductible)	30% (after deductible)	$40	$40
Generic drug	50% (after deductible)	$25	$4	$10	$10

Source: Healthcare.gov 2018 plans, Fairfax County, VA 22003

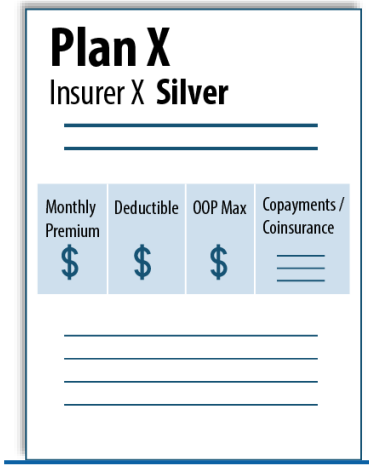
Example: How Cost Sharing Works

Health Plan Y:

Deductible	$5,500	Primary care visit	$35
OOP limit	$7,350	Specialist visit	25%
Inpatient hospital	25%	Generic drug	$25



Individual and Family Cost-Sharing Charges Differ



	Plan X (individual)	Plan X (family)
Deductible	$3,000	$6,000
OOP limit	$7,350	$14,700
Inpatient hospital	35% after deductible	35% after deductible
Primary care visit	$30	$30
Specialist visit	$50	$50
Generic drug cost	$15	$15

Embedded vs. Aggregate Family Cost Sharing

Embedded Family Cost Sharing:

- **Embedded deductible:** In addition to a family deductible, smaller individual deductibles apply to each family member
- **Embedded OOP limit:** In addition to a family out-of-pocket limit, smaller individual out-of-pocket limits apply to each individual

Aggregate Family Cost Sharing:

- **Aggregate deductible:** All family members' expenses are pooled toward a combined deductible
- **Aggregate OOP limit:** All family members' expenses are pooled toward a combined out-of-pocket limit

However, each family member is also protected by the individual maximum OOP limit of ($7,900 per year in 2019, less for people receiving cost-sharing reductions)

Example: In-Network vs. Out-of-Network Cost Sharing

		Annual Deductible	Annual OOP Limit	Hospital Admission	Primary Care Visit	Specialist Visit
Plan A Carrier A Silver	In-Network	$5,000	$7,900	$1,500 (per admission)	$25	30%
	Out-of-Network	$10,000	None	50%	50%	50%
Plan B Carrier B Silver	In-Network	$4,000	$7,900	30%	$60	30%
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Plan C Carrier C Silver	Tier I	$2,000	$5,000	30%	$20	$40
	Tier II	$4,000	$7,900	50%	$40	$60
	Tier III	$8,000	$15,800	50%	50%	50%

Example: In-Network vs. Out-of-Network Cost Sharing

Plan A Carrier A Silver	Annual Deductible	Annual OOP Limit	Hospital Admission	Primary Care Visit
In-Network	$5,000	$7,900	$1,500 (per admission)	$25
Out-of-Network	$10,000	None	50%	50%

Network Physician

Doctor's bill: $200

Plan allowed amount: $100

Plan pays: $75

Patient pays: $25 *(copay)*

Counts towards in-network OOP limit

Out-of-Network Physician

Doctor's bill: $200

Plan allowed amount: $100

Plan pays: $50

Patient pays: $150 *(50% + $100)*

Does not count towards in-network OOP limit

Cost-Sharing Reductions

What are Cost-Sharing Reductions?

- A federal benefit that reduces the out-of-pocket charges an enrollee pays for medical care covered by the plan
- People with income up to 250% FPL are eligible
- Must enroll in a silver plan through the Marketplace

3 Levels of Cost-Sharing Reduction Plans Based on Income:				
	Standard Silver **No CSR**	**CSR Plan** **Level 1**	**CSR Plan** **Level 2**	**CSR Plan** **Level 3**
Income Range	Above 250% FPL	201–250% FPL	151–200% FPL	Up to 150% FPL
Actuarial Value	70% AV	73% AV	87% AV	94% AV
Max OOP Limit ***Individual in 2019***	$7,900	$6,300	$2,600	$2,600
Max OOP Limit ***Family in 2019***	$15,800	$12,600	$5,200	$5,200

Cost-Sharing Reductions: Example Plan A

	Plan A Geisinger Health Silver	Plan A Geisinger Health Silver	Plan A Geisinger Health Silver	Plan A Geisinger Health Silver
CSR Level	No CSR	201–250% FPL	151–200% FPL	<150% FPL
Actuarial value	70% AV	73% AV	87% AV	94% AV
Deductible	$4,650	$3,500	$1,000	$300
OOP limit	$7,350	$5,850	$2,450	$2,450
Inpatient hospital	20% (after deductible)	20% (after deductible)	No charge (after deductible)	No charge (after deductible)
Primary care visit	$30	$30	$20	$10
Specialist visit	$60	$60	$40	$20
Generic drugs	$20	$20	$15	$1
Specialty drugs	50%	50%	40%	20%

Source: Healthcare.gov 2018 silver plan variations, Lancaster County, PA 17573

Cost-Sharing Reductions: Example Plan B

	Plan B Highmark Silver	Plan B Highmark Silver	Plan B Highmark Silver	Plan B Highmark Silver
CSR Level	No CSR	201–250% FPL	151–200% FPL	<150% FPL
Actuarial value	70% AV	73% AV	87% AV	94% AV
Deductible	$7,150	$4,500	$800	$250
OOP limit	$7,350	$5,700	$1,700	$550
Inpatient hospital	30% (after deductible)	30% (after deductible)	10% (after deductible)	10% (after deductible)
Primary care visit	$70	$30	$10	$5
Specialist visit	$90	$50	$40	$20
Generic drugs	15%	15%	15%	15%
Specialty drugs	50%	50%	50%	50%

Source: Healthcare.gov 2018 silver plan variations, Lancaster County, PA 17573

Comparing Two Insurers' CSR Variations

	Deductible	OOP limit	Inpatient hospital	Primary care visit	Specialist visit	Generic drugs	Specialty drugs
Plan A Geisinger Health **Silver** **AV: 94%**	$300	$2,450	No charge (after ded.)	$10	$20	$1	20%
Plan B Highmark **Silver** **AV: 94%**	$250	$550	10% (after ded.)	$5	$20	15%	50%

Source: Healthcare.gov 2018 silver plan variations, Lancaster County, PA 17573

Termination of CSR Payments

- Last year, the federal government terminated reimbursements to insurance companies for cost-sharing reduction (CSR) plans
  - ! **People who are eligible for CSRs are still eligible for assistance and can enroll in a plan with reduced cost-sharing charges**
  - ! **Plan designs for CSR plans are not affected by this change**

- To cover the costs resulting from the termination of CSR payments, insurers increased premiums, most often (depending on the state) by loading the costs onto the premiums for silver Marketplace plans ("silver loading")
  - → Because PTC calculations are tied to silver plans, PTC amounts rose with premium increases
  - → Silver loading led to much higher unsubsidized Marketplace premiums for silver plans relative to premiums for bronze or gold plans
  - → In many areas, the unsubsidized premium of the lowest-cost gold plan in 2018 has a comparable cost to lowest-cost silver plan, and bronze plans can be near zero cost after PTC

Cost Sharing for American Indians and Alaska Natives

- Special assistance available to members of federally-recognized Native American tribes and Alaska Native Claims Settlement Act (ANCSA) Corporation shareholders (AI/AN)
- They can enroll in or change Marketplace plans each month

- **For AI/AN people between 100% and 300% FPL** who qualify for PTC, zero cost-sharing plans are available
  - → Enrollees pay no deductibles, co-payments, or other cost-sharing when using in-network medical care
  - → Some out-of-network care is also available with zero cost-sharing

- **For AI/AN people with incomes below 100% FPL or above 300% FPL**, there is a "limited" cost-sharing plan available
  - → Enrollee pays no cost-sharing charges to receive services from an Indian Health Services (IHS) provider or from another provider if referred from an IHS provider

Skimpy Plans

What are skimpy plans?

- Skimpy plans may be exempt from some or all insurance market standards and consumer protections. Some can:
  - → Charge higher premiums based on age, gender, and health status
  - → Deny coverage based on pre-existing conditions
  - → Deny claims for pre-existing conditions
  - → Leave out coverage of essential health benefits

- Availability of several different types of skimpy plans is likely to increase:
  - → Short-term, limited-duration plans
  - → Association health plans (AHPs)
    - Expanded to cover more small businesses and self-employed people, form more easily, and avoid standards and protections that would otherwise apply to health plans that cover individuals and small groups
  - → Health care sharing ministries
  - → Other types: indemnity plans, combination or “bundled” products

Skimpy Plans vs. ACA-Compliant Plans

	Reform	Description	ACA Plans	Short-Term Plans	AHPs	Sharing ministries
ACCESSIBILITY	Guaranteed issue	Requires insurers to accept every individual who applies for coverage.	✓	✗	✗	✗
	Dependent coverage to age 26	Requires plans that already provide dependent coverage to make it available until the dependent turns 26.	✓	✗	✓	✗
	Rescissions	Prohibits plans from retroactively canceling coverage (except in the case of a subscriber's fraud or intentional misrepresentation of material fact).	✓	✗	✓	✗
AFFORDABILITY	Rating requirements	Prohibits plans from charging a higher premium based on health status and gender.	✓	✗	*	✗
	Medical loss ratio (MLR)	Individual health insurers must spend at least 80 percent of premiums on health care and quality improvement.	✓	✗	**	✗
TRANSPARENCY	Summary of benefits and coverage	Requires insurers to provide standardized, easy-to-understand summaries of the benefits, cost-sharing, limitations, and exclusions of a plan.	✓	✗	✓	✗
RISK MITIGATION	Single risk pool	Each insurer must consider the claims experience of all of their enrollees in all of their individual market plans when setting premium rates.	✓	✗	✗	✗
	Risk-adjustment program	Transfers funds from insurers with relatively low-risk enrollees to insurers with relatively high-risk enrollees.	✓	✗	✗	✗

*AHPs formed under the new federal rules will be allowed to charge higher rates based on factors such as age, gender, occupation, and group size, but will not be able to charge more for health status.

**Self-funded AHPs are exempt from the ACA's MLR requirements, but large-group market standards (85% MLR) apply to large-group policies sold to fully insured AHPs.

Source: The Commonwealth Fund, State Regulation of Coverage Options Outside of the ACA

Skimpy Plans vs. ACA-Compliant Plans

	Reform	Description	ACA Plans	Short-Term Plans	AHPs	Sharing ministries
ADEQUACY	Preexisting condition exclusions	Prohibits insurers from imposing preexisting condition exclusions with respect to coverage.	✓	✗	✓	✗
	Essential health benefits	Requires coverage of 10 categories of essential benefits defined in the ACA	✓	✗	✗	✗
	Actuarial value	Requires plans to meet a minimum actuarial value standard of at least 60 percent of total plan costs; requires plans to meet one of four actuarial value tiers — bronze (60%), silver (70%), gold (80%), or platinum (90%) — as a measure of how much of a consumer's medical costs are covered by the plan.	✓	✗	✗	✗
	Annual cost-sharing limits	Requires insurers to limit each enrollee's annual out-of-pocket costs, including copayments, coinsurance, and deductibles.	✓	✗	✓	✗
	Annual dollar limits	Prohibits annual limits on the dollar value of covered essential health benefits.	✓	✗	✓	✗
	Lifetime dollar limits	Prohibits lifetime limits on the dollar value of covered essential health benefits.	✓	✗	✓	✗
	Preventive services without cost-sharing	Requires coverage of specified preventive health services without cost-sharing, such as copayments, coinsurance, and deductibles, when the insured uses an in-network provider.	✓	✗	✓	✗

Source: The Commonwealth Fund, State Regulation of Coverage Options Outside of the ACA

Short-Term Plans

- New federal rules allow short-term plans exempt from pre-existing condition protections and benefit standards to last for up to one year and to be renewed
  - → Used to be less than 3 months
  - → Allows a parallel market for skimpy plans operating alongside market for comprehensive coverage
  - → Effective October 2, 2018
  - → States retain authority to limit and set standards for short-term plans

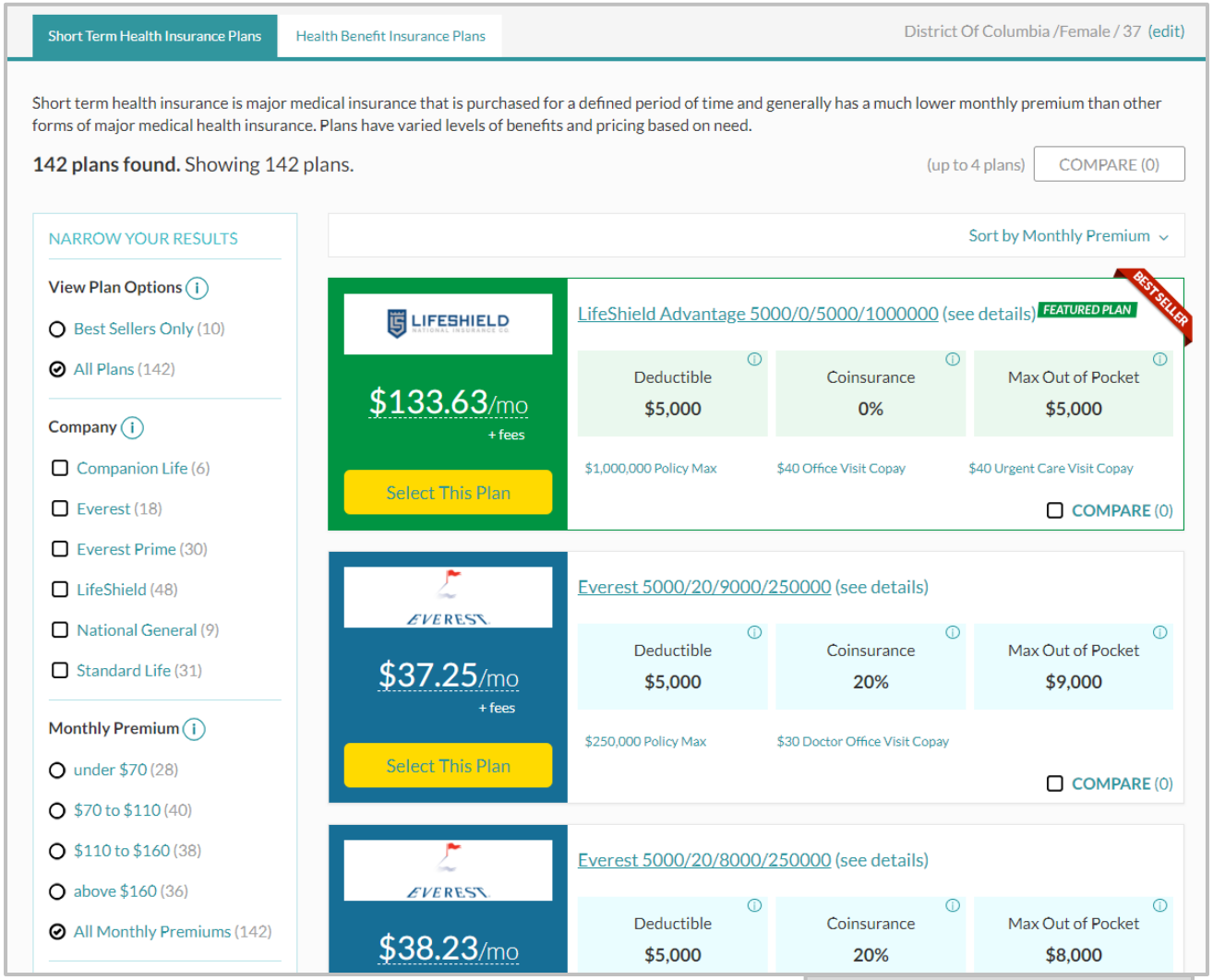
- Healthy people who enroll in these plans may find themselves facing gaps in coverage and exposed to catastrophic costs if they get sick and need care
  - → May look like a comprehensive health plan (with a premium, deductible, and a provider network) but leave out key protections and coverage
  - → Doesn't count as minimum essential coverage, so when the plan ends, it does not trigger a special enrollment period for the enrollee

For more info, see Key Flaws of Short-Term Health Plans Pose Risks to Consumers

Short-Term Plans: Exempt from Most Standards

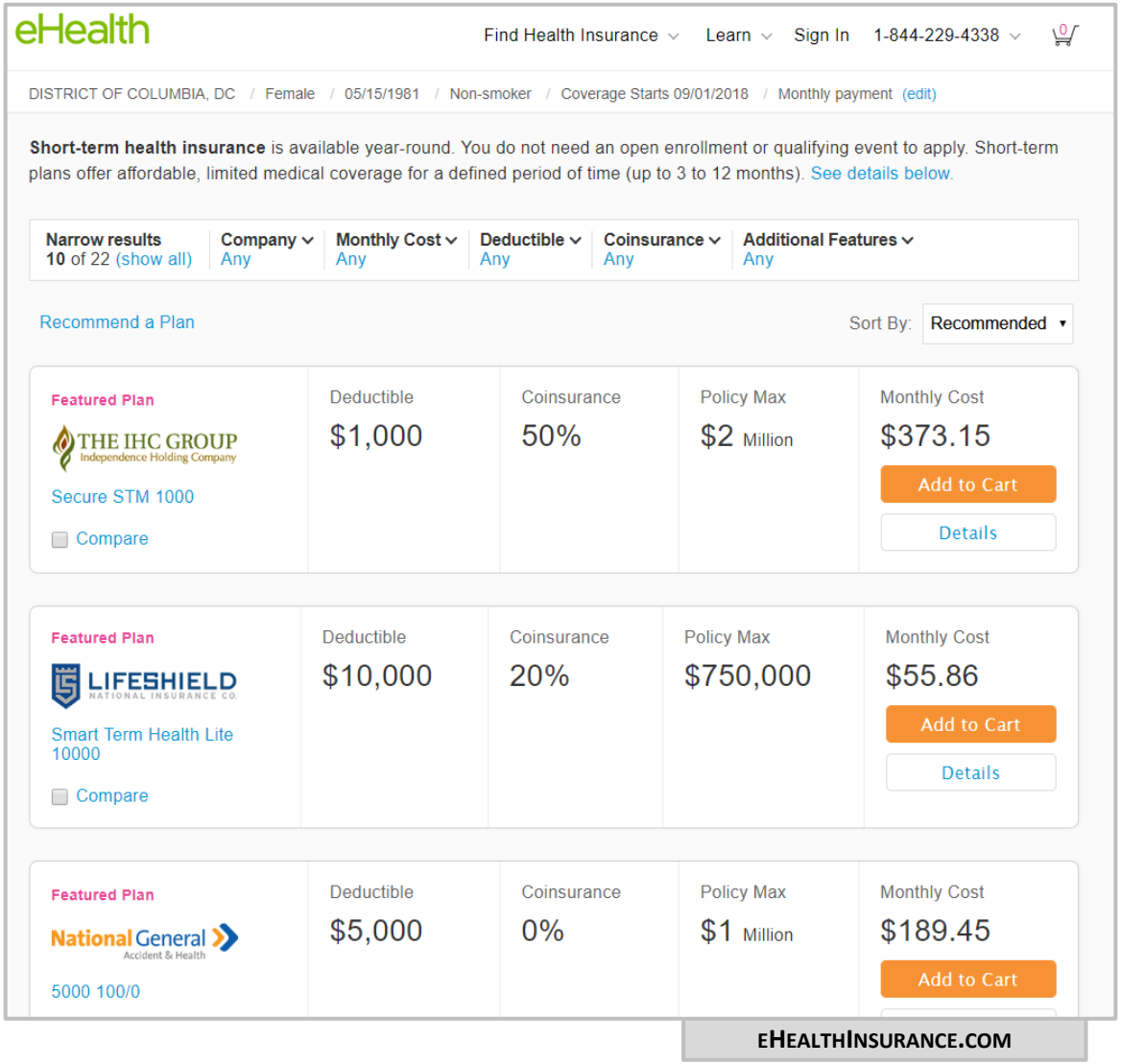
- Typically exclude coverage for pre-existing conditions
  - → People with pre-existing conditions may be denied a policy outright
  - → Insurers broadly exclude coverage of pre-existing conditions and then deny claims related to such conditions
  - → Insurers may conduct "post-claims underwriting," in which an insurer investigates the health history of an enrollee with costly claims, in order to find a link to a "pre-existing" health condition
  - → Plans may consider a condition "pre-existing" even if it was not previously diagnosed or treated and even if the enrollee was not aware of the condition (varies by state)
- Not required to cover essential health benefits, and often don't cover:
  - → Prescription drugs
  - → Maternity care
  - → Mental health benefits
  - → Substance-use disorder treatment
- Can impose overall limits on plan benefits, lifetime limits, and per-service limits
- Not subject to cost-sharing limits

Plans Appear Similar to ACA Plans



AGILE HEALTH INSURANCE

Plans Appear Similar to ACA Plans



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Coverage Limitations are Common in Short-Term Plans

- Plans generally include:
  - → Deductibles
  - → Out-of-pocket maximums
  - → Coinsurance and copays
- But…
  - → Benefits may provide a specified amount of coverage per day or per visit
  - → Plan may cap total amount plan it will pay (i.e., the coverage period maximum)
  - → Deductible and out-of-pocket maximum generally apply to a shorter period of time

	FLEX	ADVANTAGE
Coinsurance	80/20, or 100/0	80/20, or 100/0
Deductible	$1,000, $2,500, $5,000	$1,000, $2,500, $5,000
Out-Of-Pocket Maximum	$2,000, $3,000, $4,000	$2,000, $3,000, $4,000
Coverage Period Maximum	$750,000, $1,000,000	$750,000, $1,000,000
Unless specified otherwise, the following benefits are for Insured and each Covered Dependent subject to the plan Deductible, Coinsurance Percentage, Out-Of-Pocket Maximum and Policy Maximum chosen. Benefits are limited to the Maximum Allowable Expense or each Covered Expense, in addition to any specific limits stated in the policy.		
Doctor Office Consultation		
Copay	$30 Copay, maximum 3	$40, unlimited
Wellness Benefit Copay	$50 Copay, maximum 1	$50 copay, maximum 1
Inpatient Hospital Services		
Average Standard Room Rate	$1,000 per day	Average Standard Room Rate
Hospital ICU	$1,250 per day	Average Standard Room Rate
Doctor Visits	$50 per day, maximum $500	Subject to Coinsurance and Deductible
Outpatient Services		
Surgical Facility	$1,250 per day	Subject to Coinsurance and Deductible
Outpatient Surgery Deductible	N/A	$500 Additional deductible applies, maximum 3
Emergency Room - Deductible	N/A	$500 Additional deductible applies
Emergency Room - Benefit	$250 per visit	Subject to Coinsurance and Deductible
Advanced Diagnostic Studies Deductible	N/A	$500 Additional deductible applies, maximum 3
Ambulance	Injury and Sickness: $250 per transport	Injury and Sickness: $250 per transport
Extended Care Facility	$150 per day, maximum 30 days	$150 per day, maximum 30 days
Home Health Care	$50 per visit, maximum 30 days	$50 per visit, maximum 30 days
Physical, Occupational and Speech Therapy	$50 per day, maximum 20 visits	$50 per day, maximum 20 visits
Mental Disorders		
Inpatient	$100 per day, maximum 31 days	$100 per day, maximum 31 days
Outpatient	$50 per day, maximum 10 visits	$50 per day, maximum 10 visits
Substance Abuse		
Inpatient	$100 per day, maximum 31 days	$100 per day, maximum 31 days
Outpatient	$50 per day, maximum 10 visits	$50 per day, maximum 10 visits

LIFESHIELD

Pre-Existing Conditions Excluded from Short-Term Plans

1. Pre-Existing Conditions:
   a. Charges resulting directly or indirectly from a condition for which a Covered Person received medical treatment, diagnosis, care or advice within the 60-month period immediately preceding such person's Certificate Effective Date are excluded for the first 12 months of coverage hereunder.
   b. Pre-Existing Conditions includes conditions that produced any symptoms which would have caused a reasonable prudent person to seek diagnosis, care or treatment within the 60-0month period immediately prior to the Covered Person's Certificate Effective Date of coverage under the Policy.

LIFESHIELD

Pre-existing condition limitation

Secure STM will not provide benefits for any loss caused by or resulting from a pre-existing condition. A pre-existing condition is any medical condition or sickness for which medical advice, care, diagnosis, treatment, consultation or medication was recommended or received from a doctor within five years immediately preceding the covered person's effective date of coverage; or symptoms within the five years immediately prior to the coverage that would cause a reasonable person to seek diagnosis, care or treatment.

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Pre-existing condition exclusion

Charges resulting directly from a pre-existing condition are excluded from coverage. Pre-existing conditions are referred to as conditions for which medical advice, diagnosis, care, or treatment (including services and supplies, consultations, diagnostic tests or prescription medicines) was recommended or received within the 12 months immediately preceding the effective date, unless a lesser period is required by state regulation.

This exclusion does not apply to a newborn or newly adopted child who is added in accordance with the coverage eligibility and effective date sections within the certificate of coverage.

This exclusion also does not apply to routine follow-up care for breast cancer to determine whether a breast cancer has recurred in a covered person who has been previously diagnosed with breast cancer, unless evidence of breast cancer is found during or as a result of follow-up care.

GENERAL

Some Essential Health Benefits are Not Covered

No coverage for prescription drugs or maternity care

7. Outpatient Prescription Drugs, unless specifically covered under the Policy as an Eligible Expense.

8. Medications, vitamins, and mineral or food supplements including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a Doctor.

17. Routine pre-natal care, Pregnancy, child birth, and post natal care. (This exclusion does not apply to "Complications of Pregnancy" as defined.)

LIFESHIELD

- Outpatient prescription or legend drugs and medications

- Pregnancy or childbirth, except for complications of pregnancy; newborn treatment prior to discharge from the hospital, unless the charges are medically necessary to treat premature birth, congenital injury or sickness, or sickness or injury sustained during or after the birth; any infertility or sterilization treatments

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- Outpatient prescription drugs, medications, vitamins, mineral or food supplements, including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a doctor except as provided in the Benefits section for diabetes.

- Normal pregnancy or childbirth; routine well baby care including hospital nursery charges at birth; or abortion, except for complications of pregnancy, as defined herein.

NATIONAL GENERAL

For Pivot Health Economy plan, outpatient prescription drugs, medications, vitamins, and supplements including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a doctor.

Routine pre-natal care, pregnancy, childbirth, and post natal care. (This exclusion does not apply to "Complications of Pregnancy").

COMPANION LIFE

Some Essential Health Benefits are Not Covered

May exclude coverage of mental health or treatment of substance use disorders

- Treatment of mental health conditions, substance use disorders; and outpatient treatment of mental and nervous disorders, except as specifically covered.

NATIONAL GENERAL

- Learning disabilities, attention deficit disorder, hyperactivity or autism
- Mental illness or nervous disorders, suicide or attempted suicide
- Alcohol or drug dependency and disorders

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Or limit benefits

Mental Illness

Outpatient: $50 per visit; 10 visit max; inpatient: $100 per day, 31 day max

COMPANION LIFE

Mental Disorders	
Inpatient	$100 per day, maximum 31 days
Outpatient	$50 per day, maximum 10 visits
Substance Abuse	
Inpatient	$100 per day, maximum 31 days
Outpatient	$50 per day, maximum 10 visits

LIFESHIELD

Short-Term Plans: Important to Read the Fine Print

Medical Expenses Not Covered

Loss caused by, contributed to or resulting from the following is excluded or otherwise limited as specified:

1. Pre-Existing Conditions:
   a. Charges resulting directly or indirectly from a condition for which a Covered Person received medical treatment, diagnosis, care or advice within the 60-month period immediately preceding such person's Certificate Effective Date are excluded for the first 12 months of coverage hereunder.
   b. Pre-Existing Conditions includes conditions that produced any symptoms which would have caused a reasonable prudent person to seek diagnosis, care or treatment within the 60-0month period immediately prior to the Covered Person's Certificate Effective Date of coverage under the Policy.

This exclusion does not apply to a newborn child or newborn adopted child who is added to coverage in accordance with **PART II – ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE.**

2. Waiting Period:
   a. Covered Persons will only be entitled to receive benefits for Sicknesses that begin, by occurrence of symptoms and/or receipt of treatment, more than 5 days following the Covered Person's Certificate Effective Date of coverage under the Policy.
   b. Covered Persons will only be entitled to receive benefits for Cancer that begins, by occurrence of symptoms or receipt of treatment more than 30 days following the Covered Person's Certificate Effective Date of coverage under the Policy.

3. Expenses during the first 6 months after the Certificate Effective Date of coverage for a Covered Person for the following:
   a. Total or partial hysterectomy, unless it is Medically Necessary due to diagnosis of carcinoma;
   b. Tonsillectomy
   c. Adenoidctomy;
   d. Repare of deviated nasal septum or any type of surgery involving the sinus;
   e. Myringotomy;
   f. Tympanotomy;
   g. Herniorraphy;
   h. Cholecystectomy.

However, if such condition is a Pre-Existing Condition any benefit consideration will be in accordance with the Pre-Existing Conditions limitation.

4. The benefits payable for the following conditions or procedures are limited to the specified amounts shown in the Schedule of Benefits:
   a. Kidney Stones
   b. Appendectomy
   c. Joint or Tendon Surgery
   d. Knee Injury or Disorder
   e. Acquired Immune Deficiency Syndrome (AIDS)/ Human Immuno-deficiency Virus (HIV)
   f. Gallbladder Surgery

5. Mental, emotional or nervous disorders or counseling of any type, except as specifically covered as an Eligible Expense.

6. Treatment for Substance Abuse, unless specifically covered under the Policy as an Eligible Expense.

7. Outpatient Prescription Drugs, unless specifically covered under the Policy as an Eligible Expense.

8. Medications, vitamins, and mineral or food supplements including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a Doctor.

9. Any drug, treatment or procedure that either promotes or prevents conception including but not limited to: artificial insemination, treatment for infertility or impotency, sterilization or reversal of sterilization.

10. Any drug, treatment or procedure that corrects impotency or non-organic sexual dysfunction.

11. Modifications of the physical body in order to improve the psychological, mental or emotional well-being of the Covered Person, such as sex-change surgery.

12. Surgeries, treatments, services or supplies for cosmetic or aesthetic reasons, except for reconstructive surgery where expressly covered under the Policy.

13. Weight modification or surgical treatment of obesity.

14. Eye surgery, such as LASIX, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.

15. Dental treatment and dental surgery except as necessary to restore or replace sound and natural teeth lost or damaged as a result of a covered Injury.

16. Expenses incurred in the treatment by any method for jaw joint problems including temporomandibular joint dysfunction (TMJ), TMJ pain syndromes, craniomandibular disorders, myofacial pain dysfunction or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the joint, unless specifically covered under the Policy as an Eligible Expense.

17. Routine pre-natal care, Pregnancy, child birth, and post natal care. (This exclusion does not apply to "Complications of Pregnancy" as defined.)

overed (cont.)

35. Hypnotherapy when used to treat conditions that are not recognized as Mental Disorders by the American Psychiatric Association, and biofeedback and non-medical self-care or self-help programs.

36. Eyeglasses, contact lenses, hearing aids, hearing implants, eye refraction, visual therapy, orthoptics, visual eye training and any examination or fitting related to these devices, and all vision and hearing tests and examinations.

37. Care, treatment or supplies for the feet, orthopedic shoes, orthopedic prescription devices to be attached to or placed in shoes, treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions and treatment of corns, calluses or toenails.

38. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Doctor.

39. Exercise programs, whether or not prescribed or recommended by a Doctor.

40. Telephone or Internet consultations and/or treatment or failure to keep a scheduled appointment.

41. Charges for travel or accommodations, except as expressly provided for local ambulance.

42. All charges incurred while confined primarily to receive Custodial or Convalescent Care.

43. Services received or supplies purchased outside the United States, its territories or possessions, or Canada, unless specifically covered under the Policy as an Eligible Expense.

44. Any services or supplies in connection with cigarette smoking cessation.

45. Any services performed or supplies provided by a member of the Insured's Immediate Family.

46. Services received for any condition caused by a Covered Person's commission of or attempt to commit an assault, battery, or felony or to which a contributing cause was the Covered Person being engaged in an illegal occupation.

47. Services or supplies which are not included as Eligible Expenses as described herein.

48. Participating in hazardous occupations or other activity including participating, instructing, demonstrating, guiding or accompanying others in the following: operation of a flight in an aircraft other than a regularly scheduled flight by an airline, professional or semi-professional sports, extreme sports, parachute jumping, hot-air ballooning, hang-gliding, base jumping, mountain climbing, bungee jumping, scuba diving, sail gliding,

ered (cont.)

returned to the Covered Person on a pro-rated basis.

54. Costs for Routine Physical Exams or other services not needed for medical treatment, unless specifically covered under the Policy as an Eligible Expense.

55. Amounts in excess of the Usual and Customary charges made for covered services or supplies.

56. Expenses You or Your Covered Dependent are not required to pay, or which would not have been billed, if no insurance existed.

57. Expenses to the extent that they are paid or payable under other valid or collectible group insurance or medica prepayment plan.

58. Charges that are eligible for payment by Medicare or any other government program except Medicaid. Costs for care in government institutions unless You or Your Covered Dependent are obligated to pay for such care.

59. Expenses for which benefits are paid or payable under workers' compensation or similar laws.

60. Medical expenses which are payable under any automobile insurance policy without regard to fault (does not apply in any state where prohibited).

LIFESHIELD

Examples: Limitations and Exclusions

No coverage for injuries resulting from "hazardous activities" or organized sports…

48. Participating in hazardous occupations or other activity including participating, instructing, demonstrating, guiding or accompanying others in the following: operation of a flight in an aircraft other than a regularly scheduled flight by an airline, professional or semi-professional sports, extreme sports, parachute jumping, hot-air ballooning, hang-gliding, base jumping, mountain climbing, bungee jumping, scuba diving, sail gliding, parasailing, parakiting, rock or mountain climbing, cave exploration, parkour, racing including stunt show or speed test of any motorized or non-motorized vehicle, rodeo activities, or similar hazardous activities. Also excluded is Injury received while practicing, exercising, undergoing conditional or physical preparation for such activity.

49. Injuries or Sicknesses resulting from participation in interscholastic, intercollegiate or organized competitive sports. This does not include dependent children participating in local community sports activities.

LIFESHIELD

- Participation in school or organized competitive sports or any high-risk sport, including riding an all-terrain vehicle, snowmobile or go-cart

THE IHC GROUP

- Treatment or services required due to injury sustained while participating in any inter-collegiate sport, contest or competition or while practicing, exercising, undergoing conditioning or physical preparation for any such sport, contest or competition.

- Treatment or services required due to injury received while engaging in any hazardous occupation or other activity, including the following: participating, instructing, demonstrating, guiding or accompanying others in parachute jumping, hang-gliding, bungee jumping, flight in an aircraft other than a regularly scheduled flight by an airline, racing any motorized or non-motorized vehicle, rock or mountain climbing, professional or semi-professional contact sports of any kind. Also excluded are treatment and services required due to injury received while practicing, exercising, undergoing conditioning or physical preparation for any such activity.
- Treatment or services required due to injury received while engaging in any hazardous occupation or other activity for which compensation is received, including the following: participating, instructing, demonstrating, guiding or accompanying others in skiing and horse riding. Also excluded are treatment and services required due to injury received while practicing, exercising, undergoing conditioning or physical preparation for any such compensated activity.

NATIONAL GENERAL

Examples: Limitations and Exclusions

…or any coverage for injuries sustained while someone is intoxicated or that are self-inflicted

50. Injury resulting from being under the influence of or due wholly or partly to the effects of alcohol or drugs, other than drugs taken in accordance with treatment prescribed by a Doctor, but not for the treatment of Substance Abuse.

51. Willfully self-inflicted Injury or Sickness.

LIFESHIELD

Injury resulting from being under the influence of or due wholly or partly to the effects of alcohol or drugs, other than drugs taken in accordance with treatment prescribed by a doctor

Willfully self-inflicted injury or sickness.

COMPANION LIFE

48. Injury resulting from being under the influence of or due wholly or partly to the effects of alcohol or drugs, other than drugs taken in accordance with treatment prescribed by a Doctor, but not for the treatment of Substance Abuse.

49. Willfully self-inflicted Injury or Sickness.

STANDARD LIFE SELECT

- An injury or illness, incurred due to, or contracted as a consequence of a covered person being intoxicated or under the influence of illegal narcotics or other drugs, unless the drug is administered by a doctor and taken in accordance with the prescribed dosage
- Intentionally self-inflicted injury or illness while sane; except a self-inflicted injury or illness that is the result of a medical condition

UNITED HEALTHCARE

- Resulting from intoxication, as defined by state law where the illness or injury occurred, or while under the influence of illegal narcotics or controlled substances, unless administered or prescribed by a doctor.

Examples: Limitations and Exclusions

Waiting periods and per-illness deductibles

Expenses during the first 6 months after the effective date of coverage for a covered person for the following (subject to all other coverage provisions, including but not limited to the pre-existing condition exclusion):

- *Total or partial hysterectomy, unless it is medically necessary due to a diagnosis of carcinoma;*
- *Tonsillectomy;*
- *Adenoidectomy;*
- *Myringotomy;*
- *Tympanotomy;*
- *Repair of deviated nasal septum or any type of surgery involving the sinus;*
- *Herniorraphy;*
- *Cholecystectomy.*

3. Expenses during the first 6 months after the Certificate Effective Date of coverage for a Covered Person for the following:
   a. Total or partial hysterectomy, unless it is Medically Necessary due to diagnosis of carcinoma;
   b. Tonsillectomy
   c. Adenoidctomy;
   d. Repare of deviated nasal septum or any type of surgery involving the sinus;
   e. Myringotomy;
   f. Tympanotomy;
   g. Herniorraphy;
   h. Cholecystectomy.

Exclusions Within First 6 Months

Waiting Periods

Waiting Period: Covered Persons will only be entitled to receive benefits for Sicknesses that begin, by occurrence of symptoms and/ or receipt of treatment, at least 5 days following the Covered Person's Effective Date of coverage under the policy. Covered Persons will only be entitled to receive benefits for Cancer that begins, by occurrence of symptoms or receipt of treatment at least 30 days following the Covered Person's Effective Date of coverage under the policy.

2. Waiting Period:
   a. Covered Persons will only be entitled to receive benefits for Sicknesses that begin, by occurrence of symptoms and/or receipt of treatment, more than 5 days following the Covered Person's Certificate Effective Date of coverage under the Policy.
   b. Covered Persons will only be entitled to receive benefits for Cancer that begins, by occurrence of symptoms or receipt of treatment more than 30 days following the Covered Person's Certificate Effective Date of coverage under the Policy.

Per injury or illness deductible

If you selected a per injury or illness deductible, the deductible must be satisfied for each separate covered injury or illness before covered benefits under the policy are paid. The deductible applies per covered person for each period of treatment. However, if multiple covered persons in a family are injured in the same accident, only one deductible must be satisfied for each period of treatment.

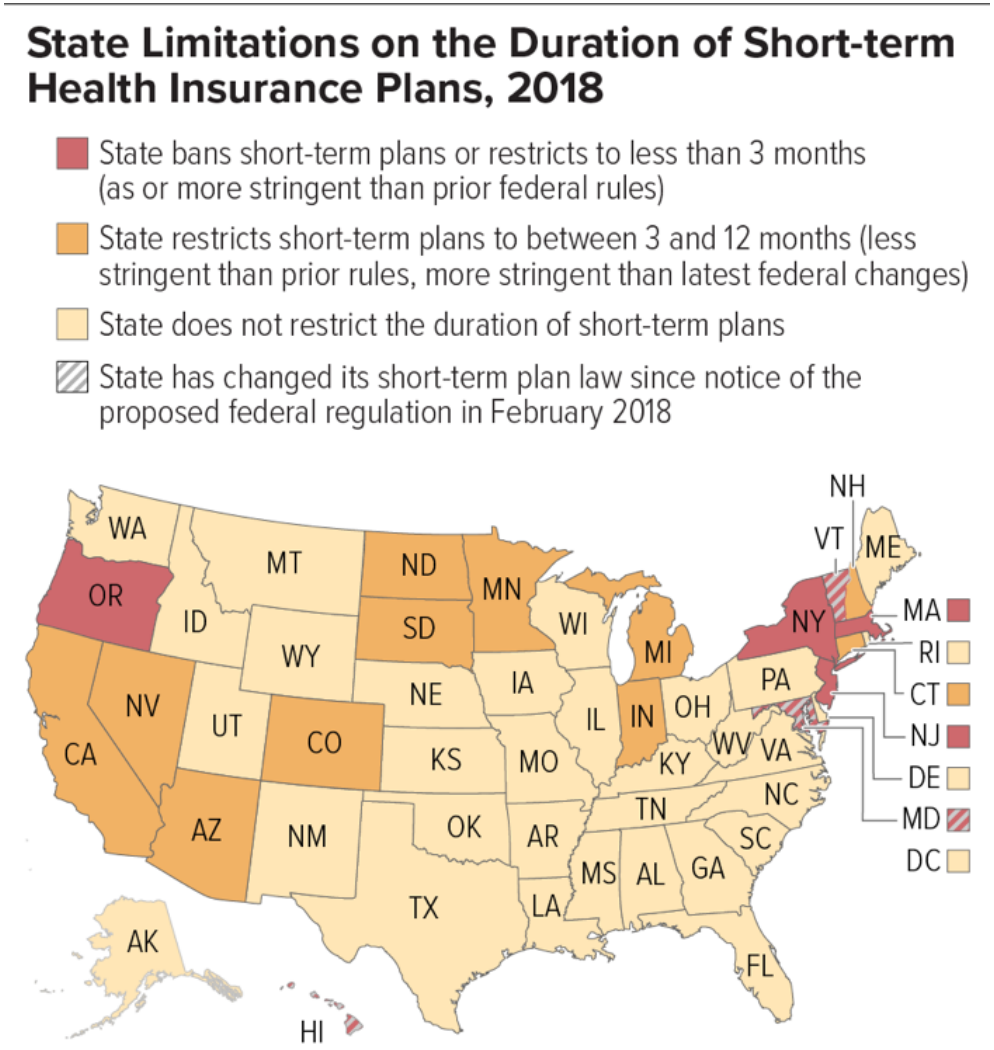
Period of treatment

A period of treatment begins for a covered injury or illness (1) when a covered person is initially admitted to the hospital, (2) when services are provided in an outpatient surgical facility or (3) when chemotherapy or radiation therapy is received on an outpatient basis. The period of treatment ends 180 consecutive days following that date for the same or related injury or illness. If treatment extends past 180 days for the same injury or illness, a new period of treatment will begin and a new per injury or illness deductible will be required. A separate period of treatment will apply to each covered injury or illness.

Per Injury Deductible and Period of Treatment

State Actions to Limit Short-Term Plans

- States have the authority to set their own standards for short-term plans and other types of skimpy plans
- Maryland, Vermont and Hawai'i all enacted protections against short-term plans since the new rules were announced
- California and Washington state are moving to ban or limit the plans in their states



For more info, see [With Federal Rules Weakened, States Should Act to Protect Against Short-Term Health Plans]

What Can You Do?

- Promote open enrollment for plans that meet ACA standards and are eligible for federal subsidies

- Understand and inform people about the risks of short-term plans and other skimpy coverage
  - → Help people see past low premiums

- Promote special enrollment periods for people who face short or long coverage gaps

- Track and report what is happening on the ground
  - → Look for misleading or fraudulent marketing tactics
  - → Monitor accuracy of information provided to consumers
  - → Track the experiences of consumers who enroll in these plans
  - → Inform insurance regulators about potential fraud and misinformation
  - → Inform individuals about their right to complain about wrongdoing and misinformation

Resources

- Key Facts:
  - → Cost-Sharing Charges
  - → Cost-Sharing Reductions
- Papers and Blogs:
  - → Key Flaws of Short-Term Health Plans Pose Risks to Consumers
  - → With Federal Rules Weakened, States Should Act to Protect Against Short-Term Health Plans
  - → Expanding Skimpy Health Plans Is the Wrong Solution for Uninsured Farmers and Farm Workers

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- Kaiser Family Foundation:
  - → Understanding Short-Term Limited Duration Health Insurance
- The Commonwealth Fund:
  - → Expanding Access to Short-Term Health Plans Is Bad for Consumers and the Individual Market
  - → State Regulation of Coverage Options Outside of the ACA

Contact Info

- Sarah Lueck, lueck@cbpp.org
  - → Twitter: @sarahL202
- Halley Cloud, cloud@cbpp.org
- General inquiries: beyondthebasics@cbpp.org

For more information and resources, please visit:

www.healthreformbeyondthebasics.org

This is a project of the Center on Budget and Policy Priorities, www.cbpp.org