maryland health connection℠

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MARYLAND HEALTH BENEFIT EXCHANGE

2014 ANNUAL REPORT

Introduction

The Maryland Health Benefit Exchange Act of 2011 requires the Maryland Health Benefit Exchange (MHBE) to forward to the Secretary of the U.S. Department of Health and Human Services (HHS), the Governor, and the Maryland General Assembly an annual report on its activities in a standardized format required by the Secretary.[1] Specifically, the MHBE must report on health plan participation; consumer choice and participation; financial integrity; and the agency's fraud, waste, and abuse detection and prevention program.[2]

This report includes information on plan participation for both the 2014 and upcoming 2015 benefit years. Also included is consumer choice information based on data for the first open enrollment and continuing through September 30, 2014. The report also provides consumer satisfaction information for those individuals who sought the assistance of Connector Entities, and it details the results of consumer surveys on Marylanders' familiarity with Maryland Health Connection. Finally, the report contains a summary of activities related to MHBE's financial integrity, marketing and outreach, and the fraud, waste, and abuse program.

[1] *Md. Code Ann., Ins. § 31-119(d).*

[2] *Md. Code Ann., Ins. § 31-119(d)(2)(ii).*

CONTENTS

1 Plan participation

Individual Marketplace

Maryland Health Connection (MHC) had strong insurer participation in its first year, with eight carriers offering qualified health and stand-alone dental plans in the individual marketplace. For the 2015 benefit year, 10 carriers are offering qualified health and stand-alone dental plans in the individual marketplace.

To offer a qualified health plan (QHP) through the MHC, a carrier must obtain prior approval of rates and benefits from the Maryland Insurance Administration.[3] Under the Patient Protection and Affordable Care Act (PPACA; also known as the ACA)[4] and State law, the only factors by which an individual can be rated are: household size, the age of those covered (3:1 maximum ratio for adults aged 19–64 years), tobacco use (1:1.5), and rating region (Baltimore, Eastern and Southern Maryland, Washington DC Metropolitan, and Western Maryland).[5] Rates for products approved for sale through the MHC for the 2014 benefit year can be seen at **mdinsurance.state.md.us/sa/consumer/md-health-connection-plans.html**, as well as in Exhibit A. Rates for products approved for offer through the MHC for the 2015 benefit year can be seen at **healthrates.mdinsurance.state.md.us/**, as well as in Exhibit B. Further, financial assistance in the form of advanced premium tax credits (APTCs) and cost-sharing reductions (CSRs) has the additional impact of significantly lowering the cost of premiums and out-of-pocket expenses, making health insurance more affordable for many of the State's uninsured. Sample scenarios for the 2014 and 2015 benefit years are depicted in Exhibits C and D.

The comprehensive nature of the benchmark plan chosen by the State also enhances the value of the QHPs offered through the MHC. Specifically, all QHPs must offer essential health benefits covering 10 required service categories: ambulatory services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; preventive/wellness services and chronic disease management; and pediatric services, including oral and vision care.[6]

In December 2012, the Maryland Health Care Reform Coordinating Council (HCRCC) selected the State's small group health plan as the State's benchmark to ensure that all ten essential health benefits were covered (Exhibit E). To further protect against any potential gaps, the HCRCC supplemented the benchmark plan with the Maryland Children's Health

[3] Md. Code Ann., Ins. § 31-115(b)(2)
[4] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).
[5] Md. Code Ann., Ins. § 15-1205

TABLE 1. QUALIFIED HEALTH PLANS BY CARRIER, 2014 BENEFIT YEAR

PARENT COMPANY	LICENSED ENTITY	NUMBER OF PLANS	METAL LEVELS
CareFirst	CareFirst Blue Choice	11	1 platinum, 3 gold, 3 silver, 3 bronze, 1 catastrophic
	CareFirst of Maryland Inc. (CFMI)	2	1 platinum, 1 bronze
	Group Hospitalization and Medical Services Inc.	2	1 platinum, 1 bronze
CareFirst (Multi-State Plan)	CareFirst of Maryland Inc.	2	1 gold, 1 silver
	Group Hopitalization and Medical Services Inc.	2	1 gold, 1 silver
Evergreen	Evergreen Health Cooperative	9	4 gold, 4 silver, 1 bronze
Kaiser Permanente	Kaiser Foundation Health Plan	9	2 gold, 3 silver, 3 bronze, 1 catastrophic
UnitedHealthcare	All Savers Insurance Co.	8	1 gold, 4 silver, 2 bronze, 1 catastrophic
Total		45	

TABLE 2. QUALIFIED HEALTH PLANS BY CARRIER, 2015 BENEFIT YEAR

PARENT COMPANY	LICENSED ENTITY	NUMBER OF PLANS	METAL LEVELS
CareFirst	CareFirst BlueChoice, Inc.	11	3 bronze, 3 silver, 3 gold, 1 platinum, 1 catastrophic
	CareFirst of Maryland Inc.	4	1 bronze, 1 silver, 1 gold, 1 platinum
	Group Hospitalization and Medical Services Inc.	4	1 bronze, 1 silver, 1 gold, 1 platinum
CareFirst (Multi-State Plan)	CareFirst of Maryland Inc.	2	1 silver, 1 gold
	Group Hopitalization and Medical Services Inc.	2	1 silver, 1 gold
CIGNA	CIGNA Health and Life Insurance Co.	3	1 bronze, 1 silver, 1 gold
Evergreen	Evergreen Health Cooperative	12	4 bronze, 3 silver, 3 gold, 1 platinum, 1 catastrophic
Kaiser Permanente	Kaiser Foundation Health Plan of the Mid-Atlantic States	10	3 bronze, 3 silver, 2 gold, 1 platinum, 1 catastrophic
UnitedHealthcare	All Savers Insurance Co.	8	2 bronze, 4 silver, 1 gold, 1 catastrophic
	UnitedHealthcare of the Mid-Atlantic, Inc.	5	2 bronze, 2 silver, 1 gold
Total		61	

[6] Pediatric dental is not required to be embedded in a medical plan as long as a stand-alone dental plan is offered on the MHC.

Program dental benefit and Federal Employee Program BlueVision high plan, substituted a more comprehensive federal employee (GEHA) behavioral health benefit, and added an adult component to the existing child habilitative services benefit. In addition, the ACA now requires all plans to cover certain preventive services at no costs. The result is that Marylanders now have access to a comprehensive benefit package (Exhibit F).

This comprehensive essential health benefit package required of all plans notwithstanding, variations in cost-sharing and plan design offer consumers a wide variety of options in choosing a plan that best suits their needs. Carriers can set the value of their products at four different actuarial levels — platinum (90%), gold (80%), silver (70%), and bronze (60%) — and may also offer catastrophic plans (available to only those individuals who are under age 30, and covering mainly preventive services). As such, carriers participating on MHC have offered a variety of choices. Tables 1 and 2 display QHP offerings by carrier for the 2014 and 2015 benefit years, respectively.[7]

Small Business Health Options (SHOP) Marketplace

In April 2014, the MHBE opened the State's SHOP Exchange through the SHOP Direct Enrollment Program. This program allowed Maryland's small businesses to access to the Small Business Health Care Tax Credit. The SHOP Direct Enrollment Program used SHOP authorized brokers to connect small businesses with the tax credit-eligible plans offered by participating carriers. Each of the participating carriers were certified by the MHBE to offer SHOP plans via direct enrollment. Small businesses could also purchase certified stand-alone dental plans through the direct enrollment process. The SHOP Direct Enrollment Program only allowed for the Employer Choice model for plan selection. Tables 3 and 4 display certified SHOP Medical Plans for the 2014 and 2015 benefit years, respectively.

For the 2015 benefit year, the MHBE has established a SHOP Administrator program that will partner with selected Third Party Administrators (TPAs) to provide a technical and operational solution to implement the SHOP for Maryland. The solution will include employee choice options. By leveraging the experience and technology of Maryland TPAs, small employers in the State will have the choice of using the health insurance shopping and administration process that best meets their needs including:

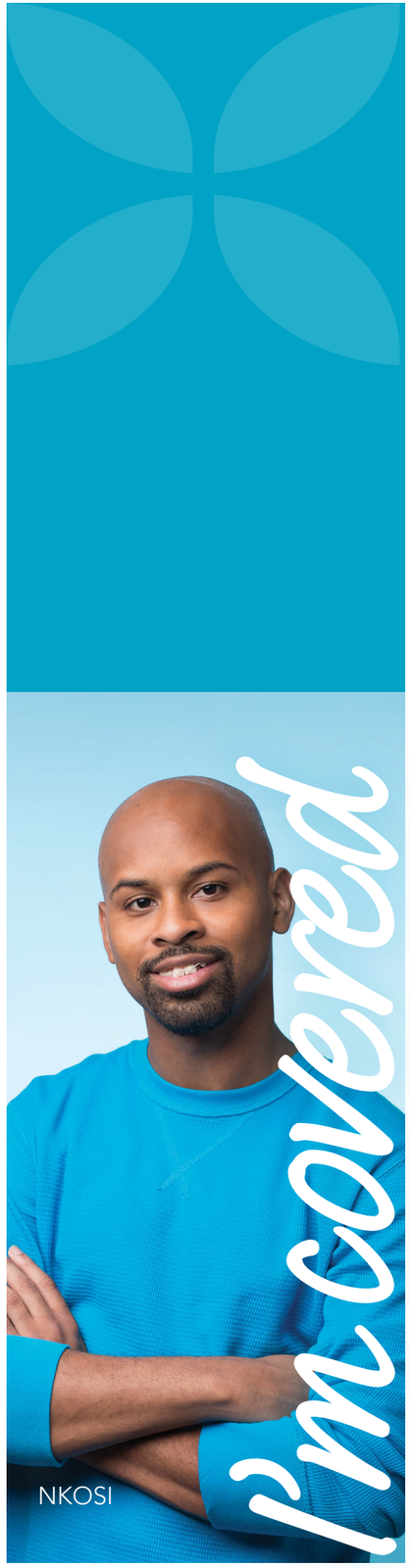
[7] The Multi-State Plans are not counted in the total number of plans as they are administered by CareFirst and therefore already counted in their CFMI and GHMSI totals.

TABLE 3. CERTIFIED SHOP MEDICAL PLANS, 2014 BENEFIT YEAR

PARENT COMPANY	LICENSED ENTITY	NUMBER OF PLANS	METAL LEVELS
CareFirst	CareFirst Blue Choice	6	2 bronze, 1 silver, 1 gold, 2 platinum
	CareFirst of Maryland Inc. (CFMI)	2	1 silver, 1 gold
	Group Hospitalization and Medical Services Inc.		
Coventry	Coventry Health and Life Company	6	2 bronze, 2 silver, 2 gold
	Coventry Health Care of Delaware		
Evergreen	Evergreen Health Cooperative	9	1 bronze, 4 silver, 4 gold
Kaiser Permanente	Kaiser Foundation Health Plan	15	4 bronze, 4 silver, 4 gold, 3 platinum
UHC	MAMSI Life and Health	14	3 bronze, 4 silver, 4 gold, 3 platinum
	Optimum Choice	14	3 bronze, 4 silver, 4 gold, 3 platinum
	UnitedHealthcare Insurance Co	12	1 bronze, 4 silver, 4 gold, 3 platinum
	UnitedHealthcare of the Mid-Atlantic	15	4 bronze, 4 silver, 4 gold, 3 platinum
Total		**93**	

TABLE 4. CERTIFIED SHOP MEDICAL PLANS, 2015 BENEFIT YEAR

PARENT COMPANY	LICENSED ENTITY	NUMBER OF PLANS	METAL LEVELS
Aetna	Aetna Health, Inc.	9	3 bronze, 3 silver, 3 gold
	Aetna Life Insurance Company		
CareFirst	CareFirst Blue Choice	4	1 bronze, 1 silver, 1 gold, 1 platinum
	CareFirst of Maryland Inc. (CFMI)	4	1 bronze, 1 silver,1 gold, 1 platinum
	Group Hospitalization and Medical Services Inc. (GHMSI)	4	1 bronze, 1 silver, 1 gold, 1 platinum
Evergreen	Evergreen Health Cooperative	9	1 bronze, 4 silver, 4 gold
Kaiser Permanente	Kaiser Foundation Health Plan	15	4 bronze, 4 silver, 4 gold, 3 platinum
UHC	MAMSI Life and Health	15	3 bronze, 4 silver, 4 gold, 4 platinum
	Optimum Choice	15	3 bronze, 4 silver, 4 gold, 4 platinum
	UnitedHealthcare Insurance Co	13	1 bronze, 4 silver, 4 gold, 4 platinum
	UnitedHealthcare of the Mid-Atlantic	16	4 bronze, 4 silver, 4 gold, 4 platinum
Total		**110**	



supporting the employer and employee as they compare and select QHPs; administering enrollment and eligibility changes; premium aggregation; and collections. The MHBE has contracted with three TPAs licensed in the State of Maryland to provide value-added services to the MHBE, carriers, and employers in connecting to SHOP Plans and administering those plans. Three TPAs were approved by the MHBE Board in August 2014: Kelly Services, Group Benefit Services, and Benefit Mall.

2 Consumer Participation, Choice, and Satisfaction

Consumer Participation

The first open enrollment period extended from October 1, 2013 through March 31, 2014.[8] Outside of open enrollment, consumers may enroll in a QHP if they qualify for a special enrollment period, and may apply for Medicaid at anytime. As of September 29, 2014, 376,850 individuals gained Medicaid coverage. This includes the 95,889 Primary Adult Care (PAC) program enrollees who were automatically converted to full-benefit Medicaid on January 1, 2014.[9] As of September 30, 2014, 81,553 individuals enrolled in QHPs.

Table 5 shows QHP enrollment by county. Montgomery, Prince George's, and Baltimore counties have the largest percentage of QHP enrollment (28.1 percent, 16.7 percent, and 11.8 percent, respectively). The following counties each have less than 1 percent of QHP enrollment: Allegany, Caroline, Dorchester, Garrett, Kent, Queen Anne's, Somerset, St. Mary's, and Talbot.

While 81,553 individuals enrolled in QHPs, as of September 30, 2014, 124,346 individuals were determined eligible for a QHP. Table 6 shows that 79 percent of individuals eligible for a QHP were eligible for some type of financial assistance: either APTC, CSRs, or both. Only 21 percent of individuals deemed eligible for a QHP were not eligible for financial assistance.

TABLE 6. FINANCIAL ASSISTANCE ELIGIBILITY FOR INDIVIDUALS ELIGIBLE FOR A QHP*

ELIGIBILITY CATEGORY	NUMBER	PERCENTAGE
Eligible with APTCs + CSRs	98,434	79.2%
Eligible without FA	25,912	20.8%
Total Eligible	**124,346**	**100%**

*As of September 30, 2014

TABLE 5. MARYLAND QHP ENROLLMENT BY COUNTY*

COUNTY	NUMBER	PERCENTAGE
Allegany	485	0.6%
Anne Arundel	6,020	7.4%
Baltimore City	6,891	8.5%
Baltimore County	9,606	11.8%
Calvert	818	1.0%
Caroline	382	0.5%
Carroll	1,582	1.9%
Cecil	1,059	1.3%
Charles	1,431	1.8%
Dorchester	332	0.4%
Frederick	2,836	3.5%
Garrett	359	0.4%
Harford	2,510	3.1%
Howard	4,787	5.9%
Kent	345	0.4%
Montgomery	22,902	28.1%
Prince George's	13,642	16.7%
Queen Anne's	495	0.6%
Somerset	227	0.3%
St. Mary's	671	0.8%
Talbot	560	0.7%
Washington	1,300	1.6%
Wicomico	1,207	1.5%
Worcester	1,062	1.3%
Out of State/Other	10	0.0%
Total	**85,519**	**100%**

*As of September 22, 2014

[8] Though open enrollment ended on March 31, 2014, enrollments for individuals who initially had difficulty gaining coverage through the MHC online system continued past this date.
[9] See October 3, 2014 Maryland Health Connection Press Release, available at: http://marylandhbe.com/wp-content/uploads/2014/10/MHBEMonthlyReport100314.pdf.

Slightly more women than men enrolled in QHPs. Table 7 shows that 54 percent of QHP enrollees were female, and 46 percent were male.

TABLE 7. MARYLAND QHP ENROLLMENT BY GENDER*

GENDER	NUMBER	PERCENTAGE
Male	37,156	45.6%
Female	44,397	54.4%
Total	**81,553**	**100%**

*As of September 30, 2014

Table 8 presents QHP enrollment by age group. Nearly half of all QHP enrollees were aged 45 to 64 years, and nearly 40 percent were aged 26 through 44 years. Only 1 percent of enrollees were over the age of 65, and 4 percent were under the age of 18.

TABLE 8. MARYLAND QHP ENROLLMENT BY AGE GROUP*

AGE GROUP (YEARS)	NUMBER	PERCENTAGE
Under 18	2,935	3.6%
18–25	7,937	9.7%
26–34	15,105	18.5%
35–44	15,128	18.5%
45–54	19,251	23.6%
55–64	20,079	24.6%
Over 65	1,118	1.4%
Total	**81,553**	**100%**

*As of September 30, 2014

Consumer Choice

Table 9 shows QHP enrollment by metal level.[10] The majority of enrollees, 54 percent, enrolled in a silver plan. Bronze was the second most popular metal level, accounting for 27 percent of enrollees. Only 6 percent of enrollees selected a platinum plan, and 1 percent selected a catastrophic plan.

[10] The metal level refers to the actuarial value of a plan. Carriers can set the value of their products at four different actuarial levels-platinum (90%), gold (80%), silver (70%), bronze (60%) – and may also offer catastrophic plans only to those under 30.

TABLE 9. MARYLAND QHP ENROLLMENT BY PLAN METAL LEVEL*

PLAN METAL LEVEL	NUMBER	PERCENTAGE
Catastrophic	514	0.6%
Bronze	22,365	27.4%
Silver	44,290	54.3%
Gold	9,717	11.9%
Platinum	4,667	5.7%
Total	**81,553**	**100%**

*As of September 30, 2014

Most enrollees (95 percent) selected CareFirst as their insurance carrier, as can be seen in Table 10.

TABLE 10. MARYLAND QHP ENROLLMENT BY INSURANCE CARRIER*

CARRIER	NUMBER	PERCENTAGE
CareFirst	76,835	94.2%
Kaiser	3,853	4.7%
Evergreen	563	0.7%
United Healthcare	302	0.4%
Total	**81,553**	**100%**

*As of September 30, 2014

Table 11 displays the average monthly premium for an individual policy for each metal level after the APTC is applied. The average individual premium ranged from $114 for a catastrophic plan to $752 for a platinum plan.

TABLE 11. AVERAGE INDIVIDUAL MONTHLY PREMIUM WITH APTC BY PLAN METAL LEVEL

PLAN METAL LEVEL	AVERAGE INDIVIDUAL PREMIUM WITH APTC
Catastrophic	$114
Bronze	$330
Silver	$475
Gold	$605
Platinum	$752

Consumer Assistance and Satisfaction

MHBE has a robust consumer assistance network throughout the State. This network includes Connector Entities, with Navigators and Assisters, as well as Insurance Producers and Certified Application Counselors. All of these consumer assistance workers provided valuable assistance to consumers seeking to enroll in health insurance plans.

The MHBE Connector Entity program, the state's Navigator program, provides assistance with eligibility determinations and enrollment in QHPs. Under the Connector Entity program, the state is divided into six regions. A map of the regions and their associated Connector Entities is provided in Exhibit G.

Each Connector Entity conducted a consumer satisfaction survey as part of their grant agreement with the MHBE. The Connector Entities reported on the results of the survey earlier this year. The survey included the following five questions:

- The Maryland Health Connection in-person helper was eager to help me.
- The Maryland Health Connection in-person helper took time to listen to me.
- The Maryland Health Connection in-person helper was knowledgeable and clear.
- The information given by the MHC in-person helper resolved my questions.
- The overall experience with MHC in-person helper was satisfactory.

The results of the consumer satisfaction survey, by region, are provided in Exhibit H. Overall, people expressed satisfaction with their experience with the Connector Entities, with rates of "strong satisfaction" ranging from 48.6 percent to 98.4 percent.

3 Financial Integrity

The MHBE has and will continue to use the financial guidelines prescribed by the Maryland Comptroller to ensure its financial integrity.[11] In areas where MHBE has been exempted from various State procedures that affect the finances and/or procurement of the agency, the MHBE must adhere to policies that have been approved by the MHBE Board of Trustees. For procurement, they are listed in Exhibit I. The MHBE is also the subject of ongoing state and federal audits, and it will comply with any recommendations resulting from these audits.

Fee Assessments

The Maryland State Comptroller is responsible for collecting the assessment generated by "…the 2% premium tax on each authorized insurance company, surplus lines broker, or unauthorized insurance company that sells, or an individual who independently procures, any type of insurance coverage upon a risk that is located in the State."[12]

Because more people are covered in private plans as a result of Maryland Health Connection, MHBE projects approximately $15 to $20 million more in revenue will come to the state through the existing insurance assessment in calendar year 2014. Because the insurance assessment also applies to Medicaid managed care plans, MHBE also projects approximately $23 million more in special funds in calendar year 2014 will come to the state as a result of the expansion. The total attributable revenues will likely exceed the state contribution to Maryland Health Connection in FY 2015. In future years, as coverage further expands, the revenue brought in through the insurance assessment as a result of coverage expansions will likely exceed the statutory minimum budget in state general funds of $35 million each year.

Status of the MHBE Fund

The MHBE's enabling legislation created a special non-lapsing fund which would consist of user fees or other assessments collected by the Exchange, all revenue deposited into the fund derived from a 2% tax on premiums, all revenue deposited into the fund from the Maryland Health Insurance Plan Fund, income from investments made on behalf of the fund, interest on deposits or investment of money in the fund, money collected by the Board as a result of a legal or other actions, money donated to the fund, money awarded to the fund through grants, and any other source accepted on behalf of the fund. However, the Maryland Health Progress Act of 2013 reversed prior legislation and required that any funds in the Exchange operations account from the premium tax that remain unspent at the end of the State fiscal year shall revert to the State General Fund. In effect, the MHBE no longer has a special non-lapsing fund. The MHBE was appropriated $12,941,830 in special fund revenue in Fiscal Year 2015 and was not in receipt of any special fund revenue in previous fiscal years.

[11] See Comptroller of Maryland, Accounting Procedures Manual, available at: http://comptroller.marylandtaxes.com/Government_Services/State_Accounting_Information/Accounting_Procedures/Accounting_Procedures_Manual.shtml.

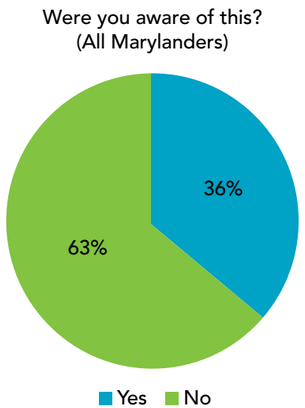
[12] See Department of Legislative Services Fiscal and Policy Note – HB228, Maryland Health Progress Act of 2013, available at: http://mgaleg.maryland.gov/2013RS/fnotes/bil_0008/hb0228.pdf.

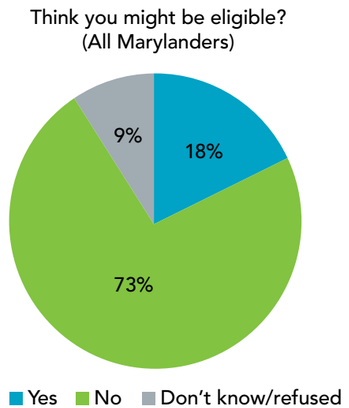
4 Marketing and Outreach

Marketing and outreach is vital to the success of the MHBE. According to state and national surveys, consumers are still largely unaware of the new, affordable health coverage offered through marketplaces under the ACA. Percentages of people who are familiar with this new opportunity are even lower among the uninsured and other key target populations.

In an August 2014 survey[13] of 800 Maryland residents, 37 percent responded they were very or somewhat familiar with the Maryland health insurance marketplace. Respondents who said they were unfamiliar with the program ranged as high as 54 percent in Western Maryland. And although 80 percent of health-care enrollees during the first year received financial assistance, 63 percent of survey respondents said they were unaware of that assistance and 73 percent did not believe they would qualify. Also, 73 percent said they would be more interested in exploring Maryland Health Connection if they thought they were eligible for a subsidy; 30 percent said they would be much more interested.

Survey Question: "Residents of Maryland can go to Maryland Health Connection to determine if they are eligible for tax subsidies and credits that can reduce the cost of health insurance."





[13] 15-minute telephone survey of 800 Maryland residents, including landline and cell phone samples, collected through Random Digit Dialing by KRC Research for Weber Shandwick, August 2014

First Open Enrollment: MHC's website, **MarylandHealthConnection.gov**, had 2.7 million visitors between Oct. 1, 2013, and Sept. 30, 2014. From October 2013 to March 2014, MHBE used a multimedia mix of TV/cable, radio, print, digital and other forms of out-of-home advertising including billboards and transit ads for its "Gonna Get It" campaign. The goal was to reach an estimated audience of 800,000 Marylanders without health insurance, or 14 percent of the state population of 5.8 million, as well as Marylanders who are underinsured or could obtain more affordable coverage through MHC. The first campaign registered more than 170 million paid media impressions[14], or views, and several times that in additional unpaid media.

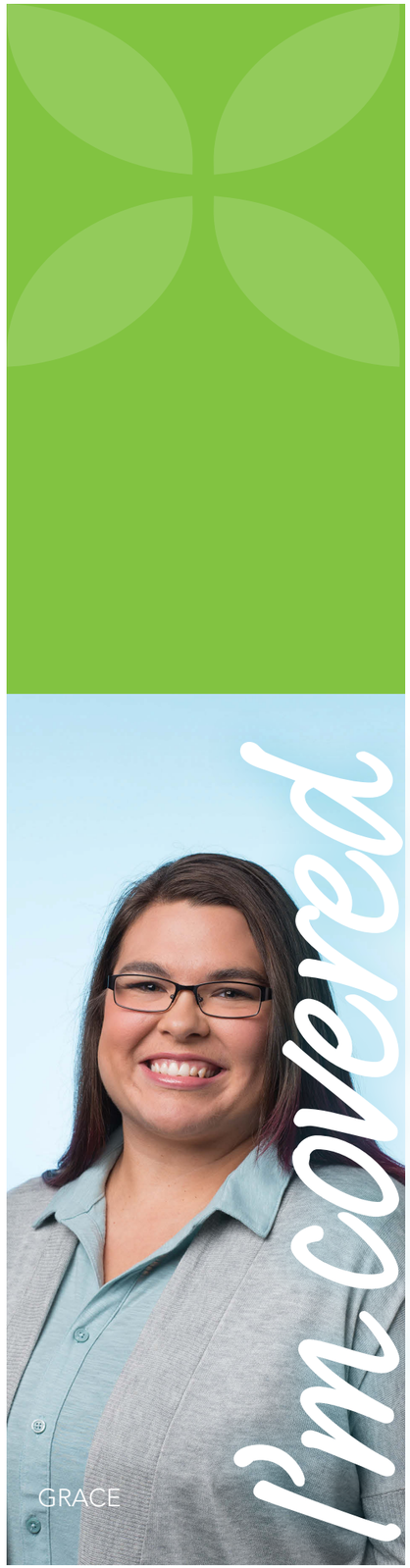
- 20.4m gross TV/Cable impressions
- 2.4m gross radio impressions
- 3.7m gross print impressions
- 59.9m gross digital impressions
- 87m gross out of home impressions

MHC entered a partnership with the 2012 Super Bowl Champion, the Baltimore Ravens, in December 2013 to connect with Maryland residents, based on research that showed that two-thirds of the uninsured population in Maryland watched, attended, or listened to a Ravens game during the prior year. Other partnerships established with Giant Food and CVS Pharmacy helped to distribute information from nearly 300 points of purchase. Events at CVS, Giant, and Safeway and a statewide ConnecTour bus campaign reached more than 2,200 Marylanders.

Second Open Enrollment: For the second Open Enrollment period that began November 15, 2014 and runs through February 15, 2015, MHBE has developed a new marketing campaign and made adjustments to its outreach strategy based on lessons learned from the first open enrollment. The most significant change, however, was the development of a new website — faster, easier to use, more functional and informative — with technology used successfully by Connecticut during the first open enrollment.

The new and improved website has a friendlier and easier-to-use interface for consumers, as well as educational and testimonial videos. New pages highlight the availability of financial help through MHC and are also designed to appeal to consumers aged 18 to 35. Improvements also

[14] Maryland Health Connection Open Enrollment Media Campaign Analysis (Weber Shandwick), May 23, 2014



include helping consumers through common questions, such as what happens after they enroll and how to find a doctor who accepts their new plan.

E-mail marketing is being employed in 2014–15 to retarget visitors to the website. A new paid advertising campaign, titled "We're Covered, I'm Covered," features consumers who were happy to gain insurance through the program in its initial year. Digital advertising on job-search sites and mobile advertising to youth-oriented online games are geared to the "young invincible" audience (those that are young and healthy but uninsured); other advertising is aimed at "influencers" of those "young invincibles," such as mothers and grandmothers.

The marketing program also greatly expanded in-person events and social media to improve outreach and communications. More than 20 enrollment fairs around the state were scheduled; four times as many as during the first open enrollment. Pamphlets and fact sheets, created in both English and Spanish, were distributed to Maryland hospitals, county social service agencies, religious organizations, fitness centers, libraries, recreation centers, supermarkets and Mercados, laundromats, and retail stores. The MHBE also entered into partnerships with the Entravision Spanish broadcasting and the AFRO American Newspaper. The latter disseminated information to African American-serving churches, Historically Black Colleges and Universities, the NAACP, Baltimore Urban League and Associated Black Charities.

The Marketing and Outreach program expanded its social media outreach in 2014 through its channels on Facebook, Twitter, and YouTube. By the start of open enrollment on November 15, 2014, the MHBE built a social media community of more than 11,000 fans and followers. With a paid social advertising campaign on Facebook that has extended the reach of the MHBE's page content to about 300,000 unique users per month, the MHBE expects to significantly grow its social media presence and increase the reach of its messaging in 2015. Real-time customer support on "Maryland Connect" social media channels improved consumer sentiment and relieved call center wait times. A "Share Your Story" campaign through social media highlighted experiences of real Marylanders who got coverage and showed that, above all, the outcome mattered.

5 Fraud, Waste and Abuse Detection

The Maryland Health Benefit Exchange Act of 2012 requires the MHBE to establish a Fraud, Waste, and Abuse Detection and Prevention Program designed to ensure MHBE's compliance with federal and State laws for the detection and prevention of fraud, waste, and abuse.[15]

The basis for an effective oversight and monitoring program is a set of clear guidelines and expectations that promote communication, implementation, and enforcement of the standards. In 2014, MHBE created a Compliance and Ethics Plan to address seven key areas that constitute an effective compliance program. The program includes a code of conduct; procedures for identifying, investigating, and resolving potential misconduct; a non-retaliation, non-intimidation policy; management controls to prevent fraud, waste, and abuse; risk management practices; financial integrity policies; and quality controls. While the Chief Compliance Officer has primary responsibility for the overall compliance program, program managers are charged with the responsibility to oversee the appropriate and timely implementation of practices that support the overall goals of the MHBE.

All new employees receive compliance training and information related to fraud, waste, and abuse; how to report actual or suspected violations; privacy and security; and conflict of interest. Employees review and sign conflict of interest statements, while managers complete the State's required attestations regarding conflicts of interest.

In addition, the MHBE's partners are required to comply with federal, state, and agency requirements. To this end, Navigators, Application Counselor Sponsoring Entities, and brokers sign conflict of interest statements, disclosures and/or attestations. This past year, Connector Entities also received a privacy and security training update as well as a self-monitoring tool to objectively assess their internal compliance programs. Training consisted of a variety of modalities — classroom, in person assistance, guides, manuals, briefings and meetings — and the web-based Navigator training was also restructured prior to open enrollment.

No actual or suspected fraud, waste or abuse incidents were reported through the MHBE's confidential hotline in 2014. Nine hotline calls/ complaints were investigated within the required 10-day timeline and acted upon and/or reported, accordingly.

[15] Md. Code Ann., Ins. § 31-119(b)(1).

Enforcement standards were established through the Code of Conduct, as well as various fraud, waste, and abuse compliance and human resource-related policies and procedures. Should potential areas of fraud, waste, or abuse be identified, the Chief Compliance Office would investigate the issue, mitigate further risk through the development of corrective action plans and/or disciplinary action, and oversee ongoing implementation of corrective actions to ensure actions have their desired effect.

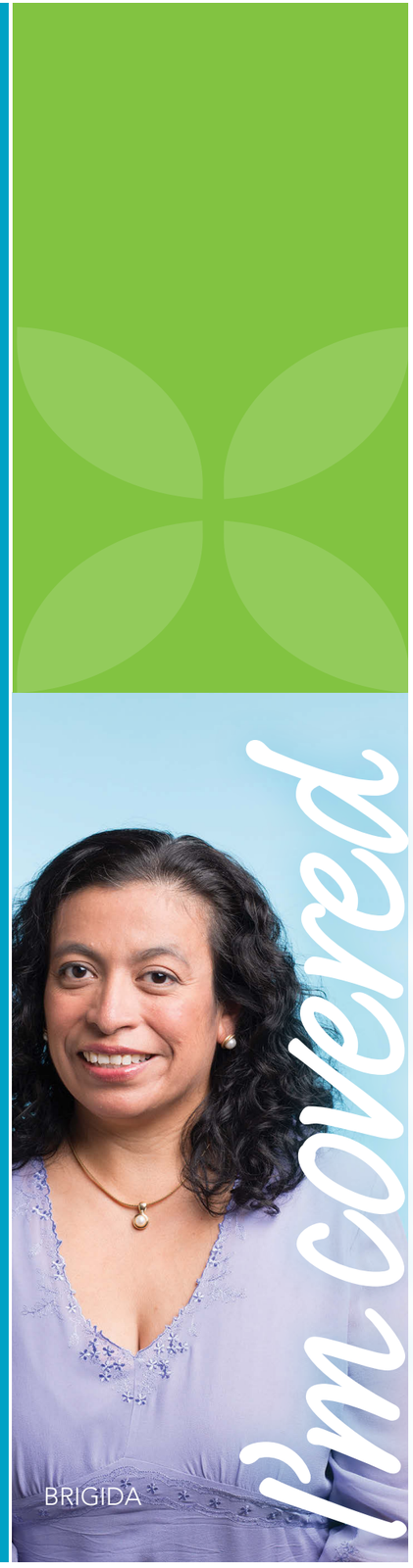
The MHBE also undertook various reporting and quality improvement activities, including reviewing eligibility and enrollment metrics and call center statistics related to volume, customer satisfaction, and turn-around times, and providing oversight and monitoring of privacy and security standards to ensure compliance with federal tax information, confidentiality, and ACA requirements. Quality improvements included the introduction of new, non-exchange entity privacy and security agreements, and the incorporation of Internal Revenue Service safeguard language into applicable contracts. The MHBE has also begun a review and enhancement of procurement and contract monitoring processes to promote transparency and consistency across all agency functions and contracts.

6 Early Successes for 2015 and Future Challenges

With the successful launch of the upgraded MHC website on November 15, 2014, for the second open enrollment period, more than 25,000 individuals enrolled into coverage as of November 24, 2014. This figure included 14,749 individuals who enrolled in a QHP, and 11,031 individuals who enrolled in Medicaid. Significant challenges lie ahead for the Maryland health insurance marketplace. Perhaps foremost among them is targeting assistance, outreach, and communications to rural areas of the state where lack of health insurance is most prevalent, as depicted in the maps in Exhibit J. For example, while the Lower Eastern Shore includes some of the highest rates of uninsured in Maryland, enrollment in the Lower Eastern Shore counties in the first year was 1 percent or less of the total state enrollment. This gap needs to be addressed.

Conclusion

The wide variety of affordable plans offered through MHC is a critical component of its long term success. With the financial assistance also available through MHC, many more Marylanders can now afford to select among different affordable options that meet their unique needs. During year one of operations, nearly 458,000 Marylanders enrolled into health coverage through MHC. MHC also has a robust Connector Entity program and a productive partnership with the insurance broker community, both of which assisted many individuals in gaining health care coverage during year one. The new online system, and on-going work in the areas of plan management, consumer assistance, finance, marketing and outreach, and compliance, ensure that as the program matures, it will continue to work effectively toward the goal of providing access to high-quality and affordable health-care coverage to all Marylanders.



Exhibits

Exhibit A 2014 Rate Review

MARYLAND INSURANCE ADMINISTRATION
2014 HEALTH INSURANCE PREMIUM RATE DECISION
NON-GRANDFATHERED PLAN

Insurer and Filing Information

Company Name	All Savers Insurance Company	Company NAIC#	82406
Product Name	Individual MHBE PPO Plan	SERFF #	AMMS-128944485
Type of Insurance	Medical	Rate Filing Date	March 28, 2013
Market Segment	Individual	Rate Decision Date	July 26, 2013
Product ID #	36677MD002 36677MD003 36677MD004 36677MD005 36677MD006 36677MD007 36677MD008 36677MD009	Rate Effective Date	January 1, 2014

Requested and Approved Average Premium Rates

Requested Average Premium Rate	$478.48	Approximate Number of Maryland Policyholders Enrolled in a Similar Product Currently Offered by the Company	Company has no current policyholders in the Maryland individual market
Approved Average Premium Rate	$323.20	Estimated Difference Between the Company's Current Average Premium Rate and the Approved Average Premium Rate**	N/A
Difference Between Requested and Approved Average Premium Rates*	-33%		

The difference is rounded to the nearest full percentage point.
****This estimate reflects the difference between the Company's approved average premium rate, per member, per month (PMPM) for non-grandfathered plans in the individual market in 2014 as compared with its existing average premium rate PMPM for non-grandfathered plans in the individual market. The estimate involves assumptions about which plans current policyholders will choose for 2014.***

These rate figures are averages. Your own premium rate may be higher or lower, depending upon your age, whether you use tobacco, where you live, and cost-sharing under your plan.

Rate Review Standards and Considerations

The Insurance Commissioner approves health insurance rates in Maryland. Under Maryland law, rates may not be inadequate, unfairly discriminatory or excessive in relation to benefits. Each rate filing is reviewed on its own merits. The Commissioner's rate decisions must be based on statistical analysis and reasonable assumptions. To assist the Commissioner in making these decisions, Maryland Insurance Administration (MIA) actuaries examine the data, methods, and assumptions used by each insurance company. They review numerous factors related to proposed premium rates, including the company's actual and projected claims experience, medical and prescription costs, administrative costs, and profits or losses. The Commissioner also considers the impact premium rates will have on Maryland consumers. Under the federal Patient Protection and Affordable Care Act and Maryland law, in the individual and small group markets, 80 cents of every premium dollar must be spent on paying claims or on quality improvement activities; that figure increases to 85 cents in the large group market. If an insurance carrier does not meet these targets, the carrier must pay rebates to policyholders.

Modifications to Requested Rates and Reasons for Those Modifications

Some of the data provided by the Company and some of the Company's assumptions did not support the originally proposed premium rates.

In response to MIA inquiries during the course of the rate review process, All Savers reduced its requested average premium rates by 16.5%. This 16.5% was achieved by a combination of the following three factors:

- Reducing the "morbidity factor" used to account for the anticipated health of enrollees in its individual market products in 2014 from 25% to 12.5%;
- Increasing the loss ratio target, net of reinsurance, from 74.3% to 78.0%; and
- Reducing administrative expenses from 12.5% to 6.5%.

All Savers' original rate filing included an Exchange fee of 3.5% of premium. When questioned about this, All Savers eliminated this Exchange fee and replaced it with a 3.5% commission rate.

The Commissioner required further modifications of certain assumptions used by the Company in developing it proposed rates as follows.

- All Savers' initial individual rate filing, as filed on March 28, 2013, was based upon Maryland small group experience as filed on April 5, 2013 under SERFF UHLC-128948506. On May 8, 2013, All Savers reduced its rates in that small group filing by 15.6%. Therefore, All Savers' requested average premium rate for the individual market was reduced by an additional 15.6%.
- All Savers used an overall annual trend figure of 9% in developing its rates. This figure included a 1% "margin". Trend is inherently an estimate and inclusion of a "margin" in trend is not appropriate. Therefore, the 1% margin in trend for 2 years was removed. This reduced the average premium rate by an additional 2%.
- The Commissioner required a further reduction in the morbidity factor from 12.5% to 10%.

The Company further modified its proposed rates accordingly.

The Company's approved average premium rate, as modified during the rate review process, is approximately 33% less than the average premium rate as filed.

Final Determination

Pursuant to § 11-603(c)(2) of the Insurance Article, Annotated Code of Maryland, the Company's requested premium rates, as modified during the rate review process, are not inadequate, unfairly discriminatory, or excessive in relation to benefits.

MARYLAND INSURANCE ADMINISTRATION
2014 HEALTH INSURANCE PREMIUM RATE DECISION
NON-GRANDFATHERED PLAN

Insurer and Filing Information

Company Name	CareFirst BlueChoice, Inc.	Company NAIC#	96202
Product Name	BlueChoice Plus; BlueChoice HMO; HealthyBlue	SERFF #	CFBC-128965637; CFBC-128965510; CFBC-128965654
Type of Insurance	Medical	Rate Filing Date	April 1, 2013
Market Segment	Individual	Rate Decision Date	July 26, 2013
Product ID #	28137MD037 28137MD038 28137MD039 28137MD040	Rate Effective Date	January 1, 2014

Requested and Approved Average Premium Rates

Average Premium Rate Requested by the Company	$217.67	Approximate Number of Maryland Policyholders Enrolled in a Similar Product Currently Offered by the Company	10,530
Average Premium Rate Approved by the MIA	$193.42	Estimated Difference Between the Company's Current Average Premium Rate and the Approved Average Premium Rate**	11.3%
Difference Between Requested and Approved Average Premium Rates*	-11%		

The difference is rounded to the nearest full percentage point.
****This estimate reflects the difference between the Company's approved average premium rate, per member, per month (PMPM) for non-grandfathered plans in the individual market in 2014 as compared with its existing average premium rate PMPM for non-grandfathered plans in the individual market. The estimate involves assumptions about which plans current policyholders will choose for 2014.***

These rate figures are averages. Your own premium rate may be higher or lower, depending upon your age, whether you use tobacco, where you live, and cost-sharing under your plan.

Rate Review Standards and Considerations

The Insurance Commissioner approves health insurance rates in Maryland. Under Maryland law, rates may not be inadequate, unfairly discriminatory or excessive in relation to benefits. Each rate filing is reviewed on its own merits. The Commissioner's rate decisions must be based on statistical analysis and reasonable assumptions. To assist the Commissioner in making these decisions, Maryland Insurance Administration (MIA) actuaries examine the data, methods, and assumptions used by each insurance company. They review numerous factors related to proposed premium rates, including the company's actual and projected claims experience, medical and prescription costs, administrative costs, and profits

or losses. The Commissioner also considers the impact premium rates will have on Maryland consumers. Under the federal Patient Protection and Affordable Care Act and Maryland law, in the individual and small group markets, 80 cents of every premium dollar must be spent on paying claims or on quality improvement activities; that figure increases to 85 cents in the large group market. If an insurance carrier does not meet these targets, the carrier must pay rebates to policyholders.

Modifications to Requested Rates and Reasons for Those Modifications

Some of the data provided by the Company and some of the Company's assumptions did not support the originally proposed premium rates.

The MIA objected to the Company's original model of its anticipated membership in the 2014 individual market because the Company did not allocate the cost of out-of-network benefits for certain contracts to the companies providing those benefits. The Company modified its proposed rates in response to this objection. Those changes resulted in a 0.9% reduction in the proposed average premium rate.

During the course of the rate review process, the Company proposed additional modifications to the originally proposed premium rates as follows. The Company:

- updated its claims experience with more recent data (resulting in a 0.1% decrease);
- changed its reinsurance recovery request to be consistent with a federal estimate (resulting in a 6.2% decrease);
- corrected its age normalization calculation (resulting in a 3.1% increase);
- removed tobacco rating factors (resulting in a 3.6% increase);
- made an adjustment to its estimated cost of enhanced mental health and substance abuse benefits (resulting in a 0.5% decrease);
- updated its cost for vision benefits to reflect a new contract (resulting in a 0.1% increase); and
- decreased the charge for abortion services to comply with the federal minimum (resulting in a 0.1% increase).

The total effect of these changes was a 0.3% decrease in the proposed average premium rate.

Additionally, the Company corrected calculation errors in the average premium rate contained in its initial filing. This resulted in an additional 10.2% decrease to the average premium rate.

The average premium rate, as corrected by the Company and as modified during the rate review process, decreased by approximately 11% from the average premium rate as proposed in the Company's filing.

Final Determination

Pursuant to § 11-603(c)(2) of the Insurance Article, Annotated Code of Maryland, the Company's requested premium rates, as corrected by the Company and as modified by the Company during the rate review process, are not inadequate, unfairly discriminatory, or excessive in relation to benefits.

MARYLAND INSURANCE ADMINISTRATION
2014 HEALTH INSURANCE PREMIUM RATE DECISION
NON-GRANDFATHERED PLAN

Insurance Company and Filing Information

Company Name	CareFirst of Maryland, Inc.	Company NAIC#	47058
Product Name	BluePreferred Multistate PPO	SERFF #	CFBC-128966539
Type of Insurance	Medical	Rate Filing Date	April 1, 2013
Market Segment	Individual	Rate Decision Date	July 26, 2013
Product ID #	45532MD023 45532MD029	Rate Effective Date	January 1, 2014

Requested and Approved Average Premium Rate

Average Premium Rate Requested by the Company	$252.31	Approximate Number of Maryland Policyholders Enrolled in a Similar Product Currently Offered by the Company	11,164
Average Premium Rate Approved by the MIA	$222.56	Estimated Difference Between the Company's Current Average Premium Rate and the Approved Average Premium Rate**	15.4%
Difference Between Requested and Approved Average Premium Rates*	-12%		

The difference is rounded to the nearest full percentage point.
This estimate reflects the difference between the Company's approved average premium rate, per member, per month (PMPM) for non-grandfathered plans in the individual market in 2014 as compared with its existing average premium rate PMPM for non-grandfathered plans in the individual market. The estimate involves assumptions about which plans current policyholders will choose for 2014.

These rate figures are averages. Your own premium rate may be higher or lower, depending upon your age, whether you use tobacco, where you live, and cost-sharing under your plan.

Rate Review Standards and Considerations

The Insurance Commissioner approves health insurance rates in Maryland. Under Maryland law, rates may not be inadequate, unfairly discriminatory or excessive in relation to benefits. Each rate filing is reviewed on its own merits. The Commissioner's rate decisions must be based on statistical analysis and reasonable assumptions. To assist the Commissioner in making these decisions, Maryland Insurance Administration (MIA) actuaries examine the data, methods, and assumptions used by each insurance company. They review numerous factors related to proposed premium rates, including the company's actual and projected claims experience, medical and prescription costs, administrative costs, and profits or losses. The Commissioner also considers the impact premium rates will have on Maryland consumers. Under the federal Patient Protection and Affordable Care Act and Maryland law, in the individual and small group markets, 80 cents of every premium dollar must be spent on paying claims or on quality improvement activities; that figure increases to 85 cents in the large group market. If an insurance carrier does not meet these targets, the carrier must pay rebates to policyholders.

Modifications to Requested Rates and Reasons for Those Modifications

Some of the data provided by the Company and some of the Company's assumptions did not support the originally proposed premium rates.

The MIA objected to the Company's original model of its anticipated membership in the 2014 individual market because: (a) the Company used an unreasonable assumption about the number of policyholders who will move from a Preferred Provider Organization (PPO) to a Health Maintenance Organization (HMO); and (b) the Company did not allocate the cost of out-of-network benefits for certain contracts to the companies providing those benefits. The Company modified its proposed rates in response to these objections. Those changes resulted in a 4.7% reduction to the proposed average premium rate, consisting of 4.5% because of (a) and 0.2% because of (b).

During the course of the rate review process, the Company proposed additional modifications to the originally proposed premium rates as follows. The Company:

- updated its claims experience with more recent data (resulting in a 0.8% decrease to the average premium rate);
- changed its reinsurance recovery request to be consistent with a federal estimate (resulting in a 6.2% decrease to the average premium rate);
- corrected its age normalization calculation (resulting in a 3.1% increase to the average premium rate);
- removed tobacco rating factors (resulting in a 3.6% increase to the average premium rate);
- made an adjustment to its estimated cost of enhanced mental health and substance abuse benefits (resulting in a 0.5% decrease to the average premium rate);
- updated its cost for vision benefits to reflect a new contract (resulting in a 0.1% increase to the average premium rate); and
- increased the charge for abortion services to comply with the federal minimum (resulting in a 0.1% increase to the average premium rate).

The effect of these changes was a net 1.0% decrease in the proposed average premium rate.

Additionally, the Company corrected calculation errors in the average premium rate contained in its initial filing. This resulted in an additional 6.5% decrease to the average premium rate. The average premium rate, as corrected by the Company and as modified during the rate review process, decreased by approximately 12% from the average premium rate as proposed in the Company's filing.

The company removed elective abortion coverage from the multistate product. The result was a 0.5% rate decrease. That rate decrease is not reflected in the tabulated figures because those are based on Essential Health Benefits, which do not include abortion coverage.

Final Determination

Pursuant to § 11-603(c)(2) of the Insurance Article, Annotated Code of Maryland, the Company's requested premium rates, as corrected by the Company and as modified by the Company during the rate review process, are not inadequate, unfairly discriminatory, or excessive in relation to benefits.

MARYLAND INSURANCE ADMINISTRATION
2014 HEALTH INSURANCE PREMIUM RATE DECISION
NON-GRANDFATHERED PLAN

Insurance Company and Filing Information

Company Name	CareFirst of Maryland, Inc.	Company NAIC#	47058
Product Name	BluePreferred PPO	SERFF #	CFBC-128965513
Type of Insurance	Medical	Rate Filing Date	April 1, 2013
Market Segment	Individual	Rate Decision Date	July 26, 2013
Product ID #	45532MD025 45532MD026	Rate Effective Date	January 1, 2014

Requested and Approved Average Premium Rate

Average Premium Rate Requested by the Company	$252.31	Approximate Number of Maryland Policyholders Enrolled in a Similar Product Currently Offered by the Company	11,164
Average Premium Rate Approved by the MIA	$222.56	Estimated Difference Between the Company's Current Average Premium Rate and the Approved Average Premium Rate**	15.4%
Difference Between Requested and Approved Average Premium Rates*	-12%		

The difference is rounded to the nearest full percentage point.
****This estimate reflects the difference between the Company's approved average premium rate, per member, per month (PMPM) for non-grandfathered plans in the individual market in 2014 as compared with its existing average premium rate PMPM for non-grandfathered plans in the individual market. The estimate involves assumptions about which plans current policyholders will choose for 2014.***

These rate figures are averages. Your own premium rate may be higher or lower, depending upon your age, whether you use tobacco, where you live, and cost-sharing under your plan.

Rate Review Standards and Considerations

The Insurance Commissioner approves health insurance rates in Maryland. Under Maryland law, rates may not be inadequate, unfairly discriminatory or excessive in relation to benefits. Each rate filing is reviewed on its own merits. The Commissioner's rate decisions must be based on statistical analysis and reasonable assumptions. To assist the Commissioner in making these decisions, Maryland Insurance Administration (MIA) actuaries examine the data, methods, and assumptions used by each insurance company. They review numerous factors related to proposed premium rates, including the company's actual and projected claims experience, medical and prescription costs, administrative costs, and profits or losses. The Commissioner also considers the impact premium rates will have on Maryland consumers. Under the federal Patient Protection and Affordable Care Act and Maryland law, in the individual and small group markets, 80 cents of every premium dollar must be spent on paying claims or on quality improvement activities; that figure increases to 85 cents in the large group market. If an insurance carrier does not meet these targets, the carrier must pay rebates to policyholders.

Modifications to Requested Rates and Reasons for Those Modifications

Some of the data provided by the Company and some of the Company's assumptions did not support the originally proposed premium rates.

The MIA objected to the Company's original model of its anticipated membership in the 2014 individual market because: (a) the Company used an unreasonable assumption about the number of policyholders who will move from a Preferred Provider Organization (PPO) to a Health Maintenance Organization (HMO); and (b) the Company did not allocate the cost of out-of-network benefits for certain contracts to the companies providing those benefits. The Company modified its proposed rates in response to these objections. Those changes resulted in a 4.7% reduction to the proposed average premium rate, consisting of 4.5% because of (a) and 0.2% because of (b).

During the course of the rate review process, the Company proposed additional modifications to the originally proposed premium rates as follows. The Company:

- updated its claims experience with more recent data (resulting in a 0.8% decrease to the average premium rate);
- changed its reinsurance recovery request to be consistent with a federal estimate (resulting in a 6.2% decrease to the average premium rate);
- corrected its age normalization calculation (resulting in a 3.1% increase to the average premium rate);
- removed tobacco rating factors (resulting in a 3.6% increase to the average premium rate);
- made an adjustment to its estimated cost of enhanced mental health and substance abuse benefits (resulting in a 0.5% decrease to the average premium rate);
- updated its cost for vision benefits to reflect a new contract (resulting in a 0.1% increase to the average premium rate); and
- increased the charge for abortion services to comply with the federal minimum (resulting in a 0.1% increase to the average premium rate).

The effect of these changes was a net 1.0% decrease in the proposed average premium rate.

Additionally, the Company corrected calculation errors in the average premium rate contained in its initial filing. This resulted in an additional 6.5% decrease to the average premium rate. The average premium rate, as corrected by the Company and as modified during the rate review process, decreased by approximately 12% from the average premium rate as proposed in the Company's filing.

Final Determination

Pursuant to § 11-603(c)(2) of the Insurance Article, Annotated Code of Maryland, the Company's requested premium rates, as corrected by the Company and as modified by the Company during the rate review process, are not inadequate, unfairly discriminatory, or excessive in relation to benefits.

MARYLAND INSURANCE ADMINISTRATION
2014 HEALTH INSURANCE PREMIUM RATE DECISION
NON-GRANDFATHERED PLAN

Insurance Company and Filing Information

Company Name	Evergreen Health Cooperative, Inc.	Company NAIC#	None (HIOS Issuer ID 72564)
Product Name	Evergreen Health Individual	SERFF #	EGHC-128964708
Market Segment	Individual	Rate Filing Date	March 30, 2013
Type of Insurance	Medical	Rate Decision Date	July 26, 2013
Product ID #	72564MD0010001 72564MD0010003 72564MD0030001 72564MD0030003 72564MD0010002 72564MD0010007 72564MD0030002 72564MD0030007 72564MD0030011	Rate Effective Date	January 1, 2014

Requested and Approved Average Premium Rates

Average Premium Rate Requested by the Company	$351.49	Approximate Number of Maryland Policyholders Enrolled in a Similar Product Currently Offered by the Company	Company has no current policyholders in the Maryland individual market
Average Premium Rate Approved by the MIA	$307.89	Estimated Difference Between the Company's Current Average Premium Rate and the Approved Average Premium Rate**	0
Difference Between Requested and Approved Average Premium Rates*	-12%		

The difference is rounded to the nearest full percentage point.
****This estimate reflects the difference between the Company's approved average premium rate, per member, per month (PMPM) for non-grandfathered plans in the individual market in 2014 as compared with its existing average premium rate PMPM for non-grandfathered plans in the individual market. The estimate involves assumptions about which plans current policyholders will choose for 2014.***

These rate figures are averages. Your own premium rate may be higher or lower, depending upon your age, whether you use tobacco, where you live, and cost-sharing under your plan.

Rate Review Standards and Considerations

The Insurance Commissioner approves health insurance rates in Maryland. Under Maryland law, rates may not be inadequate, unfairly discriminatory or excessive in relation to benefits. Each rate filing is reviewed on its own merits. The Commissioner's rate decisions must be based on statistical analysis and reasonable assumptions. To assist the Commissioner in making these decisions, Maryland Insurance Administration (MIA) actuaries examine the data, methods, and assumptions used by each insurance company. They review numerous factors related to proposed premium rates, including the company's actual and projected claims experience, medical and prescription costs, administrative costs, and profits or losses. The Commissioner also considers the impact premium rates will have on Maryland consumers. Under the federal Patient Protection and Affordable Care Act and Maryland law, in the individual and small group markets, 80 cents of every premium dollar must be spent on paying claims or on quality improvement activities; that figure increases to 85 cents in the large group market. If an insurance carrier does not meet these targets, the carrier must pay rebates to policyholders.

Modifications to Requested Rates and Reasons for Those Modifications

Some of the data provided by the Company and some of the Company's assumptions did not support the originally proposed premium rates.

In response to the MIA's inquiries during the course of the rate review process, the Company proposed a modified premium rate that reduced the originally proposed premium rates as follows:

- Reinsurance Recovery Assumptions – The Company assumed an unreasonably low reinsurance reimbursement payment for reinsurance claims of 80% of the amount between $60,000 and $250,000. The Company's original figure of $8.00 PMPM was only 2% of claims cost. The Company agreed to increase the reinsurance payment to $28.00 PMPM. This modification results in an 8% decrease in Evergreen's average premium rate.
- Assumptions about the Anticipated Health of the Population - The Company modified its projections regarding the anticipated health of enrollees in its individual market products in 2014, which resulted in a reduction of approximately 3.4% in its average premium rate.
- Adjustment to Risk Adjustment, Profit, and Administrative Expense – Changes related to the expected claims cost described above resulted in a change to the risk adjustment, profit, and administrative expense amounts resulting in a 1% decrease to Evergreen's average premium rate.

The Company's approved average premium rate, as modified during the rate review process, is approximately 12% less than the average premium rate as filed.

Final Determination

Pursuant to § 11-603(c)(2) of the Insurance Article, Annotated Code of Maryland, the Company's requested premium rates, as modified by the Company during the rate review process, are not inadequate, unfairly discriminatory, or excessive in relation to benefits.

MARYLAND INSURANCE ADMINISTRATION
2014 HEALTH INSURANCE PREMIUM RATE DECISION
NON-GRANDFATHERED PLAN

Insurance Company and Filing Information

Company Name	Group Hospitalization and Medical	Company NAIC#	47058
Product Name	BluePreferred PPO	SERFF #	CFBC-128965516
Type of Insurance	Medical	Rate Filing Date	April 1, 2013
Market Segment	Individual	Rate Decision Date	July 26, 2013
Product ID #	45532MD025 45532MD026	Rate Effective Date	January 1, 2014

Requested and Approved Average Premium Rate

Average Premium Rate Requested by the Company	$252.31	Approximate Number of Maryland Policyholders Enrolled in a Similar Product Currently Offered by the Company	11,164
Average Premium Rate Approved by the MIA	$222.56	Estimated Difference Between the Company's Current Average Premium Rate and the Approved Average Premium Rate**	12.1%
Difference Between Requested and Approved Average Premium Rates*	-12%		

The difference is rounded to the nearest full percentage point.
This estimate reflects the difference between the Company's approved average premium rate, per member, per month (PMPM) for non-grandfathered plans in the individual market in 2014 as compared with its existing average premium rate PMPM for non-grandfathered plans in the individual market. The estimate involves assumptions about which plans current policyholders will choose for 2014.

These rate figures are averages. Your own premium rate may be higher or lower, depending upon your age, whether you use tobacco, where you live, and cost-sharing under your plan.

Rate Review Standards and Considerations

The Insurance Commissioner approves health insurance rates in Maryland. Under Maryland law, rates may not be inadequate, unfairly discriminatory or excessive in relation to benefits. Each rate filing is reviewed on its own merits. The Commissioner's rate decisions must be based on statistical analysis and reasonable assumptions. To assist the Commissioner in making these decisions, Maryland Insurance Administration (MIA) actuaries examine the data, methods, and assumptions used by each insurance company. They review numerous factors related to proposed premium rates, including the company's actual and projected claims experience, medical and prescription costs, administrative costs, and profits or losses. The Commissioner also considers the impact premium rates will have on Maryland consumers. Under the federal Patient Protection and Affordable Care Act and Maryland law, in the individual and small group markets, 80 cents of every premium dollar must be spent on paying claims or

on quality improvement activities; that figure increases to 85 cents in the large group market. If an insurance carrier does not meet these targets, the carrier must pay rebates to policyholders.

Modifications to Requested Rates and Reasons for Those Modifications

Some of the data provided by the Company and some of the Company's assumptions did not support the originally proposed premium rates.

The MIA objected to the Company's original model of its anticipated membership in the 2014 individual market because: (a) the Company used an unreasonable assumption about the number of policyholders who will move from a Preferred Provider Organization (PPO) to a Health Maintenance Organization (HMO); and (b) the Company did not allocate the cost of out-of-network benefits for certain contracts to the companies providing those benefits. The Company modified its proposed rates in response to these objections. Those changes resulted in an average premium rate reduction of 4.7%, consisting of 4.5% because of (a) and 0.2% because of (b).

During the course of the rate review process, the Company proposed additional modifications to the originally proposed premium rates as follows. The Company:

- updated its claims experience with more recent data (resulting in a 0.8% decrease to the average premium rate);
- changed its reinsurance recovery request to be consistent with a federal estimate (resulting in a 6.2% decrease to the average premium rate);
- corrected its age normalization calculation (resulting in a 3.1% increase to the average premium rate);
- removed tobacco rating factors (resulting in a 3.6% increase to the average premium rate);
- made an adjustment to its estimated cost of enhanced mental health and substance abuse benefits (resulting in a 0.5% decrease to the average premium rate);
- updated its cost for vision benefits to reflect a new contract (resulting in a 0.1% increase to the average premium rate); and
- increased the charge for abortion services to comply with the federal minimum (resulting in a 0.1% increase to the average premium rate).

The effect of these changes was a net 1.0% decrease in the proposed average premium rate.

Additionally, the Company corrected calculation errors in the average premium rate contained in its initial filing. This resulted in an additional 6.5% decrease to the average premium rate. The average premium rate, as corrected by the Company and as modified during the rate review process, decreased by approximately 12% from the average premium rate as proposed in the Company's filing.

Final Determination

Pursuant to § 11-603(c)(2) of the Insurance Article, Annotated Code of Maryland, the Company's requested premium rates, as corrected by the Company and as modified by the Company during the rate review process, are not inadequate, unfairly discriminatory, or excessive in relation to benefits

MARYLAND INSURANCE ADMINISTRATION
2014 HEALTH INSURANCE PREMIUM RATE DECISION
NON-GRANDFATHERED PLANS

Insurance Company and Filing Information

Company Name	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	Company NAIC#	95639
Product Name	Individual Health Organization – Health Maintenance (HMO)	SERFF #	KPMA-128967538
Type of Insurance	Medical	Rate Filing Date	April 1, 2013
Market Segment	Individual	Rate Decision Date Amended Decision Date	July 26, 2013 August 29, 2013
Product ID #	90296MD001001 90296MD001002	Rate Effective Date	January 1, 2014

Requested and Approved Average Premium Rates

Average Premium Rate Requested by the Company	$336.33*	Approximate Number of Maryland Policyholders Enrolled in a Similar Product Currently Offered by the Company	3,787
Average Premium Rate Approved by the MIA	$332.97	Estimated Difference Between the Company's Existing Average Premium Rate and the Approved Average Premium Rate**	-0.9%
Difference Between Requested and Approved Average Premium Rates	-1%		

In its original rate filing, the Company requested an average premium rate per member per month (PMPM) of $331.09. As explained more fully below, the Company subsequently made certain amendments to the products it filed for approval, along with corresponding changes to its requested rates.
****This estimate reflects the difference between the Company's approved average premium rate PMPM for non-grandfathered plans in the individual market in 2014 as compared with its existing average premium rate PMPM for non-grandfathered plans in the individual market. The estimate involves assumptions about which plans current policyholders will choose for 2014.***

These rate figures are averages. Your own premium rate may be higher or lower, depending upon your age, whether you use tobacco, where you live, and cost-sharing under your plan.

Rate Review Standards and Considerations

The Insurance Commissioner approves health insurance rates in Maryland. Under Maryland law, rates may not be inadequate, unfairly discriminatory or excessive in relation to benefits. Each rate filing is reviewed on its own merits. The Commissioner's rate decisions must be based on statistical analysis and reasonable assumptions. To assist the Commissioner in making these decisions, Maryland Insurance Administration (MIA) actuaries examine the data, methods, and assumptions used by each insurance company. They review numerous factors related to proposed premium rates, including the company's

actual and projected claims experience, medical and prescription costs, administrative costs, and profits or losses. The Commissioner also considers the impact premium rates will have on Maryland consumers. Under the federal Patient Protection and Affordable Care Act and Maryland law, in the individual and small group markets, 80 cents of every premium dollar must be spent on paying claims or on quality improvement activities; that figure increases to 85 cents in the large group market. If an insurance carrier does not meet these targets, the carrier must pay rebates to policyholders.

Modifications to Requested Rates and Reasons for Those Modifications

The Company made certain amendments to the products it filed for approval, along with corresponding changes in its requested rates. Specifically, the Company requested, and the MIA approved, reopening its rate and form filings to embed pediatric dental in its on-Exchange health benefit plans for the individual market, consistent with amendments to its off-Exchange filings for the individual market in accordance with Affordable Care Act requirements. The amendments resulted in an increase of 2% to the proposed average premium rate per member per month (PMPM).

Generally, the data provided by the Company and the Company's assumptions supported the proposed premium rates.

However, during the course of the rate review process, the MIA determined that the Company had used an unreasonably high 10% pent-up demand factor for currently uninsured individuals who are projected to become Kaiser Foundation individual market members in 2014. The MIA required that the pent-up demand factor be reduced to 5%. The effect of this rate modification is an approximately 1% reduction to the average premium rate as filed by the Company.

Final Determination

Pursuant to § 11-603)c)(2) of the Insurance Article, Annotated Code of Maryland, the Company's requested premium rates, as amended to accommodate changes in its individual market products, and as modified by the Company during the rate review process, are not inadequate, unfairly discriminatory, or excessive in relation to benefits.

Exhibit B 2015 Rate Review

MARYLAND INSURANCE ADMINISTRATION
2015 HEALTH INSURANCE PREMIUM RATE DECISION

Company and Filing Information

Company Name	All Savers Insurance Company	Company NAIC#	82406
Product Name	PPO (Copay Select, HSA, and Select Saver)	SERFF Filing #	AMMS-129516324; AMMS-129533717
Type of Insurance	Major Medical	Rate Filing Date	May 1, 2014; May 27, 2014
Market Segment	Individual	Rate Decision Date	August 22, 2014
Product ID #	36677MD002	Rate Effective Date	January 1, 2015

Requested and Approved Changes in Premium Rates

Average Year-Over-Year Rate Change Requested (rounded to nearest 0.1%)	+4.8%
Average Year-Over-Year Rate Change Approved (rounded to nearest 0.1%)	-6.7%
Estimated Number of Maryland Members Currently Enrolled in Product(s)	186

Sample Premiums

The chart below shows only a sample of requested and approved premiums for the Company's catastrophic and lowest-priced bronze, silver, and gold plans for one person, before any financial assistance for which the person may be eligible. (The Company is not offering any platinum level plans.) Your rates may vary depending on your age, the part of the State in which you live, your family composition, and the plan you choose.

	Plan Level	Monthly Premium Requested	Monthly Premium Approved
Age 21 Baltimore Metro Area	Catastrophic	$228.01	$203.01
	Lowest-Priced Bronze	$249.39	$222.05
	Lowest-Priced Silver	$277.13	$246.75
	Lowest-Priced Gold	$346.78	$308.76
	Lowest-Priced Platinum	N/A	N/A
Age 40 Baltimore Metro Area	Lowest-Priced Bronze	$318.72	$283.78
	Lowest-Priced Silver	$354.17	$315.35
	Lowest-Priced Gold	$443.18	$394.60
	Lowest-Priced Platinum	N/A	N/A
Age 60 Baltimore Metro Area	Lowest-Priced Bronze	$676.84	$602.64
	Lowest-Priced Silver	$752.13	$669.68
	Lowest-Priced Gold	$941.16	$837.97
	Lowest-Priced Platinum	N/A	N/A

MARYLAND INSURANCE ADMINISTRATION
2015 HEALTH INSURANCE PREMIUM RATE DECISION

Company and Filing Information

Company Name	CareFirst BlueChoice, Inc.	Company NAIC#	96202
Product Name	BlueChoice BlueChoice HSA BlueChoice Plus HealthyBlue	SERFF Filing #	CFBC-129518298 (on Exchange) CFBC-129518301 (off Exchange)
Type of Insurance	HMO and POS	Rate Filing Date	May 1, 2014; May 23, 2014
Market Segment	Individual	Rate Decision Date	August 22, 2014
Product ID #	28137MD037 28137MD038 28137MD039 28137MD040	Rate Effective Date	January 1, 2015

Requested and Approved Changes in Premium Rates

Average Year-Over-Year Rate Change Requested (rounded to the nearest 0.1%)	+22.8%
Average Year-Over-Year Rate Change Approved (rounded to the nearest 0.1%)	+9.8%
Estimated Number of Maryland Members Currently Enrolled in Product(s)	74,708

Sample Premiums

The chart below shows only a sample of requested and approved premiums for the Company's catastrophic and lowest-priced bronze, silver, gold and platinum plans for one person, before any financial assistance for which the person may be eligible. Your rates may vary depending on your age, the part of the State in which you live, your family composition, and the plan you choose.

	Plan Level	Monthly Premium Requested	Monthly Premium Approved
Age 21 Baltimore Metro Area	Catastrophic	$127.00	$113.50
	Lowest-Priced Bronze	$144.78	$129.39
	Lowest-Priced Silver	$213.70	$190.97
	Lowest-Priced Gold	$260.13	$232.47
	Lowest-Priced Platinum	$353.80	$316.18
Age 40 Baltimore Metro Area	Lowest-Priced Bronze	$185.03	$165.36
	Lowest-Priced Silver	$273.10	$244.06
	Lowest-Priced Gold	$332.44	$297.10
	Lowest-Priced Platinum	$452.16	$404.08
Age 60 Baltimore Metro Area	Lowest-Priced Bronze	$392.94	$351.17
	Lowest-Priced Silver	$579.97	$518.29
	Lowest-Priced Gold	$705.98	$630.93
	Lowest-Priced Platinum	$960.22	$858.11

Rate Review Standards and Considerations

The Insurance Commissioner approves health insurance rates in Maryland. Under Maryland law, rates may not be inadequate, unfairly discriminatory, or excessive in relation to benefits. Each rate filing is reviewed on its own merits. The Commissioner's rate decisions must be based on statistical analysis and reasonable assumptions. To assist the Commissioner in making these decisions, Maryland Insurance Administration ("MIA") actuaries examine the data, methods and assumptions used by each insurer, non-profit health service plan, or HMO ("carrier"). They review numerous factors related to proposed premium rates, including the carrier's actual and projected claims experience, medical and prescription costs, administrative costs, and profits or losses. The Commissioner also considers the impact premium rates will have on Maryland consumers. Under the federal Affordable Care Act and Maryland law, in the individual and small group markets, 80 cents of every premium dollar must be spent on paying claims or on quality improvement activities; that figure increases to 85 cents in the large group market. If an insurance carrier does not meet these targets, the carrier must pay rebates to policyholders.

Modifications to Requested Premium Rates and Basis of Modifications

On May 1, 2014, All Savers Insurance Company ("All Savers") submitted SERFF filing #AMMS-129516324, requesting an average premium rate increase of 4.8%. That filing was rejected because it had failed to include required 2015 amendments to policy forms. On May 27, 2014, the Company submitted replacement filing #AMMS-129533717. In that filing, All Savers modified its rate change request to an average premium rate reduction of 2.2%. Unlike its May 1, 2014 filing, and in response to an earlier MIA objection, All Savers' revised filing took into account Maryland's supplemental reinsurance program. During the rate review process, All Savers also revised downward its assumption about morbidity in Maryland's individual market. The combined effect of both revisions was a downward adjustment of 11.0% in proposed rates, on average.

As modified during the rate review process, All Savers' final request is for an average 6.7% reduction in 2015 premium rates as compared with premium rates for 2014.

Final Determination

Pursuant to § 11-603(c)(2) of the Insurance Article, Annotated Code of Maryland, the Commissioner has determined that the Company's requested premium rates, as modified during the rate review process, are not inadequate, unfairly discriminatory, or excessive in relation to benefits.

Rate Review Standards and Considerations

The Insurance Commissioner approves health insurance rates in Maryland. Under Maryland law, rates may not be inadequate, unfairly discriminatory, or excessive in relation to benefits. Each rate filing is reviewed on its own merits. The Commissioner's rate decisions must be based on statistical analysis and reasonable assumptions. To assist the Commissioner in making these decisions, Maryland Insurance Administration ("MIA") actuaries examine the data, methods and assumptions used by each insurer, non-profit health service plan, or HMO ("carrier"). They review numerous factors related to proposed premium rates, including the carrier's actual and projected claims experience, medical and prescription costs, administrative costs, and profits or losses. The Commissioner also considers the impact premium rates will have on Maryland consumers. Under the federal Affordable Care Act and Maryland law, in the individual and small group markets, 80 cents of every premium dollar must be spent on paying claims or on quality improvement activities; that figure increases to 85 cents in the large group market. If an insurance carrier does not meet these targets, the carrier must pay rebates to policyholders.

Modifications to Requested Premium Rates and Basis of Modifications

CareFirst BlueChoice submitted a rate filing on May 1, 2014, requesting an average rate increase of 33.5%. On May 23, 2014, the Company amended its filing to request an average rate increase of 22.8%. The amended rate filing reflected certain minor adjustments in response to MIA objections, such as modifying its assumptions about projected average age and the projected cost and utilization of dental benefits. The most significant change, however, was a reduction in the Company's projections about the morbidity of its 2015 individual market enrollees as compared with the morbidity of its 2013 individual market enrollees. Specifically, in its amended filing, the Company assigned to its projected 2015 individual market enrollees a morbidity factor that was 1.60 times the morbidity of its 2013 individual market enrollees. In its May 1, 2014 filing, the Company had assumed a morbidity factor of 1.75. The MIA proceeded to review the amended May 23, 2014 filing.

The MIA concluded that certain of the Company's data, methods, and assumptions were not well supported, including certain assumptions about the projected morbidity of its individual product enrollees in 2015. In particular, the Company had not adequately supported its assumptions regarding the number of small group enrollees projected to migrate to its individual products, or its assumptions about the morbidity levels of previously uninsured enrollees. The MIA further concluded that the Company's actual experience during the first half of 2014, as well as other considerations relating to actual and projected enrollment in the 2014 and 2015 individual market, did not support a 1.60 morbidity factor. The Commissioner also concluded that the requested average premium rate increase of 22.8% would have an abrupt, substantial, and adverse impact on the approximately 74,708 Marylanders currently enrolled in CareFirst BlueChoice Affordable Care Act-compliant plans in the individual market, and would introduce a high level of volatility into Maryland's individual health insurance market.

The MIA prescribed a morbidity factor of 1.40, rather than the Company's requested morbidity factor of 1.60. This modification resulted in an approximately 10.6% reduction in the Company's proposed premium rates for 2015.

As modified during the rate review process, CareFirst BlueChoice's premium rates for 2015 reflect an approximately 9.8% increase as compared with its premium rates for 2014.

Final Determination

Pursuant to § 11-603(c)(2) of the Insurance Article, Annotated Code of Maryland, the Commissioner has determined that the Company's premium rates, as modified during the rate review process, are not inadequate, unfairly discriminatory, or excessive in relation to benefits.

MARYLAND INSURANCE ADMINISTRATION
2015 HEALTH INSURANCE PREMIUM RATE DECISION

Company and Filing Information

Company Name	CareFirst of Maryland, Inc.	Company NAIC#	47058
Product Name	BluePreferred HSA BluePreferred HSA Multi-State Plan BluePreferred Multi-State Plan BluePreferred	SERFF Filing #	CFBC-129518365 (on Exchange) CFBC-129518383 (off Exchange)
Type of Insurance	PPO	Rate Filing Date	May 1, 2014; May 23, 2014
Market Segment	Individual	Rate Decision Date	August 22, 2014
Product ID #	45532MD026 45532MD029 45532MD023 45532MD025	Rate Effective Date	January 1, 2015

Requested and Approved Changes in Premium Rates

Average Year-Over-Year Rate Change Requested (rounded to the nearest 0.1%)	+30.2%
Average Year-Over-Year Rate Change Approved (rounded to the nearest 0.1%)	+16.2%
Estimated Number of Maryland Members Currently Enrolled in Product(s)	20,179

Sample Premiums

The chart below shows only a sample of requested and approved premiums for the Company's lowest-priced bronze, silver, gold and platinum plans for one person, before any financial assistance for which the person may be eligible. (The Company is not offering a catastrophic plan.) Your rates may vary depending on your age, the part of the State in which you live, your family composition, and the plan you choose.

	Plan Level	Monthly Premium Requested	Monthly Premium Approved
Age 21 Baltimore Metro Area	Catastrophic	N/A	N/A
	Lowest-Priced Bronze	$193.40	$172.62
	Lowest-Priced Silver	$239.14	$213.43
	Lowest-Priced Gold	$317.22	$283.13
	Lowest-Priced Platinum	$388.87	$347.08
Age 40 Baltimore Metro Area	Lowest-Priced Bronze	$247.17	$220.61
	Lowest-Priced Silver	$305.62	$272.77
	Lowest-Priced Gold	$405.41	$361.84
	Lowest-Priced Platinum	$496.98	$443.56
Age 60 Baltimore Metro Area	Lowest-Priced Bronze	$524.90	$468.49
	Lowest-Priced Silver	$649.02	$579.26
	Lowest-Priced Gold	$860.94	$768.42
	Lowest-Priced Platinum	$1,055.39	$941.97

Rate Review Standards and Considerations

The Insurance Commissioner approves health insurance rates in Maryland. Under Maryland law, rates may not be inadequate, unfairly discriminatory, or excessive in relation to benefits. Each rate filing is reviewed on its own merits. The Commissioner's rate decisions must be based on statistical analysis and reasonable assumptions. To assist the Commissioner in making these decisions, Maryland Insurance Administration ("MIA") actuaries examine the data, methods and assumptions used by each insurer, non-profit health service plan, or HMO ("carrier"). They review numerous factors related to proposed premium rates, including the carrier's actual and projected claims experience, medical and prescription costs, administrative costs, and profits or losses. The Commissioner also considers the impact premium rates will have on Maryland consumers. Under the federal Affordable Care Act and Maryland law, in the individual and small group markets, 80 cents of every premium dollar must be spent on paying claims or on quality improvement activities; that figure increases to 85 cents in the large group market. If an insurance carrier does not meet these targets, the carrier must pay rebates to policyholders.

Modifications to Requested Premium Rates and Basis of Modifications

CareFirst of Maryland, Inc. submitted a rate filing on May 1, 2014, requesting an average rate increase of 38.1%. On May 23, 2014, the Company amended its filing to request an average rate increase of 30.2%. The amended rate filing reflected certain minor adjustments in response to MIA objections, such as modifying its assumptions about projected average age and the projected cost and utilization of dental benefits. The most significant change, however, was a reduction in the Company's projections about the morbidity of its 2015 individual market enrollees as compared with the morbidity of its 2013 individual market enrollees. Specifically, in its amended filing, the Company assigned to its projected 2015 individual market enrollees a morbidity factor that was 1.60 times the morbidity of its 2013 individual market enrollees. In its May 1, 2014 filing, the Company had assumed a morbidity factor of 1.75. The MIA proceeded to review the amended May 23, 2014 filing.

The MIA concluded that certain of the Company's data, methods, and assumptions were not well supported, including certain assumptions about the projected morbidity of its individual product enrollees in 2015. In particular, the Company had not adequately supported its assumptions regarding the number of small group enrollees projected to migrate to its individual products, or its assumptions about the morbidity levels of previously uninsured enrollees. The MIA further concluded that the Company's actual experience during the first half of 2014, as well as other considerations relating to actual and projected enrollment in the 2014 and 2015 individual market, did not support a 1.60 morbidity factor. The Commissioner also concluded that the requested average premium rate increase of 30.2% would have an abrupt, substantial, and adverse impact on the approximately 20,179 Marylanders currently enrolled in CareFirst of Maryland, Inc.'s Affordable Care Act-compliant plans in the individual market, and would introduce a high level of volatility into Maryland's individual health insurance market.

The MIA prescribed a morbidity factor of 1.40, rather than the Company's requested morbidity factor of 1.60. This modification resulted in an approximately 10.6% reduction in the Company's proposed premium rates for 2015.

As modified during the rate review process, CareFirst of Maryland, Inc.'s premium rates for 2015 reflect an approximately 16.2% increase as compared with its premium rates for 2014.

Final Determination

Pursuant to § 11-603(c)(2) of the Insurance Article, Annotated Code of Maryland, the Commissioner has determined that the Company's premium rates, as modified during the rate review process, are not inadequate, unfairly discriminatory, or excessive in relation to benefits.

MARYLAND INSURANCE ADMINISTRATION
2015 HEALTH INSURANCE PREMIUM RATE DECISION

Company and Filing Information

Company Name	Cigna Health and Life Insurance Company	Company NAIC#	67369
Product Name	MyCigna Health(PPO)	SERFF Filing #	CCGH-129494530
Type of Insurance	Medical	Rate Filing Date	May 1, 2014
Market Segment	Individual	Rate Decision Date	August 22, 2014
Product ID #	32812MD001	Rate Effective Date	January 1, 2015

Requested and Approved Changes in Premium Rates

Average Year-Over-Year Rate Change Requested	N/A (New Market Entrant)
Average Year-Over-Year Rate Change Approved	N/A (New Market Entrant)
Estimated Number of Maryland Members Currently Enrolled in Product(s)	N/A (New Market Entrant)

Sample Premiums

The chart below shows only a sample of requested and approved premiums for the Company's lowest-priced bronze, silver, and gold plans for one person, before any financial assistance for which the person may be eligible. (The Company is not offering any catastrophic or platinum level plans.) Your rates may vary depending on your age, the part of the State in which you live, your family composition, and the plan you choose.

	Plan Level	Monthly Premium Requested	Monthly Premium Approved
Age 21 Baltimore Metro Area	Catastrophic	N/A	N/A
	Lowest-Priced Bronze	$229.46	$221.93
	Lowest-Priced Silver	$275.14	$266.10
	Lowest-Priced Gold	$309.02	$298.87
	Lowest-Priced Platinum	N/A	N/A
Age 40 Baltimore Metro Area	Lowest-Priced Bronze	$293.25	$283.63
	Lowest-Priced Silver	$351.63	$340.08
	Lowest-Priced Gold	$394.93	$381.96
	Lowest-Priced Platinum	N/A	N/A
Age 60 Baltimore Metro Area	Lowest-Priced Bronze	$622.75	$602.32
	Lowest-Priced Silver	$746.73	$722.20
	Lowest-Priced Gold	$838.68	$811.13
	Lowest-Priced Platinum	N/A	N/A

MARYLAND INSURANCE ADMINISTRATION
2015 HEALTH INSURANCE PREMIUM RATE DECISION

Company and Filing Information

Company Name	Evergreen Health Cooperative	Company NAIC#	15090
Product Name	Evergreen Health HMO Evergreen Health POS	SERFF Filing #	EGHC-129498585 (on Exchange) EGHC-129515549 (off Exchange) EGHC-129520529 (on Exchange) EGHC-129520633 (off Exchange)
Type of Insurance	Major Medical	Rate Filing Date	April 30, 2014; May 6, 2014
Market Segment	Individual	Rate Decision Date	August 22, 2014
Product ID #	72564MD009 72564MD011	Rate Effective Date	January 1, 2015

Requested and Approved Changes in Premium Rates

Average Year-Over-Year Rate Change Requested (rounded to the nearest 0.1%)	-10.3%
Average Year-Over-Year Rate Change Approved (rounded to the nearest 0.1%)	-10.3%
Estimated Number of Maryland Members Currently Enrolled in Product(s)	415

Sample Premiums

The chart below shows only a sample of requested and approved premiums for the Company's catastrophic and lowest-priced bronze, silver, gold and platinum plans for one person, before any financial assistance for which the person may be eligible. Your rates may vary depending on your age, the part of the State in which you live, your family composition, and the plan you choose.

	Plan Level	Monthly Premium Requested	Monthly Premium Approved
Age 21 Baltimore Metro Area	Catastrophic	$115.84	$116.59
	Lowest-Priced Bronze	$141.17	$141.33
	Lowest-Priced Silver	$183.86	$183.84
	Lowest-Priced Gold	$216.45	$216.68
	Lowest-Priced Platinum	$266.83	$266.87
Age 40 Baltimore Metro Area	Lowest-Priced Bronze	$180.42	$180.62
	Lowest-Priced Silver	$234.98	$234.95
	Lowest-Priced Gold	$276.63	$276.92
	Lowest-Priced Platinum	$341.01	$341.06
Age 60 Baltimore Metro Area	Lowest-Priced Bronze	$383.14	$383.56
	Lowest-Priced Silver	$499.01	$498.94
	Lowest-Priced Gold	$587.45	$588.08
	Lowest-Priced Platinum	$724.18	$724.29

Rate Review Standards and Considerations

The Insurance Commissioner approves health insurance rates in Maryland. Under Maryland law, rates may not be inadequate, unfairly discriminatory, or excessive in relation to benefits. Each rate filing is reviewed on its own merits. The Commissioner's rate decisions must be based on statistical analysis and reasonable assumptions. To assist the Commissioner in making these decisions, Maryland Insurance Administration ("MIA") actuaries examine the data, methods and assumptions used by each insurer, non-profit health service plan, or HMO ("carrier"). They review numerous factors related to proposed premium rates, including the carrier's actual and projected claims experience, medical and prescription costs, administrative costs, and profits or losses. The Commissioner also considers the impact premium rates will have on Maryland consumers. Under the federal Affordable Care Act and Maryland law, in the individual and small group markets, 80 cents of every premium dollar must be spent on paying claims or on quality improvement activities; that figure increases to 85 cents in the large group market. If an insurance carrier does not meet these targets, the carrier must pay rebates to policyholders.

Modifications to Requested Premium Rates and Basis of Modifications

On May 1, 2014, Cigna Health and Life Insurance Company submitted SERFF filing # CCGH-129494530. In response to MIA objections, Cigna revised it proposed rates downward by approximately 3.3%, on average, taking into account (1) that Maryland does not charge an Exchange User Fee (-2.91%) and (2) hospital rates reflecting a projected reduction in uncompensated care (-.39%).

Final Determination

Pursuant to § 11-603(c)(2) of the Insurance Article, Annotated Code of Maryland, the Commissioner has determined that the Company's requested premium rates, as modified during the rate review process, are not inadequate, unfairly discriminatory, or excessive in relation to benefits.

MARYLAND INSURANCE ADMINISTRATION
2015 HEALTH INSURANCE PREMIUM RATE DECISION

Company and Filing Information

Company Name	Group Hospitalization and Medical Services, Inc.	Company NAIC#	53007
Product Name	BluePreferred HSA BluePreferred HSA Multi-State Plan BluePreferred Multi-State Plan BluePreferred	SERFF Filing #	CFBC-129518366 (on Exchange) CFBC-129518384 (off Exchange)
Type of Insurance	PPO	Rate Filing Date	May 1, 2014; May 23, 2014
Market Segment	Individual	Rate Decision Date	August 22, 2014
Product ID #	94084MD014 94084MD019 94084MD017 94084MD013	Rate Effective Date	January 1, 2015

Requested and Approved Changes in Premium Rates

Average Year-Over-Year Rate Change Requested (rounded to the nearest 0.1%)	+30.2%
Average Year-Over-Year Rate Change Approved (rounded to the nearest 0.1%)	+16.2%
Estimated Number of Maryland Members Currently Enrolled in Product(s)	12,714

Sample Premiums

The chart below shows only a sample of requested and approved premiums for the Company's lowest-priced bronze, silver, gold and platinum plans for one person, before any financial assistance for which the person may be eligible. (The Company is not offering a catastrophic plan.) Your rates may vary depending on your age, the part of the State in which you live, your family composition, and the plan you choose.

	Plan Level	Monthly Premium Requested	Monthly Premium Approved
Age 21 Baltimore Metro Area	Catastrophic	N/A	N/A
	Lowest-Priced Bronze	$193.40	$172.62
	Lowest-Priced Silver	$239.14	$213.43
	Lowest-Priced Gold	$317.22	$283.13
	Lowest-Priced Platinum	$388.87	$347.08
Age 40 Baltimore Metro Area	Lowest-Priced Bronze	$247.17	$220.61
	Lowest-Priced Silver	$305.62	$272.77
	Lowest-Priced Gold	$405.41	$361.84
	Lowest-Priced Platinum	$496.98	$443.56
Age 60 Baltimore Metro Area	Lowest-Priced Bronze	$524.90	$468.49
	Lowest-Priced Silver	$649.02	$579.26
	Lowest-Priced Gold	$860.94	$768.42
	Lowest-Priced Platinum	$1,055.39	$941.97

Rate Review Standards and Considerations

Rate Review Standards and Considerations

The Insurance Commissioner approves health insurance rates in Maryland. Under Maryland law, rates may not be inadequate, unfairly discriminatory, or excessive in relation to benefits. Each rate filing is reviewed on its own merits. The Commissioner's rate decisions must be based on statistical analysis and reasonable assumptions. To assist the Commissioner in making these decisions, Maryland Insurance Administration ("MIA") actuaries examine the data, methods and assumptions used by each insurer, non-profit health service plan, or HMO ("carrier"). They review numerous factors related to proposed premium rates, including the carrier's actual and projected claims experience, medical and prescription costs, administrative costs, and profits or losses. The Commissioner also considers the impact premium rates will have on Maryland consumers. Under the federal Affordable Care Act and Maryland law, in the individual and small group markets, 80 cents of every premium dollar must be spent on paying claims or on quality improvement activities; that figure increases to 85 cents in the large group market. If an insurance carrier does not meet these targets, the carrier must pay rebates to policyholders.

Modifications to Requested Premium Rates and Basis of Modifications

Evergreen Health Cooperative submitted its rate filings on April 30, 2014, and modified them on May 6, 2014, to take into account Maryland's State Supplemental Reinsurance program. The MIA reviewed the rates submitted on May 6, 2014. During the course of review, the MIA discovered that Evergreen was incorrectly treating adult vision benefits as Essential Health Benefits. Because of the way the effects of the federal Risk Adjustment and Reinsurance programs are allocated among plans in proportion to the cost of Essential Health Benefits, some minor adjustments to plan rates were necessary, resulting in an increase of 0.01%, on average.

Final Determination

Pursuant to § 11-603(c)(2) of the Insurance Article, Annotated Code of Maryland, the Commissioner has determined that the Company's requested premium rates, as modified slightly during the rate review process, are not inadequate, unfairly discriminatory, or excessive in relation to benefits.

The Insurance Commissioner approves health insurance rates in Maryland. Under Maryland law, rates may not be inadequate, unfairly discriminatory, or excessive in relation to benefits. Each rate filing is reviewed on its own merits. The Commissioner's rate decisions must be based on statistical analysis and reasonable assumptions. To assist the Commissioner in making these decisions, Maryland Insurance Administration ("MIA") actuaries examine the data, methods and assumptions used by each insurer, non-profit health service plan, or HMO ("carrier"). They review numerous factors related to proposed premium rates, including the carrier's actual and projected claims experience, medical and prescription costs, administrative costs, and profits or losses. The Commissioner also considers the impact premium rates will have on Maryland consumers. Under the federal Affordable Care Act and Maryland law, in the individual and small group markets, 80 cents of every premium dollar must be spent on paying claims or on quality improvement activities; that figure increases to 85 cents in the large group market. If an insurance carrier does not meet these targets, the carrier must pay rebates to policyholders.

Modifications to Requested Premium Rates and Basis of Modifications

Group Hospitalization and Medical Services, Inc. submitted a rate filing on May 1, 2014, requesting an average rate increase of 38.1%. On May 23, 2014, the Company amended its filing to request an average rate increase of 30.2%. The amended rate filing reflected certain minor adjustments in response to MIA objections, such as modifying its assumptions about projected average age and the projected cost and utilization of dental benefits. The most significant change, however, was a reduction in the Company's projections about the morbidity of its 2015 individual market enrollees as compared with the morbidity of its 2013 individual market enrollees. Specifically, in its amended filing, the Company assigned to its projected 2015 individual market enrollees a morbidity factor that was 1.60 times the morbidity of its 2013 individual market enrollees. In its May 1, 2014 filing, the Company had assumed a morbidity factor of 1.75. The MIA proceeded to review the amended May 23, 2014 filing.

The MIA concluded that certain of the Company's data, methods, and assumptions were not well supported, including certain assumptions about the projected morbidity of its individual product enrollees in 2015. In particular, the Company had not adequately supported its assumptions regarding the number of small group enrollees projected to migrate to its individual products, or its assumptions about the morbidity levels of previously uninsured enrollees. The MIA further concluded that the Company's actual experience during the first half of 2014, as well as other considerations relating to actual and projected enrollment in the 2014 and 2015 individual market, did not support a 1.60 morbidity factor. The Commissioner also concluded that the requested average premium rate increase of 30.2% would have an abrupt, substantial, and adverse impact on the approximately 12,714 Marylanders currently enrolled in Group Hospitalization and Medical Services, Inc.'s Affordable Care Act-compliant plans in the individual market, and would introduce a high level of volatility into Maryland's individual health insurance market.

The MIA prescribed a morbidity factor of 1.40, rather than the Company's requested morbidity factor of 1.60. This modification resulted in an approximately 10.6% reduction in the Company's proposed premium rates for 2015.

As modified during the rate review process, Group Hospitalization and Medical Services, Inc.'s premium rates for 2015 reflect an approximately 16.2% increase as compared with its premium rates for 2014.

Determination

Pursuant to § 11-603(c)(2) of the Insurance Article, Annotated Code of Maryland, the Commissioner has determined that the Company's premium rates, as modified during the rate review process, are not inadequate, unfairly discriminatory, or excessive in relation to benefits.

MARYLAND INSURANCE ADMINISTRATION
2015 HEALTH INSURANCE PREMIUM RATE DECISION

Company and Filing Information

Company Name	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	Company NAIC#	95639
Product Name	Kaiser Permanente for Individuals and Families	SERFF Filing #	KPMA-129523744
Type of Insurance	HMO	Rate Filing Date	April 30, 2014
Market Segment	Individual	Rate Decision Date	August 22, 2014
Product ID #	90296MD061 90296MD062	Rate Effective Date	January 1, 2015

Requested and Approved Changes in Premium Rates

Average Year-Over-Year Rate Change Requested (rounded to the nearest 0.1%)	-12.1%
Average Year-Over-Year Rate Change Approved (rounded to the nearest 0.1%)	-14.1%
Estimated Number of Maryland Members Currently Enrolled in Product(s)	5,173

Sample Premiums

The chart below shows only a sample of requested and approved premiums for the Company's catastrophic and lowest-priced bronze, silver, gold and platinum plans for one person, before any financial assistance for which the person may be eligible. Your rates may vary depending on your age, the part of the State in which you live, your family composition, and the plan you choose.

	Plan Level	Monthly Premium Requested	Monthly Premium Approved
Age 21 Baltimore Metro Area	Catastrophic	$114.99	$112.52
	Lowest-Priced Bronze	$139.99	$136.99
	Lowest-Priced Silver	$181.01	$177.14
	Lowest-Priced Gold	$218.54	$213.86
	Lowest-Priced Platinum	$261.83	$256.23
Age 40 Baltimore Metro Area	Lowest-Priced Bronze	$178.90	$175.07
	Lowest-Priced Silver	$231.33	$226.38
	Lowest-Priced Gold	$279.29	$273.32
	Lowest-Priced Platinum	$334.62	$327.46
Age 60 Baltimore Metro Area	Lowest-Priced Bronze	$379.92	$371.79
	Lowest-Priced Silver	$491.26	$480.74
	Lowest-Priced Gold	$593.11	$580.42
	Lowest-Priced Platinum	$710.60	$695.40

Rate Review Standards and Considerations

The Insurance Commissioner approves health insurance rates in Maryland. Under Maryland law, rates may not be inadequate, unfairly discriminatory, or excessive in relation to benefits. Each rate filing is reviewed on its own merits. The Commissioner's rate decisions must be based on statistical analysis and reasonable assumptions. To assist the Commissioner in making these decisions, Maryland Insurance Administration actuaries examine the data, methods and assumptions used by each insurer, non-profit health service plan, or HMO ("carrier"). They review numerous factors related to proposed premium rates, including the carrier's actual and projected claims experience, medical and prescription costs, administrative costs, and profits or losses. The Commissioner also considers the impact premium rates will have on Maryland consumers. Under the federal Affordable Care Act and Maryland law, in the individual and small group markets, 80 cents of every premium dollar must be spent on paying claims or on quality improvement activities; that figure increases to 85 cents in the large group market. If an insurance carrier does not meet these targets, the carrier must pay rebates to policyholders.

Modifications to Requested Premium Rates and Basis of Modifications

During the review process, Kaiser removed tobacco use as a rating factor, resulting in an average 1.1% increase in proposed base rates for all individual plan members.

In response to an MIA objection requiring Kaiser to take into account the Maryland State Supplemental Reinsurance Program, Kaiser reduced its average proposed premium rates by approximately 2.0%. The MIA also required that Kaiser adjust its methodology for calculating federal reinsurance program recoveries, resulting in a further 1.0% reduction in proposed premium rates.

The combined effect of all three revisions was a downward adjustment of approximately 2.1%, on average, in proposed rates for 2015.

As modified during the rate review process, Kaiser's 2015 proposed premium rates reflect an average 14.1% reduction as compared with its premium rates for 2014.

Final Determination

Pursuant to § 11-603(c)(2) of the Insurance Article, Annotated Code of Maryland, the Commissioner has determined that the Company's requested premium rates, as modified during the rate review process, are not inadequate, unfairly discriminatory, or excessive in relation to benefits.

MARYLAND INSURANCE ADMINISTRATION
2015 HEALTH INSURANCE PREMIUM RATE DECISION

Company and Filing Information

Company Name	UnitedHealthCare of the Mid-Atlantic, Inc.	Company NAIC#	95025
Product Name	HMO (Gold, Silver Copay Select, Silver Smart HSA, Bronze HSA, and Bronze Copay Select)	SERFF Filing #	UHLC-129498453
Type of Insurance	Major Medical	Rate Filing Date	May 1, 2014
Market Segment	Individual	Rate Decision Date	August 22, 2014
Product ID #	31112MD003	Rate Effective Date	January 1, 2015

Requested and Approved Changes in Premium Rates

Average Year-Over-Year Rate Change Requested	N/A (New Market Entrant)
Average Year-Over-Year Rate Change Approved	N/A (New Market Entrant)
Estimated Number of Maryland Members Currently Enrolled in Product(s)	N/A (New Market Entrant)

Sample Premiums

The chart below shows only a sample of requested and approved premiums for the Company's lowest-priced bronze, silver, and gold plans for one person, before any financial assistance for which the person may be eligible. (The Company is not offering any catastrophic or platinum level plans.) Your rates may vary depending on your age, the part of the State in which you live, your family composition, and the plan you choose.

	Plan Level	Monthly Premium Requested	Monthly Premium Approved
Age 21 Baltimore Metro Area	Catastrophic	N/A	N/A
	Lowest-Priced Bronze	$179.34	$162.39
	Lowest-Priced Silver	$218.96	$198.27
	Lowest-Priced Gold	$235.36	$213.12
	Lowest-Priced Platinum	N/A	N/A
Age 40 Baltimore Metro Area	Lowest-Priced Bronze	$229.20	$207.53
	Lowest-Priced Silver	$279.83	$253.39
	Lowest-Priced Gold	$300.79	$272.37
	Lowest-Priced Platinum	N/A	N/A
Age 60 Baltimore Metro Area	Lowest-Priced Bronze	$486.73	$440.73
	Lowest-Priced Silver	$594.26	$538.10
	Lowest-Priced Gold	$638.77	$578.41
	Lowest-Priced Platinum	N/A	N/A

Rate Review Standards and Considerations

The Insurance Commissioner approves health insurance rates in Maryland. Under Maryland law, rates may not be inadequate, unfairly discriminatory, or excessive in relation to benefits. Each rate filing is reviewed on its own merits. The Commissioner's rate decisions must be based on statistical analysis and reasonable assumptions. To assist the Commissioner in making these decisions, Maryland Insurance Administration ("MIA") actuaries examine the data, methods and assumptions used by each insurer, non-profit health service plan, or HMO ("carrier"). They review numerous factors related to proposed premium rates, including the carrier's actual and projected claims experience, medical and prescription costs, administrative costs, and profits or losses. The Commissioner also considers the impact premium rates will have on Maryland consumers. Under the federal Affordable Care Act and Maryland law, in the individual and small group markets, 80 cents of every premium dollar must be spent on paying claims or on quality improvement activities; that figure increases to 85 cents in the large group market. If an insurance carrier does not meet these targets, the carrier must pay rebates to policyholders.

Modifications to Requested Premium Rates and Basis of Modifications

On May 1, 2014, UnitedHealthcare of the Mid-Atlantic, Inc. ("UHCMA") submitted SERFF filing #UHLC-129498453. In response to an MIA objection, UHCMA revised rates downward by 5.14%, taking into account Maryland's supplemental reinsurance program. During the rate review process, UHCMA also revised downward its assumption about morbidity in Maryland's individual market, further reducing proposed rates by an additional 4.54%. The combined effect of both revisions was a downward adjustment of 9.45% in proposed rates, on average.

Final Determination

Pursuant to § 11-603(c)(2) of the Insurance Article, Annotated Code of Maryland, the Commissioner has determined that the Company's requested premium rates, as modified during the rate review process, are not inadequate, unfairly discriminatory, or excessive in relation to benefits.

Exhibit C Sample 2014 Scenarios

Maryland Health Connection
Sample Rate Scenarios
October 2013

How were these rates calculated?

The rates charged by health insurance companies for each plan are developed by the health insurance company and approved by the Maryland Insurance Administration. By law, insurance companies can develop rates based only on the age, geographic location, tobacco status and family composition of a consumer. They cannot consider the health status of an individual when determining insurance prices. The rates used in these scenarios are examples of the lowest cost plans that would be available.

How are the tax credits calculated?

The Affordable Care Act states that individuals, based on their household size and income, are only allowed to pay a certain percentage of their income towards their health insurance premium. To calculate the tax credit a household may receive, we take the second lowest-cost silver plan available to that household and subtract the amount the household is allowed to pay for health insurance, and that is the amount of the tax credit.

What is a bronze, silver, gold or platinum plan?

These four classifications, also called metal levels, represent how much of your health care the health insurance company pays for. With a bronze plan, the health insurance company pays about 60% of your health care costs, which means that you pay about 40% in deductibles, copayments and other out-of-pocket expenses when you use health services. With a silver plan, the health insurance company pays about 70%. A gold plan is 80% and a platinum plan is 90%. Bronze plans are likely to have lower premiums and higher out-of-pocket costs; whereas platinum plans have higher premiums and lower out-of-pocket costs.

Generally, platinum plans would be the most cost-effective choice for individuals who plan to utilize many health care services. Gold plans would be recommended to those who utilize health care services frequently; silver plans would be recommended to those who utilize a moderate amount of health care services. Bronze would be the most cost-effective choice for individuals who don't utilize health care services very often.

How are the tax credits used?

The amount a household receives in tax credits can be used to buy any plan, not just the second lowest-cost silver plan. A household could select a more expensive plan and pay more of the cost of the premium or a less expensive plan and pay less of the cost of the premium.

The tax credit is sent to the health insurance company every month, so the bill that goes to the consumer is lower. A household could choose to have the entire tax credit sent to the health insurance company each month, or they could choose to have a smaller amount sent. In that case, they would pay more towards their premiums during the year, but would get more money back when they submit their taxes.

Note: Tax credits are determined by estimated income and are reconciled just like federal income tax. This means that you may receive a refund or owe additional money to the federal government depending on your actual income that year.

Is this what I will pay for health insurance?

No. These rates are only samples to give you an idea of what you could pay. To determine the amount of the tax credit for which your household is eligible and to see plans available in your area, visit www.MarylandHealthConnection.gov, call our consumer support center at 1-855- 642-8572, or 1-855-642-8573 for individuals who are deaf or hard of hearing or visit a local organization where someone can help you in person. You can find a list of these organizations at www.MarylandHealthConnection.gov under Consumer Assistance.

Sample Household #1

Household Composition: Single Individual, Age 21
Tobacco Status: Non-Tobacco User
Annual Income: $25,000

Baltimore Metropolitan Area (Baltimore City, Baltimore County, Harford County, Howard County and Anne Arundel County)

Monthly Tax Credit: $35.83	No Financial Assistance	**With Tax Credit**
Lowest Cost Bronze Plan	$114	**$78.17**
Lowest Cost Silver Plan	$179	**$143.17**
Second Lowest Cost Silver Plan	$180	**$144.17**
Lowest Cost Gold Plan	$204	**$168.17**
Lowest Cost Platinum Plan	$289	**$253.17**

Eastern Maryland (St. Mary's County, Charles County, Calvert County, Cecil County, Kent County, Queen Anne's County, Talbot County, Caroline County, Dorchester County, Wicomico County, Somerset County and Worcester County)

Monthly Tax Credit: $32.83	No Financial Assistance	**With Tax Credit**
Lowest Cost Bronze Plan	$112.00	**$79.17**
Lowest Cost Silver Plan	$175.00	**$142.17**
Second Lowest Cost Silver Plan	$177.00	**$144.17**
Lowest Cost Gold Plan	$200.00	**$167.17**
Lowest Cost Platinum Plan	$283.00	**$250.17**

Washington DC Metropolitan (Montgomery County and Prince George's County)

Monthly Tax Credit: $23.83	No Financial Assistance	**With Tax Credit**
Lowest Cost Bronze Plan	$107.00	**$ 83.17**
Lowest Cost Silver Plan	$166.00	**$ 142.17**
Second Lowest Cost Silver Plan	$168.00	**$ 144.17**
Lowest Cost Gold Plan	$190.00	**$ 166.17**
Lowest Cost Platinum Plan	$269.00	**$ 245.17**

Western Maryland (Garrett County, Allegany County, Washington County, Carroll County and Frederick County)

Monthly Tax Credit: $21.83	No Financial Assistance	**With Tax Credit**
Lowest Cost Bronze Plan	$105.00	**$ 83.17**
Lowest Cost Silver Plan	$165.00	**$ 143.17**
Second Lowest Cost Silver Plan	$166.00	**$ 144.17**
Lowest Cost Gold Plan	$188.00	**$ 166.17**
Lowest Cost Platinum Plan	$266.00	**$ 244.17**

Sample Household #2

Household Composition: Single Individual, Age 64
Tobacco Status: Non-Tobacco User
Annual Income: $36,000

Baltimore Metropolitan Area (Baltimore City, Baltimore County, Harford County, Howard County and Anne Arundel County)

Monthly Tax Credit: $256.00	No Financial Assistance	**With Tax Credit**
Lowest Cost Bronze Plan	$343	**$87.00**
Lowest Cost Silver Plan	$536	**$280.00**
Second Lowest Cost Silver Plan	$541	**$285.00**
Lowest Cost Gold Plan	$613	**$357.00**
Lowest Cost Platinum Plan	$866	**$610.00**

Eastern Maryland (St. Mary's County, Charles County, Calvert County, Cecil County, Kent County, Queen Anne's County, Talbot County, Caroline County, Dorchester County, Wicomico County, Somerset County and Worcester County)

Monthly Tax Credit: $245.00	No Financial Assistance	**With Tax Credit**
Lowest Cost Bronze Plan	$337	**$92.00**
Lowest Cost Silver Plan	$525	**$280.00**
Second Lowest Cost Silver Plan	$530	**$285.00**
Lowest Cost Gold Plan	$601	**$356.00**
Lowest Cost Platinum Plan	$849	**$604.00**

Washington DC Metropolitan (Montgomery County and Prince George's County)

Monthly Tax Credit: $218.00	No Financial Assistance	**With Tax Credit**
Lowest Cost Bronze Plan	$320	**$102.00**
Lowest Cost Silver Plan	$499	**$281.00**
Second Lowest Cost Silver Plan	$503	**$285.00**
Lowest Cost Gold Plan	$571	**$353.00**
Lowest Cost Platinum Plan	$806	**$588.00**

Western Maryland (Garrett County, Allegany County, Washington County, Carroll County and Frederick County)

Monthly Tax Credit: $213.00	No Financial Assistance	**With Tax Credit**
Lowest Cost Bronze Plan	$316	**$103.00**
Lowest Cost Silver Plan	$494	**$281.00**
Second Lowest Cost Silver Plan	$498	**$285.00**
Lowest Cost Gold Plan	$565	**$352.00**
Lowest Cost Platinum Plan	$798	**$585.00**

Sample Household #3

Household Composition: Family of 4 (Ages 60, 55, 24, 19)
Tobacco Status: Non-Tobacco User
Annual Income: $53,000

Baltimore Metropolitan Area (Baltimore City, Baltimore County, Harford County, Howard County and Anne Arundel County)

Monthly Tax Credit: $867.88	No Financial Assistance	**With Tax Credit**
Lowest Cost Bronze Plan	$753	**$114.88 leftover***
Lowest Cost Silver Plan	$1,175	**$307.12**
Second Lowest Cost Silver Plan	$1,185	**$317.12**
Lowest Cost Gold Plan	$1,345	**$477.12**
Lowest Cost Platinum Plan	$1,900	**$1,032.12**

Eastern Maryland (St. Mary's County, Charles County, Calvert County, Cecil County, Kent County, Queen Anne's County, Talbot County, Caroline County, Dorchester County, Wicomico County, Somerset County and Worcester County)

Monthly Tax Credit: $844.88	No Financial Assistance	**With Tax Credit**
Lowest Cost Bronze Plan	$738	**$106.88 leftover***
Lowest Cost Silver Plan	$1,152	**$307.12**
Second Lowest Cost Silver Plan	$1,162	**$317.12**
Lowest Cost Gold Plan	$1,318	**$473.12**
Lowest Cost Platinum Plan	$1,862	**$1,017.12**

Washington DC Metropolitan (Montgomery County and Prince George's County)

Monthly Tax Credit: $786.88	No Financial Assistance	**With Tax Credit**
Lowest Cost Bronze Plan	$702	**$84.88 leftover***
Lowest Cost Silver Plan	$1,094	**$307.12**
Second Lowest Cost Silver Plan	$1,104	**$317.12**
Lowest Cost Gold Plan	$1,251	**$464.12**
Lowest Cost Platinum Plan	$1,769	**$982.12**

Western Maryland (Garrett County, Allegany County, Washington County, Carroll County and Frederick County)

Monthly Tax Credit: $773.88	No Financial Assistance	**With Tax Credit**
Lowest Cost Bronze Plan	$693	**$80.88 leftover**
Lowest Cost Silver Plan	$1,082	**$308.12**
Second Lowest Cost Silver Plan	$1,091	**$317.12**
Lowest Cost Gold Plan	$1,239	**$465.12**
Lowest Cost Platinum Plan	$1,750	**$976.12**

*Leftover funds could be used to purchase stand-alone dental coverage if dental is not covered by the health plan.

Sample Household #4

Household Composition: Family of 5 (Ages 40, 38, 16, 14, 8)
Tobacco Status: Non-Tobacco User
Annual Income: $60,000

Baltimore Metropolitan Area (Baltimore City, Baltimore County, Harford County, Howard County and Anne Arundel County)

Monthly Tax Credit: $451.00	No Financial Assistance	**With Tax Credit**
Lowest Cost Bronze Plan	$508	**$57**
Lowest Cost Silver Plan	$790	**$339**
Second Lowest Cost Silver Plan	$797	**$346**
Lowest Cost Gold Plan	$906	**$455**
Lowest Cost Platinum Plan	$1,278	**$827**

Eastern Maryland (St. Mary's County, Charles County, Calvert County, Cecil County, Kent County, Queen Anne's County, Talbot County, Caroline County, Dorchester County, Wicomico County, Somerset County and Worcester County)

Monthly Tax Credit: $436.00	No Financial Assistance	**With Tax Credit**
Lowest Cost Bronze Plan	$496	**$60**
Lowest Cost Silver Plan	$775	**$339**
Second Lowest Cost Silver Plan	$782	**$346**
Lowest Cost Gold Plan	$887	**$451**
Lowest Cost Platinum Plan	$1,255	**$819**

Washington DC Metropolitan (Montgomery County and Prince George's County)

Monthly Tax Credit: $398.00	No Financial Assistance	**With Tax Credit**
Lowest Cost Bronze Plan	$473	**$75**
Lowest Cost Silver Plan	$738	**$340**
Second Lowest Cost Silver Plan	$744	**$346**
Lowest Cost Gold Plan	$843	**$445**
Lowest Cost Platinum Plan	$1,192	**$794**

Western Maryland (Garrett County, Allegany County, Washington County, Carroll County and Frederick County)

Monthly Tax Credit: $388.00	No Financial Assistance	**With Tax Credit**
Lowest Cost Bronze Plan	$467	**$79**
Lowest Cost Silver Plan	$727	**$339**
Second Lowest Cost Silver Plan	$734	**$346**
Lowest Cost Gold Plan	$836	**$448**
Lowest Cost Platinum Plan	$1,178	**$790**

Sample Household #5

Household Composition: Couple (Ages 40 and 38)
Tobacco Status: Non-Tobacco User
Annual Income: $32,000

Baltimore Metropolitan Area (Baltimore City, Baltimore County, Harford County, Howard County and Anne Arundel County)

Monthly Tax Credit: $281.13	No Financial Assistance	**With Tax Credit**
Lowest Cost Bronze Plan	$289	**$8**
Lowest Cost Silver Plan	$451	**$170**
Second Lowest Cost Silver Plan	$455	**$174**
Lowest Cost Gold Plan	$516	**$235**
Lowest Cost Platinum Plan	$729	**$448**

Eastern Maryland (St. Mary's County, Charles County, Calvert County, Cecil County, Kent County, Queen Anne's County, Talbot County, Caroline County, Dorchester County, Wicomico County, Somerset County and Worcester County)

Monthly Tax Credit: $272.13	No Financial Assistance	**With Tax Credit**
Lowest Cost Bronze Plan	$283	**$11**
Lowest Cost Silver Plan	$442	**$170**
Second Lowest Cost Silver Plan	$446	**$174**
Lowest Cost Gold Plan	$506	**$234**
Lowest Cost Platinum Plan	$715	**$443**

Washington DC Metropolitan (Montgomery County and Prince George's County)

Monthly Tax Credit: $249.13	No Financial Assistance	**With Tax Credit**
Lowest Cost Bronze Plan	$269	**$20**
Lowest Cost Silver Plan	$420	**$171**
Second Lowest Cost Silver Plan	$423	**$174**
Lowest Cost Gold Plan	$480	**$231**
Lowest Cost Platinum Plan	$679	**$430**

Western Maryland (Garrett County, Allegany County, Washington County, Carroll County and Frederick County)

Monthly Tax Credit: $245.13	No Financial Assistance	**With Tax Credit**
Lowest Cost Bronze Plan	$266	**$21**
Lowest Cost Silver Plan	$415	**$170**
Second Lowest Cost Silver Plan	$419	**$174**
Lowest Cost Gold Plan	$476	**$231**
Lowest Cost Platinum Plan	$671	**$426**

Exhibit D Sample 2015 Scenarios

Sample Household #

Household Composition: Single Individual, Age 21
Tobacco Status: Non-Tobacco User
Annual Income: $25,000

Baltimore Metropolitan Area (Baltimore City, Baltimore County, Hartford County, Howard County and Anne Arundel County)

Monthly Tax Credit: $42.38	**No Financial Assistance**	**With Tax Credit**
Lowest Cost Bronze Plan	$129.39	$87.01
Lowest Cost Silver Plan	$177.14	$134.76
Second Lowest Cost Silver Plan	$183.84	$141.46
Lowest Cost Gold	$213.12	$170.74
Lowest Cost Platinum Plan	$256.23	$213.85

Eastern Maryland (St. Mary's County, Charles County, Calvert County, Cecil County, Kent County, Queen Anne's County, Talbot County, Caroline County, Dorchester County, Wicomico County, Somerset County and Worcester County)

Monthly Tax Credit: $44.03	**No Financial Assistance**	**With Tax Credit**
Lowest Cost Bronze Plan	$126.83	$82.80
Lowest Cost Silver Plan	$177.14	$133.11
Second Lowest Cost Silver Plan	$185.49	$141.46
Lowest Cost Gold	$213.86	$169.83
Lowest Cost Platinum Plan	$256.23	$212.20

Washington DC Metropolitan (Montgomery County and Prince George's County)

Monthly Tax Credit: $36.28	**No Financial Assistance**	**With Tax Credit**
Lowest Cost Bronze Plan	$120.42	$84.14
Lowest Cost Silver Plan	$177.14	$140.86
Second Lowest Cost Silver Plan	$177.74	$141.46
Lowest Cost Gold	$213.22	$176.94
Lowest Cost Platinum Plan	$256.23	$219.95

Western Maryland (Garrett County, Allegany County, Washington County, Carroll County and Frederick County)

Monthly Tax Credit: $35.68	**No Financial Assistance**	**With Tax Credit**
Lowest Cost Bronze Plan	$119.14	$83.46
Lowest Cost Silver Plan	$175.84	$140.16
Second Lowest Cost Silver Plan	$177.14	$141.46
Lowest Cost Gold	$213.86	$178.18
Lowest Cost Platinum Plan	$256.23	$220.55

Sample Household #2

Household Composition: Single Individual, Age 64
Tobacco Status: Non-Tobacco User
Annual Income: $36,000

Baltimore Metropolitan Area (Baltimore City, Baltimore County, Hartford County, Howard County and Anne Arundel County)

Monthly Tax Credit: $266.52	**No Financial Assistance**	**With Tax Credit**
Lowest Cost Bronze Plan	$388.17	$121.65
Lowest Cost Silver Plan	$531.40	$264.88
Second Lowest Cost Silver Plan	$551.52	$285.00
Lowest Cost Gold	$639.36	$372.84
Lowest Cost Platinum Plan	$768.67	$502.15

Eastern Maryland (St. Mary's County, Charles County, Calvert County, Cecil County, Kent County, Queen Anne's County, Talbot County, Caroline County, Dorchester County, Wicomico County, Somerset County and Worcester County)

Monthly Tax Credit: $271.47	**No Financial Assistance**	**With Tax Credit**
Lowest Cost Bronze Plan	$380.49	$109.02
Lowest Cost Silver Plan	$531.40	$259.93
Second Lowest Cost Silver Plan	$556.47	$285.00
Lowest Cost Gold	$641.58	$370.11
Lowest Cost Platinum Plan	$768.67	$497.20

Washington DC Metropolitan (Montgomery County and Prince George's County)

Monthly Tax Credit: $248.21	**No Financial Assistance**	**With Tax Credit**
Lowest Cost Bronze Plan	$361.27	$113.06
Lowest Cost Silver Plan	$531.40	$283.19
Second Lowest Cost Silver Plan	$533.21	$285.00
Lowest Cost Gold	$639.65	$391.44
Lowest Cost Platinum Plan	$768.67	$520.46

Western Maryland (Garrett County, Allegany County, Washington County, Carroll County and Frederick County)

Monthly Tax Credit: $246.40	**No Financial Assistance**	**With Tax Credit**
Lowest Cost Bronze Plan	$357.43	$111.03
Lowest Cost Silver Plan	$527.53	$281.13
Second Lowest Cost Silver Plan	$531.40	$285.00
Lowest Cost Gold	$641.58	$395.18
Lowest Cost Platinum Plan	$246.40	$522..27

Sample Household #3

Household Composition: Family of 4 (Ages 60, 55, 24, 19)
Tobacco Status: Non-Tobacco User
Annual Income: $53,000

Baltimore Metropolitan Area (Baltimore City, Baltimore County, Hartford County, Howard County and Anne Arundel County)

Monthly Tax Credit: $897.22	No Financial Assistance	With Tax Credit
Lowest Cost Bronze Plan	$851.26	0
Lowest Cost Silver Plan	$1,165.37	$268.15
Second Lowest Cost Silver Plan	$1,209.48	$312.26
Lowest Cost Gold	$1,402.12	$504.90
Lowest Cost Platinum Plan	$1,685.72	$788.50

Eastern Maryland (St. Mary's County, Charles County, Calvert County, Cecil County, Kent County, Queen Anne's County, Talbot County, Caroline County, Dorchester County, Wicomico County, Somerset County and Worcester County)

Monthly Tax Credit: $908.10	No Financial Assistance	With Tax Credit
Lowest Cost Bronze Plan	$834.41	$0
Lowest Cost Silver Plan	$1,165.37	$257.27
Second Lowest Cost Silver Plan	$1,220.36	$312.26
Lowest Cost Gold	$1,406.99	$498.89
Lowest Cost Platinum Plan	$1,685.72	$777.62

Washington DC Metropolitan (Montgomery County and Prince George's County)

Monthly Tax Credit: $857.06	No Financial Assistance	With Tax Credit
Lowest Cost Bronze Plan	$792.26	$0
Lowest Cost Silver Plan	$1,165.37	$308.31
Second Lowest Cost Silver Plan	$1,169.32	$312.26
Lowest Cost Gold	$1,402.75	$545.69
Lowest Cost Platinum Plan	$1,685.72	$828.66

Western Maryland (Garrett County, Allegany County, Washington County, Carroll County and Frederick County)

Monthly Tax Credit: $853.11	No Financial Assistance	With Tax Credit
Lowest Cost Bronze Plan	$783.84	$0
Lowest Cost Silver Plan	$1,156.87	$303.76
Second Lowest Cost Silver Plan	$1,165.37	$312.26
Lowest Cost Gold	$1,406.99	$553.88
Lowest Cost Platinum Plan	$1,685.72	$832.61

Sample Household #4

Household Composition: Family of 5 (Ages 40, 38, 16, 14, 8)
Tobacco Status: Non-Tobacco User
Annual Income: $60,000

Baltimore Metropolitan Area (Baltimore City, Baltimore County, Hartford County, Howard County and Anne Arundel County)

Monthly Tax Credit: $122.51	No Financial Assistance	With Tax Credit
Lowest Cost Bronze Plan	$326.58	$204.07
Lowest Cost Silver Plan	$447.09	$324.58
Second Lowest Cost Silver Plan	$464.01	$341.50
Lowest Cost Gold	$537.92	$415.41
Lowest Cost Platinum Plan	$646.72	$524.21

Eastern Maryland (St. Mary's County, Charles County, Calvert County, Cecil County, Kent County, Queen Anne's County, Talbot County, Caroline County, Dorchester County, Wicomico County, Somerset County and Worcester County)

Monthly Tax Credit: $126.68	No Financial Assistance	With Tax Credit
Lowest Cost Bronze Plan	$320.12	$193.44
Lowest Cost Silver Plan	$447.09	$320.41
Second Lowest Cost Silver Plan	$468.18	$341.50
Lowest Cost Gold	$539.79	$413.11
Lowest Cost Platinum Plan	$646.72	$520.04

Washington DC Metropolitan (Montgomery County and Prince George's County)

Monthly Tax Credit: $107.11	No Financial Assistance	With Tax Credit
Lowest Cost Bronze Plan	$303.95	$196.84
Lowest Cost Silver Plan	$447.09	$339.98
Second Lowest Cost Silver Plan	$448.61	$341.50
Lowest Cost Gold	$538.16	$431.05
Lowest Cost Platinum Plan	$646.72	$539.61

Western Maryland (Garrett County, Allegany County, Washington County, Carroll County and Frederick County)

Monthly Tax Credit: $105.59	No Financial Assistance	With Tax Credit
Lowest Cost Bronze Plan	$300.71	$195.12
Lowest Cost Silver Plan	$443.83	$338.24
Second Lowest Cost Silver Plan	$458.88	$353.29
Lowest Cost Gold	$540.29	$434.70
Lowest Cost Platinum Plan	$695.82	$590.23

Sample Household #5

Household Composition: Couple (Ages 40 and 38)
Tobacco Status: Non-Tobacco User
Annual Income: $32,000

Baltimore Metropolitan Area (Baltimore City, Baltimore County, Hartford County, Howard County and Anne Arundel County)

Monthly Tax Credit: $293.08	No Financial Assistance	With Tax Credit
Lowest Cost Bronze Plan	$326.58	$33.50
Lowest Cost Silver Plan	$447.09	$154.01
Second Lowest Cost Silver Plan	$464.01	$170.93
Lowest Cost Gold	$537.92	$244.84
Lowest Cost Platinum Plan	$646.72	$353.64

Eastern Maryland (St. Mary's County, Charles County, Calvert County, Cecil County, Kent County, Queen Anne's County, Talbot County, Caroline County, Dorchester County, Wicomico County, Somerset County and Worcester County)

Monthly Tax Credit: $297.25	No Financial Assistance	With Tax Credit
Lowest Cost Bronze Plan	$320.12	$22.87
Lowest Cost Silver Plan	$447.09	$149.84
Second Lowest Cost Silver Plan	$468.18	$170.93
Lowest Cost Gold	$539.79	$242.54
Lowest Cost Platinum Plan	$646.72	$349.47

Washington DC Metropolitan (Montgomery County and Prince George's County)

Monthly Tax Credit: $277.68	No Financial Assistance	With Tax Credit
Lowest Cost Bronze Plan	$303.95	$26.27
Lowest Cost Silver Plan	$447.09	$169.41
Second Lowest Cost Silver Plan	$448.61	$170.93
Lowest Cost Gold	$538.16	$260.48
Lowest Cost Platinum Plan	$646.72	$369.04

Western Maryland (Garrett County, Allegany County, Washington County, Carroll County and Frederick County)

Monthly Tax Credit: $276.16	No Financial Assistance	With Tax Credit
Lowest Cost Bronze Plan	$300.71	$24.55
Lowest Cost Silver Plan	$443.83	$167.67
Second Lowest Cost Silver Plan	$447.09	$170.93
Lowest Cost Gold	$539.79	$263.63
Lowest Cost Platinum Plan	$646.72	$370.56

Exhibit E MD Benchmark Plan Essential Benefit Bulletin

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BULLETIN 13-01

Date: January 3, 2013

To: Insurers, Nonprofit Health Service Plans and Health Maintenance Organizations ("Carriers")

Re: Maryland Benchmark Plan and Essential Health Benefits

The purpose of this bulletin is to provide detailed information to carriers regarding the essential health benefits that will be required of non-grandfathered health benefit plans in the individual and small group markets with plan years (policy years for individual health benefit plans) that begin on or after January 1, 2014.

Selection of Benchmark Plan

In accordance with § 31-116 of the Insurance Article of the Annotated Code of Maryland, the Maryland Health Care Reform Coordinating Council ("MHCRCC") selected the health plan with the largest small group enrollment as the Maryland benchmark plan. The chosen benchmark plan contains benefits in addition to the comprehensive standard health plan benefits required by regulations promulgated by the Maryland Health Care Commission (COMAR 31.11.06). It includes wellness benefits, insulin pump benefits, cardiac rehabilitation benefits, extended organ transplant benefits, pulmonary rehabilitation benefits, extended nutritional counseling and medical nutrition therapy benefits, and delivery of benefits through patient centered medical homes.

The chosen benchmark plan was lacking the adult habilitative benefits and the pediatric oral and vision benefits required by 45 C.F.R. § 156.110[1]. Therefore, in accordance with the proposed rule the MHCRCC supplemented the benchmark plan with the Maryland Children's Health Insurance Plan dental benefit and the FEP Blue Vision high plan, respectively. The MHCRCC has also determined that the adult habilitative benefits will equal the rehabilitative benefits in the benchmark plan.

[1] The proposed rule on *Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation* ("proposed rule") *See* 77 Fed. Reg. 70, 644 (proposed Nov. 26, 2012)(to be codified at 45 C.F.R. pts. 147, 155, 156).

The chosen benchmark plan also needed to be enhanced for mental health and substance use disorder services. The MHCRCC determined that the benchmark's mental health/substance use benefit will be the mental health/substance use benefit found in the Government Employees Health Association, Inc. Benefit Plan.

For the individual market, in accordance with the proposed rule (45 C.F.R. § 155.170), the benchmark plan described above will be overlaid with the mandated benefits that applied to health benefit plans in the individual market as of December 31, 2011, and which do not appear in the chosen small group benchmark plan. This means that benefits for in vitro fertilization and hair prosthesis will be included as essential health benefits for the individual market.

Small Group Market Essential Health Benefits

The following is a description of the essential health benefits that will be required of each non-grandfathered health benefit plan in the small group market with plan years that begin on or after January 1, 2014. Specifically, the essential benefits shall include:

1. Except as specified in item 5 below, the benefits described in Regulations .03, .03-1 and .09 of COMAR 31.11.06.

2. Habilitative services for adults (those 19 and over) that are at least equal to the rehabilitative benefits described in COMAR 31.11.06.03A(15).

3. Pediatric vision benefits for children up to age 19 in accordance with the FEP Blue Vision high plan. The FEP Blue Vision high plan benefits include the following benefits:

   a. One routine eye examination, including dilation if professionally indicated, each year;

   b. One pair of prescription eyeglass lenses each year

   c. One frame each year;

   d. In lieu of eyeglasses, one pair of contact lenses each year; and

   e. Low vision services, including one comprehensive low vision evaluation every 5 years, 4 follow-up visits in any 5-year period, and prescribed optical devices, such as high-power spectacles, magnifiers and telescopes.

4. Pediatric dental benefits for children up to age 19[2] in accordance with the Maryland Children's Health Insurance Plan dental benefit, which includes benefits for:

[2] 45 C.F.R. § 155.1065 allows the pediatric dental component of the Essential Health Benefits (EHB) to be offered through a stand-alone dental plan in an Exchange. If stand-alone dental plans are available in the Exchange, section 1302(b)(4)(F) of the Affordable Care Act permits Qualified Health Plans offered in the Exchange to exclude coverage of the pediatric dental component of the EHB.

a. Periodic screening in accordance with the periodicity schedule developed by the American Academy of Pediatric Dentistry; and

b. Treatment of all dental services determined to be medically necessary for problems identified during screening or diagnostic evaluations. Benefits include diagnostic services, preventative services, restorative services, endodontic services, periodontic services, removable prosthodontics, maxillofacial prosthetics, fixed prosthodontics, orthodontics for children with severe dysfunctional, handicapping malocclusion, and adjunctive general services.

5. Mental health and substance use benefits in accordance with the Government Employees Health Association, Inc. Benefit Plan, which includes:

a. Professional services by licensed professional mental health and substance use practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.

i. Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:

A. Diagnostic evaluation;

B. Crisis intervention and stabilization for acute episodes;

C. Medication evaluation and management (pharmacotherapy);

D. Treatment and counseling (including individual or group therapy visits);

E. Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling;

F. Professional charges for intensive outpatient treatment in a provider's office or other professional setting.

ii. Electroconvulsive therapy;

iii. Inpatient professional fees;

iv. Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner;

v. Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility;

vi. Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment.

b. Inpatient hospital and inpatient residential treatment centers services, which includes:

i. Room and board, such as:

A. Ward, semiprivate, or intensive care accommodations (Private room is covered only if medically necessary. If private room is not medically necessary, the contract covers only the hospital's average charge for semiprivate accommodations.);

B. General nursing care;

C. Meals and special diets.

ii. Other facility services and supplies--Services provided by a hospital or residential treatment center (RTC).

c. Outpatient hospital—Services such as partial hospitalization or intensive day treatment programs.

d. Emergency room—Outpatient services and supplies billed by a hospital for emergency room treatment.

e. Permissible exclusions for the mental health and substance use benefit:

i. Services by pastoral or marital counselors;

ii. Therapy for sexual problems;

iii. Treatment for learning disabilities and intellectual disabilities;

iv. Telephone therapy;

v. Travel time to the member's home to conduct therapy;

vi. Services rendered or billed by schools, or halfway houses or members of their staffs;

vii. Marriage counseling;

viii. Services that are not medically necessary.

6. Wellness benefits, which include:

a. A health risk assessment that is completed by each individual on a voluntary basis; and

b. Written feedback to the individual who completes a health risk assessment, with recommendations for lowering risks identified in the completed health risk assessment.

7. Insulin pumps--The diabetes treatment, equipment and supplies benefit of COMAR 31.11.06.03A(29) and COMAR 31.11.06.03H is expanded to include insulin pumps.

8. Cardiac rehabilitation benefits for individuals who have been diagnosed with significant cardiac disease, or who have suffered a myocardial infarction, or have undergone invasive cardiac treatment immediately preceding referral for cardiac rehabilitation. Cardiac rehabilitation is a comprehensive program involving medical evaluation, prescribed exercise, cardiac risk factor modification, education and counseling. Benefits include:

   a. Continuous EKG telemetric monitoring during exercise, EKG rhythm strip with interpretation, physician's revision of exercise prescription, and follow up examination for physician to adjust medication or change regimen; and

   b. Increased outpatient rehabilitation services (physical therapy, speech therapy and occupational therapy) for cardiac rehabilitation of 90 visits per therapy, per contract year.

   c. Exclusions applicable to cardiac rehabilitation—

      i. Services must be provided at a place of service equipped and approved to provide cardiac rehabilitation.

      ii. Benefits will not be provided for maintenance programs. Maintenance programs consist of activities that preserve the individual's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional progress is apparent or expected to occur.

9. Solid organ transplants and other non-solid organ transplant procedures—The organ transplant benefit found in COMAR 31.11.06.03A(20) is expanded to include all medically necessary non-experimental/investigational solid organ transplant and other non-solid organ transplant procedures. Covered services include the cost of hotel lodging and air transportation for the recipient individual and a companion (or the recipient individual and two companions if the recipient individual is under the age of 18 years), to and from the site of the transplant.

10. Pulmonary rehabilitation benefits (one (1) program per lifetime) for individuals who have been diagnosed with significant pulmonary disease. Permissible limitations include:

    a. Services must be provided at a place of service equipped and approved to provide pulmonary rehabilitation services;

   b. Benefits will not be provided for maintenance programs. Maintenance programs consist of activities that preserve the individual's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional progress is apparent or expected to occur.

11. Professional nutritional counseling and medical nutrition therapy—The nutritional services benefit found in COMAR 31.11.06.03A(19) is expanded to include benefits for unlimited medically necessary nutritional counseling provided by a licensed dietician-nutritionist, physician, physician assistant or nurse practitioner for an individual at risk due to nutritional history, current dietary intake, medication use or chronic illness or condition. It also includes unlimited medical nutrition therapy provided by a licensed dietician-nutritionist, working in coordination with a primary care physician, to treat a chronic illness or condition.

12. Delivery of benefits through patient centered medical homes for individuals with chronic conditions, serious illnesses or complex health care needs who agree to participate in a patient centered medical home program. This includes associated costs for coordination of care, such as:

    a. Liaison services between the individual and the health care provider, nurse coordinator, and the care coordination team;

    b. Creation and supervision of a care plan;

    c. Education of the individual and family regarding the individual's disease, treatment compliance and self-care techniques; and

    d. Assistance with coordination of care, including arranging consultations with specialists and obtaining medically necessary supplies and services, including community resources.

13. While abortion coverage is a part of the benchmark plan, in accordance with § 1303(b)(1)(A) of the Affordable Care Act, carriers will not be required to cover these services.

With regard to permissible limitations and exclusions, the following apply:

1. The contracts may not contain any limitations or exclusions other than those listed in COMAR 31.11.06.06 or listed in items 5, 8 and 10 above with respect to specific required benefits.[3]

2. The exclusion for the purchase, examination and fitting of eyeglasses, which is currently found in COMAR 31.11.06.06B(6), is required to be revised to indicate that it does not apply to the pediatric vision benefit.

[3] Utilization review will be permitted for health benefit plans that are subject to the essential benefits described in this bulletin.

3. The exclusion for services for sterilization or reverse sterilization for a dependent minor, which is currently found in COMAR 31.11.06.06B(13), is required to be revised to indicate that it does not apply to FDA approved sterilization procedures for women with reproductive capacity as this is a required preventive benefit under the Affordable Care Act and COMAR 31.11.06.03-1.

4. The exclusion for accidents occurring while and as a result of chewing, which is currently found in COMAR 31.11.06.06B(28), is required to be revised to indicate that it does not apply to the pediatric dental benefit.

5. The exclusion for organ transplants not otherwise listed in COMAR 31.11.06.03, which currently is found in COMAR 31.11.06.06B(35), is required to be deleted. This exclusion contradicts the additional organ transplant benefit described in item 9 above.

6. The limitation that requires that all mental health and substance use services be provided through the carrier's managed care system is required to be deleted, as it violates the federal Mental Health Parity and Equity Addiction Act.

7. The exclusion for tobacco cessation, which currently appears in COMAR 31.11.06.06B(51), will not be permitted, as it contradicts the tobacco cessation preventive service benefits required by the Affordable Care Act and COMAR 31.11.06.03-1.

8. In accordance with 45 C.F.R. § 147.126, annual dollar limits on specific benefits, such as the $1400 annual limit on hearing aids, are no longer permitted.

Individual Market Essential Health Benefits

The following is a description of the essential health benefits that will be required of each non-grandfathered health benefit plan in the individual market with policy years that begin on or after January 1, 2014. Specifically, the essential benefits shall include:

1. All of the benefits required in the small group market identified above;

2. In vitro fertilization in accordance with § 15-810 of the Insurance Article, except that the $100,000 maximum lifetime benefit is not permitted by 45 C.F.R. § 147.126; and

3. Hair prosthesis in accordance with § 15-836 of the Insurance Article, except that the $350 limit is not permitted by 45 C.F.R. § 147.126.

With regard to permissible limitations and exclusions, the same permissible limitations and exclusions that are applicable in the small group market also will be applicable in the individual market, with the following exceptions:

1. The exclusion for in vitro fertilization, which is currently found in COMAR 31.11.06.06B(11), will not be permitted.

2. The exclusion for wigs or cranial prosthesis, which is currently found in COMAR 31.11.06.06B(39), is required to be revised to indicate that it does not apply to hair

prostheses for covered persons whose hair loss results from chemotherapy or radiation treatment for cancer.

The above information is based on the assumption that the Secretary of the Department of Health and Human Services approves Maryland's selection of the benchmark plan.

Questions about this bulletin may be directed to the Life/Health Section of the Maryland Insurance Administration at 410-468-2170.

Signature on original

Brenda A. Wilson
Associate Commissioner
Life and Health

Exhibit F MD EHB Benchmark Plan

Maryland EHB Benchmark Plan

Summary Information

Plan Type	Plan from largest small group product, Health Maintenance Organization
Issuer Name	CareFirst BlueChoice, Inc.
Product Name	Blue Choice HMO HSA Open Access
Plan Name	Blue Choice HMO HSA Open Access
Supplemented Categories (Supplementary Plan Type)	• Pediatric Oral (State CHIP) • Pediatric Vision (FEDVIP)
Habilitative Services Included Benchmark (Yes/No)	Yes
Habilitative Services Defined by State (Yes/No)	Yes: Habilitative benefits in the State's EHB benchmark require plans to cover habilitative services benefits for members age 19 and above in parity with benefits covered for rehabilitative services.

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
12	**Routine Eye Exam (Adult)**	Covered	Routine Eye Exam (Adult)	Yes	1	Other	Per contract year				No
13	**Urgent Care Centers or Facilities**	Covered	Urgent Care Facility	No							No
14	**Home Health Care Services**	Covered	Home Health Care Services	No							No
15	**Emergency Room Services**	Covered	Emergency Room Services	No							No
16	**Emergency Transportation/ Ambulance**	Covered	Ambulance Services	No							No
17	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Hospital Inpatient Services	No							No
18	**Inpatient Physician and Surgical Services**	Covered	Inpatient physician and surgical services	No							No
19	**Bariatric Surgery**	Covered	Surgical treatment of morbid obesity	No							No
20	**Cosmetic Surgery**	Not Covered									
21	**Skilled Nursing Facility**	Covered	Skilled Nursing Facility	Yes	100	Other	Days/contract year				No
22	**Prenatal and Postnatal Care**	Covered	Prenatal and Post Natal Care	No							No
23	**Delivery and All Inpatient Services for Maternity Care**	Covered	Delivery and all inpatient services for maternity care	No							No

BENEFITS AND LIMITS

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
1	**Primary Care Visit to Treat an Injury or Illness**	Covered	PCP visit to treat an injury or illness	No							No
2	**Specialist Visit**	Covered	Specialist visit	No							No
3	**Other Practitioner Office Visit (Nurse, Physician Assistant)**	Covered	Other practitioner office visit	No							No
4	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Outpatient Facility Services	No							No
5	**Outpatient Surgery Physician/Surgical Services**	Covered	Outpatient Surgery Physician/ Surgical Services	No							No
6	**Hospice Services**	Covered	Hospice Care	No							No
7	**Non-Emergency Care When Traveling Outside the U.S.**	Not Covered									
8	**Routine Dental Services (Adult)**	Not Covered									
9	**Infertility Treatment**	Covered	Infertility Services	No					In vitro fertilization, ovum transplants and gamete intra-fallopian tube transfer, zygote intra-fallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures.		No
10	**Long-Term/ Custodial Nursing Home Care**	Not Covered									
11	**Private-Duty Nursing**	Not Covered									

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
26	**Substance Abuse Disorder Outpatient Services**	Covered	Outpatient hospital and emergency room (non-accidental injury) substance abuse disorder services	No					- Services by pastoral, marital, drug/alcohol and other counselors including therapy for sexual problems - Treatment for learning disabilities and mental retardation - Telephone therapy - Travel time to the member's home to conduct therapy - Services rendered or billed by schools, or halfway houses or members of their staffs - Marriage counseling - Services that are not medically necessary.	Covered services include the following: - services such as partial hospitalization or intensive day treatment programs - outpatient services and supplies billed by a hospital for emergency room treatment.	No
27	**Substance Abuse Disorder Inpatient Services**	Covered	Inpatient hospital and inpatient residential treatment centers (RTC) substance abuse disorder services	No					- Services by pastoral, marital, drug/alcohol and other counselors including therapy for sexual problems - Treatment for learning disabilities and mental retardation - Telephone therapy - Travel time to the member's home to conduct therapy - Services rendered or billed by schools, or halfway houses or members of their staffs - Marriage counseling - Services that are not medically necessary.	Covered services include the following: - Room and board, such as: - Ward, semiprivate, or intensive care accommodations - General nursing care - Meals and special diets - Services provided by a hospital or licensed residential treatment center (RTC).	No
28	**Generic Drugs**	Covered	Generic Drugs	No							No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
24	**Mental/Behavioral Health Outpatient Services**	Covered	Outpatient hospital and emergency room (non-accidental injury) mental/ behavioral health services	No					- Services by pastoral, marital, drug/alcohol and other counselors including therapy for sexual problems - Treatment for learning disabilities and mental retardation - Telephone therapy - Travel time to the member's home to conduct therapy - Services rendered or billed by schools, or halfway houses or members of their staffs - Marriage counseling - Services that are not medically necessary.	Covered services include the following: - services such as partial hospitalization or intensive day treatment programs - outpatient services and supplies billed by a hospital for emergency room treatment.	No
25	**Mental/Behavioral Health Inpatient Services**	Covered	Inpatient hospital and inpatient residential treatment centers (RTC) mental/behavioral health services	No					- Services by pastoral, marital, drug/alcohol and other counselors including therapy for sexual problems - Treatment for learning disabilities and mental retardation - Telephone therapy - Travel time to the member's home to conduct therapy - Services rendered or billed by schools, or halfway houses or members of their staffs - Marriage counseling - Services that are not medically necessary.	Covered services include the following: - Room and board, such as: - Ward, semiprivate, or intensive care accommodations - General nursing care - Meals and special diets - Services provided by a hospital or licensed residential treatment center (RTC).	No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
37	**Diagnostic Test (X-Ray and Lab Work)**	Covered	Diagnostic Test (x-ray and lab work)	No							No
38	**Imaging (CT/PET Scans, MRIs)**	Covered	Imaging (CT/PET scans, MRIs)	No							No
39	**Preventive Care/ Screening/ Immunization**	Covered	Preventive Care/Screening/ Immunization	No						The following preventive care services are covered: (1) Evidence–based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current. (2) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; (3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and (4) With respect to women, evidence-informed preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.	No
40	**Routine Foot Care**	Not Covered									
41	**Acupuncture**	Covered	Acupuncture	No							No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
29	**Preferred Brand Drugs**	Covered	Preferred Brand Drugs	No							No
30	**Non-Preferred Brand Drugs**	Covered	Non-Preferred Brand Drugs	No							No
31	**Specialty Drugs**	Covered	Specialty Drugs	No							No
32	**Outpatient Rehabilitation Services**	Covered	Outpatient Rehabilitation Services (Physical Therapy, Speech Therapy, and Occupational Therapy)	Yes	30	Other	30 visits per condition per contract year for each therapy (physical therapy, speech therapy, and occupational therapy)				No
33	**Habilitation Services**	Covered	Habilitative services for Members from birth to age 19; habilitative services in parity with rehabilitative services for Members age 19 and above	Yes	30	Other	For members age 19 and above: 30 visits per condition per contract year for each therapy (physical therapy, speech therapy, and occupational therapy)			For Members from birth to age 19, habilitative services means services, including occupational therapy, physical therapy, speech therapy, orthodontics, oral surgery, otologic and audiological therapy for the treatment of children with congenital and genetic birth defects to enhance the child's ability to function. For Members age 19 and above, habilitative services means physical therapy, speech therapy, and occupational therapy in parity with outpatient rehabilitative services.	No
34	**Chiropractic Care**	Covered	Chiropractic Services	Yes	20	Other	Visits per condition per contract year				No
35	**Durable Medical Equipment**	Covered	Durable Medical Equipment	No							No
36	**Hearing Aids**	Covered	Hearing Aids for Minor Children	Yes	1	Other	Hearing aid per each hearing impaired ear every 36 months		Hearing aids for Members over age 18 are not covered.		No

OTHER BENEFITS

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
1	**Other**	Covered	Nutritional services for the treatment of cardiovascular disease, diabetes, malnutrition, cancer, cerebral vascular disease, or kidney disease	Yes	6	Other	Visits per condition per contract year				No
2	**Other**	Covered	Autologous and nonautologous bone marrow, cornea, kidney, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney transplants	No							No
3	**Other**	Covered	All non-experimental/investigational solid organ transplant, and other non-solid organ transplant procedures	No						Covered Services include the cost of hotel lodging and air transportation for the recipient Member and a companion (or the recipient Member and two companions if the recipient Member is under the age of eighteen (18) years), to and from the site of the transplant.	No
4	**Other**	Covered	Medical food for persons with metabolic disorders when ordered by a health care practitioner qualified to provide diagnosis and treatment in the field of metabolic disorders	No							No
5	**Other**	Covered	Professional nutritional counseling for members at nutritional risk due to nutritional history, current dietary intake, medication use or chronic illness or condition	No							No
6	**Other**	Covered	Medical nutrition therapy to treat a chronic illness or condition	No							No
7	**Other**	Covered	Office visits for treatment of childhood obesity	No							No
8	**Other**	Covered	Well child care visits for obesity evaluation and management	No							No
9	**Other**	Covered	Pulmonary rehabilitation services are provided to Members who have been diagnosed with significant pulmonary disease or who have undergone certain surgical procedures of the lung	Yes	1	Other	Program per lifetime				No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
42	**Weight Loss Programs**	Not Covered									
43	**Routine Eye Exam for Children**	Covered	Routine Eye Exam (Children)	Yes	1	Other	Visit/contract year			FEDVIP BlueVision High.	No
44	**Eye Glasses for Children**	Covered	Glasses and Frames or Contact Lenses	Yes	1	Other	1 pair of eyeglasses or 1 pair contact lenses per year			FEDVIP BlueVision High.	No
45	**Dental Check-Up for Children**	Covered	Clinical Oral Exam	Yes	2	Visits per year	Only fluoride from PCP, exam covered under dental plan			MCHP Healthy Smiles.	No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
14	**Other**	Covered	General anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care provided to a Member seven years of age or younger or is developmentally disabled: or extremely uncooperative, fearful, or uncommunicative children 17 years of age or younger with dental needs of such magnitude that treatment should not be delayed or deferred, and for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity	No							No
15	**Other**	Covered	Any other service approved by the plan's case management program	No							No
16	**Other**	Covered	Services for cleft lip and cleft palate, including orthodontics, oral surgery, otologic, audiological, and speech therapy, for Members from birth to age 19	No							No
17	**Other**	Covered	Cost recovery expenses for blood, blood products, derivatives, components, biologics, and serums, including: autologous services; whole blood; red blood cells; platelets; plasma; immunoglobulin; and albumin	No							No
18	**Other**	Covered	Coordination of care provided through the Patient-Centered Medical Home Program	No						Benefits will be provided for associated costs for coordination of care for the Qualifying Individual's medical conditions.	No
19	**Other**	Covered	Abortion services	No							No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
10	**Other**	Covered	Diabetes treatment, equipment and supplies	No						Diabetes equipment includes glucose monitoring equipment under the durable medical equipment coverage for Insulin-Using Beneficiaries. Insulin pumps are included. Diabetes supplies include coverage for insulin syringes and needles and testing strips for glucose monitoring equipment under the prescription drug coverage for Insulin-Using Beneficiaries.	No
11	**Other**	Covered	Increased outpatient rehabilitation (physical therapy, speech therapy, occupational therapy) benefits for cardiac rehabilitation	Yes	90	Other	Visits per therapy per contract year				No
12	**Other**	Covered	Controlled clinical trials	No							No
13	**Other**	Covered	Reconstructive breast surgery and breast prosthesis	No						Reconstructive breast surgery means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts including, all stages of reconstructive breast surgery performed on a nondiseased breast to reestablish symmetry with the diseased breast when reconstructive breast surgery is performed on the diseased breast. Reconstructive breast surgery includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.	No

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

CATEGORY	CLASS	SUBMISSION COUNT
ANALGESICS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	19
ANALGESICS	OPIOID ANALGESICS, LONG-ACTING	6
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	8
ANESTHETICS	LOCAL ANESTHETICS	2
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	ALCOHOL DETERRENTS/ANTI-CRAVING	2
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID ANTAGONISTS	2
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	SMOKING CESSATION AGENTS	0
ANTI-INFLAMMATORY AGENTS	GLUCOCORTICOIDS	1
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	19
ANTIBACTERIALS	AMINOGLYCOSIDES	4
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	10
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	8
ANTIBACTERIALS	BETA-LACTAM, OTHER	0
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	5
ANTIBACTERIALS	MACROLIDES	3
ANTIBACTERIALS	QUINOLONES	4
ANTIBACTERIALS	SULFONAMIDES	4
ANTIBACTERIALS	TETRACYCLINES	4
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	1
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	2
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	3
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	3
ANTIDEMENTIA AGENTS	ANTIDEMENTIA AGENTS, OTHER	1
ANTIDEMENTIA AGENTS	CHOLINESTERASE INHIBITORS	3
ANTIDEMENTIA AGENTS	N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST	1
ANTIDEPRESSANTS	ANTIDEPRESSANTS, OTHER	6
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	2
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	7
ANTIDEPRESSANTS	TRICYCLICS	9
ANTIEMETICS	ANTIEMETICS, OTHER	7
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	4
ANTIFUNGALS	NO USP CLASS	13
ANTIGOUT AGENTS	NO USP CLASS	4
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	1

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
20	**Other**	Covered	Professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license	No					- Services by pastoral, marital, drug/alcohol and other counselors including therapy for sexual problems - Treatment for learning disabilities and mental retardation - Telephone therapy - Travel time to the member's home to conduct therapy - Services rendered or billed by schools, or halfway houses or members of their staffs - Marriage counseling - Services that are not medically necessary.	Covered services include the following: - Diagnostic evaluation - Crisis intervention and stabilization for acute episodes - Medication evaluation and management (pharmacotherapy) - Treatment and counseling (including individual or group therapy visits) - Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling - Professional charges for intensive outpatient treatment in a provider's office or other professional setting - Electroconvulsive therapy - Inpatient professional fees.	No
21	**Other**	Covered	Diagnostics for mental/behavioral health and substance abuse disorders	No						Covered diagnostic services include the following: - Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner - Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility - Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment.	No

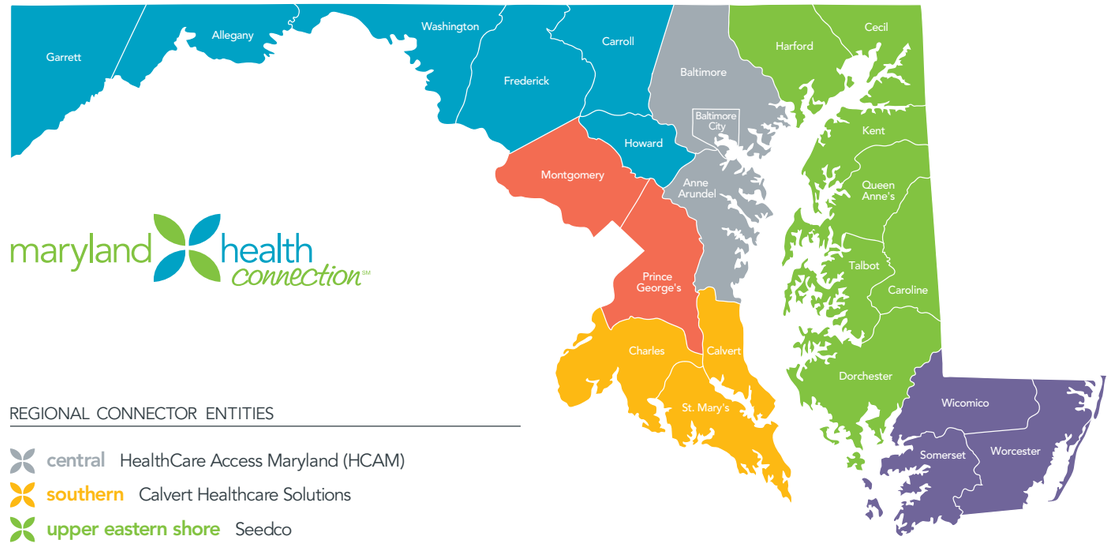
CATEGORY	CLASS	SUBMISSION COUNT
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/ SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	4
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	5
BIPOLAR AGENTS	MOOD STABILIZERS	5
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	15
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	0
BLOOD GLUCOSE REGULATORS	INSULINS	6
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	5
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	4
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	0
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	4
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	5
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC BLOCKING AGENTS	3
CARDIOVASCULAR AGENTS	ANGIOTENSIN II RECEPTOR ANTAGONISTS	5
CARDIOVASCULAR AGENTS	ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS	10
CARDIOVASCULAR AGENTS	ANTIARRHYTHMICS	7
CARDIOVASCULAR AGENTS	BETA-ADRENERGIC BLOCKING AGENTS	12
CARDIOVASCULAR AGENTS	CALCIUM CHANNEL BLOCKING AGENTS	9
CARDIOVASCULAR AGENTS	CARDIOVASCULAR AGENTS, OTHER	3
CARDIOVASCULAR AGENTS	DIURETICS, CARBONIC ANHYDRASE INHIBITORS	2
CARDIOVASCULAR AGENTS	DIURETICS, LOOP	3
CARDIOVASCULAR AGENTS	DIURETICS, POTASSIUM-SPARING	3
CARDIOVASCULAR AGENTS	DIURETICS, THIAZIDE	6
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES	2
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS	5
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, OTHER	3
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL	2
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS	3
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES	3
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES	2
CENTRAL NERVOUS SYSTEM AGENTS	CENTRAL NERVOUS SYSTEM AGENTS, OTHER	0
CENTRAL NERVOUS SYSTEM AGENTS	FIBROMYALGIA AGENTS	0
CENTRAL NERVOUS SYSTEM AGENTS	MULTIPLE SCLEROSIS AGENTS	2
DENTAL AND ORAL AGENTS	NO USP CLASS	5
DERMATOLOGICAL AGENTS	NO USP CLASS	16
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	1

CATEGORY	CLASS	SUBMISSION COUNT
ANTIMIGRAINE AGENTS	PROPHYLACTIC	3
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	2
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	2
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	1
ANTIMYCOBACTERIALS	ANTITUBERCULARS	5
ANTINEOPLASTICS	ALKYLATING AGENTS	5
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	3
ANTINEOPLASTICS	ANTIMETABOLITES	1
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	2
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	1
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	12
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	0
ANTINEOPLASTICS	RETINOIDS	2
ANTIPARASITICS	ANTHELMINTICS	1
ANTIPARASITICS	ANTIPROTOZOALS	6
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	3
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	2
ANTIPARKINSON AGENTS	ANTIPARKINSON AGENTS, OTHER	1
ANTIPARKINSON AGENTS	DOPAMINE AGONISTS	4
ANTIPARKINSON AGENTS	DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS	1
ANTIPARKINSON AGENTS	MONOAMINE OXIDASE B (MAO-B) INHIBITORS	1
ANTIPSYCHOTICS	1ST GENERATION/TYPICAL	9
ANTIPSYCHOTICS	2ND GENERATION/ATYPICAL	5
ANTIPSYCHOTICS	TREATMENT-RESISTANT	1
ANTISPASTICITY AGENTS	NO USP CLASS	3
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	1
ANTIVIRALS	ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS	5
ANTIVIRALS	ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS	11
ANTIVIRALS	ANTI-HIV AGENTS, OTHER	3
ANTIVIRALS	ANTI-HIV AGENTS, PROTEASE INHIBITORS	9
ANTIVIRALS	ANTI-INFLUENZA AGENTS	2
ANTIVIRALS	ANTIHEPATITIS AGENTS	5
ANTIVIRALS	ANTIHERPETIC AGENTS	4
ANXIOLYTICS	ANXIOLYTICS, OTHER	4

CATEGORY	CLASS	SUBMISSION COUNT
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1
METABOLIC BONE DISEASE AGENTS	NO USP CLASS	6
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	2
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	4
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	3
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	7
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	12
OTIC AGENTS	NO USP CLASS	3
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	4
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	9
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	6
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	1
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	1
SKELETAL MUSCLE RELAXANTS	NO USP CLASS	6
SLEEP DISORDER AGENTS	GABA RECEPTOR MODULATORS	2
SLEEP DISORDER AGENTS	SLEEP DISORDERS, OTHER	2
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL MODIFIERS	1
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	2

CATEGORY	CLASS	SUBMISSION COUNT
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	3
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	3
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	0
GASTROINTESTINAL AGENTS	LAXATIVES	1
GASTROINTESTINAL AGENTS	PROTECTANTS	2
GASTROINTESTINAL AGENTS	PROTON PUMP INHIBITORS	3
GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	3
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	7
GENITOURINARY AGENTS	GENITOURINARY AGENTS, OTHER	1
GENITOURINARY AGENTS	PHOSPHATE BINDERS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)	GLUCOCORTICOIDS/MINERALOCORTICOIDS	20
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	NO USP CLASS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)	NO USP CLASS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANABOLIC STEROIDS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANDROGENS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ESTROGENS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	PROGESTINS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)	NO USP CLASS	2
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	NO USP CLASS	0
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	NO USP CLASS	4
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	5
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	9
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	0
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	3
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	2
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	5

Exhibit G Connector Entities Map



maryland health connection℠

REGIONAL CONNECTOR ENTITIES

- central HealthCare Access Maryland (HCAM)
- southern Calvert Healthcare Solutions
- upper eastern shore Seedco
- lower eastern shore Worcester County Health Department
- western The Door to HealthCare Western Maryland. A Program of Healthy Howard, Inc.
- capital Montgomery County Department of Health & Human Services

Exhibit H Consumer Satisfaction Survey Results

Exhibit H

Consumer Satisfaction Survey Results

Upper Eastern Shore

Question One: My assister or navigator was eager to help me

Seedco

Response	Number	Percentage
Strongly Agree	1,058	96.5%
Moderately Agree	31	2.8%
Neither Agree Nor Disagree	2	0.2%
Moderately Disagree	1	0.1%
Strongly Disagree	4	0.4%
Total	**1,096**	**100.0%**

Question Two: My assister or navigator took time to listen to me

Seedco

Response	Number	Percentage
Strongly Agree	1,064	97.1%
Moderately Agree	25	2.3%
Neither Agree Nor Disagree	2	0.2%
Moderately Disagree	1	0.1%
Strongly Disagree	4	0.4%
Total	**1,096**	**100.0%**

Question Three: My assister or navigator was knowledgeable and clear

Seedco

Response	Number	Percentage
Strongly Agree	1,045	95.3%
Moderately Agree	41	3.7%
Neither Agree Nor Disagree	3	0.3%
Moderately Disagree	2	0.2%
Strongly Disagree	5	0.5%
Total	**1,096**	**100.0%**

Question Four: The information given by my assister or navigator answered my questions

Seedco

Response	Number	Percentage
Strongly Agree	1,045	95.3%
Moderately Agree	41	3.7%
Neither Agree Nor Disagree	3	0.3%
Moderately Disagree	2	0.2%
Strongly Disagree	5	0.5%
Total	**1,096**	**100.0%**

Question Five: My overall experience with MHC in-person helper was satisfactory.

Seedco

Response	Number	Percentage
Strongly Agree	1,060	96.7%
Moderately Agree	28	2.6%
Neither Agree Nor Disagree	0	0.0%
Moderately Disagree	1	0.1%
Strongly Disagree	7	0.6%
Total	**1,096**	**100%**

Lower Eastern Shore

Question One: My assister or navigator was eager to help me

LSHIAP

Response	Number	Percentage
Strongly Agree	334	97.1%
Moderately Agree	2	0.6%
Neither Agree Nor Disagree	1	0.3%
Moderately Disagree	0	0.0%
Strongly Disagree	7	2.0%
Total	**344**	**100.0%**

Question Two: My assister or navigator took time to listen to me

LSHIAP

Response	Number	Percentage
Strongly Agree	335	97.4%
Moderately Agree	1	0.3%
Neither Agree Nor Disagree	1	0.3%
Moderately Disagree	0	0.0%
Strongly Disagree	7	2.0%
Total	**344**	**100.0%**

Question Three: My assister or navigator was knowledgeable and clear

LSHIAP

Response	Number	Percentage
Strongly Agree	332	96.5%
Moderately Agree	4	1.2%
Neither Agree Nor Disagree	1	0.3%
Moderately Disagree	0	0.0%
Strongly Disagree	7	2.0%
Total	**344**	**100.0%**

Question Four: The information given by my assister or navigator answered my questions

LSHIAP

Response	Number	Percentage
Strongly Agree	332	96.5%
Moderately Agree	3	0.9%
Neither Agree Nor Disagree	2	0.6%
Moderately Disagree	0	0.0%
Strongly Disagree	7	2.0%
Total	**344**	**100.0%**

Question Five: My overall experience with MHC in-person helper was satisfactory.

LSHIAP

Response	Number	Percentage
Strongly Agree	334	97.1%
Moderately Agree	1	0.3%
Neither Agree Nor Disagree	2	0.6%
Moderately Disagree	0	0.0%
Strongly Disagree	7	2.0%
Total	**344**	**100%**

<u>Southern Region</u>

Question One: My assister or navigator was eager to help me

Calvert Healthcare Solutions

Response	Number	Percentage
Strongly Agree	124	98.4%
Moderately Agree	2	1.6%
Neither Agree Nor Disagree	0	0.0%
Moderately Disagree	0	0.0%
Strongly Disagree	0	0.0%
Total	**126**	**100.0%**

Question Two: My assister or navigator took time to listen to me

Calvert Healthcare Solutions

Response	Number	Percentage
Strongly Agree	125	99.2%
Moderately Agree	1	0.8%
Neither Agree Nor Disagree	0	0.0%
Moderately Disagree	0	0.0%
Strongly Disagree	0	0.0%
Total	**126**	**100.0%**

Question Three: My assister or navigator was knowledgeable and clear

Calvert Healthcare Solutions

Response	Number	Percentage
Strongly Agree	123	97.6%
Moderately Agree	3	2.4%
Neither Agree Nor Disagree	0	0.0%
Moderately Disagree	0	0.0%
Strongly Disagree	0	0.0%
Total	**126**	**100.0%**

Question Four: The information given by my assister or navigator answered my questions

Calvert Healthcare Solutions

Response	Number	Percentage
Strongly Agree	122	96.8%
Moderately Agree	2	1.6%
Neither Agree Nor Disagree	2	1.6%
Moderately Disagree	0	0.0%
Strongly Disagree	0	0.0%
Total	**126**	**100.0%**

Question Five: My overall experience with MHC in-person helper was satisfactory.

Calvert Healthcare Solutions

Response	Number	Percentage
Strongly Agree	124	98.4%
Moderately Agree	2	1.6%
Neither Agree Nor Disagree	0	0.0%
Moderately Disagree	0	0.0%
Strongly Disagree	0	0.0%
Total	**126**	**100%**

Central Region

Question One: My assister or navigator was eager to help me

HCAM

Response	Number	Percentage
Strongly Agree	467	57.0%
Moderately Agree	289	35.3%
Neither Agree Nor Disagree	56	6.8%
Moderately Disagree	7	0.9%
Strongly Disagree	0	0.0%
Total	**819**	**100.0%**

Question Two: My assister or navigator took time to listen to me

HCAM

Response	Number	Percentage
Strongly Agree	481	58.7%
Moderately Agree	333	40.7%
Neither Agree Nor Disagree	5	0.6%
Moderately Disagree	0	0.0%
Strongly Disagree	0	0.0%
Total	**819**	**100.0%**

Question Three: My assister or navigator was knowledgeable and clear

HCAM

Response	Number	Percentage
Strongly Agree	423	51.6%
Moderately Agree	381	46.5%
Neither Agree Nor Disagree	15	1.8%
Moderately Disagree	0	0.0%
Strongly Disagree	0	0.0%
Total	**819**	**100.0%**

Question Four: The information given by my assister or navigator answered my questions

HCAM

Response	Number	Percentage
Strongly Agree	405	49.3%
Moderately Agree	395	48.1%
Neither Agree Nor Disagree	21	2.6%
Moderately Disagree	0	0.0%
Strongly Disagree	0	0.0%
Total	**821**	**100.0%**

Question Five: My overall experience with MHC in-person helper was satisfactory.

HCAM

Response	Number	Percentage
Strongly Agree	398	48.6%
Moderately Agree	403	49.2%
Neither Agree Nor Disagree	18	2.2%
Moderately Disagree	0	0.0%
Strongly Disagree	0	0.0%
Total	**819**	**100%**

Capital Region

Question One: My assister or navigator was eager to help me

Montgomery County Department of Health & Human Services

Response	Number	Percentage
Strongly Agree	1,307	94.2%
Moderately Agree	55	4.0%
Neither Agree Nor Disagree	10	0.7%
Moderately Disagree	1	0.1%
Strongly Disagree	15	1.1%
Total	**1,388**	**100.0%**

Question Two: My assister or navigator took time to listen to me

Montgomery County Department of Health & Human Services

Response	Number	Percentage
Strongly Agree	1,300	93.5%
Moderately Agree	62	4.5%
Neither Agree Nor Disagree	8	0.6%
Moderately Disagree	4	0.3%
Strongly Disagree	16	1.2%
Total	**1,390**	**100.0%**

Question Three: My assister or navigator was knowledgeable and clear

Montgomery County Department of Health & Human Services

Response	Number	Percentage
Strongly Agree	1,300	93.3%
Moderately Agree	64	4.6%
Neither Agree Nor Disagree	14	1.0%
Moderately Disagree	2	0.1%
Strongly Disagree	14	1.0%
Total	**1,394**	**100.0%**

Question Four: The information given by my assister or navigator answered my questions

Montgomery County Department of Health & Human Services

Response	Number	Percentage
Strongly Agree	1,281	92.4%
Moderately Agree	65	4.7%
Neither Agree Nor Disagree	21	1.5%
Moderately Disagree	4	0.3%
Strongly Disagree	15	1.1%
Total	**1,386**	**100.0%**

Question Five: My overall experience with MHC in-person helper was satisfactory.

Montgomery County Department of Health & Human Services

Response	Number	Percentage
Strongly Agree	1,282	92.8%
Moderately Agree	67	4.8%
Neither Agree Nor Disagree	12	0.9%
Moderately Disagree	4	0.3%
Strongly Disagree	17	1.2%
Total	**1,382**	**100%**

<u>Western Region</u>

Question One: My assister or navigator was eager to help me

Healthy Howard, Inc.

Response	Number	Percentage
Strongly Agree	149	93.7%
Moderately Agree	10	6.3%
Neither Agree Nor Disagree	0	0.0%
Moderately Disagree	0	0.0%
Strongly Disagree	0	0.0%
Total	**159**	**100.0%**

Question Two: My assister or navigator took time to listen to me

Healthy Howard, Inc.

Response	Number	Percentage
Strongly Agree	152	95.6%
Moderately Agree	7	4.4%
Neither Agree Nor Disagree	0	0.0%
Moderately Disagree	0	0.0%
Strongly Disagree	0	0.0%
Total	**159**	**100.0%**

Question Three: My assister or navigator was knowledgeable and clear

Healthy Howard, Inc.

Response	Number	Percentage
Strongly Agree	152	95.6%
Moderately Agree	7	4.4%
Neither Agree Nor Disagree	0	0.0%
Moderately Disagree	0	0.0%
Strongly Disagree	0	0.0%
Total	**159**	**100.0%**

Question Four: The information given by my assister or navigator answered my questions

Healthy Howard, Inc.

Response	Number	Percentage
Strongly Agree	152	95.6%
Moderately Agree	7	4.4%
Neither Agree Nor Disagree	0	0.0%
Moderately Disagree	0	0.0%
Strongly Disagree	0	0.0%
Total	**159**	**100.0%**

Question Five: My overall experience with MHC in-person helper was satisfactory.

Healthy Howard, Inc.

Response	Number	Percentage
Strongly Agree	147	91.9%
Moderately Agree	8	5.0%
Neither Agree Nor Disagree	5	3.1%
Moderately Disagree	0	0.0%
Strongly Disagree	0	0.0%
Total	**1,382**	**100%**

Exhibit I Resolution Adopting Procurement Policies

RESOLUTION OF BOARD OF TRUSTEES
ADOPTING PROCUREMENT POLICIES AND PROCEDURES

WHEREAS, the Maryland Health Benefit Exchange Act of 2011 ("the Exchange Act") directs the Board of Trustees of the Maryland Health Benefit Exchange to adopt written policies and procedures governing all procurements of the Exchange, *see* Md. Code Ann., Ins. §31-106(f); and

WHEREAS, the Exchange Act mandates that the Exchange's procurement policies shall comport with Title 12, Subtitle 4 of the State Finance and Procurement Article and Title 14, Subtitle 3 of the State Finance and Procurement Article, but that the Exchange otherwise is not subject to Division II of the State Finance and Procurement Article; and

WHEREAS, the Exchange Act further mandates that the Exchange's procurement policies shall, to the fullest extent practicable, and in a manner that does not impair the Exchange's ability to carry out the purposes for which it was created, establish an open and transparent process that (1) promotes public confidence in the Exchange's procurements; (2) ensures the fair and equitable treatment of all persons and entities that participate in the Exchange's procurement system; (3) fosters appropriate competition and provides safeguards for maintaining a procurement system of quality and integrity; (4) promotes increased economic efficiency and responsibility on the part of the Exchange; (5) achieves the maximum benefit from the Exchange's purchasing power; and (6) provides clarity and simplicity in the rules and procedures governing the Exchange's procurements; and

WHEREAS, the Board of Trustees, at its initial meeting on June 3, 2011, adopted an Interim Policy for the procurement of assistance in developing and conducting the studies mandated in Section 5 of the Exchange Act and required to be completed by December 23, 2011, but did not adopt a comprehensive policy addressing all procurements undertaken by the Exchange;

NOW, THEREFORE, BE IT RESOLVED that the Board of Trustees hereby adopts, as its policy governing the procurements of the Exchange, the document entitled Maryland Health Benefit Exchange Procurement Policies and Procedures, attached hereto as **Exhibit A**.

I HEREBY CERTIFY that the foregoing Resolution was adopted on this 27th day of June, 2011, by the Board of Trustees of the Maryland Health Benefit Exchange.

Joshua M. Sharfstein, Chair

MARYLAND HEALTH BENEFIT EXCHANGE
PROCUREMENT POLICIES AND PROCEDURES

I. INTRODUCTION AND STATEMENT OF PURPOSE

A. These Procurement Policies and Procedures are intended to establish an open and transparent procurement process for the Maryland Health Benefit Exchange ("the Exchange") that (1) promotes public confidence in the Exchange's procurements; (2) ensures the fair and equitable treatment of all persons and entities that participate in the Exchange's procurement system; (3) fosters appropriate competition and provides safeguards for maintaining a procurement system of quality and integrity; (4) promotes increased economic efficiency and responsibility on the part of the Exchange; (5) achieves the maximum benefit from the Exchange's purchasing power; and (6) provides clarity and simplicity in the rules and procedures governing the Exchange's procurements.

B. Under § 31-103 of the Insurance Article of the Maryland Code, the Exchange is subject to the provisions of State law governing procurement by "exempt units," *see* Md. Code Ann., State Fin. & Proc. § 12-401 *et seq*., and establishing requirements and guidelines for minority business participation in procurement, *see id*. § 14-301 *et seq*. These Procurement Policies and Procedures, and the applicable provisions of State law, govern all procurements undertaken by the Exchange, except as set forth in Section X, below.

II. METHODS OF PROCUREMENT

Except as noted in Section X, below, all procurements by the Exchange shall be awarded by one of the following methods:

A. Competitive Sealed Bidding
B. Competitive Sealed Proposals
C. Expedited Procurement
D. Emergency Procurement
E. Sole Source Procurement
F. Simplified Methods for Small Procurements
G. Inter-Governmental Procurement

Subject to the limitations set forth below, the Executive Director of the Exchange shall have authority to select the method of procurement that best serves the needs of the Exchange and achieves the purposes of these Procurement Policies and Procedures. When the Executive Director proposes to select a method of procurement described below as non-competitive, and when it is reasonably anticipated that any contract resulting from the procurement would be valued at $50,000 or more, the Executive Director shall give advance notice to the Board of Trustees of the proposed non-competitive procurement and shall not proceed with the procurement for five calendar days or until the Board approves the proposal to proceed with a non-competitive procurement, whichever first occurs.

A. Competitive Sealed Bidding

1. Competitive sealed bidding is a competitive method of procurement and shall be used where (a) the award will be made on the basis of price and other price-related factors, (b) it will not be necessary to conduct negotiations with offerors, (c) time permits the solicitation, submission and evaluation of sealed bids, and (d) there is a reasonable expectation of receiving more than one bid.

2. Each invitation for bids shall be in writing, shall be in a form approved by the Executive Director, shall establish a process for the evaluation of bids, and shall identify the factors on which the contract will be awarded.

3. Each invitation for bids shall be published on eMaryland Marketplace and the website of the Exchange and shall be advertised in any other reasonable manner that would promote competition and transparency in the procurement process as determined by the Executive Director or a procurement officer designated by the Executive Director. The Executive Director or designated procurement officer may solicit bids directly from any vendor.

4. The Executive Director shall ensure that there is reasonable time, after publication of an invitation for bids, for potential bidders to prepare and submit bids.

5. Prequalification of bidders may be required.

6. Bids must be submitted in a sealed envelope marked with the bidder's name. All bids shall be publicly opened at the time and place stated in the request.

7. Contracts shall be awarded with reasonable promptness after the date of bid opening according to the process established in the invitation for bids and based on the factors identified in the invitation for bids.

8. All bids may be rejected if the Board of Trustees or the Executive Director determines that it is in the Exchange's best interest to do so.

B. Competitive Sealed Proposals

1. Competitive sealed proposals is a competitive method of procurement and may be used where the award will be made on factors that include but are not limited to price, and where time permits the solicitation, submission and evaluation of sealed proposals.

2. Each request for proposals shall be in writing, shall be in a form approved by the Executive Director, shall establish a process for the evaluation of proposals, and shall identify the factors on which the contract will be awarded.

3. Each request for proposals shall be published on eMaryland Marketplace and the website of the Exchange and shall be advertised in any other reasonable manner that would promote competition and transparency in the procurement process as determined by the Executive Director or a procurement officer designated by the Executive Director. The Executive Director or designated procurement officer may solicit proposals directly from any vendor.

4. The Executive Director shall ensure that there is reasonable time, after publication of a request for proposals, for potential offerors to prepare and submit proposals.

5. The Executive Director or designated procurement officer may conduct discussions or negotiations with any offeror after the receipt of proposals. The person conducting the discussions or negotiations shall keep a record of all such communications and shall treat all offerors fairly in conducting discussions or negotiations.

6. The Executive Director or designated procurement officer may request that offerors revise their proposals by submitting a best and final offer or a series of best and final offers.

7. Contracts shall be awarded according to the process established in the request for proposals and based on the factors identified in the request for proposals.

8. All proposals may be rejected if the Board of Trustees or the Executive Director determines that it is in the Exchange's best interest to do so.

C. Expedited Procurement

1. Expedited procurement is a competitive procurement method and may only be used after a written determination, by the Executive Director or a procurement officer designated by the Executive Director that urgent circumstances make it impractical for a procurement to be undertaken through more formal competitive procurement methods.

2. The urgent circumstances under which an expedited procurement may be undertaken include the need to make progress toward compliance with long-range deadlines set forth in federal or State law, in policy guidance from a federal or State agency, or in the terms of a grant received by the Exchange, where the use of more formal procurement methods would prevent the Exchange from making adequate progress toward compliance.

3. Each solicitation shall be in writing and shall be in a form approved by the Executive Director.

4. Each solicitation shall be published on eMaryland Marketplace and the website of the Exchange and shall be advertised in any other reasonable manner that would promote competition and transparency in the procurement process as determined by the Executive Director or designated procurement officer. The Executive Director or designated procurement officer may also solicit responses directly from any vendor.

5. The Executive Director shall ensure that responses are received and evaluated in the manner best suited to maximize competition and transparency, consistent with the urgent circumstances presented.

6. The Executive Director or designated procurement officer may conduct discussions or negotiations with any offeror after the receipt of responses. The person conducting the discussions or negotiations shall keep a record of all such communications and shall attempt to treat all offerors fairly in conducting discussions or negotiations, consistent with the urgent circumstances presented.

7. Contracts shall be awarded according to any process established in the solicitation and based on any factors identified in the solicitation, and, in any event, to the offeror whose response is deemed most advantageous to the Exchange under the urgent circumstances of the procurement.

8. All responses may be rejected if the Board of Trustees or the Executive Director determines that it is in the Exchange's best interest to do so.

D. Emergency Procurement

1. Emergency procurement is a non-competitive procurement method and may only be used after a written determination, by the Executive Director or a procurement officer designated by the Executive Director, that it is not possible to undertake a competitive procurement because of an emergency requiring the Exchange to (a) protect the public health, safety or welfare; (b) preserve or protect the Exchange's property or systems; or (c) mitigate a threat to the continuation of services provided by the Exchange.

2. An emergency procurement shall be limited to the procurement of only the types and quantities of goods or services needed to meet the immediate emergency and shall not be used to meet long-term requirements.

3. The Executive Director, or a procurement officer designated by the Executive Director, shall solicit responses from as many vendors as practicable and shall ensure that any emergency procurement is undertaken with the maximum amount of transparency consistent with the circumstances of the emergency.

4. The Executive Director or designated procurement officer shall seek the most favorable price and the most favorable terms and conditions that can be obtained under the circumstances of the emergency.

5. Contracts shall be awarded to the offeror whose response is deemed most advantageous to the Exchange under the circumstances of the emergency.

E. Sole Source Procurement

1. Sole source procurement is a non-competitive procurement method and may only be used after a written determination, by the Executive Director or a procurement officer designated by the Executive Director, that there is only one source for goods or services that the Exchange requires.

2. The Executive Director shall ensure that sole source procurement is used only in circumstances in which it is both necessary and in the best interest of the Exchange.

3. The Executive Director or designated procurement officer shall use a letter to request a proposal for a sole source procurement. The letter shall refer to, or attach, the terms and conditions of a proposed contract.

4. The Executive Director or designated procurement officer shall negotiate with the source of the procurement for the most favorable price and the most favorable terms and conditions that can be obtained.

5. A contract may be awarded where, based on the negotiated price and terms and conditions, it is in the best interest of the Exchange to award the contract.

6. The Executive Director or designated procurement officer shall take action whenever possible to avoid the need to continue to procure the same goods or services without competition.

F. Simplified Methods for Small Procurements.

1. For contracts valued at less than $75,000, a simplified competitive method may be used that does not incorporate all of the elements of a formal competitive procurement.

2. Each solicitation shall be in writing and shall be in a form approved by the Executive Director or a procurement officer designated by the Executive Director.

3. Each solicitation shall be published on eMaryland Marketplace and the website of the Exchange and shall be advertised in any other reasonable manner that would promote competition and transparency in the procurement process as determined by the Executive Director or designated procurement officer. The Executive Director or designated procurement officer may solicit responses directly from any vendor.

4. The Executive Director shall ensure that responses are received and evaluated in a manner that promotes competition and transparency and that is fair to all offerors.

5. The Executive Director or designated procurement officer may conduct discussions or negotiations with any offeror after the receipt of responses and shall attempt to treat all offerors fairly in conducting discussions or negotiations.

6. Contracts shall be awarded to the offeror whose response is deemed most advantageous to the Exchange.

7. All responses may be rejected if the Executive Director or designated procurement officer determines that it is in the Exchange's best interest to do so.

8. For contracts valued at less than $15,000, competitive selection is preferred, but not required. For such contracts, the procurement shall be considered a competitive procurement if the Executive Director, or a procurement officer designated by the Executive Director, orally solicits and obtains responses from at least two vendors. The Executive Director or designated procurement officer may award a contract when it is in the best interest of the Exchange to do so.

9. Contracts may not be artificially divided for the purpose of bringing them within the dollar ranges in which these Procurement Policies and Procedures permit the use of simplified procurement methods.

G. Inter-Governmental Procurement and Cooperative Purchasing

1. When it is in the best interest of the Exchange, the Exchange may, without competition, enter into an agreement to procure goods or services from an agency or unit of (a) the State of Maryland, (b) a political subdivision of the State of Maryland, (c) the federal government, or (d) another state government, including another state's health benefits exchange.

2. When it is in the best interests of the Exchange, the Exchange may, without competition, enter into an inter-governmental cooperative purchasing agreement, as that term is defined in § 13-110(a)(4) of the State Finance and Procurement Article.

3. Any inter-governmental agreement described in this Paragraph II.G valued at $200,000 or more may be approved only by vote of the Board of Trustees. The Executive Director shall have authority to approve any such agreement valued at less than $200,000; a procurement officer designated by the Executive Director shall have authority to approve any such agreement valued at less than $25,000.

III. CONTRACT APPROVAL AUTHORITY AND REPORTING REQUIREMENTS

A. Where a competitive method of source selection has been utilized, the Executive Director shall have authority to award any contract valued at less than $200,000; any contract valued at $200,000 or more may only be awarded by vote of the Board of Trustees.

B. Where a noncompetitive source selection method other than emergency procurement has been utilized, the Executive Director shall have authority to award any contract valued at less than $50,000; any contract valued at $50,000 or more may only be awarded by vote of the Board of Trustees.

C. The Executive Director may award any contract where the emergency procurement method has been properly utilized and where the emergency does not permit the Executive Director to obtain the prior approval of the Board of Trustees.

D. A contract valued at less than $25,000 may be awarded by a procurement officer designated by the Executive Director.

E. The Executive Director shall report to the Board of Trustees, at the next regular meeting of the Board following the award of any contract, (a) the award of any contract valued at $25,000 or more, and (b) the award of any contract valued at $10,000 or more where a noncompetitive method of source selection has been utilized.

F. At each annual meeting of the Board of Trustees, the Executive Director shall present a written report identifying all contracts awarded by the Exchange in the preceding year.

IV. MINORITY BUSINESS PARTICIPATION

A. All procurements shall comply with Title 14, Subtitle 3 of the State Finance and Procurement Article, which governs minority business participation in procurement.

B. The Executive Director shall designate a liaison officer for minority business participation, who shall coordinate agency outreach to the minority business community and review the Exchange's contracting to ensure compliance with the law governing minority business participation.

V. CONTRACT REQUIREMENTS

A. All contracts shall be in writing and shall be in a form approved by the Executive Director. Contracts valued at less than $10,000 may be in the form of a purchase order.

B. Term contracts are limited to a maximum initial term of three years, with renewal options for a maximum combined total of five years.

C. All contracts valued at $10,000 or more shall include a provision stating that contracts awarded in violation of these Procurement Policies and Procedures shall be voidable at the election of the Exchange.

D. The Board may from time to time identify additional mandatory provisions for all contracts or for certain categories of contracts and may do so either by amending these Procurement Policies and Procedures or by adopting a separate policy concerning contract terms.

VI. CONTRACT MODIFICATIONS

The Executive Director, or a procurement officer designated by the Executive Director, may agree on behalf of the Exchange to modify the terms of a contract. The Executive Director may, without prior approval of the Board of Trustees, agree to any contract modification (a) valued at less than $25,000, or (b) valued at (i) less than $100,000 and (ii) less than 20% of the total amount of the contract prior to the modification. A designated procurement officer may, without prior approval of the Board, agree to any contract modification (a) valued at less than $25,000, or (b) valued at (i) less than $50,000 and (ii) less than 10% of the total amount of the contract prior to the modification. All other contract modifications require prior approval of the Board.

VII. BID PROTESTS

A. Time Restrictions

1. A protest based upon alleged improprieties in a solicitation that are apparent before bid opening or the closing date for receipt of proposals must be submitted to the Executive Director before bid opening or the closing date for receipt of proposals.

2. In all other cases, protests must be submitted to the Executive Director not later than seven calendar days after the basis for protest is known, or should have been known, whichever is earlier.

B. Form and Content of Protest

1. Any protest must be submitted in writing and must be addressed to the Executive Director.

2. Any protest must include the name and address of the protestor; appropriate identification of the procurement; a statement of the reasons for the protest; and supporting exhibits, evidence, or documents to substantiate the reasons for the protest.

C. Decision of Executive Director or Procurement Officer

1. The Executive Director may deny any bid protest (a) received after the time periods set forth in Paragraph VII.A, or (b) lacking the required elements set forth in Paragraph VII.B.

2. With regard to all other bid protests, the Executive Director or a procurement officer designated by the Executive Director shall resolve the protest.

3. The Executive Director or designated procurement officer (a) may notify other interested parties of the existence of the protest and may obtain the views of other interested parties, and (b) may conduct discussions or negotiations with the protestor or with other interested parties and attempt to resolve the protest by agreement.

4. The Executive Director or designated procurement officer shall issue a written decision resolving any bid protest that cannot be resolved by agreement.

5. For bid protests associated with contracts valued at less than $75,000, or with a procurement in which the contract is reasonably anticipated to be valued at less than $75,000, the decision of the Executive Director or designated procurement officer is final.

D. Appeal

1. Except in cases where, as set forth above, the decision of the Executive Director or designated procurement officer is final, a protestor may appeal from the

decision of the Executive Director or designated procurement officer to the Board of Trustees. The appeal must be in writing, must be addressed to the Chair of the Board of Trustees, must identify each ground on which the protestor claims that the protest was resolved in error, and must include a copy of the initial protest and the decision of the Executive Director or designated procurement officer resolving the protest. Appeals must be postmarked within ten calendar days after issuance of the decision resolving the protest. Ten copies of all required materials must be submitted.

2. The Board of Trustees may deny any appeal (a) received after the time periods set forth in Paragraph VII.D.1, or (b) lacking the required elements set forth in Paragraph VII.D.1.

3. The Board of Trustees may determine that a hearing would assist in the resolution of any appeal. The Board may elect to hold the hearing itself or may refer the matter for a hearing and recommended decision to a member of the Board, to a panel consisting of two or more members of the Board, or to another impartial decision-maker, such as the Office of Administrative Hearings.

4. A final decision resolving the appeal will be issued by vote of the Board of the Trustees.

E. Award Pending Protest

The Board of Trustees may vote to award a contract before there is a final decision of the Exchange resolving a bid protest. Otherwise, a contract shall not be awarded during the pendency before the Exchange of a bid protest related to that contract.

F. Resolution of Protest

In resolving a bid protest, the Board of Trustees, Executive Director or designated procurement officer may (a) deny the protest, (b) sustain the protest but nonetheless determine that the procurement should proceed, consistent with Paragraph VIII.B, below, or (c) sustain the protest and declare a contract to be void, order that all bids be re-evaluated for award, order that a solicitation be re-issued, or require that any other action be taken that fairly addresses the protest.

VIII. CONTRACTS VOIDABLE FOR NONCOMPLIANCE

A. If the Board of Trustees or a person with authority to award a contract under these Procurement Policies and Procedures finds that a procurement violates these Policies and Procedures, or that a contract has been awarded in violation of these Policies and Procedures, the Board or person with authority may order that any action be taken to resolve the violation and may declare void a contract awarded in violation of these Policies and Procedures.

B. Alternatively, the Board or person with authority may determine that a procurement should proceed, or that a contract should not be declared void, notwithstanding a violation of these Procurement Policies and Procedures, if (a) the parties acted in good faith, (b) proceeding with the procurement or ratification of the contract would not undermine the purposes of these Policies and Procedures, (c) the violation was insignificant or otherwise did not prevent substantial compliance with these Policies and Procedures, and (d) proceeding with the procurement or ratification would be in the best interest of the Exchange.

IX. AUTHORITY OF CHAIR PRIOR TO APPOINTMENT OF EXECUTIVE DIRECTOR

Prior to the appointment of an Executive Director, the Chair of the Board of Trustees shall have authority to take any action that these Procurement Policies and Procedures authorize the Executive Director to take, including the designation of a procurement officer in any circumstance where the Executive Director is authorized to designate a procurement officer.

X. STATUS OF JUNE 3, 2011 INTERIM POLICY FOR PROCUREMENT OF STUDIES

The Interim Policy for Procurement of Studies Mandated in Maryland Health Benefit Exchange Act of 2011, adopted by the Board of Trustees on June 3, 2011, shall remain in effect until December 23, 2011, the date by which the studies mandated in Section 5 of the Exchange Act must be completed, except that (a) the Chair may delegate to the Executive Director any authority or responsibility delegated to the Chair under the Interim Policy; (b) if the Board, the Chair, or the Executive Director determines that the Exchange has failed to obtain the required assistance through a procurement undertaken in accordance with the Interim Policy, a new procurement may be undertaken in accordance with these Procurement Policies and

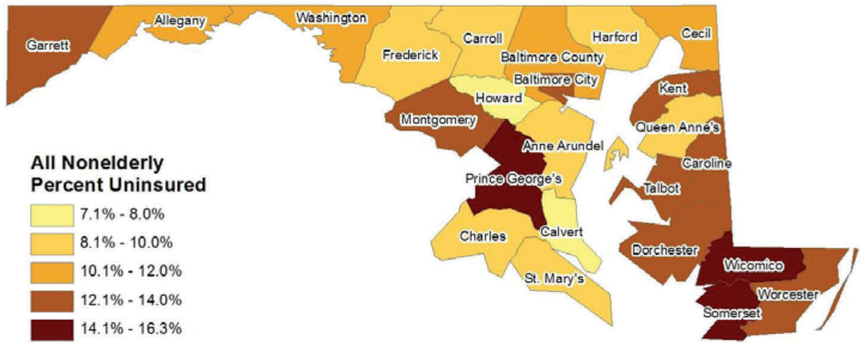
Procedures; and (c) if the Executive Director determines, after June 27, 2011, that assistance beyond that sought pursuant to the Interim Policy is required for timely completion of the studies mandated in Section 5 of the Exchange Act, the procurement of such additional assistance shall be undertaken in accordance with these Policies and Procedures.

XI. ANNUAL REPORT

In the annual report or reports prepared pursuant to § 31-111(c) of the Insurance Article of the Maryland Code and Article VIII, Section 3 of the Bylaws of the Board of Trustees, the Executive Director shall include (a) a list of all contracts awarded by the Exchange valued at $15,000 or more, the persons or entities to which the contract was awarded, the purpose of the contract, and the amount of the contract; and (b) a report on the Exchange's compliance with Title 14, Subtitle 3 of the State Finance and Procurement Article and other efforts to encourage minority business participation.

Exhibit J Eligibility and Rates of Uninsured by County

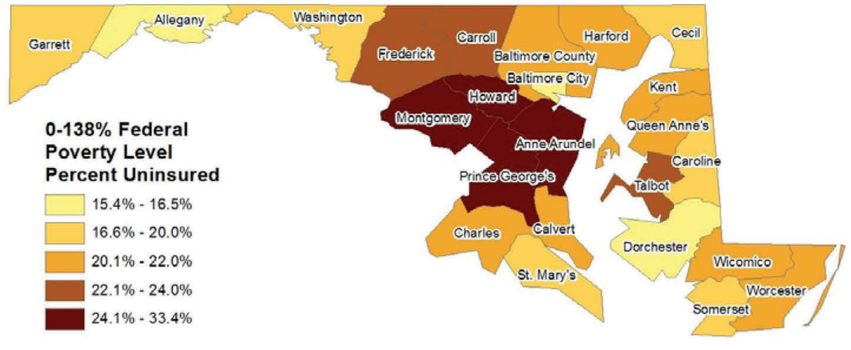
Maryland Uninsured
Likely Eligible for New ACA Coverage Options



Data Source:
The estimates are from the 2012 Small Area Health Insurance Estimates (SAHIE) program at the U.S. Census Bureau: http://www.census.gov/did/www/sahie/. The SAHIE program models health insurance coverage by combining survey estimates with administrative records, population estimates, and the decennial census.

shadac

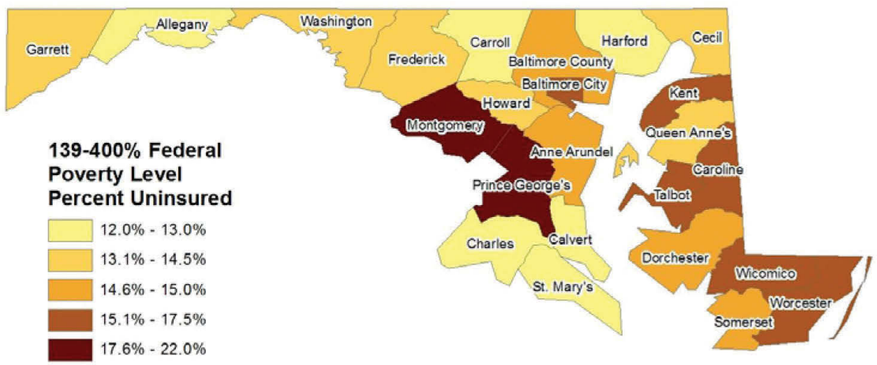
Maryland Uninsured
Likely Eligible for Medicaid



Data Source:
The estimates are from the 2012 Small Area Health Insurance Estimates (SAHIE) program at the U.S. Census Bureau: http://www.census.gov/did/www/sahie/. The SAHIE program models health insurance coverage by combining survey estimates with administrative records, population estimates, and the decennial census.

shadac

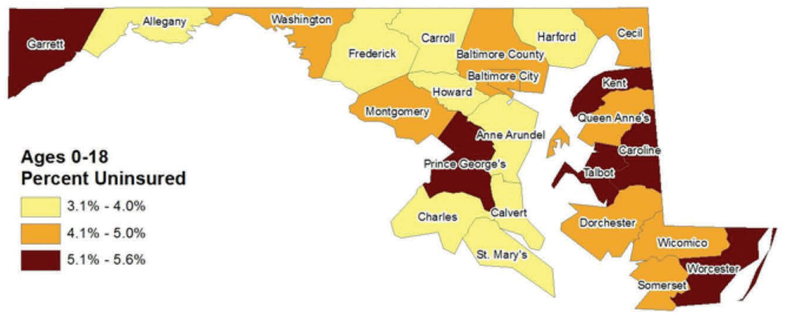
Maryland Uninsured
Likely Eligible for Exchange Subsidies



Data Source:
The estimates are from the 2012 Small Area Health Insurance Estimates (SAHIE) program at the U.S. Census Bureau: http://www.census.gov/did/www/sahie/. The SAHIE program models health insurance coverage by combining survey estimates with administrative records, population estimates, and the decennial census.

shadac

Maryland Uninsured
Ages 0-18



Data Source:
The estimates are from the 2012 Small Area Health Insurance Estimates (SAHIE) program at the U.S. Census Bureau: http://www.census.gov/did/www/sahie/. The SAHIE program models health insurance coverage by combining survey estimates with administrative records, population estimates, and the decennial census.

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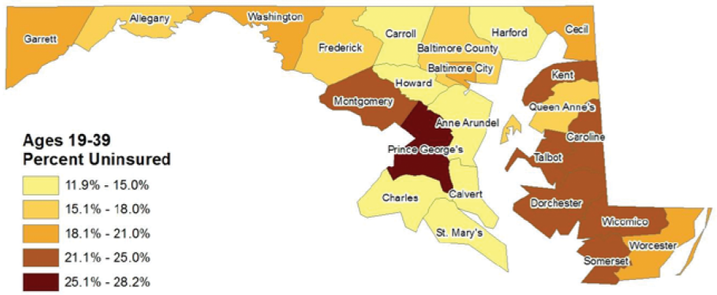
Maryland Uninsured
Ages 19-39



Data Source:
The estimates are from the 2012 Small Area Health Insurance Estimates (SAHIE) program at the U.S. Census Bureau: http://www.census.gov/did/www/sahie/. The SAHIE program models health insurance coverage by combining survey estimates with administrative records, population estimates, and the decennial census.

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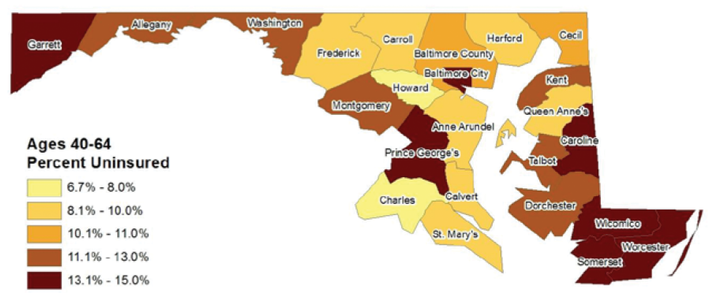
Maryland Uninsured
Ages 40-64



Data Source:
The estimates are from the 2012 Small Area Health Insurance Estimates (SAHIE) program at the U.S. Census Bureau: http://www.census.gov/did/www/sahie/. The SAHIE program models health insurance coverage by combining survey estimates with administrative records, population estimates, and the decennial census.

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Data: 2012 Small Area Health Insurance Estimates (SAHIE) program, U.S. Census Bureau
Credit: Elizabeth Lukanen, State Health Access Data Assistance Center (SHADAC)

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