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**State:** Vermont **Filing Company:** TVHP  
**TOI/Sub-TOI:** ML02 Multi-Line - Other/ML02.000 Multi-Line - Other  
**Product Name:** 2Q 2014 TVHP Benefit Relativity Factor Filing  
**Project Name/Number:** /

## Filing at a Glance

Company: TVHP  
Product Name: 2Q 2014 TVHP Benefit Relativity Factor Filing  
State: Vermont  
TOI: ML02 Multi-Line - Other  
Sub-TOI: ML02.000 Multi-Line - Other  
Filing Type: GMCB Trend / Admin Charge  
Date Submitted: 01/13/2014  
SERFF Tr Num: BCVT-129370736  
SERFF Status: Assigned  
State Tr Num:  
State Status:  
Co Tr Num:  
  
Implementation: On Approval  
Date Requested:  
Author(s): Vince Mace, Pam Young, Seth Abbene, Jude Daye, Martine Brisson-Lemieux  
Reviewer(s): Thomas Crompton (primary), Kelly Macnee, David Dillon, Jacqueline Lee  
Disposition Date:  
Disposition Status:  
Implementation Date:  
  
State Filing Description:

**State:** Vermont  
**TOI/Sub-TOI:** ML02 Multi-Line - Other/ML02.000 Multi-Line - Other  
**Product Name:** 2Q 2014 TVHP Benefit Relativity Factor Filing  
**Project Name/Number:** /

**Filing Company:** TVHP

## General Information

Project Name: Status of Filing in Domicile:  
Project Number: Date Approved in Domicile:  
Requested Filing Mode: Review & Approval Domicile Status Comments:  
Explanation for Combination/Other: Market Type: Group  
Submission Type: New Submission Group Market Size: Small and Large  
Group Market Type: Employer, Association Overall Rate Impact:  
Filing Status Changed: 01/13/2014  
State Status Changed: Deemer Date:  
Created By: Jude Daye Submitted By: Jude Daye  
Corresponding Filing Tracking Number:

Filing Description:  
January 8, 2014

Judith Henkin, Esq.  
Health Policy Director  
Green Mountain Care Board  
89 Main Street, Third Floor, City Center  
Montpelier, Vermont 05620

SUBJECT: The Vermont Health Plan – NAIC # 95696  
Q2 2014 Benefit Relativity Factor Filing

Dear Ms. Henkin:

We are submitting for your review and approval benefit relativity factors for The Vermont Health Plan (TVHP). It is our desire to use these factors in the rating of TVHP large group products, for business that is new or renewing in the second quarter of 2014 or later.

Please let me know if we can answer any questions or provide further information during your review.

Sincerely,

Kevin Goddard

cc: Tom Crompton/GMGB  
Ruth Greene/BCBSVT  
Vince Mace/BCBSVT  
Paul Schultz/BCBSVT

## Company and Contact

### Filing Contact Information

Jude Daye, Executive Assistant  
445 Industrial Lane  
Montpelier, VT 05601

dayej@bcbsvt.com  
802-371-3244 [Phone]

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**State:** Vermont **Filing Company:** TVHP  
**TOI/Sub-TOI:** ML02 Multi-Line - Other/ML02.000 Multi-Line - Other  
**Product Name:** 2Q 2014 TVHP Benefit Relativity Factor Filing  
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**Filing Company Information**

TVHP	CoCode: 95696	State of Domicile: Vermont
PO BOX 186	Group Code:	Company Type: HMO
Montpelier, VT 05601	Group Name:	State ID Number:
(802) 371-3450 ext. [Phone]	FEIN Number: 03-0354356	

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**Filing Fees**

Fee Required? No  
 Retaliatory? No  
 Fee Explanation:

SERFF Tracking #:

BCVT-129370736

State Tracking #:

Company Tracking #:

<b>State:</b>	Vermont	<b>Filing Company:</b>	TVHP
<b>TOI/Sub-TOI:</b>	ML02 Multi-Line - Other/ML02.000 Multi-Line - Other		
<b>Product Name:</b>	2Q 2014 TVHP Benefit Relativity Factor Filing		
<b>Project Name/Number:</b>	/		

## Supporting Document Schedules

<b>Satisfied - Item:</b>	Actuarial Memorandum
<b>Comments:</b>	
<b>Attachment(s):</b>	TVHP Q2 2014 BRV Filing - Actuarial Memorandum.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Bypassed - Item:</b>	Civil Union Rating Requirements
<b>Bypass Reason:</b>	Not required.
<b>Attachment(s):</b>	
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Filing Compliance Certification
<b>Comments:</b>	
<b>Attachment(s):</b>	Filing Compliance Certification.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Bypassed - Item:</b>	Third Party Filing Authorization
<b>Bypass Reason:</b>	BCBSVT does not use a Third Party to submit filings.
<b>Attachment(s):</b>	
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Plain Language Summary and Exhibits
<b>Comments:</b>	
<b>Attachment(s):</b>	TVHP Q2 2014 BRV Filing - Plain Language Summary.pdf TVHP Q2 2014 BRV Filing - Exhibits.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

# The Vermont Health Plan Q2 2014 Benefit Relativity Methodology Actuarial Memorandum

## Purpose

The purpose of this narrative is to describe the methodology for determining a common set of benefit relativities for the rating of The Vermont Health Plan (TVHP) plans. It is our desire to use the relativity factors derived from this methodology, and displayed in the exhibits, for the rating of large group business that is new or renewing in the second quarter of 2014 or later. The relativities will be used as described in the approved TVHP Group Merit Rating Program filing (SERFF# BCVT-128888672, VFN 64785). For any future benefit variations or special benefits not contained in the enclosed exhibits, relativities will be calculated using the same method described in this filing.

## Overview

To determine standardized premium rate relationships, also called relativities, BCBSVT has created models that simulate the impact of member benefits for all types of plans. The models determine the allowed charges for the completed 12 months of claims included in the study, and “re-adjudicate” the claims, thereby simulating the impact of member cost sharing for a given benefit plan.

Claims data is from BCBSVT’s data warehouse. All claim and enrollment data comes from the BCBSVT’s data warehouse except where noted below. To ensure accuracy, the claims data used has been reconciled against internal reserving, enrollment and other financial reports. The starting point of the analysis is allowed charges as determined by the BCBSVT claims adjudication system. The claims data includes benefit codes that enable us to identify the services and benefit structures (copays, deductibles, and coinsurance).

For each benefit plan of interest, the models produced the simulated PMPM values of the benefits. Using the average allowed charges and average experience paid-to-allowed ratio, we calculated a “base” PMPM, also called the manual rate. This is the manual rate referred to as the “Book of Business Standard Plan Expected Single Claims Rate” in section VI.D of the TVHP Group Merit Rating Program Filing. The PMPM for each plan was then divided by the manual rate to produce its relativity. Relativities are included for medical only plans, Rx only plans, and CDHP plans.

## Details about the Medical Benefit Model

Incurred allowed charges from August 2012 to July 2013, paid through October 2013, were used. We avoided using calendar year 2012 because experience for the first quarter of 2012 for BCBSVT’s Indemnity products was worse than normal, and may have skewed the benefit relationships. The allowed charges were trended to July 1, 2015. This date is the midpoint of the 12-month period that begins January 1, 2015. The majority of the business that will be renewed using these relativity factors has a January 1 renewal date; the TVHP Group Merit Rating Program formula adjusts the trend for non-January renewals.

## The Vermont Health Plan Q2 2014 Benefit Relativity Methodology Actuarial Memorandum

The claims from Insured Group and Self Funded business are included in the analysis. Only plans with both medical and pharmacy benefits are included. We excluded claims for Individual lines of business, as well as claims for Large Groups with special benefits. Claims and members that have Medicare as their primary insurance were also excluded.

Claims from both BCBSVT and TVHP are used. An adjustment was made to the TVHP allowed charges to restate all claims on the 2013 contract basis. Using the contracted reimbursement schedule, we calculated network factors that represent the different network contracts. Using these factors, we can include all claims in each of the three networks by adjusting each claim. This enables us to combine all the experience for each plan design. This also increases the number of member months used to 1,567,815, and enables us to use the same membership base in both the medical and pharmacy models.

The claims were categorized according to how benefits are paid, and one record was generated for each member, date of service, and type of service. Each record was then assigned a cost share (deductible/coinsurance, copay, covered in full) for each plan available.

The plan designs modeled are:

- Blue Care HMO (HMO)
- Blue Care Point of Service (POS)
- Blue Care Open Access (OAP)
- Blue Care Lo Option (LO)
- Consumer Driven Health Plan (CDHP)

For all products, claims for preventive mandated benefits were assigned a “covered in full” cost share, independently of the product that is being modeled.

The model tested one benefit design at a time. It determined the member portion of the allowed charges, and from this, a total simulated paid PMPM for each benefit design. The impact of the office copay, deductible, coinsurance, out-of-pocket maximum, and preventive mandated benefits were all considered. If the average allowed cost of a category was less than the copay being examined, it was assumed that the member paid for the full cost of the service.

POS and OAP plans have an out-of-network benefit. In the administration of this benefit, there is no overlap between the in-network and out-of-network deductible and coinsurance. For LO, and CDHP, all claims were included and adjudicated under the one overall benefit. The allowed charges associated with out-of-network benefits were adjusted by applying a factor equal to the ratio of out-of-network charges PMPM for each plan in the base data to the analogous PMPM in the aggregate base data, in order to account for the “freedom” associated with the plan. For HMO and LO plans, a smaller portion of the overall out-of-network allowed charges was included to account for the authorized out-of-network claims (ER, Specialty procedures, etc).

**The Vermont Health Plan  
Q2 2014 Benefit Relativity Methodology  
Actuarial Memorandum**

**Benefit Induced Utilization: Medical**

An independent analysis was performed to measure the correlation between the benefit design and the quantity of medical services consumed. Claims and membership data from January 2009 through August 2013 were examined, and a modeled paid-to-allowed ratio was assigned to every benefit in the experience period. The correlation used the paid-to-allowed ratio as the independent variable and the utilization frequency (defined as Professional and Outpatient visits + Inpatient Admissions) as the dependent variable. A 2<sup>nd</sup> order polynomial was found to best fit the data. The polynomial was then normalized such that the paid-to-allowed ratio underlying the base BRV benefit (manual rate) returned a utilization adjustment of 1.00. In other words, if a simulated benefit has a paid-to-allowed ratio less than that of the average benefit, then utilization will be reduced (i.e. factor < 1.00). If a simulated benefit has a paid-to-allowed ratio greater than the average, then the benefit will have induced utilization (i.e. factor > 1.00).

**Details about the Pharmacy Benefit Model**

As with medical claims described above, incurred allowed drug charges from August 2012 to July 2013, paid through October 2013, were used. The charges were completed and trended to July 1, 2015. Included are claims from Insured Group, Self Funded and TVHP Group business. Since both TVHP and BCBSVT have the same Pharmacy Benefit Manager (PBM) contract, no adjustment was needed to combine the claims from the two companies. We excluded claims from Individual lines of business, as well as claims for Large Groups with special benefits. Only plans with both medical and pharmacy benefits are included.

Within the model, pharmacy scripts are assigned to one of six categories:

- Retail Generic
- Retail Preferred Brand
- Retail non-Preferred Brand
- Mail Generic
- Mail Preferred Brand
- Mail non-Preferred Brand

The experience period data was adjusted to reflect the major brands that are expected to become generic during 2014 and 2015. The list was based on a report provided by ESI, our PBM.

For these brands, the following adjustments were made:

- For the first 6 months (exclusivity period), we reduced the Average Wholesale Price (AWP) by 10% and kept the brand discount.
- For the months after the exclusivity period, we reduced the AWP by 10% and changed the discount to the generic discount. The 10% reductions in AWP are based upon industry standard assumptions, supported by our own analysis of AWP changes for drugs that have moved from brand to generic over the past several years.

One record was created for each member and date of service combination. One record can have more than one script category. The model tested one benefit design

**The Vermont Health Plan  
Q2 2014 Benefit Relativity Methodology  
Actuarial Memorandum**

at a time. It determined the member portion of the allowed charges and a total simulated paid PMPM for each benefit design. The impact of the deductible, coinsurance, copays and out-of-pocket maximum (OOPM) were considered. Following the ACA, contraceptives were excluded from the cost sharing. If the average allowed cost of a category is less than the copay being examined, it is assumed that the member pays for the full cost of the script. With Vermont Act 171, all pharmacy benefits now have an OOPM of \$1,250. It is expected that this limit will increase to an unknown amount, following the IRC rules for Health Savings Account and High Deductible Plans, in 2015. The exhibits include the \$1,250 OOPM benefit on pharmacy.

TVHP also offers different riders for pharmacy benefits. These riders will be modeled in the same way described above.

**Benefit Induced Utilization: Pharmacy**

Independent analysis was performed to measure the correlation between the benefit design and the quantity of pharmacy prescriptions consumed. The pharmacy benefits are adjusted in two ways. First, the generic utilization varies with the benefit designs. Claims and membership data from January 2009 through August 2013 were examined, and a table was created to adjust the base generic utilization up or down depending on the difference in the Generic and Brand copays of the member's drug plan.

Second, a separate analysis was done to adjust for the overall pharmacy benefit. A modeled paid-to-allowed ratio was assigned to every benefit in the experience period. The correlation used the paid-to-allowed ratio as the independent variable and utilization frequency (defined as number of scripts) as the dependent variable. A line was found to best fit the data. The line was then normalized such that the paid-to-allowed ratio underlying the base BRV benefit (manual rate) returned a utilization adjustment of 1.00.

**Details about the Integrated Benefit Model (CDHP)**

The CDHP model combines both the medical and pharmacy models described above. One record was created for each member, date of service and type of service combination. A separate medical and pharmacy paid-to-allowed ratio was calculated, and the appropriate utilization adjustment was made.

**Details about the Manual Rate (Base Plan PMPM)**

The manual rate is based on the experience average allowed charges and average paid-to-allowed ratio in the experience period. The Experience Paid-to-Allowed Ratios are calculated before any adjustment is made to the claims. The manual rate used in this filing is \$408.35.

**The Vermont Health Plan  
Q2 2014 Benefit Relativity Methodology  
Actuarial Memorandum**

	PMPM Allowed	Experience Paid-to-Allowed Ratio	PMPM Paid
Medical	\$412.48	84.46%	\$348.38
Rx	\$71.31	84.10%	\$59.97
Total	\$483.79	84.41%	\$408.35

The ratio of medical to pharmacy allowed charges has shifted with the updated experience and trends. The table below shows the prior and current ratios:

	Medical Weight	Pharmacy Weight
Prior Filing	82.1%	17.9%
Current Filing	85.3%	14.7%

The new medical to pharmacy ratio is reflected in the final benefit relative values.

**Actuarial Opinion**

The purpose of this filing is to develop benefit relative value factors for use in the rating of TVHP large group benefit plans. This filing is not intended to be used for other purposes.

The data used in this analysis has been reviewed for reasonableness and consistency; however, it has not been audited.

It is my opinion that the benefit relative value factors presented in this filing fall within a range of reasonable values. They will produce premium rates that are reasonable in relation to the benefits provided, adequate, not excessive, and not unfairly discriminatory.

I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries, and I meet the Academy's Qualification Standards to render this opinion.

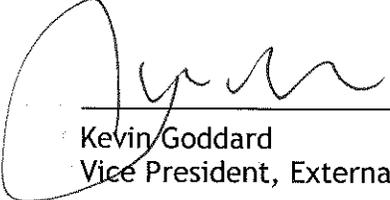



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Paul Schultz, F.S.A., M.A.A.A.

January 6, 2014

I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and, to the best of my knowledge, the filing complies with all applicable statutory and regulatory provisions for the state of Vermont



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Kevin Goddard  
Vice President, External Affairs and Sales

11/9/14

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Date

**The Vermont Health Plan  
Q2 2014 Benefit Relativity Methodology  
Plain Language Summary**

The purpose of this filing is to establish a common set of benefit relativities for the rating of The Vermont Health Plan (TVHP) plans. The relativity factors will be used in the rating of large group business that is new or renewing in the second quarter of 2014 or later.

In developing rates for Merit rated (i.e. experience rated) groups it is typically the case that the plans of benefits to be rated are different from those from which the experience arose. To adjust for this, benefit relativity values are calculated for each plan of benefits. This is done by taking the claims for our entire book of business and recalculating the paid claims based on each provider network and plan design. Adjustments are made for the fact that utilization patterns for richer than average/ (leaner than average) benefit levels are higher/ (lower) than for an average benefit level. The resulting expected claim amounts for each benefit plan are compared to the average block of business claim amount to produce a series of index values, or benefit relativities. These relativities are used to convert a case's experience under the plan in force in its experience period to the expected experience under any new plan in the rating period.

The series of benefit relativity factors are themselves, on the whole, neutral to the cost of coverage. Rather, the factors are used to create reasonable and adequate pricing differentials among specific benefit plan designs.

For cases that are not fully credible, the block of business average PMPM is used to generate "manually rated" expected claims for the rating period. The manual rate is blended with the case's actual experience based upon the level of credibility assigned to the case. While this methodology is described in detail within the TVHP Group Merit Rating Program filing, the development of the book of business average PMPM is described within this filing.

**The Vermont Health Plan  
Benefit Plan Relative Value Factors  
BlueCare LO Options (BCLO) and Open Access (OAP) Medical Plans**

index	Product	In-Network						Out-of-Network			Relativity
		Deductible	Coinsurance	Out-of-Pocket	Office Copay	Specialist Copay	ER <sup>1</sup> Copay	Deductible	Coinsurance	Out-of-Pocket	Active
1	LO	\$2,500	0%	\$2,500							0.7036
2	LO	\$5,000	0%	\$5,000	\$30	\$30					0.6142
3	OAP	\$500	20%	\$1,500	\$20	\$20	\$100	\$1,000	40%	\$3,000	0.8956
4	OAP	\$2,000	20%	\$4,000	\$30	\$30	\$100	\$4,000	40%	\$8,000	0.7086
5	OAP	\$3,000	0%	\$3,000	\$30	\$30	\$100	\$5,000	40%	\$10,000	0.7291

1. **ER Copay:** the displayed member copay goes toward the facility allowed charges.  
Associated physician and ancillary charges are the covered at 100%.
2. For the BCLO product, Office and Specialist Copay can be under the deductible.
3. BCLO does not have Out-of-Network benefits.

**The Vermont Health Plan  
Benefit Plan Relative Value Factors  
Consumer Driven Health Plans (CDHP's)**

index	Product	In-Network						Relativity
		Deductible	Coinsurance	Out-of-Pocket	Rx OOPM Limit <sup>3</sup>	Wellness Rx <sup>1</sup>	Drugs After Deductible <sup>2</sup>	Active
1	CDHP	\$1,500	0%	\$1,500	\$1,250	N/A	0%	0.9724
2	CDHP	\$1,500	0%	\$1,500	\$1,250	0%	0%	0.9774
3	CDHP	\$1,500	20%	\$2,500	\$1,250	N/A	20%	0.8913
4	CDHP	\$1,800	0%	\$1,800	\$1,250	N/A	0%	0.9327
5	CDHP	\$2,000	0%	\$2,000	\$1,250	N/A	0%	0.9092
6	CDHP	\$2,000	10%	\$3,500	\$1,250	N/A	10%/40%/50%	0.8450
7	CDHP	\$2,000	20%	\$3,500	\$1,250	N/A	10%/25%/25%	0.8236
8	CDHP	\$2,000	0%	\$2,000	\$1,250	0%	0%	0.9154
9	CDHP	\$2,000	0%	\$2,000	\$1,250	\$10/\$30/\$50	0%	0.9111
10	CDHP	\$2,000	20%	\$3,000	\$1,250	N/A	20%	0.8405
11	CDHP	\$2,250	0%	\$2,250	\$1,250	N/A	0%	0.8831
12	CDHP	\$2,250	0%	\$2,250	\$1,250	0%	0%	0.8896
13	CDHP	\$2,250	20%	\$3,250	\$1,250	\$15/\$40/\$60	20%	0.8197
14	CDHP	\$2,500	0%	\$2,500	\$1,250	0%	0%	0.8663
15	CDHP	\$2,500	0%	\$2,500	\$1,250	N/A	0%	0.8595
16	CDHP	\$2,500	0%	\$2,500	\$1,250	\$10/\$30/\$50	0%	0.8613
17	CDHP	\$2,500	0%	\$2,500	\$1,250	\$10/\$30/\$50	0%	0.8613
18	CDHP	\$2,500	10%	\$5,000	\$1,250	N/A	10%	0.7941
19	CDHP	\$3,000	0%	\$3,000	\$1,250	N/A	0%	0.8186
20	CDHP	\$3,000	0%	\$3,000	\$1,250	0%	0%	0.8261
21	CDHP	\$3,000	0%	\$3,000	\$1,250	\$10/\$30/\$50	0%	0.8204
22	CDHP	\$3,000	20%	\$5,000	\$1,250	0%	20%	0.7508
23	CDHP	\$3,000	20%	\$5,500	\$1,250	N/A	10%/25%/25%	0.7331
24	CDHP	\$3,000	0%	\$3,000	\$1,250	\$5/\$15/\$40	0%	0.8224
25	CDHP	\$3,000	0%	\$3,000	\$1,250	0%	0%	0.8261
26	CDHP	\$3,000	0%	\$3,000	\$1,250	\$5/40%/60%	0%	0.8197
27	CDHP	\$3,000	0%	\$4,000	\$1,250	\$10/\$30/\$50	\$10/\$30/\$50	0.8096
28	CDHP	\$3,000	20%	\$4,000	\$1,250	0%	20%	0.7753
29	CDHP	\$3,250	20%	\$4,250	\$1,250	\$15/\$40/\$60	20%	0.7520
30	CDHP	\$4,000	0%	\$4,000	\$1,250	0%	0%	0.7630
31	CDHP	\$4,000	0%	\$4,000	\$1,250	N/A	0%	0.7543
32	CDHP	\$5,000	0%	\$5,000	\$1,250	0%	0%	0.7151
33	CDHP	\$5,000	0%	\$5,000	\$1,250	N/A	0%	0.7054
34	CDHP	\$5,000	0%	\$5,000	\$1,250	\$10/\$30/\$50	0%	0.7081

1. **Wellness Rx:** if applicable, cost sharing rules apply *before* the deductible is satisfied.

The member's cost share for **Wellness Rx** accumulates toward the Out-of-Pocket Maximum.

2. **All other drugs** are subject to deductible. Once the deductible is met, drugs are subject to the **Drugs After Deductible** cost share until the Out-of-Pocket Maximum is met.

3. The **Rx OOPM** Limit is as described in Vermont Act 171.

**The Vermont Health Plan  
Benefit Plan Relative Value Factors  
BlueCare (HMO) Medical Plans**

index	Product <sup>1</sup>	In-Network								Relativity
		IP	OP	HOSP	PCP	SCP	ER	AMB	OOPM	Active
1	HMO	\$2,000	\$1,000		\$20	\$30	\$50	\$50	\$6,350	1.0002
2	HMO	\$250	\$100		\$20	\$30	\$50	\$0	\$6,350	1.0546
3	HMO	\$0	\$0		\$10	\$20	\$50	\$0	\$6,350	1.0772
4	HMO	\$250	\$100		\$10	\$20	\$50	\$0	\$6,350	1.0734
5	HMO	\$250	\$100		\$15	\$25	\$50	\$0	\$6,350	1.0667
6	HMO	\$0	\$0		\$20	\$30	\$50	\$0	\$6,350	1.0620
7	HMO	\$0	\$100		\$20	\$30	\$50	\$0	\$6,350	1.0586
8	HMO			\$1,000	\$20	\$30	\$50	\$50	\$6,350	1.0181
9	HMO	\$250	\$100		\$20	\$30	\$100	\$0	\$6,350	1.0502
10	HMO			\$3,000	\$20	\$30	\$100	\$50	\$6,350	0.9448
11	HMO	\$500	\$200		\$20	\$30	\$100	\$100	\$6,350	1.0420
12	HMO			\$750	\$20	\$30	\$50	\$50	\$6,350	1.0282
13	HMO	\$250	\$100		\$25	\$40	\$100	\$50	\$6,350	1.0292
14	HMO	\$1,500	\$750		\$20	\$30	\$50	\$50	\$6,350	1.0146
15	HMO	\$2,000	\$1,000		\$20	\$30	\$50	\$50	\$6,350	1.0002

PCP	Primary Care Physician Copay
SCP	Specialist Physician Copay
IP	Inpatient Care Deductible (max of 2/yr per family)
OP	Outpatient Surgery Copay
HOSP	Combined Inpatient Care & Outpatient Surgery Deductible (max of 2/yr per family)
ER	Emergency Room Copay
AMB	Ambulance Copay

1. All HMO Plans have a DME rider benefit of: \$100 deductible, 80% coinsurance, built into the relativity.
2. HMO Plans do not have Out-of-Network benefits.

The Vermont Health Plan  
 Benefit Plan Relative Value Factors  
 Prescription Drug Cards

index	Type	Deductible	Copay (\$) / Coinsurance (%)						OOPM	Diabetic Supplies	Lifestyle Exclusion Rider	Relativity
			Retail Generic	Retail Preferred Brand	Retail Non-Preferred Brand	Mail Order Generic	Mail Order Preferred Brand	Mail Order Non-Preferred Brand				Active
1	COP	\$0	\$10	\$20	\$35	\$20	\$40	\$70	\$1,250	100%	N	0.1616
2	COP	\$0	\$10	\$25	\$40	\$20	\$50	\$80	\$1,250	100%	N	0.1523
3	COP	\$0	\$15	\$25	\$40	\$30	\$50	\$80	\$1,250	100%	N	0.1533
4	COP	\$0	\$5	\$20	\$45	\$10	\$40	\$90	\$600	100%	N	0.1644
5	COP	\$100	\$10	\$30	\$50	\$20	\$60	\$100	\$1,250	100%	N	0.1359
6	COP	\$0	\$10	\$30	\$50	\$20	\$60	\$100	\$1,250	100%	N	0.1459
7	COP	\$0	\$10	\$30	\$60	\$20	\$60	\$120	\$1,250	100%	N	0.1444
8	COP	\$0	\$5	\$25	\$50	\$10	\$50	\$100	\$1,250	100%	N	0.1566
9	COP	\$100	\$10	\$30	\$45	\$20	\$60	\$90	\$1,250	100%	N	0.1366
10	COP	\$100	\$5	\$25	\$50	\$10	\$50	\$100	\$1,250	100%	N	0.1437
11	COP	\$100	\$5	\$35	\$50	\$10	\$70	\$100	\$1,250	100%	N	0.1390
12	COP	\$50	\$10	\$20	\$35	\$20	\$40	\$70	\$1,250	100%	N	0.1557
13	CMB	\$50	\$10	20%	20%	20%	20%	20%	\$1,250	SAAO	N	0.1276
14	COI	\$0	50%	50%	50%	50%	50%	50%	\$1,250	SAAO	N	0.1153
15	COI	\$0	0%	20%	50%	0%	20%	50%	\$1,250	SAAO	N	0.1500
16	COP	\$0	\$10	\$30	\$50	\$20	\$60	\$100	\$1,250	SAAO	N	0.1434
17	COP	\$0	\$15	\$25	\$40	\$30	\$50	\$80	\$1,250	SAAO	N	0.1509
18	COP	\$0	\$5	\$10	\$25	\$10	\$20	\$50	\$1,250	SAAO	N	0.1752
19	COP	\$0	\$5	\$20	\$35	\$10	\$40	\$70	\$1,250	SAAO	N	0.1620
20	COP	\$100	\$0	\$20	\$40	\$0	\$40	\$80	\$1,250	SAAO	N	0.1557
21	COP	\$100	\$10	\$15	\$30	\$20	\$30	\$60	\$1,250	SAAO	N	0.1507
22	COP	\$100	\$10	\$20	\$40	\$20	\$40	\$80	\$1,250	SAAO	N	0.1473
23	COP	\$100	\$10	\$25	\$45	\$20	\$50	\$90	\$1,250	SAAO	N	0.1386
24	COP	\$100	\$10	\$30	\$50	\$20	\$60	\$100	\$1,250	SAAO	N	0.1334
25	COP	\$50	\$10	\$20	\$35	\$20	\$40	\$70	\$1,250	SAAO	N	0.1534
26	COP	\$50	\$10	\$20	\$50	\$20	\$40	\$100	\$1,250	SAAO	N	0.1506
27	COP	\$50	\$10	\$25	\$40	\$20	\$50	\$80	\$1,250	SAAO	N	0.1443
28	COP	\$50	\$10	\$30	\$50	\$20	\$60	\$100	\$1,250	SAAO	N	0.1381
29	COP	\$50	\$5	\$10	\$25	\$10	\$20	\$50	\$1,250	SAAO	N	0.1673
30	COP	\$0	\$10	\$20	\$40	\$20	\$40	\$80	\$1,250	SAAO	N	0.1582
31	COP	\$0	\$10	\$25	\$40	\$20	\$50	\$80	\$1,250	SAAO	N	0.1498
32	COP	\$0	\$10	\$30	\$60	\$20	\$60	\$120	\$1,250	SAAO	N	0.1419
33	COP	\$0	\$10	\$35	\$60	\$20	\$70	\$120	\$1,250	SAAO	N	0.1380
34	COP	\$0	\$15	\$30	\$45	\$30	\$60	\$90	\$1,250	SAAO	N	0.1418
35	COP	\$0	\$5	\$20	\$45	\$10	\$40	\$90	\$1,250	SAAO	N	0.1600
36	COP	\$0	\$5	\$30	\$50	\$10	\$60	\$100	\$1,250	SAAO	N	0.1501
37	COP	\$100	\$10	\$30	\$45	\$20	\$60	\$90	\$1,250	SAAO	N	0.1341
38	COP	\$100	\$10	\$30	\$50	\$20	\$60	\$100	\$1,200	SAAO	N	0.1336
39	COP	\$100	\$15	\$30	\$45	\$30	\$60	\$90	\$1,250	SAAO	N	0.1331
40	COP	\$100	\$15	\$30	\$50	\$30	\$60	\$100	\$1,250	SAAO	N	0.1324
41	COP	\$100	\$5	\$20	\$40	\$10	\$40	\$80	\$1,250	SAAO	N	0.1476
42	COP	\$100	\$5	\$20	\$45	\$10	\$40	\$90	\$1,250	SAAO	N	0.1468
43	COP	\$150	\$10	\$30	\$50	\$20	\$60	\$100	\$1,250	SAAO	N	0.1294
44	COP	\$50	\$10	\$25	\$35	\$20	\$50	\$70	\$1,250	SAAO	N	0.1452
45	COP	\$50	\$10	\$35	\$70	\$20	\$70	\$140	\$1,250	SAAO	N	0.1318
46	COP	\$50	\$15	\$25	\$40	\$30	\$50	\$80	\$1,250	SAAO	N	0.1460

\* **Type:** COI = coinsurance; COP = copay; CMB = combined

\* **Diabetic:** If "100%" then Diabetic supplies are covered at 100% of allowed charges;

If "SAAO" then Diabetic supplies are subject to cost sharing same as any other prescription drug.

\* **Lifestyle Exclusion Rider :** If "Y" then the benefit has the Lifestyle Exclusion Rider.