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State/Territory Name: Indiana

State Plan Amendment (SPA) #: IN-15-0014-HIP Link

This file contains the following documents in the order listed:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

October 6, 2015

Joe Moser, Director of Medicaid
Indiana Office of Medicaid Policy and Planning
402 West Washington Street, Room W374
Indianapolis, Indiana 46204

ATTN: Kelly Flynn

RE: IN SPA TN# 15-0014 – Alternative Benefit Package for Healthy Indiana Plan Link (ABP – HIP Link)

Dear Mr. Moser,

Enclosed for your records is an approved copy of the following State Plan Amendment (SPA).

Transmittal #15-0014:

- This SPA defines the new ABP for the optional premium assistance HIP Link program.
- Effective Date: July 1, 2015

All requirements pertaining to ABPs must be met including but not limited to: benefits, payment rates, reimbursement methodologies, cost-sharing state plan pages, and (if applicable) managed care service delivery systems (waivers and contracts). Amendments to the state's approved Medicaid program (SPAs, waivers, contracts) may require corresponding amendments to the ABP if the change to the benefit in the approved State plan will be mirrored in the ABP.

If you have any questions, please have a member of your staff contact Tannisse Joyce at (312) 886-5121 or by email at tannisse.joyce@cms.hhs.gov.

Sincerely,

/s/

Ruth A. Hughes
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Jason Frandson, CMCS
Kelly Flynn, OMPP

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory Name: Indiana

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

IN-15-014

Proposed Effective Date

07/01/2015 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

42 C.F.R. 435.119; 42 C.F.R. 440, Subpart C

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2015	$ 0.00
Second Year	2016	$ 0.00

Subject of Amendment

This amendment outlines the ABPs for HIP Link.

Governor's Office Review

- ○ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**

  Describe:

- ○ **No reply received within 45 days of submittal**
- ◉ **Other, as specified**

  Describe:

  Indiana's State Plan does not require Goverenor's office review. Please see section 7.4 of the State Plan.

Signature of State Agency Official

Submitted By:
Amber Swartzell
Last Revision Date:
Oct 1, 2015
Submit Date:
Sep 28, 2015

PLAN APPROVED – ONE COPY ATTACHED

DATE RECEIVED: Sep. 28, 2015
DATE APPROVED: Oct. 6, 2015
EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2015
SIGNATURE OF REGIONAL OFFICIAL: /s/
TYPED NAME: Ruth A. Hughes
TITLE: Associate Regional Administrator

Alternative Benefit Plan

State Name: Indiana

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: IN - 15 - 0014

OMB Expiration date: 10/31/2014

Alternative Benefit Plan Populations ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: Healthy Indiana Plan (HIP) Link

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Parents and Other Caretaker Relatives	Voluntary	X
+	Transitional Medical Assistance	Voluntary	X
+	Pregnant Women	Voluntary	X
+	Adult Group	Mandatory	X

Enrollment is available for all individuals in these eligibility group(s). No

Targeting Criteria (select all that apply):

☐ Income Standard.

☐ Disease/Condition/Diagnosis/Disorder.

☒ Other.

Other Targeting Criteria (Describe):

To be HIP Link eligible an individual must: (1) be eligible for and/or enrolled in the Healthy Indiana Plan, (2) be eligible to enroll in HIP Link qualifying employer sponsored insurance (ESI) plan, and (3) elect to enroll in such ESI through HIP Link.

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

To enroll in HIP Link an individual must have access to qualifying ESI and elect to enroll in that ESI through HIP Link. Not all individuals eligible for and/or enrolled in HIP will be eligible for the HIP Link ABP since they may not have access to or be eligible to enroll in qualifying ESI or they may not elect to enroll in ESI through HIP Link. Individuals not eligible for HIP Link due to lacking access to affordable employer sponsored insurance, or who are eligible but who choose not to enroll in HIP Link will be enrolled in either the HIP Basic or HIP Plus ABPs or the ABP that is the State Plan as applicable to the individual.

Individuals who enroll in HIP Link and are pregnant at their annual redetermination may elect to remain in the HIP Link ABP or transfer to Medicaid for pregnant women. Individuals age 19 and 20 will have access to EPSDT services outside of the scope of their HIP Link qualifying ESI.

Alternative Benefit Plan

PRA Disclosure Statement

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

V.20140415

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L- ☐

OMB Expiration date: 10/31/2014

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

ABP2a

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.

No

These assurances must be made by the state/territory if the Adult eligibility group is included in the ABP Population.

☑ The state/territory shall enroll all participants in the "Individuals at or below 133% FPL Age 19 through 64" (section 1902(a)(10)(A)(i)(VIII)) eligibility group in the Alternative Benefit Plan specified in this state plan amendment, except as follows: A beneficiary in the eligibility group at section 1902(a)(10)(A)(i)(VIII) who is determined to meet one of the exemption criteria at 45 CFR 440.315 will receive a choice of a benefit package that is either an Alternative Benefit Plan that includes Essential Health Benefits and is subject to all 1937 requirements or an Alternative Benefit Plan that is the state/territory's approved Medicaid state plan not subject to 1937 requirements. The state/territory's approved Medicaid state plan includes all approved state plan programs based on any state plan authority, and approved 1915(c) waivers, if the state has amended them to include the eligibility group at section 1902(a)(10)(A)(i)(VIII).

☑ The state/territory must have a process in place to identify individuals that meet the exemption criteria and the state/territory must comply with requirements related to providing the option of enrollment in an Alternative Benefit Plan defined using section 1937 requirements, or an Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan that is not subject to section 1937 requirements.

☑ Once an individual is identified, the state/territory assures it will effectively inform the individual of the following:

a) Enrollment in the specified Alternative Benefit Plan is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan defined subject to section 1937 requirements at any time and instead receive an Alternative Benefit Plan defined as the approved state/territory Medicaid state plan that is not subject to section 1937 requirements; and

c) What the process is for transferring to the state plan-based Alternative Benefit Plan.

☑ The state/territory assures it will inform the individual of:

a) The benefits available as Alternative Benefit Plan coverage defined using section 1937 requirements as compared to Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan and not subject to section 1937 requirements; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan subject to 1937 requirements differs from the Alternative Benefit Plan defined as the approved Medicaid state/territory plan benefits.

How will the state/territory inform individuals about their options for enrollment? (Check all that apply)

☒ Letter

☐ Email

☒ Other

Describe:

All HIP Link enrollees must make two distinct opt-in choices to enroll in HIP Link: (1) the HIP Link enrollee must have requested HIP Link as their coverage option and (2) the HIP Link enrollee must separately enroll with the employer in a HIP Link eligible health plan by completing the employer's enrollment paperwork.

Applicants may enroll in HIP Link by making the selection of HIP Link on the application and providing the HIP Link employer information. Current HIP members and conditional HIP members may make the election to enroll in HIP Link by calling the Division of Family Resources and using the change reporting process to request a transfer from HIP to HIP Link. No applicant or member is enrolled in or transfered to HIP Link without making an affirmative selection of HIP Link either through the application for health coverage or through the change reporting process. In addition, to be HIP Link eligible an applicant must have completed the group health coverage enrollment paperwork with their employer and already be receiving ESI benefits or have an employer confirmed start date for ESI benefits for HIP Link eligibility to be established.

Prior to enrollment in HIP Link the applicant's or member's employer will verify that the applicant or member is enrolled in HIP Link eligible ESI plan. Once the employer receives a request for verification, the employer will have five business days to complete the verification. If the employer does not complete the verification in five business days, current member's will remain in HIP Plus, HIP Basic, or HIP State Plan benefits, as applicable. Applicants will be enrolled into HIP as a HIP Plus or HIP State Plan Plus conditional member. The employer's failure to comply with the five day time line does not prevent the applicant from requesting HIP Link again in the future, but rater it establishes a specific time frame for the employer to help ensure timely enrollment into HIP Link when requested by the applicant. Verification of HIP Link eligibility can be appealed by the member to the state through the standard appeals process, and members may also request, via the change reporting process, to have their HIP Link eligibility verified again at any time. Appeals of HIP Link eligibility are handled by the state through the standard appeals process. If the employer confirms the applicant's or member's enrollment in HIP Link eligible ESI benefits, HIP Link benefits will begin as described below.

For current HIP members, as with other changes to HIP eligibility, HIP Link benefits begin the first of the month following the employer's verification of active enrollment in ESI, such that there is no overlap between HIP and HIP Link coverage. For example, if the employer confirms in July that the employee is eligible for and enrolled in HIP Link eligible ESI as of July 3rd, then the HIP member will transfer to HIP Link on August 1st. If the employer confirms in July that the employee ESI benefits will begin August 17th, then the HIP Member will transfer from their active HIP benefits to HIP Link on September 1.

For new applicants, HIP Link benefits begin the first day of the month where employer confirms the member was actively enrolled in ESI on the first of the month. For example, if the employer confirms in July that the applicant was enrolled in HIP Link eligible ESI on July 1, then HIP Link benefits will begin July 1. If the employer confirms in July that the applicant's ESI benefits will begin August 17th, then the applicant may enroll in HIP pending their HIP Link enrollment effective September 1. Individuals that lose eligibility for HIP Link due to loss of access to employer sponsored insurance will be immediately transfered from HIP Link to HIP Plus or HIP State Plan Plus as applicable for the individuals eligibility group, individuals that lose access to ESI will not experience a gap in coverage during the transition back to HIP coverage.

Current members that request a transfer to HIP Link will be notified at the time of request that selection of HIP Link will mean that they will be enrolled HIP Link until their next annual redetermination or the end of their employers insurance, which could be up to a period of 12 months depending on when the member requests the transfer to HIP Link. Information will be provided when the member requests a HIP Link transfer on the opt-out at anytime option for frail members and how to contact the enrollment broker for benefits counseling. Members may withdraw requests for transfers to HIP Link as long as the employer has not verified that the member is enrolled in ESI and the member has not been receiving premium reimbursement checks.

Members eligible to disenroll from HIP Link due to medically frail status may do so at any time. To disenroll, medically frail individuals utilize the change reporting process to request transfer from HIP Link to HIP Plus. When the medically frail individual makes the request, they will receive a form by mail which they must complete to attest to their medically frail condition. Effective the first of the month following the receipt of the completed form by the state, the medically frail individual will be transfered from HIP Link to HIP State Plan Plus. Members will have to separately contact their employer to disenroll from the employer sponsored insurance.

All applicants and HIP members that request a transfer to HIP Link will receive an eligibility notice from the state that informs them if their HIP Link eligibility was verified with their employer and if so, what their HIP Link start date is. This notice also provides information on how to access enrollment counseling for information on the differences between the HIP and HIP Link benefit packages, advises the member that individuals with serious medical or mental health conditions may transfer from HIP to HIP Link at any time, and informs the member that those age 19 and 20 will receive EPSDT benefits that includes all medically necessary 1905(a) benefits via use of the HIP Link card if these benefits are not provided under their employer health plan. Information on enrollment counseling and the ability for some groups to transfer from HIP Link to HIP at any time is also included in member materials and HIP Link marketing and informational materials accessible through the HIP Link website.

The time between the receipt of the member eligibility notice, and the start of the HIP Link benefits will vary based on the date which the applicant or member has active enrollment in HIP Link eligible ESI. The applicant may receive their HIP Link approval notice during the month in which their HIP Link enrollment begins if they are already enrolled in ESI. Or the applicants that have a waiting period for ESI enrollment will receive the HIP Link eligibility notice in the month or months prior to the start of HIP Link enrollment. During any applicable ESI waiting period, the member may access the standard HIP conditional enrollment process to gain coverage for the months between authorization and the start of their HIP Link benefits.

Regardless of the HIP Link start date, at any time applicants, prospective applicants, or members can contact the enrollment broker for counseling on the differences between HIP Link and the applicable HIP benefits. All members seeking counseling who are medically frail based on their case record will receive counseling from the enrollment broker about the the differences between the individual's current HIP State Plan Basic or HIP State Plan Plus benefits and the benefits available under the HIP Link approved ESI as well as counseling on cost-sharing. The enrollment broker will have access to the benefit documents provided by the HIP Link approved employer health plans and the HIP Link Employer Counseling Team's plan review notes to assist them in advising the member on the differences between HIP Basic and HIP Plus and HIP State Plan benefits and cost sharing. For applicants and prospective applicants, the enrollment broker will advise the individuals that if they have a health condition that may qualify them as medically frail then they may qualify for enhanced benefits under the HIP option that are not available under the HIP Link option. Enrollment counseling is not required for applicants or members to enroll in HIP Link, but it is an option for all prospective HIP Link enrollees, including the medically frail. Enrollment counseling continues to be available after the individual enrolls in HIP Link to help individuals decide if HIP Link remains the best coverage option. The medically frail can leverage ongoing enrollment counseling to support decision making around transferring from HIP Link to HIP.

In addition to the eligibility notice and enrollment counseling tailored to the benefits and cost sharing of the specific employer sponsored health plan, HIP Link members will also receive a member manual that serves as a comprehensive program guide and covers content relevant to members from eligibility, calculation of their contribution and the member prepayment schedule. The member manual includes information on the benefits in HIP Link and the potential benefit differences between their HIP Link employer plan and the benefits available in HIP. The member manual details benefits that are available to the medically frail through the HIP State Plan benefit option. The member manual provides reference for the qualifying events, including becoming medically frail, that allow an individual to transfer from HIP Link back to HIP and provides a guide of how to request a transfer to HIP utilizing the change reporting process. All HIP Link members will receive a HIP Link member manual when they enroll into HIP Link.

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about their options for enrollment.

An attachment is submitted.

When did/will the state/territory inform the individuals?

Applicants and current members that request a transfer to HIP Link will receive notification on the times outlined above. Depending on the start date of their HIP Link eligible ESI, applicants may be directly enrolled into HIP Link effective the first of the month in which they receive their eligibility notice.

Alternative Benefit Plan

Please describe the state/territory's process for allowing individuals in the Section 1902(a)(10)(A)(i)(VIII) eligibility group who meet exemption criteria to disenroll from the Alternative Benefit Plan defined using section 1937 requirements and enroll in the Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan.

The medically frail may disenroll from HIP Link at any time by contacting the Division of Family Resources and utilizing the existing change reporting process to request a transfer from HIP Link to HIP. Individuals requesting a transfer from HIP Link to HIP due to medically frail status are provided with a health condition questionnaire. To complete the transfer the individual must complete the questionnaire. The health conditions indicated by the individual are not subject to verification to transfer from HIP Link to HIP. The transfer to HIP will occur effective the first of the month following the receipt of the medically frail attestation form.

☑ The state/territory assures it will document in the exempt individual's eligibility file that the individual:

a) Was informed in accordance with this section prior to enrollment;

b) Was given ample time to arrive at an informed choice; and

c) Chose to enroll in Alternative Benefit Plan coverage subject to section 1937 requirements or defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Where will the information be documented? (Check all that apply)

☐ In the eligibility system.

☐ In the hard copy of the case record.

☒ Other

Describe:

All individuals that enroll in HIP Link will may access options counseling through the enrollment broker and will be informed that upon enrollment into HIP Link they will be covered by their employer sponsored insurance and not HIP. Individuals that call for options counseling will have their request for counseling documented in the enrollment brokers call tracking system. Information on how to access options counseling for HIP Link is provided in general HIP Link marketing and outreach materials, including materials posted online, member manuals and other member material, all specific notices that go to individuals requesting HIP Link, and by the call center when members ask about HIP Link or request a transfer from HIP to HIP Link.

What documentation will be maintained in the eligibility file? (Check all that apply)

☐ Copy of correspondence sent to the individual.

☐ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.

☒ Other

Describe:

Eligibility notices sent to HIP Link members inform all members of the option for enrollment counseling via the enrollment broker and that individuals who are medically frail may disenroll at any time through the change reporting process. For individuals that contact the enrollment broker for specific options counseling, record that the individual took part in the enrollment counseling will be noted in the individuals record. Depending on if the individual contacts the enrollment broker for HIP Link options counseling during the application process or after being determined eligible for HIP, the record of the counseling process may be associated with the member's name as provided to the enrollment broker, or the members identification number.

Alternative Benefit Plan

☑ The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in either Alternative Benefit Plan coverage subject to section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Other information related to benefit package selection assurances for exempt participants (optional):

PRA Disclosure Statement

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

V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L- ☐

OMB Expiration date: 10/31/2014

Voluntary Enrollment Assurances for Eligibility Groups other than the Adult Group under section 1902(a)(10)(A)(i)(VIII) of the Act — ABP2b

These assurances must be made by the state/territory if the ABP Population includes any eligibility groups other than or in addition to the Adult eligibility group.

When offering voluntary enrollment in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent), prior to enrollment:

☑ The state/territory must inform the individual they are exempt and the state/territory must comply with all requirements related to voluntary enrollment.

☑ The state/territory assures it will effectively inform individuals who voluntary enroll of the following:

a) Enrollment is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan at any time and regain immediate access to full standard state/territory plan coverage;

c) What the process is for disenrolling.

☑ The state/territory assures it will inform the individual of:

a) The benefits available under the Alternative Benefit Plan; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan differs from the approved Medicaid state/territory plan.

How will the state/territory inform individuals about voluntary enrollment? (Check all that apply.)

☒ Letter

☐ Email

☒ Other:

Describe:

All HIP Link enrollees must make two distinct opt-in choices to enroll in HIP Link: (1) the HIP Link enrollee must have requested HIP Link as their coverage option and (2) the HIP Link enrollee must separately enroll with the employer in a HIP Link eligible health plan by completing the employer's enrollment paperwork. This opt in process for HIP Link is the same for populations that cannot have mandatory enrollment into an ABP including low income parents and caretakers, low income 19 and 20 year olds, individuals eligible for transitional medical assistance, and pregnant women who elect to stay in HIP Link at their annual redetermination.

Enrollment for these voluntary applicants follows the same process as described in ABP 2(a). The voluntary enrollment process is the same for all members enrolling into HIP Link. Members with these eligibility types can be distinguished when the member calls to request a transfer to HIP Link. When requesting a transfer these members will be informed that they may opt out of HIP Link at any time. Information on opting out of HIP Link is also included in the members eligibility notice, member manual, and general program FAQs. All materials and member contacts also advise the member that the enrollment broker can provide more detailed benefit information on the differences between HIP and HIP Link.

When members that are eligible for voluntary enrollment in the HIP Link ABP elect to disenroll from HIP Link they do so by contacting the Division of Family Resources utilizing the change reporting process and request to be transfered from HIP Link to HIP. The transfer is effective the first of the month following the receipt of the transfer request. The member is responsible for disenrolling from the employer sponsored insurance once the coverage is effective.

Like all applicants and HIP members that request a transfer to HIP Link, those eligible for voluntary enrollment in the ABP will receive an eligibility notice from the state that informs them if their HIP Link eligibility was verified with their employer and if so, what their HIP Link start date is. This notice also provides information on how to access enrollment counseling for information on the differences between the HIP and HIP Link benefit packages, advises the member that individuals exempt from mandatory enrollment may transfer from HIP to HIP Link at any time, and informs the member that those age 19 and 20 will receive EPSDT benefits that includes all medically necessary 1905(a) benefits via use of the HIP Link card if these benefits are not provided under their employer health plan. Information on enrollment counseling and the ability for some groups to transfer from HIP Link to HIP at any time is also included in member materials and HIP Link marketing and informational materials accessible through the HIP Link website.

All members seeking counseling who are exempt from mandatory enrollment in ABP based on their case record, including Section 1931 low-income parents and caretakers, pregnant women, and transitional medical assistance, will receive counseling from the enrollment broker about the the differences between the individual's current HIP State Plan benefits and the benefits available under the HIP Link approved ESI as well as counseling on cost-sharing. The enrollment broker will have access to the benefit documents provided by the HIP Link approved employer health plans and the HIP Link Employer Counseling Team's plan review notes to assist them in advising the member on the differences between HIP Basic, HIP Plus, and the HIP State Plan benefits. For applicants and prospective applicants, the enrollment broker will ask basic income questions and advise individuals with income levels that may qualify them as a low-income parent and caretaker that they may be eligible for additional benefits not present in commercial coverage through the HIP State Plan benefit package if they are found eligible for those benefits in HIP. Enrollment counseling is not required for applicants or members to enroll in HIP Link, but it is an option for all prospective HIP Link enrollees including low-income parents and caretakers, transitional medical assistance, and pregnant women. Enrollment counseling continues to be available after the individual enrolls in HIP Link to help individuals decide if HIP Link remains the best coverage option. Those exempt from mandatory enrollment in an ABP can leverage ongoing enrollment counseling to support decision making around transferring from HIP Link to HIP.

In addition to the eligibility notice and enrollment counseling tailored to the benefits and cost sharing of the specific employer sponsored health plan, HIP Link members will also receive a member manual that serves as a comprehensive program guide and covers content relevant to members from eligibility, calculation of their contribution and the member prepayment schedule. The member manual includes information on the benefits in HIP Link and the potential benefit differences between their HIP Link employer plan and the benefits available in HIP. The member manual details benefits that are available to the populations exempt from mandatory enrollment in an ABP through the HIP State Plan benefit option. The member manual provides reference for the qualifying events, including becoming medically frail, that allow an individual to transfer from HIP Link back to HIP and provides a guide of how to request a transfer to HIP utilizing the change reporting process. All HIP Link members will receive a HIP Link member manual when they enroll into HIP Link.

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about voluntary enrollment.

An attachment is submitted.

When did/will the state/territory inform the individuals?

Applicants and current members that request a transfer to HIP Link will receive notification on the times outlined above. Depending on the start date of their HIP Link eligible ESI, applicants may be directly enrolled into HIP Link effective the first of the month in which they receive their eligibility notice.

Please describe the state/territory's process for allowing voluntarily enrolled individuals to disenroll.

Section 1931 Parents and Caretakers, low-income 19 and 20 year olds, individuals eligible for transitional medical assistance, and pregnant women may disenroll from HIP Link at any time by contacting the Division of Family Resources and utilizing the existing change reporting process to request a transfer from HIP Link to HIP. Disenrollment for these populations will be effective the first of the month following the disenrollment request.

☑ The state/territory assures it will document in the exempt individual's eligibility file that the individual:

a) Was informed in accordance with this section prior to enrollment;

b) Was given ample time to arrive at an informed choice; and

c) Voluntarily and affirmatively chose to enroll in the Alternative Benefit Plan.

Where will the information be documented? (Check all that apply.)

- ☐ In the eligibility system.
- ☐ In the hard copy of the case record.
- ☒ Other:

Describe:

All individuals that enroll in HIP Link will may access options counseling through the enrollment broker and will be informed that upon enrollment into HIP Link they will be covered by their employer sponsored insurance and not HIP. Individuals that call for options counseling will have their request for counseling documented in the enrollment brokers call tracking system. Information on how to access options counseling for HIP Link is provided in general HIP Link marketing and outreach materials, including materials posted online, member manuals and other member material, all specific notices that go to individuals requesting HIP Link, and by the call center when members ask about HIP Link or request a transfer from HIP to HIP Link.

What documentation will be maintained in the eligibility file? (Check all that apply.)

- ☐ Copy of correspondence sent to the individual.
- ☐ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.
- ☒ Other:

Describe:

Eligibility notices sent to HIP Link members inform all members of the option for enrollment counseling via the enrollment broker. That individuals who are exempt from mandatory ABP enrollment may disenroll at any time through the change reporting process is detailed in the HIP Link member manual . For individuals that contact the enrollment broker for specific options counseling, record that the individual took part in the enrollment counseling will be noted in the individuals record. Depending on if the individual contacts the enrollment broker for HIP Link options counseling during the application process or after being determined eligible for HIP, the record of the counseling process may be associated with the member's name as provided to the enrollment broker, or the members identification number.

- ☑ The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in an Alternative Benefit Plan and the total number who have disenrolled.

Other Information Related to Enrollment Assurance for Voluntary Participants (optional):

PRA Disclosure Statement

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

V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

Enrollment Assurances - Mandatory Participants — ABP2c

These assurances must be made by the state/territory if enrollment is mandatory for any of the target populations or sub-populations.

When mandatorily enrolling eligibility groups in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent Plan) that could have exempt individuals, prior to enrollment:

☑ The state/territory assures it will appropriately identify any individuals in the eligibility groups that are exempt from mandatory enrollment in an Alternative Benefit Plan or individuals who meet the exemption criteria and are given a choice of Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, not subject to section 1937 requirements.

How will the state/territory identify these individuals? (Check all that apply)

☒ Review of eligibility criteria (e.g., age, disorder/diagnosis/condition)

Describe:

Individuals that are already enrolled in HIP may request transfer to HIP Link at any time. Medically frail HIP enrollees will be identified in HIP and if they request to transfer to Link, they may return to HIP through the standard change reporting process.

☒ Self-identification

Describe:

Individuals that develop a condition that qualifies as medically frail may report this condition at any time to the state through the standard change reporting process. If an individual reports that they have developed a condition that qualifies them as medically frail, they may leave HIP Link at any time by completing and returning the health condition frail questionnaire. If they request a transfer from HIP Link to HIP, their condition will be verified at the start of their HIP enrollment.

☐ Other

☑ The state/territory must inform the individual they are exempt or meet the exemption criteria and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the “Individuals at or below 133% FPL Age 19 through 64” eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

☑ The state/territory assures that for individuals who have become exempt from enrollment in an Alternative Benefit Plan, the state/territory must inform the individual they are now exempt and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the “Individuals at or below 133% FPL Age 19 through 64” eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

How will the state/territory identify if an individual becomes exempt? (Check all that apply)

☐ Review of claims data

☒ Self-identification

☐ Review at the time of eligibility redetermination

☐ Provider identification

Alternative Benefit Plan

☐ Change in eligibility group

☐ Other

How frequently will the state/territory review the Alternative Benefit Plan population to determine if individuals are exempt from mandatory enrollment or meet the exemption criteria?

○ Monthly

○ Quarterly

○ Annually

○ Ad hoc basis

◉ Other

Describe:

Individuals enrolled in HIP Link who are medically frail may leave HIP Link at any time and return to HIP. Transfers from HIP Link to HIP are effective the first of the month following the receipt of the medically frail questionnaire. To return to enrollment in HIP, the individual will report that they have developed a condition, complete and return the health condition questionnaire, and request to transfer from HIP Link to HIP. Individuals transfered to HIP will have their condition verified in accordance with the HIP Plus or HIP Basic ABP medically frail verification process utilizing the Milliman Underwriting Guidelines.

☑ The state/territory assures that it will promptly process all requests made by exempt individuals for disenrollment from the Alternative Benefit Plan and has in place a process that ensures exempt individuals have access to all standard state/territory plan services or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

Describe the process for processing requests made by exempt individuals to be disenrolled from the Alternative Benefit Plan:

The medically frail may disenroll from HIP Link at any time by contacting the Division of Family Resources and utilizing the change reporting process to request a transfer from HIP Link to HIP. Individuals requesting a transfer from HIP Link to HIP due to medically frail status are provided with a health condition questionnaire and to complete the transfer the individual must complete the questionnaire. The health conditions indicated by the individual are not subject to verification to transfer from HIP Link to HIP but will be verified in HIP as detailed by the HIP Basic and HIP Plus ABPs.

Other Information Related to Enrollment Assurance for Mandatory Participants (optional):

Individuals who have depleted funds in their power account are subject to additional cost-effectiveness analysis and may be transferred back to HIP Plus or Basic.

PRA Disclosure Statement

V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- [ ]

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package ABP3

Select one of the following:

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

Name of benefit package: HIP Link

Selection of the Section 1937 Coverage Option

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

- ◉ Benchmark Benefit Package.
- ○ Benchmark-Equivalent Benefit Package.

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

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

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

The HIP Link benefits are benchmarked to the Indiana Essential Health Benefits Benchmark. Through 2017 the Indiana Essential Health Benefit Benchmark is the Anthem Small Group Blue Access PPO plan. HIP Link coverage will be offered through employer sponsored health plans. To be eligible for HIP Link, employer sponsored health plans will be reviewed by the state to confirm that (1) the Indiana Department of Insurance has already certified the plan as meeting the Indiana Essential Health Benefit requirements, (2) that the Indiana Family and Social Services HIP Link Employer Counseling Team has reviewed the benefits offered in the plan and indicated that the plan meets the HIP Link minimum value requirements and essential health benefit requirements that are the floor of coverage as detailed in ABP 5.

Variation in benefits from the essential benefits offered in the Indiana essential health benefits is permitted when one of the following pathways to review and approve Employer Plans for HIP Link ABP is utilized:
* For plans found compliant by the Indiana Department of Insurance for the QHP or small group essential health benefits, no further EHB review is needed. These plans are substantially equal to the HIP Link ABP.
*After determination by the state that EHB is met in each ESI plan, plans that are found to offer benefits at least equal to the floor of coverage in the HIP Link ABP are considered substantially equal to the ABP.
*For ESI plans with variations in benefits from the HIP Link ABP floor of coverage there are two paths:

a. Use the benchmark-equivalent pathway to determine aggregate actuarial value of an ESI plan and compare it to the actuarial value of the HIP Link ABP, following the process described in 440.335 and 440.340, OR
b. Demonstrate actuarial equivalence on a benefit to benefit basis within the same EHB category for those different benefit/s offered in the ESI plan to those offered in the HIP Plink ABP

If the employee plan has the same set of benefits as the HIP Link base benchmark, but is more limited in its amount, duration and scope, the state will ensure that these services are provided to the level in the base benchmark through the HIP Link POWER account.

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

Selection of Base Benchmark Plan

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

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

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

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

Plan name: Anthem Blue PPO SG Option 6

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

The state assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5.
The state assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the base benchmark.

PRA Disclosure Statement

V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

Alternative Benefit Plan Cost-Sharing — ABP4

☐ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. Yes

☐ The state/territory has completed and attached to this submission Attachment 4.18-F to indicate the Alternative Benefit Plan's cost-sharing provisions that are different from those otherwise approved in the state plan.

An attachment is submitted.

Other Information Related to Cost Sharing Requirements (optional):

A description of the HIP Link cost sharing is contained Indiana's HIP 2.0 1115 Demonstration and associated HIP Link protocol.

PRA Disclosure Statement

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

V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- [ ]

Benefits Description ABP5

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

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Blue 5 Blue Access PPO Medical Option 6 Rx Option G
Anthem Ins Companies Inc (Anthem BCBS)

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

Secretary-Approved

Alternative Benefit Plan

■ 1. Essential Health Benefit: Ambulatory patient services Collapse All ☐

Benefit Provided: Primary Care Visit to Treat an Injury or Illness

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Benefit Provided: Specialist visit

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Benefit Provided: Other practitioner office visit (e.g. nurse, PA)

Source: Base Benchmark Small Group

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Remove

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

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

Benefit Provided:

Outpatient facility (e.g. Amb. surgery center)

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

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

Benefit Provided:

Outpatient surgery physician/surgical services

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

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

Alternative Benefit Plan

Benefit Provided:
Private Duty Nursing

Source:
Base Benchmark Small Group

Remove

Authorization:
Other

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
82 visit per plan year, 164 per lifetime

Duration Limit:
None

Scope Limit:
None

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

Base benchmark contained a $50,000 per benefit period (benchmark plan limit) which is equal to 82 visits per benefit period in the Indiana EHB. $100,000 per lifetime (benchmark plan limit) is equal to 164 visits per lifetime in the Indiana EHB. Limit applies to in-home setting, service is non-covered in an inpatient setting.

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

Benefit Provided:
Urgent Care Centers or Facilities

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Benefit Provided:
Home Health Care Services

Source:
Base Benchmark Small Group

Authorization:
Other

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
90 visits per plan year

Duration Limit:
None

Scope Limit:

Member must be confined to the home for medical reasons and be physically unable to obtain needed medical services on an outpatient basis. Custodial care is not covered.

Remove

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

Home Health Care includes professional, technical, and health aide services. Does not include in home manipulation therapy.

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

Benefit Provided:

Dialysis

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

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

Benefit Provided:

Radiation Therapy

Source:

Base Benchmark Small Group

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

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

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

Remove

Benefit Provided: Chemotherapy

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Benefit Provided: Infusion Therapy

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Benefit Provided: Renal Dialysis/Hemodialysis

Source: Base Benchmark Small Group

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Remove

Scope Limit: None

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

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

Benefit Provided: Allergy Treatment

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Benefit Provided: Dental Services for accidental injury

Source: Base Benchmark Small Group

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Coverage for treatment performed within 12 months of injury. Damage to teeth due to chewing or biting not considered accidental injury and is not covered.

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

Benefit limited to $3,000 of coverage. For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is

not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Remove

Benefit Provided: Clinical trials for cancer treatment

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Benefit Provided: Voluntary sterilization for males

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Benefit Provided: TMJ

Source: Base Benchmark Small Group

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Remove

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Chiropractic

Source:
Base Benchmark Small Group

Remove

Authorization:
Other

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
12 visits per plan year

Duration Limit:
None

Scope Limit:
Covers spinal manipulation and manual medical intervention services including OMT. Services not covered in an in home setting.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Visit limit is for all manipulation treatments including chiropractic and osteopathic manipulation treatment.

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

Add

Alternative Benefit Plan

☑ 2. Essential Health Benefit: Emergency services Collapse All ☐

Benefit Provided: Emergency Department Services

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Emergency Transportation (e.g. Ambulance)

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Coverage for transportation to emergency services only.

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

Add

Alternative Benefit Plan

■ 3. Essential Health Benefit: Hospitalization Collapse All ☐

Benefit Provided:
Inpatient hospital services (e.g. Hospital stay)

Source:
Base Benchmark Small Group

Remove

Authorization:
Other

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Inpatient physician and surgical services

Source:
Base Benchmark Small Group

Remove

Authorization:
Other

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Human organ and tissue transplant services

Source:
Base Benchmark Small Group

Authorization:
Other

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
Other

Duration Limit:
None

Scope Limit:

Medically necessary human organ and tissue transplant services. When a human organ or tissue transplant is provided from a living donor to a covered person, both the recipient and the donor may receive the benefits of the health plan.

Remove

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

Unrelated Donor Searches is limited to $30,000 per transplant.

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

Benefit Provided:

Non-cosmetic reconstructive surgery

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered.

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

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

Benefit Provided:

Mastectomy - Reconstructive surgery

Source:

Base Benchmark Small Group

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

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

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

Remove

Benefit Provided:

Anesthesia

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

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

Add

Alternative Benefit Plan

■ 4. Essential Health Benefit: Maternity and newborn care — Collapse All ☐

Benefit Provided: Prenatal and postnatal care

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Surrogate services not covered

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

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

Benefit Provided: Delivery and all inpatient services for maternity

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Surrogate services not covered

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

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

Add

Alternative Benefit Plan

Collapse All ☐

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

Benefit Provided: Mental/behavioral health outpatient services

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Benefit Provided: Mental/behavioral health inpatient services

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Custodial care and residential treatment services are not covered.

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

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

Benefit Provided: Substance abuse disorder outpatient services

Source: Base Benchmark Small Group

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Alternative Benefit Plan

Amount Limit: None

Duration Limit: None

Remove

Scope Limit: None

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

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

Benefit Provided: Substance abuse disorder inpatient services

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Custodial care and residential treatment services are not covered.

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

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

Add

■ 6. Essential Health Benefit: Prescription drugs

Benefit Provided:

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

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	Yes	State licensed
☒ Limit on number of prescriptions		
☒ Limit on brand drugs		
☒ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

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

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

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

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

Alternative Benefit Plan

■ 7. Essential Health Benefit: Rehabilitative and habilitative services and devices Collapse All ☐

Benefit Provided:
Skilled Nursing Facility

Source:
Base Benchmark Small Group

Remove

Authorization:
Other

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
90 days per plan year

Duration Limit:
None

Scope Limit:
Custodial care is not covered.

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

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

Benefit Provided:
Physical, Speech and Occupational Therapy

Source:
Base Benchmark Small Group

Remove

Authorization:
Other

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
20 visits per therapy per plan year

Duration Limit:
None

Scope Limit:
Visit limit includes both rehabilitative and rehabilitative services

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

Coverage provided for at least 20 visits for each of the following: physical therapy, occupational therapy, speech therapy.

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

Benefit Provided:
Durable medical equipment

Source:
Base Benchmark Small Group

Authorization:
Other

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Remove

Scope Limit:

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

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

Benefit Provided: Vision correction after surgery or accident

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Covered if medically necessary.

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

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

Benefit Provided: Inpatient rehabilitation therapy

Source: Base Benchmark Small Group

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: 60 days per benefit year

Duration Limit: None

Scope Limit: Pulmonary rehab in the acute inpatient setting is not covered.

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

Limit is combined for all inpatient rehabilitation types. For authorization, the member's primary coverage

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

Remove

Benefit Provided: Prosthetics

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Covered if medically necessary.

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

A prosthetic device means an artificial arm or leg or any portion of limb. Covered services include the purchase, replacement or adjustment of artificial limbs when required due to a change in a benficiaries physical condition or body size due to normal growth.

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

Benefit Provided: Othotics

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Covered if medically necessary.

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

Orthotic devices are covered under this benefit as braces or supports designed as part of the artificial arm or leg.

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

Alternative Benefit Plan

Benefit Provided: Medical supplies

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Covered if medically necessary.

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

Benefit includes but may not be limited to diabetic supplies and equipment, casts, dressings, splints, and other devices used for reduction of fractures and dislocations.

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

Benefit Provided: Hospice Services

Source: Base Benchmark Small Group

Remove

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as confirmed by the attending Physician. Covered Services will continue if the Member lives longer than six months. Housekeeping services not covered

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

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

Benefit Provided: Autism Services

Source: Base Benchmark Small Group

Authorization: Other

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Remove

Scope Limit:
See below.

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

Coverage is provided for the treatment of pervasive developmental disorders. Treatment is limited to services prescribed by a physician in accordance with a treatment plan. Pervasive developmental disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

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

Benefit Provided:
Cardiac Therapy

Source:
Base Benchmark Small Group

Remove

Authorization:
Other

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
36 visits per plan year

Duration Limit:
None

Scope Limit:
None

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

Coverage provided for 36 visits of cardiac therapy.

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

Benefit Provided:
Pulmonary Therapy

Source:
Base Benchmark Small Group

Authorization:
Other

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
20 visits per plan year

Duration Limit:
None

Alternative Benefit Plan

Scope Limit:

None

Remove

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

Coverage provided for 20 visits per plan year.

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

Add

Alternative Benefit Plan

■ 8. Essential Health Benefit: Laboratory services Collapse All ☐

Benefit Provided:
Diagnostic test (e.g. lab work)

Source:
Base Benchmark Small Group

Remove

Authorization:
Other

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Imaging (e.g. CT/PET scans, EKGs, MRIs)

Source:
Base Benchmark Small Group

Remove

Authorization:
Other

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
For authorization, the member's primary coverage provided through the employer sponsored insurance may require prior authorization. Prior authorization may include but is not limited to provision of general member information, a justification of services rendered for the medical needs of the member and a planned course of treatment, if applicable, as related to the number of services provided and duration of treatment.

Benefit Provided:
Pathology

Source:
Base Benchmark Small Group

Authorization:
Other

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Alternative Benefit Plan

Scope Limit:

Covered if medically necessary.

Remove

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

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

Benefit Provided:

Radiology

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Covered if medically necessary.

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

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

Add

■ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management Collapse All ☐

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

Benefit Provided:
Preventive care, screening, immunization

Source:
Base Benchmark Small Group

Remove

Authorization:
Other

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Preventive care provided in accordance with minimum requirements.

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

Benefit Provided:
Diabetes education

Source:
Base Benchmark Small Group

Authorization:
Other

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Coverage for palliative foot care, medical supplies, equipment, and education for diabetes care for all diabetics.

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

Diabetes Self Management Training for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when: medically necessary; ordered in writing by a physician or a podiatrist; and provided by a health care professional who is licensed, registered, or certified under state law.

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

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

Remove

Benefit Provided:

Routine PSA test

Source:

Base Benchmark Small Group

Remove

Authorization:

Other

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

1 per year

Duration Limit:

None

Scope Limit:

Coverage for individuals who are at least 50 years old or less than 50 if high risk for prostate cancer. Covered if medically necessary.

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

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

Add

Alternative Benefit Plan

■ 10. Essential Health Benefit: Pediatric services including oral and vision care Collapse All ☐

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Available to enrollees age 20 and under

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
This benefit will be provided by Medicaid if the service or treatment is not covered on the employer plan or if the employer plan limits coverage of any medically necessary 1905(a) benefit to the EPSDT population.

Add

☐ 11. Other Covered Benefits from Base Benchmark Collapse All ☐

Alternative Benefit Plan

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

Alternative Benefit Plan

☒ 13. Other Base Benchmark Benefits Not Covered Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Non-emergency care when traveling outside the U.S.

Source: Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:

This benefit is in the Indiana EHB base benchmark and may be included in HIP Link approved plans. This benefit is not considered an essential health benefit for the ABP and health plans will not be disqualified from HIP Link if they do not offer this coverage. This services is not permissible under federal Medcaid rules.

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Transplant Services- Transportation and Lodging

Source: Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:

This benefit has a $10,000 dollar limit that cannot be converted to a service limit. It is not considered an essential health benefit. HIP Link employer plans may offer this benefit but the $10,000 of coverage for this benefit is not required for HIP Link.

Add

Alternative Benefit Plan

☐ 14. Other 1937 Covered Benefits that are not Essential Health Benefits Collapse All ☐

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

Collapse All ☐

PRA Disclosure Statement

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

V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

Benefits Assurances — ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

○ Through an Alternative Benefit Plan.

◉ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Per 42 CFR 440.345, please describe how the additional benefits will be provided, how access to additional benefits will be coordinated and how beneficiaries and providers will be informed of these processes in order to ensure individuals have access to the full EPSDT benefit.

Indicate whether additional EPSDT benefits will be provided through fee-for-service or contracts with a provider:

◉ State/territory provides additional EPSDT benefits through fee-for-service.

○ State/territory contracts with a provider for additional EPSDT services.

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

HIP Link participants under age 21 can access EPSDT services when they visit a Medicaid enrolled provider and present their HIP Link card. EPSDT services will be covered in addition to coverage provided by the employer plan and will be covered beyond any limits present in the employer plan.

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

Alternative Benefit Plan

- ☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.
- ☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.
- ☑ The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.
- ☑ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- ☑ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
- ☑ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
- ☑ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.
- ☑ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: “A” and “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

Service Delivery Systems — ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

☐ Managed care.

☐ Fee-for-service.

☒ Other service delivery system.

Other Service Delivery Model

Name of service delivery system:

HIP Employer Benefit Link - Premium Assistance

Provide a narrative description of the model:

HIP Link is an optional defined contribution insurance program for all HIP eligible individuals who have access to HIP Link qualifying employer sponsored insurance (ESI). HIP Link allows HIP eligible individuals to choose to enroll into their qualifying ESI instead of into HIP. This option increases choice for beneficiaries and also reduces crowd out of private health insurance.

HIP Link maintains HIP's consumer directed framework by providing enrolled individuals with a HIP Link Personal Wellness and Responsibility (POWER) account valued at $4,000. This Health Savings like account holds the state's defined contribution for ESI coverage of $4,000 and will cover the premiums and out of pocket costs associated with enrollment in ESI. Additionally, the account serves as supplemental coverage for medical expenses incurred during the employer's annual coverage period. Like HIP Plus, individuals enrolled in HIP Link will be required to contribute 2 percent of their income towards the cost of their employer sponsored insurance. Premiums will be deducted from the employee's paycheck as usual, and the state will send the employee prepayment for the difference between the premium amount and their 2 percent POWER account contribution.

The individual who elects to enroll into HIP Link will receive the benefits offered by the HIP Link qualified employer health insurance instead of the HIP Plus, HIP Basic, or HIP State Plan benefits as applicable. HIP Link beneficiaries will access benefits provided through their employer sponsored insurance and limited additional benefits as specified in this ABP.

The state will provide HIP participants with support as they contemplate enrolling in HIP or HIP Link. The state's enrollment broker will provide counseling to assist them with their decision. The enrollment broker will have access to information detailing the benefits in each employer sponsored plan and will be able to explain the differences between HIP and HIP Link, as well as answering questions about HIP Link.

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L- ☐

OMB Expiration date: 10/31/2014

Employer Sponsored Insurance and Payment of Premiums — ABP9

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.	No
The state/territory otherwise provides for payment of premiums.	Yes

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

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

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

HIP Link provides enrolled individuals with a $4,000 HIP Link Personal Wellness and Responsibility (POWER) account. This health savings-like account holds the state's defined contribution for ESI coverage of $4,000 and will cover the premiums and out of pocket costs associated with enrollment in ESI.

When two or more individuals in a family are enrolled together, the HIP Link accounts are combined. For example, enrolled spouses will have a combined $8,000 HIP Link account. Like an account for a single enrolled employee, a portion of the combined account is allocated to the ESI premiums, and the remainder of the account covers the out-of-pocket costs for ESI on a first in-first out basis, regardless of which enrolled Link individual the claim applied to.

Individuals enrolled in HIP Link will be required to contribute 2 percent of their income towards the cost of their employer sponsored insurance. Premiums will be deducted from the employee's paycheck as usual, and the state will mail the employee pre-payment checks for the difference between the premium amount and their 2 percent POWER account contribution. Individuals 2 percent contributions are in addition to the $4,000 provided by the state to cover premiums and out of pocket costs. Once a month, the HIP Link enrolled ESI policy holder will receive a check prospectively from the state for the difference between their 2 percent required contributions and their required premium payments for the next month. To ensure that the pre-payment to the individual is accurate, on a monthly basis all HIP Link eligible employers will confirm the HIP Link member's continued eligibility for ESI and the premium amounts that will be deducted for the next month's coverage.

To be eligible for HIP Link, an employer plan must meet the HIP Link affordability test. Plan affordability is a function of the premiums the employer applies to employees and eligible dependents enrolled in their plan, the plan deductibles, coinsurance, out-of-pocket maximums and any funds in the form of Health Reimbursement Accounts (HRA) that are provided by the employer to cover the costs of coverage. Since some of these requirements may vary by employer, it is possible that a small group plan that is HIP Link eligible with one employer is not HIP Link eligible with another employer due to a higher premium amount or not offering an HRA.

The state's actuary, Milliman Inc., has developed a plan affordability tool that takes inputs of employee premium contribution amounts, plan deductibles, out of pocket maximums, average coinsurance, and employer HRA contributions. These inputs are compared to the funding available in the HIP Link POWER account ($4,000 for an individual and $8,000 for a couple, etc.), average HIP Link enrollee 2% contribution limits, the projected costs of coverage on HIP Link with the applicable cost sharing limits, and the costs of coverage in HIP. If the affordability tool analysis determines that the employer plan is less costly than standard HIP, then the plan will be considered affordable and eligible for HIP Link.

Individuals enrolled in HIP Link will receive the benefits offered by the HIP Link qualified employer health insurance instead of the HIP Plus, HIP Basic, or HIP State Plan benefits as applicable. HIP Link beneficiaries will access benefits provided through their employer sponsored insurance. Benefits offered on the employer plan are reviewed for alignment with the ABP which are based on the state essential health benefits and that coverage in all EHB categories, with the exception of pediatric dental and vision is required.

HIP Link will also cover services, required by the alternative benefit plan that may not be covered by the primary insurer including family planning at non-network providers, 72 hour emergency supply of pharmaceuticals, FQHC and RHC services, and non-emergency transportation for low-income parents and caretakers. Payments for these services will come from the HIP Link POWER account and be accessed by providers submitting claims to HIP Link utilizing the information on the member's HIP Link card. Low-income parents and caretakers, transitional medical assistance, or women that become pregnant and elect to stay in HIP Link at their redetermination period, will have access to non-emergency transportation benefits. These services will be reimbursed at state plan Medicaid reimbursement rates.

HIP Link members that complete a year of coverage in HIP Link will be eligible for rollover. HIP Link rollover is similar to HIP Basic Rollover in the initial coverage year and will be based on the amount remaining in the HIP Link POWER account. HIP Link enrollees may reduce their future year's HIP Link contribution amount by up to 50 percent based on the percentage of HIP Link funds remaining in their HIP Link account. In future years of HIP Link enrollment, HIP Link enrollees may be eligible to increase this rollover to 100 percent if they participate in an employee wellness program or complete recommended preventive services.

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

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

PRA Disclosure Statement

V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

General Assurances — ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

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

V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

Payment Methodology — ABP11

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

V.20131219