

## 2017 Health Insurance Survey

Thank you for taking this required survey. Please note that the paper version of this survey cannot be mailed in. It is being provided as an added convenience to allow you to gather data before beginning the online version. Your time and effort are greatly appreciated.

Pages and questions may be skipped depending on the answers to certain questions. Many questions are based on answers to prior questions.



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Please answer the following questions as they apply to active, full-time employees as of January 1, 2017.

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1. Is the employee offered a stipend so that they may purchase their own medical insurance from the Affordable Care Act Marketplace?

Yes  No

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2. Are full-time employees offered some form of health insurance coverage (Medical, Vision, Dental, or Life)?

Yes  No

Go to Question 3 if answered Yes to Question 1.

Go to Question 176 if answered no to both questions above.

3. What is the **annual dollar amount** of the stipend offered to employees to use in the marketplace to buy medical insurance? If there is one rate for all enrollees, please fill in "Composite Rate" only.

*Note: A composite rate is a flat rate offered to all employees regardless if they have a single or family plan.*

Single: (Annual)

Single plus Child: (Annual)

Single plus Spouse: (Annual)

Single plus One: (Annual)

Family: (Annual)

Composite Rate: (Annual)

Other comments?

Go to question 176 if answered No to question 2

4. Are part-time employees offered some form of health insurance coverage (Medical, Vision, Dental, or Life)?

Yes  No

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5. Please check the box next to each health insurance plan or benefit offered by the organization:

*Please check all that apply.*

*Note: A flexible spending account is a tax-advantaged financial account that allows employees to set aside pre-tax income for premiums and qualified medical, dental, child or dependent care expenses.*

- Medical
  - Pharmaceutical
  - Dental
  - Vision
  - Flexible Spending Account
-

6. If an employee could be covered by another medical insurance policy (through spouse or other family member), does the organization offer an incentive or require them to waive their right to health insurance through their employer?

- Incentive offered
- Requirement to take other insurance as primary
- Neither
- No answer
- Other

Skip Question 7 & 8 unless selected incentive offered.

In the previous question you stated that the organization offers an incentive to employees to waive their right to health insurance through the employer. Please answer the following two questions.

7. How many employees have accepted the waiver during the current plan year?

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8. If a monetary incentive is offered to waive their right to health insurance, what is the annual amount offered? (If a percentage of the premium is offered, please state the dollar equivalent below.)

Not applicable

	Dollar Amount Offered To Waive Health Insurance
Single: (Annual)	<input type="text"/>
Single and Child: (Annual)	<input type="text"/>
Single and Spouse: (Annual)	<input type="text"/>
Single plus One: (Annual)	<input type="text"/>
Family: (Annual)	<input type="text"/>

**Skip Questions 9 – 11 unless Employer offers a Flex Spending Account**

**9. You indicated that the employer offers a flexible spending account (FSA). What type of plan is it?**

*Check all that apply*

- Healthcare premium pass-through only
  - Medical and dental expense account
  - Child and dependent care account
- 

**10. Does the employer contribute to employee flexible spending accounts?**

- Yes  No

**Skip question 11 unless selected Yes in Question 10**

**11. Please enter the annual dollar amount the employer contributes to the flexible spending accounts.**

	<b>Dollar Amount</b>
Single: (Annual)	<input type="text"/>
Single plus Child: (Annual)	<input type="text"/>
Single plus Spouse: (Annual)	<input type="text"/>
Single plus One: (Annual)	<input type="text"/>
Family: (Annual)	<input type="text"/>

**12. If an employee's spouse is offered health insurance through their place of employment, do any of the following restrictions apply?**

*Please check all that apply.*

- Incentive offered for the spouse to elect coverage through their employer.
- Penalty charged (e.g., charge an extra \$100 per month to insure spouse)
- Requirement for the spouse to take their insurance as primary (e.g. coordination of benefits)
- Employee's spouse is not eligible for coverage if they have access to insurance through their own employer (e.g. spousal carve-out)
- None of the above
- Other

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**13. Has the organization had a dependent eligibility audit conducted at any time during the past three years?**

*Note: A dependent eligibility audit is a procedure undertaken to identify ineligible health plan participants and remove them from an organization's health insurance plan.*

- Yes  No
- 

**14. Does the organization have a formal labor-management health insurance committee that assists in the procurement of the employer's health insurance plan(s)?**

- Yes  No

**15. Does the organization participate in a joint health insurance purchasing arrangement (e.g., council of government, consortium, cooperative, MEWA) to provide health insurance to its employees?**

- Yes  No

**Skip Questions 16 – 19 unless answered Yes in Question 15**

**16. Please provide the following information about your joint purchasing arrangement (consortium):**

Name of Joint Purchasing Arrangement:

Contact Person:

Phone Number:

Email: (N/A if not applicable)

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**17. How many years have you participated in this consortium?**

**18. Why did you decide to join a consortium? (Please check all that apply)**

- Save money
  - Received more extensive health benefits for our employees
  - Easier to join the consortium than to buy insurance ourselves
  - Our insurance agent recommended that we join the consortium
  - Our Union(s) endorsed the idea
  - Other
- 

**19. Do you think that your organization will participate in this same health benefit consortium next year?**

- Yes
- No
- I don't know

**20. Does the organization work with an independent health insurance broker, consultant, or agent?**

- Yes
- No

**Skip Question 21-22 if answered No to Question 20**

**21. Please provide the following information for your broker, consultant, or agent:**

Agency Name:

Agent/Broker/Consultant Name:

Phone Number:

Email Address: (N/A if not applicable)

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22. Please select which is the compensation basis for the agent, broker, or consultant and enter the **annual compensation amount** in the space provided.

Note: If fee is per employee please calculate what that amount would be on an annual basis.

Not applicable

	Yes	No	Dollar Amount
Commission as a percentage of the premium (Annual)	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Fee (Annual)	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Commission as a percentage of the premium plus a fee (Annual)	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Don't know (Annual)			

23. Does the organization have an active worksite wellness or health promotion program that is independent of the medical plan(s)?

Yes  No

Skip Question 24 – 25 if answered no to question 23

24. Please select the year your organization started utilizing a wellness plan.

25. Please identify each component of the organization's worksite health promotion program

Check all that apply

- Health education (e.g. education or counseling opportunities relative to physical activity, nutrition, workplace injury prevention, etc.)
- Supportive social and physical work environment (e.g., policies against tobacco and alcohol use, classes or counseling on nutrition, fitness, etc.)
- Integration of worksite program into the organization's structure (e.g. dedicated staff, office, or budget)
- Related programs (e.g., employee assistance, work/family, occupational safety and health programs, etc.)
- Screening programs (e.g. blood pressure, blood cholesterol screening programs)
- Other

26. Did any of the following actions or events occur between January 1, 2016 and January 1, 2017?

*Required: Check any that apply*

- Restricted or eliminated part-time employee eligibility for medical insurance plan coverage
- Increased the number of preventative services offered or decreased their cost
- Increased medical insurance plan premium contributions from employees
- Implemented a worksite health promotion program
- Increased medical insurance plan cost-sharing (e.g., deductibles, copayments)
- Made data available to medical insurance plan participants on provider quality and/or cost
- Created or expanded a loss control program (e.g., paying for fitness center membership)
- Changed the medical insurance plan offered to employees (e.g., PPO replaced by CDHP plan)
- Added a cheaper plan with more cost-sharing (e.g. higher deductibles and/or of pocket maximums)
- Created or expanded a risk avoidance program (e.g., smoking cessation program)
- Restricted or eliminated spousal eligibility for medical insurance plan coverage
- Switched health insurance companies or third party administrators
- None of the above actions or events occurred

## MEDICAL PLAN 1

27. How many medical plans were available to full-time employees as of **January 1, 2017**?

If you have more than one plan available you can enter up to two additional plans later in the survey. If the employer offers more than 3 medical plans, please complete the survey for the 3 plans with the largest number of employees enrolled.

Note: The following questions relate to your first medical plan. Later in the survey there are sections for your second and third medical plans if applicable.

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28. What type of medical plan is offered to employees?

Note: If the plan has deductibles high enough to make employees eligible for a Health Savings Account, please check "High Deductible Health Plan" even if the plan is a traditional indemnity plan, PPO, HMO, or POS.

- Traditional Indemnity Plan (Fee for Service; Base and Major Medical or Comprehensive Major Medical)
- Preferred Provider Organization (PPO)
- Point of Service (POS)
- Health Maintenance Organization (HMO)
- Health Savings Account Eligible High Deductible Health Plan (HDHP)
- Exclusive Provider Organization (EPO)
- Other

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29. Please upload your summary of benefits (which outlines deductibles, coinsurances, etc.) for Medical Plan 1.

Note: PDF, Excel, and Word Documents are accepted

**Upload Summary of Benefits**

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30. Does the employer contribute to a Health Savings Account (HSA)?

- Yes  No

31. Please indicate the employer's **annual contribution** to each employee's HSA (Health Savings Account). (Mark 'Not Applicable' if answered NO in previous question)

Not applicable

	Employer <b>Annual</b> Contribution Amount To Each Employee's HSA
Single: (Annual)	<input type="text"/>
Single and Child: (Annual)	<input type="text"/>
Single and Spouse: (Annual)	<input type="text"/>
Single plus One: (Annual)	<input type="text"/>
Family: (Annual)	<input type="text"/>

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32. Does the employer have a Health Reimbursement Arrangement (HRA) for uncovered medical expenses/deductibles?

*Note: A Health Reimbursement Arrangement (HRA) differs from an HSA in that only the employer or insurance company reimburses the employee either by having an account for that individual or providing reimbursement once costs are incurred. Unlike an HSA account, money in an HRA account is not portable; so the employee cannot take the money with them after ending their tenure with the employer.*

Yes  No

33. What is the maximum amount the employer will contribute each year to an employee's HRA (Health Reimbursement Arrangement)? (Mark 'Not Applicable' if answered NO in previous question)

Not applicable

	Employer <b>Annual</b> Contribution Amount To Each Employee's HRA
Single: (Annual)	<input type="text"/>
Single and Child: (Annual)	<input type="text"/>
Single and Spouse: (Annual)	<input type="text"/>
Single plus One: (Annual)	<input type="text"/>
Family: (Annual)	<input type="text"/>

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34. How many employees were eligible to participate in this medical plan as of January 1, 2017?

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35. How many employees were enrolled in the medical plan as of January 1, 2017?

	Number of Employees Enrolled
Employees choosing single plan:	<input type="text"/>
Employees choosing single and child plan:	<input type="text"/>
Employees choosing single and spouse plan:	<input type="text"/>
Employees choosing single plus one plan:	<input type="text"/>
Employees choosing family plan:	<input type="text"/>

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36. How many **total employees plus dependents** are covered by the medical plan as of January 1, 2017?

**Note:** This number should be greater than the sum of the responses in the previous question.

**Example:** Employee plus 3 children = 4

*Note: Can be found on your Renewal Development Statement*

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37. Is this medical plan fully-insured or self-insured?

*Note: If the medical plan is through a joint purchasing arrangement, which self-funds, please select "Self-Insured".*

*Note: If you have stop-loss insurance, please select "Self-Insured".*

- Fully-insured
  - Self-insured
  - Other
-

**38. Does the medical insurance plan include an employee wellness program?**

*Note: The term 'employee wellness program' refers to a program that is designed to increase awareness, assess risks, educate, and promote voluntary behavior change to improve the health of an individual, encourage modifications of his or her health status, and enhance his or her personal well-being and productivity, with a goal of preventing illness and injury.*

Yes  No

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**39. Does the medical plan include a disease state management program?**

*Note: The term 'disease state management' means a program that includes both education and support activities designed to increase individuals' awareness and understanding of their disease(s), promote voluntary behavior change, improve self-care, with the goal of preventing or managing complications associated with targeted chronic diseases.*

Yes  No

**40. What are the co-payments that are associated with the services below in this medical insurance plan?**

If the plan has co-insurance, but no co-payments enter "0"

**Note: If your plan does not require co-pays for preventive office visits, please provide co-pays associated with non-preventive office visits. You can find the information needed to answer this question on your Summary of Benefits, provided by your insurance company.**

	<b>Co-Payment Dollar Amount</b>
Office Visit:	<input type="text"/>
Emergency Room Visit: (if not admitted)	<input type="text"/>
Urgent Care Visit:	<input type="text"/>

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**41. What is the amount of the deductible (e.g. 200) paid by the employee? If non-network does not apply, please only fill out the "network" portion. Please enter the amount that appears on the Summary of Benefits. Do not deduct FSA or HRA amount. Please indicate if network deductible is 0.**

*Note: If the plan does not require a deductible for preventative care, please provide the deductible for non-preventative care. You can find the information needed to answer this question on your Summary of Benefits, provided by your insurance company.*

	<b>Single</b>	<b>Family</b>
Network:	<input type="text"/>	<input type="text"/>
Non-Network: (if applicable)	<input type="text"/>	<input type="text"/>

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42. What is the co-insurance percent that the plan covers? If the employee's share of the percentage is listed on the Summary of Benefits, subtract it from 100 to get the percentage that the plan covers. If non-network does not apply, please only fill out the "network" portion.

**Example: The medical plan covers 80%.**

*Note: Network should Be Above 70% (Example: Plan Covers 100% Employee responsible for 0%)*

*Note: Non-Network should be above 50%*

Note: If the plan does not require co-insurance for preventive care, please provide the co-insurance associated with non-preventive care. In the response options which follow, the term "network" refers to a panel of health care providers. In these arrangements, participants pay less for services obtained at network providers than for services obtained at non-network providers. You can find the information needed to answer this question on your Summary of Benefits or Summary Plan Document, provided by your insurance company.

	Co-insurance Percent
Network: (% Plan Covers)	<input type="text"/>
Non-Network: (% Plan Covers)	<input type="text"/>

43. What is the amount of the out-of-pocket maximum **including the deductible** (e.g. 1,000)? If out-of-pocket maximum is **unlimited** please enter value **999996**. If non-network does not apply, please only fill out the "network" portion. The out-of-pocket maximum may include or exclude the deductible on the Summary of Benefits. If the deductible is excluded, please add it into the out-of-pocket maximum.

*Note: This is the maximum amount the employee would have to pay out of his/her pocket for healthcare services during a particular time period. The medical plan usually pays 100% once this maximum is reached.*

Note: You can find the information needed to answer this question on your Summary of Benefits, provided by your insurance company.

	Single	Family
Network:	<input type="text"/>	<input type="text"/>
Non-Network: (if applicable)	<input type="text"/>	<input type="text"/>

44. Please enter the employer and employee monthly premium contributions for employees who participate in this medical insurance plan.

*Note: Please use the employee contribution requirements that apply to the greatest number of employees. Enter "0" if employee does not contribute to the premium.*

*Please do not include the cost of prescription, dental or vision insurance if those benefits are paid apart from this medical insurance plan. For self-insured plans, please enter the monthly funding rate, not just the administrative fee.*

**Note 2: Employer Monthly Premium + Employee Monthly Premium = Total Monthly Premium**

**Note 3: Column A + Column B = Column C**

	MONTHLY PREMIUM FUNDING RATES PER EMPLOYEE		
	Employer +	Employee =	Total
Single: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Single and Child: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Single and Spouse: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Single plus One: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Family: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>

45. Please specify who receives benefits from this plan. If you have a collective bargaining agreement, please specify which unit is offered this plan and contributes to the employee premium in the previous question. An example might be: All employees, All Teachers, All Police, or All Fire only. Also specify who is excluded from this medical plan.

46. Please identify the name of the health insurance company (if fully-insured) or third party administrator (if self-insured) that administers this medical insurance plan:

47. Does the employer offer prescription drug coverage?

Yes  No

Go to question 69 if answered no to question 47

48. Is the cost of the prescription drug plan included in the medical premium?

Yes  No

Go to question 55 if answered yes to question 48

49. How many employees were eligible to participate in this prescription drug plan as of January 1, 2017?

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50. How many employees were enrolled in this prescription drug plan as of January 1, 2017?

Note: Prescription drug plan is separate from medical plan

	Quantity of Employees Enrolled
Employees choosing single plan:	<input type="text"/>
Employees choosing single and child plan:	<input type="text"/>
Employees choosing single and spouse plan:	<input type="text"/>
Employees choosing single plus one plan:	<input type="text"/>
Employees choosing family plan:	<input type="text"/>

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51. How many total **employees plus dependents** are covered by this prescription drug plan as of January 1, 2017?

Note: This number should be greater than the sum of the responses in the previous question.

Example: Employee plus 3 children = 4

Note: Can be found on your Renewal Development Statement

52. In the spaces provided below, please identify the prescription plans **monthly premium** for employer and employees. Enter "0" if employee does not contribute to the premium.

*Note: Employer Monthly Premium + Employee Monthly Premium = Total Monthly Premium*

*Note: Column A + Column B = Column C*

	MONTHLY PREMIUM FUNDING RATES PER EMPLOYEE		
	Employer +	Employee =	Total
Single: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Single and Child: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Single and Spouse: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Single plus One: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Family: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>

53. Is this prescription drug plan fully-insured or self-insured?

- Fully-insured
- Self-insured
- Other

54. Please identify the name of the insurance company (if fully-insured) or third party administrator (if self-insured) that administers the prescription drug plan.

**55. How many tiers does your prescription drug plan have?**

*Choose one of the following answers*

- High Deductible Health Plan - employee pays 100% of prescription drug until deductible is met
- One rate (no tiers) (go to question 57)
- Two tiers (generic and brand only) (go to question 58)
- Three tiers (generic, preferred, non-preferred) (Go to question 60)
- Four tiers (generic, preferred, non-preferred, and specialty/biologic) (Go to question 62)

**56. Once the deductible is met, how are prescription drugs covered?**

*Choose one of the following answers*

- Prescription drugs are paid at 100% once deductible is met. (go to question 64)
- One rate (no tiers) (go to question 57)
- Two tiers (generic and brand only) (go to question 58)
- Three tiers (generic, preferred, non-preferred) (Go to question 60)
- Four tiers (generic, preferred, non-preferred, and specialty/biologic) (Go to question 62)

**57. Please identify the prescription plan's co-payment or coinsurance requirements in the appropriate space:**

*Note: Leave field blank if it is N/A*

*Note: Please fill in only the % or \$ column. If your prescription copay is a percent, but has a dollar amount cap, please fill out the dollar amount cap only.*

	<b>Dollar (\$)</b>	<b>Percent (%)</b>
Retail	<input type="text"/>	<input type="text"/>
Mail	<input type="text"/>	<input type="text"/>

(go to question 64)

58. Please identify the retail prescription plan's co-payment or coinsurance requirements:

Note: Leave field blank if it is N/A

Note: Please fill in only the % or \$ column. If your prescription copay is a percent, but has a dollar amount cap, please fill out the dollar amount cap only.

	Dollar (\$)	Percent (%)
Generic	<input type="text"/>	<input type="text"/>
Brand	<input type="text"/>	<input type="text"/>

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59. Please identify the mail order prescription plan's co-payment or coinsurance requirements:

Note: Leave field blank if it is N/A

Note: Please fill in only the % or \$ column. If your prescription copay is a percent, but has a dollar amount cap, please fill out the dollar amount cap only.

	Dollar (\$)	Percent (%)
Generic	<input type="text"/>	<input type="text"/>
Brand	<input type="text"/>	<input type="text"/>

(go to question 64)

**60. Please identify the retail prescription plan's co-payment or coinsurance requirements:**

*Note: Leave field blank if it is N/A*

*Note: Please fill in only the % or \$ column. If your prescription copay is a percent, but has a dollar amount cap, please fill out the dollar amount cap only.*

	Dollar (\$)	Percent (%)
Tier 1 - Generic	<input type="text"/>	<input type="text"/>
Tier 2 - Formulary (Preferred)	<input type="text"/>	<input type="text"/>
Tier 3 - Non-formulary (Non-preferred)	<input type="text"/>	<input type="text"/>

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**61. Please identify the mail order prescription plan's co-payment or coinsurance requirements:**

*Note: Leave field blank if it is N/A*

*Note: Please fill in only the % or \$ column. If your prescription copay is a percent, but has a dollar amount cap, please fill out the dollar amount cap only.*

	Dollar (\$)	Percent (%)
Tier 1 - Generic	<input type="text"/>	<input type="text"/>
Tier 2 - Formulary (Preferred)	<input type="text"/>	<input type="text"/>
Tier 3 - Non-formulary (Non-preferred)	<input type="text"/>	<input type="text"/>

**(go to question 64)**

**62. Please identify the retail prescription plan’s co-payment or coinsurance requirements:**

*Note: Leave field blank if it is N/A*

*Note: Please fill in only the % or \$ column. If your prescription copay is a percent, but has a dollar amount cap, please fill out the dollar amount cap only.*

	Dollar (\$)	Percent (%)
Tier 1 - Generic	<input type="text"/>	<input type="text"/>
Tier 2 - Formulary (Preferred)	<input type="text"/>	<input type="text"/>
Tier 3 - Non-formulary (Non-preferred)	<input type="text"/>	<input type="text"/>
Tier 4 - Specialty / Biologic	<input type="text"/>	<input type="text"/>

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**63. Please identify the mail order prescription plan’s co-payment or coinsurance requirements:**

*Note: Leave field blank if it is N/A*

*Note: Please fill in only the % or \$ column. If your prescription copay is a percent, but has a dollar amount cap, please fill out the dollar amount cap only.*

	Dollar (\$)	Percent (%)
Tier 1 - Generic	<input type="text"/>	<input type="text"/>
Tier 2 - Formulary (Preferred)	<input type="text"/>	<input type="text"/>
Tier 3 - Non-formulary (Non-preferred)	<input type="text"/>	<input type="text"/>
Tier 4 - Specialty / Biologic	<input type="text"/>	<input type="text"/>

64. Does the prescription drug plan exclude any specific drug class from coverage (e.g., cosmetic, hair-loss drugs, fertility or sexual dysfunction drugs, and/or weight-control drugs)?

Yes  No

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65. Does the prescription drug plan feature any prior authorization requirement?

*Note: Prior authorization procedures are often established to require pharmacy benefit management approval for certain classes of drugs or to limit drug access to patients with a certain condition or history.*

Yes  No

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66. Does the prescription drug plan feature any step therapy (or fail-first) requirement?

*Note: Step therapy programs limit access to certain drugs unless other drug therapies have been tried first.*

Yes  No

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67. Is there a penalty associated with using a formulary or brand-name drug when a generic drug is available? (e.g. insured person pays difference between the cost of the generic and brand drug)

*Note: For example, if a patient chooses a brand-name drug when a generic drug is available, they could be charged for the difference in price between the brand-name and generic drug in addition to the generic drug co-payment.*

Yes  No

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68. Does the prescription drug plan have a mandatory mail-order requirement for maintenance medications?

Yes  No

(go to question 151 if employer offers only one medical plan)

## MEDICAL PLAN 2

Note: The following questions relate to your **second medical plan**.

### 69. What is the second medical plan offered to employees?

*Note: If the plan has deductibles high enough to make employees eligible for a Health Savings Account, please check "High Deductible Health Plan" even if the plan is a traditional indemnity plan, PPO, HMO, or POS. Please indicate one type of medical health insurance plan.*

- Traditional Indemnity Plan (Fee for Service; Base and Major Medical or Comprehensive Major Medical)
  - Preferred Provider Organization (PPO)
  - Point of Service (POS)
  - Health Maintenance Organization (HMO)
  - Health Savings Account Eligible High Deductible Health Plan (HDHP)
  - Exclusive Provider Organization (EPO)
  - Other
- 

### 70. Please upload your summary of benefits (which outlines deductibles, coinsurances, etc.) for Medical Plan 2 in case we have any questions.

*Note: PDF, Excel, and Word Documents are accepted.*

**Upload Summary of Benefits**

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### 71. Does the employer contribute to a Health Savings Account (HSA)?

- Yes  No

72. Please indicate the employer's **annual contribution** to each employee's HSA (Health Savings Account). (Mark 'Not Applicable' if answered NO in previous question)

Not applicable

	Employer <b>Annual</b> Contribution Amount To Each Employee's HSA
Single: (Annual)	<input type="text"/>
Single and Child: (Annual)	<input type="text"/>
Single and Spouse: (Annual)	<input type="text"/>
Single plus One: (Annual)	<input type="text"/>
Family: (Annual)	<input type="text"/>

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73. Does the employer have a Health Reimbursement Arrangement (HRA) for uncovered medical expenses/deductibles?

*Note: A Health Reimbursement Arrangement (HRA) differs from an HSA in that only the employer or insurance company reimburses the employee either by having an account for that individual or providing reimbursement once costs are incurred. Unlike an HSA account, money in an HRA account is not portable; so the employee cannot take the money with them after ending their tenure with the employer.*

Yes  No

74. What is the maximum amount the employer will contribute each year to an employee's HRA (Health Reimbursement Arrangement)? (Mark 'Not Applicable' if answered NO in previous question)

Not applicable

	Employer <b>Annual</b> Contribution Amount To Each Employee's HRA
Single: (Annual)	<input type="text"/>
Single and Child: (Annual)	<input type="text"/>
Single and Spouse: (Annual)	<input type="text"/>
Single plus One: (Annual)	<input type="text"/>
Family: (Annual)	<input type="text"/>

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75. How many employees were eligible to participate in this medical plan as of January 1, 2017?

76. How many employees were enrolled in the medical plan as of January 1, 2017?

	Quantity of Employees Enrolled
Employees choosing single plan:	<input type="text"/>
Employees choosing single and child plan:	<input type="text"/>
Employees choosing single and spouse plan:	<input type="text"/>
Employees choosing single plus one plan:	<input type="text"/>
Employees choosing family plan:	<input type="text"/>

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77. How many **total employees plus dependents** are covered by the medical plan as of January 1, 2017?

Note: This number should be greater than the sum of the responses in the previous question.

Example: Employee plus 3 children = 4

Note: Can be found on your Renewal Development Statement

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78. Is this medical plan fully-insured or self-insured?

Note: If the medical plan is through a joint purchasing arrangement, which self-funds, please select "Self-Insured".

Note: If you have stop-loss insurance, please select "Self-Insured".

- Fully-insured
  - Self-insured
  - Other
- 

79. Does the medical insurance plan include an employee wellness program?

Note: The term 'employee wellness program' refers to a program that is designed to increase awareness, assess risks, educate, and promote voluntary behavior change to improve the health of an individual, encourage modifications of his or her health status, and enhance his or her personal well-being and productivity, with a goal of preventing illness and injury.

- Yes
- No

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**80. Does the medical plan include a disease state management program?**

*Note: The term 'disease state management' means a program that includes both education and support activities designed to increase individuals' awareness and understanding of their disease(s), promote voluntary behavior change, improve self-care, with the goal of preventing or managing complications associated with targeted chronic diseases.*

Yes  No

**81. What are the co-payments that are associated with the services below in this medical insurance plan?**

If the plan has co-insurance, but no co-payments enter "0"

**Note: If your plan does not require co-pays for preventive office visits, please provide co-pays associated with non-preventive office visits. You can find the information needed to answer this question on your Summary of Benefits, provided by your insurance company.**

	<b>Co-Payment Dollar Amount</b>
Office Visit:	<input type="text"/>
Emergency Room Visit: (if not admitted)	<input type="text"/>
Urgent Care Visit:	<input type="text"/>

---

**82. What is the amount of the deductible (e.g. 200) paid by the employee? If non-network does not apply, please only fill out the "network" portion. Please enter the amount that appears on the Summary of Benefits. Do not deduct FSA or HRA amount. Please indicate if network deductible is 0.**

*Note: If the plan does not require a deductible for preventative care, please provide the deductible for non-preventative care. You can find the information needed to answer this question on your Summary of Benefits, provided by your insurance company.*

	<b>Single</b>	<b>Family</b>
Network:	<input type="text"/>	<input type="text"/>
Non-Network: (if applicable)	<input type="text"/>	<input type="text"/>

83. What is the co-insurance percent that the plan covers? If the employee's share of the percentage is listed on the Summary of Benefits, subtract it from 100 to get the percentage that the plan covers. If non-network does not apply, please only fill out the "network" portion.

**Example: The medical plan covers 80%.**

*Note: Network should Be Above 70% (Example: Plan Covers 100% Employee responsible for 0%)*

*Note: Non-Network should be above 50%*

*Note: If the plan does not require co-insurance for preventive care, please provide the co-insurance associated with non-preventive care. In the response options which follow, the term "network" refers to a panel of health care providers. In these arrangements, participants pay less for services obtained at network providers than for services obtained at non-network providers. You can find the information needed to answer this question on your Summary of Benefits or Summary Plan Document, provided by your insurance company.*

	Co-insurance Percent
Network: (% plan covers)	<input type="text"/>
Non-Network: (% plan covers)	<input type="text"/>

84. What is the amount of the out-of-pocket maximum **including the deductible** (e.g. 1,000)? If out-of-pocket maximum is **unlimited** please enter value **999996**. If non-network does not apply, please only fill out the "network" portion. The out-of-pocket maximum may include or exclude the deductible on the Summary of Benefits. If the deductible is excluded, please add it into the out-of-pocket maximum.

*Note: This is the maximum amount the employee would have to pay out of his/her pocket for healthcare services during a particular time period. The medical plan usually pays 100% once this maximum is reached.*

Note: You can find the information needed to answer this question on your Summary of Benefits, provided by your insurance company.

	Single	Family
Network:	<input type="text"/>	<input type="text"/>
Non-Network: (if applicable)	<input type="text"/>	<input type="text"/>

85. Please enter the employer and employee monthly premium contributions for employees who participate in this medical insurance plan

Note: Using the employee contribution requirements that apply to the greatest number of employees. Enter "0" if employee does not contribute to the premium.

Please do not include the cost of prescription, dental, or vision insurance if those benefits are paid apart from this medical insurance plan. For self-insured plans, please enter the monthly funding rate, not just the administrative fee.

Note 2: Employer Monthly Premium + Employee Monthly Premium = Total Monthly Premium

Note 2: Column A + Column B = Column C

	MONTHLY PREMIUM FUNDING RATES PER EMPLOYEE		
	Employer +	Employee =	Total
Single: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Single and Child: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Single and Spouse: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Single plus One: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Family: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>

86. Please specify who receives benefits from this plan. If you have a collective bargaining agreement, please specify which unit is offered this plan and contributes to the employee premium in the previous question. An example might be: All employees, All Teachers, All Police, or All Fire only. Also specify who is excluded from this medical plan.

0 / 2000

0 / 2000

87. Please identify the name of the health insurance company (if fully-insured) or third party administrator (if self-insured) that administers this medical insurance plan:

88. Does the employer offer prescription drug coverage?

Yes  No

(Go to question 105 if answered no to question 88)

89. Is the cost of the prescription drug plan included in the medical premium?

Yes  No

(Go to question 96 if answered yes to question 89)

90. How many employees were eligible to participate in this prescription drug plan as of January 1, 2017?

---

91. How many employees were enrolled in this prescription drug plan as of January 1, 2017?

Note: Prescription drug plan is separate from medical plan

	Quantity of Employees Enrolled
Employees choosing single plan:	<input type="text"/>
Employees choosing single and child plan:	<input type="text"/>
Employees choosing single and spouse plan:	<input type="text"/>
Employees choosing single plus one plan:	<input type="text"/>
Employees choosing family plan:	<input type="text"/>

---

92. How many total **employees plus dependents** are covered by this prescription drug plan as of January 1, 2017?

Note: This number should be greater than the sum of the responses in the previous question.

Example: Employee plus 3 children = 4

Note: Can be found on your Renewal Development Statement

93. In the spaces provided below, please identify the prescription plan's **monthly premium** for employer and employees. Enter "0" if employee does not contribute to the premium.

*Note: Employer Monthly Premium + Employee Monthly Premium = Total Monthly Premium*

*Note: Column A + Column B = Column C*

	MONTHLY PREMIUM FUNDING RATES PER EMPLOYEE		
	Employer +	Employee =	Total
Single: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Single and Child: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Single and Spouse: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Single plus One: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Family: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>

---

94. Is this prescription drug plan fully-insured or self-insured?

- Fully-insured
- Self-insured
- Other

---

95. Please identify the name of the insurance company (if fully-insured) or third party administrator (if self-insured) that administers the prescription drug plan.

96. How many tiers does your prescription drug plan have?

Choose one of the following answers

- High Deductible Health Plan - employee pays 100% of prescription drug until deductible is met
- One rate (no tiers) (go to question 98)
- Two tiers (generic and brand only) (go to question 99)
- Three tiers (generic, preferred, and non-preferred) (go to question 101)
- Four tiers (generic, preferred, non-preferred, and specialty/biologic) (go to question 103)

97. Once the deductible is met, how are prescription drugs covered?

Choose one of the following answers

- Prescription drugs are paid at 100% once deductible is met. (go to question 105)
- One rate (no tiers) (go to question 98)
- Two tiers (generic and brand only) (go to question 99)
- Three tiers (generic, preferred, and non-preferred) (go to question 101)
- Four tiers (generic, preferred, non-preferred, and specialty/biologic) (go to question 103)

98. Please identify the prescription plan's co-payment or coinsurance requirements in the appropriate space:

Note: Leave field blank if it is N/A

Note: Please fill in only the % or \$ column. If your prescription copay is a percent, but has a dollar amount cap, please fill out the dollar amount cap only.

	Dollar (\$)	Percent (%)
Retail	<input type="text"/>	<input type="text"/>
Mail	<input type="text"/>	<input type="text"/>

(go to question 105)

99. Please identify the retail prescription plan's co-payment or coinsurance requirements:

Note: Leave field blank if it is N/A

Note: Please fill in only the % or \$ column. If your prescription copay is a percent, but has a dollar amount cap, please fill out the dollar amount cap only.

	Dollar (\$)	Percent (%)
Generic	<input type="text"/>	<input type="text"/>
Brand	<input type="text"/>	<input type="text"/>

---

100. Please identify the mail order prescription plan's co-payment or coinsurance requirements:

Note: Leave field blank if it is N/A

Note: Please fill in only the % or \$ column. If your prescription copay is a percent, but has a dollar amount cap, please fill out the dollar amount cap only.

	Dollar (\$)	Percent (%)
Generic	<input type="text"/>	<input type="text"/>
Brand	<input type="text"/>	<input type="text"/>

(go to question 105)

**101. Please identify the retail prescription plan's co-payment or coinsurance requirements:**

*Note: Leave field blank if it is N/A*

*Note: Please fill in only the % or \$ column. If your prescription copay is a percent, but has a dollar amount cap, please fill out the dollar amount cap only.*

	<b>Dollar (\$)</b>	<b>Percent (%)</b>
Tier 1 - Generic	<input type="text"/>	<input type="text"/>
Tier 2 - Formulary (Preferred)	<input type="text"/>	<input type="text"/>
Tier 3 - Non-formulary (Non-preferred)	<input type="text"/>	<input type="text"/>

---

**102. Please identify the mail order prescription plan's co-payment or coinsurance requirements:**

*Note: Leave field blank if it is N/A*

*Note: Please fill in only the % or \$ column. If your prescription copay is a percent, but has a dollar amount cap, please fill out the dollar amount cap only.*

	<b>Dollar (\$)</b>	<b>Percent (%)</b>
Tier 1 - Generic	<input type="text"/>	<input type="text"/>
Tier 2 - Formulary (Preferred)	<input type="text"/>	<input type="text"/>
Tier 3 - Non-formulary (Non-preferred)	<input type="text"/>	<input type="text"/>

**(go to question 105)**

**103. Please identify the retail prescription plan's co-payment or coinsurance requirements:**

*Note: Leave field blank if it is N/A*

*Note: Please fill in only the % or \$ column. If your prescription copay is a percent, but has a dollar amount cap, please fill out the dollar amount cap only.*

	<b>Dollar (\$)</b>	<b>Percent (%)</b>
Tier 1 - Generic	<input type="text"/>	<input type="text"/>
Tier 2 - Formulary (Preferred)	<input type="text"/>	<input type="text"/>
Tier 3 - Non-formulary (Non-preferred)	<input type="text"/>	<input type="text"/>
Tier 4 - Specialty / Biologic	<input type="text"/>	<input type="text"/>

---

**104. Please identify the mail order prescription plan's co-payment or coinsurance requirements:**

*Note: Leave field blank if it is N/A*

*Note: Please fill in only the % or \$ column. If your prescription copay is a percent, but has a dollar amount cap, please fill out the dollar amount cap only.*

	<b>Dollar (\$)</b>	<b>Percent (%)</b>
Tier 1 - Generic	<input type="text"/>	<input type="text"/>
Tier 2 - Formulary (Preferred)	<input type="text"/>	<input type="text"/>
Tier 3 - Non-formulary (Non-preferred)	<input type="text"/>	<input type="text"/>
Tier 4 - Specialty / Biologic	<input type="text"/>	<input type="text"/>

**105. Does the prescription drug plan exclude any specific drug class from coverage (e.g., cosmetic, hair-loss drugs, fertility or sexual dysfunction drugs, and/or weight-control drugs)?**

Yes  No

---

**106. Does the prescription drug plan feature any prior authorization requirement?**

*Note: Prior authorization procedures are often established to require pharmacy benefit management approval for certain classes of drugs or to limit drug access to patients with a certain condition or history.*

Yes  No

---

**107. Does the prescription drug plan feature any step therapy (or fail-first) requirement?**

*Note: Step therapy programs limit access to certain drugs unless other drug therapies have been tried first.*

Yes  No

---

**108. Is there a penalty associated with using a formulary or brand-name drug when a generic drug is available? (e.g. insured person pays difference between the cost of the generic and brand drug)**

*Note: For example, if a patient chooses a brand-name drug when a generic drug is available, they could be charged for the difference in price between the brand-name and generic drug in addition to the generic drug co-payment.*

Yes  No

---

**109. Does the prescription drug plan have a mandatory mail-order requirement for maintenance medications?**

Yes  No

**(go to question 151 if employer offers only two medical plans)**

### MEDICAL PLAN 3

Note: The following questions relate to your **third medical plan**.

#### 110. What is the third medical plan offered to employees?

*Note: If the plan has deductibles high enough to make employees eligible for a Health Savings Account, please check "High Deductible Health Plan" even if the plan is a traditional indemnity plan, PPO, HMO, or POS. Please indicate one type of medical health insurance plan.*

- Traditional Indemnity Plan (Fee for Service; Base and Major Medical or Comprehensive Major Medical)
  - Preferred Provider Organization (PPO)
  - Point of Service (POS)
  - Health Maintenance Organization (HMO)
  - Health Savings Account Eligible High Deductible Health Plan (HDHP)
  - Exclusive Provider Organization (EPO)
  - Other
- 

#### 111. Please upload your summary of benefits (which outlines deductibles, coinsurances, etc.) for Medical Plan 3 in case we have any questions.

*Note: PDF, Excel, and Word Documents are accepted.*

**Upload Summary of Benefits**

---

#### 112. Does the employer contribute to a Health Savings Account (HSA)?

- Yes  No

113. Please indicate the employer's **annual contribution** to each employee's HSA (Health Savings Account). (Mark 'Not Applicable' if answered NO in previous question)

Not applicable

	Employer <b>Annual</b> Contribution Amount To Each Employee's HSA
Single: (Annual)	<input type="text"/>
Single and Child: (Annual)	<input type="text"/>
Single and Spouse: (Annual)	<input type="text"/>
Single plus One: (Annual)	<input type="text"/>
Family: (Annual)	<input type="text"/>

---

114. Does the employer have a Health Reimbursement Arrangement (HRA) for uncovered medical expenses/deductibles?

*Note: A Health Reimbursement Arrangement (HRA) differs from an HSA in that only the employer or insurance company reimburses the employee either by having an account for that individual or providing reimbursement once costs are incurred. Unlike an HSA account, money in an HRA account is not portable; so the employee cannot take the money with them after ending their tenure with the employer.*

Yes  No

115. What is the maximum amount the employer will contribute each year to an employee's HRA (Health Reimbursement Arrangement)? (Mark Not Applicable if answered NO in previous question)

Not applicable

	Employer <b>Annual</b> Contribution Amount To Each Employee's HRA
Single: (Annual)	<input type="text"/>
Single and Child: (Annual)	<input type="text"/>
Single and Spouse: (Annual)	<input type="text"/>
Single plus One: (Annual)	<input type="text"/>
Family: (Annual)	<input type="text"/>

---

116. How many employees were eligible to participate in this medical plan as of January 1, 2017:

117. How many employees were enrolled in the medical plan as of January 1, 2017?

	Quantity of Employees Enrolled
Employees choosing single contract:	<input type="text"/>
Employees choosing single and child contract:	<input type="text"/>
Employees choosing single and spouse contract:	<input type="text"/>
Employees choosing single plus one contract:	<input type="text"/>
Employees choosing family contract:	<input type="text"/>

---

118. How many **total employees plus dependents** are covered by the medical plan as of January 1, 2017?

Note: This number should be greater than the sum of the responses in the previous question.

Example: Employee plus 3 children = 4

Note: Can be found on your Renewal Development Statement

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119. Is this medical plan fully-insured or self-insured?

Note: If the medical plan is through a joint purchasing arrangement, which self-funds, please select "Self-Insured".

Note: If you have stop-loss insurance, please select "Self-Insured".

- Fully-insured
- Self-insured
- Other

120. Does the medical insurance plan include an employee wellness program?

Note: The term 'employee wellness program' refers to a program that is designed to increase awareness, assess risks, educate, and promote voluntary behavior change to improve the health of an individual, encourage modifications of his or her health status, and enhance his or her personal well-being and productivity, with a goal of preventing illness and injury.

- Yes
  - No
-

**121. Does the medical plan include a disease state management program?**

*Note: The term 'disease state management' means a program that includes both education and support activities designed to increase individuals' awareness and understanding of their disease(s), promote voluntary behavior change, improve self-care, with the goal of preventing or managing complications associated with targeted chronic diseases.*

Yes  No

**122. What are the co-payments that are associated with the services below in this medical insurance plan?**

If the plan has co-insurance, but no co-payments enter "0"

**Note: If your plan does not require co-pays for preventive office visits, please provide co-pays associated with non-preventive office visits. You can find the information needed to answer this question on your Summary of Benefits, provided by your insurance company.**

	<b>Co-Payment Dollar Amount</b>
Office Visit:	<input type="text"/>
Emergency Room Visit: (if not admitted)	<input type="text"/>
Urgent Care Visit:	<input type="text"/>

---

**123. What is the amount of the deductible (e.g. 200) paid by the employee? If non-network does not apply, please only fill out the "network" portion. Please enter the amount that appears on the Summary of Benefits. Do not deduct FSA or HRA amount. Please indicate if the network deductible is 0.**

*Note: If the plan does not require a deductible for preventative care, please provide the deductible for non-preventative care. You can find the information needed to answer this question on your Summary of Benefits, provided by your insurance company.*

	<b>Single</b>	<b>Family</b>
Network:	<input type="text"/>	<input type="text"/>
Non-Network: (if applicable)	<input type="text"/>	<input type="text"/>

124. What is the co-insurance percent that the plan covers? If the employee's share of the percentage is listed on the Summary of Benefits, subtract it from 100 to get the percentage that the plan covers. If non-network does not apply, please only fill out the "network" portion.

**Example: The medical plan covers 80%.**

*Note: Network should Be Above 70% (Example: Plan Covers 100% Employee responsible for 0%)*

*Note: Non-Network should be above 50%*

*Note: If the plan does not require co-insurance for preventive care, please provide the co-insurance associated with non-preventive care. In the response options which follow, the term "network" refers to a panel of health care providers. In these arrangements, participants pay less for services obtained at network providers than for services obtained at non-network providers. You can find the information needed to answer this question on your Summary of Benefits or Summary Plan Document, provided by your insurance company.*

	Co-insurance Percent
Network: (% plan covers)	<input type="text"/>
Non-Network: (% plan covers)	<input type="text"/>

125. What is the amount of the out-of-pocket maximum **including the deductible** (e.g. 1,000)? If out-of-pocket maximum is unlimited please enter value **999996**. If non-network does not apply, please only fill out the "network" portion. The out-of-pocket maximum may include or exclude the deductible on the Summary of Benefits. If the deductible is excluded, please add it into the out-of-pocket maximum.

*Note: This is the maximum amount the employee would have to pay out of his/her pocket for healthcare services during a particular time period. The medical plan usually pays 100% once this maximum is reached.*

*Note: You can find the information needed to answer this question on your Summary of Benefits, provided by your insurance company.*

	Single	Family
Network:	<input type="text"/>	<input type="text"/>
Non-Network: (if applicable)	<input type="text"/>	<input type="text"/>

126. Please enter the employer and employee monthly premium contributions for employees who participate in this medical insurance plan

Note: Please use the employee contribution requirements that apply to the greatest number of employees. Enter "0" if employee does not contribute to the premium.

Please do not include the cost of prescription, dental or vision insurance if those benefits are paid apart from this medical insurance plan. For self-insured plans, please enter the monthly funding rate, not just the administrative fee.

Note 2: Employer Monthly Premium + Employee Monthly Premium = Total Monthly Premium

Note 3: Column A + Column B = Column C

	MONTHLY PREMIUM FUNDING RATES PER EMPLOYEE		
	Employer +	Employee =	Total
Single: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Single and Child: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Single and Spouse: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Single plus One: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Family: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>

127. Please specify who receives benefits from this plan. If you have a collective bargaining agreement, please specify which unit is offered this plan and contributes to the employee premium in the previous question. An example might be: All employees, All Teachers, All Police, or All Fire only. Also specify who is excluded from this medical plan.

0 / 2000  
 0 / 2000

128. Please identify the name of the health insurance company (if fully-insured) or third party administrator (if self-insured) that administers this medical insurance plan:

129. Does the employer offer prescription drug coverage?

Yes
  No

(Go to question 146 if answered no in previous question)

130. Is the cost of the prescription drug plan included in the medical premium?

Yes  No

(Go to question 137 if answered yes in the question 130)

131. How many employees were eligible to participate in this prescription drug plan as of January 1, 2017?

---

132. How many employees were enrolled in this prescription drug plan as of Jan. 1, 2017?

Note: Prescription drug plan is separate from medical plan.

	Quantity of Employees Enrolled
Employees choosing single plan:	<input type="text"/>
Employees choosing single and child plan:	<input type="text"/>
Employees choosing single and spouse plan:	<input type="text"/>
Employees choosing single plus one plan:	<input type="text"/>
Employees choosing family plan:	<input type="text"/>

---

133. How many total **employees plus dependents** are covered by this prescription drug plan as of January 1, 2017?

Note: This number should be greater than the sum of the responses in the previous question.

Example: Employee plus 3 children = 4

Note: Can be found on your Renewal Development Statement

134. In the spaces provided below, please identify the prescription plan's **monthly premium** for employer and employees. Enter "0" if employee does not contribute to the premium.

*Note: Employer Monthly Premium + Employee Monthly Premium = Total Monthly Premium*

*Note: Column A + Column B = Column C*

	MONTHLY PREMIUM FUNDING RATES PER EMPLOYEE		
	Employer +	Employee =	Total
Single: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Single and Child: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Single and Spouse: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Single plus One: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Family: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>

135. Is this prescription drug plan fully-insured or self-insured?

- Fully-insured
- Self-insured
- Other

136. Please identify the name of the insurance company (if fully-insured) or third party administrator (if self-insured) that administers the prescription drug plan.

**137. How many tiers does your prescription drug plan have?**

*Choose one of the following answers*

- High Deductible Health Plan - employee pays 100% of prescription drug until deductible is met
- One rate (no tiers) **(Go to Question 139)**
- Two tiers (generic and brand only) **(Go to Question 140)**
- Three tiers (generic, preferred, and non-preferred) **(Go to Question 142)**
- Four tiers (generic, preferred, non-preferred, and specialty/biologic) **(Go to Question 144)**

**138. Once the deductible is met, how are prescription drugs covered?**

*Choose one of the following answers*

- Prescription drugs are paid at 100% once deductible is met. **(Go to Question 146)**
- One rate (no tiers) **(Go to Question 139)**
- Two tiers (generic and brand only) **(Go to Question 140)**
- Three tiers (generic, preferred, and non-preferred) **(Go to Question 142)**
- Four tiers (generic, preferred, non-preferred, and specialty/biologic) **(Go to Question 144)**

**139. Please identify the prescription plan's co-payment or coinsurance requirements in the appropriate space:**

*Note: Leave field blank if it is N/A*

*Note: Please fill in only the % or \$ column. **If your prescription copay is a percent, but has a dollar amount cap, please fill out the dollar amount cap only.***

	<b>Dollar (\$)</b>	<b>Percent (%)</b>
Retail	<input type="text"/>	<input type="text"/>
Mail	<input type="text"/>	<input type="text"/>

**(Go to Question 146)**

140. Please identify the retail prescription plan's co-payment or coinsurance requirements:

Note: Leave field blank if it is N/A

Note: Please fill in only the % or \$ column. If your prescription copay is a percent, but has a dollar amount cap, please fill out the dollar amount cap only.

	Dollar (\$)	Percent (%)
Generic	<input type="text"/>	<input type="text"/>
Brand	<input type="text"/>	<input type="text"/>

---

141. Please identify the mail order prescription plan's co-payment or coinsurance requirements:

Note: Leave field blank if it is N/A

Note: Please fill in only the % or \$ column. If your prescription copay is a percent, but has a dollar amount cap, please fill out the dollar amount cap only.

	Dollar (\$)	Percent (%)
Generic	<input type="text"/>	<input type="text"/>
Brand	<input type="text"/>	<input type="text"/>

(Go to Question 146)

142. Please identify the retail prescription plan's co-payment or coinsurance requirements:

Note: Leave field blank if it is N/A

Note: Please fill in only the % or \$ column. If your prescription copay is a percent, but has a dollar amount cap, please fill out the dollar amount cap only.

	Dollar (\$)	Percent (%)
Tier 1 - Generic	<input type="text"/>	<input type="text"/>
Tier 2 - Formulary (Preferred)	<input type="text"/>	<input type="text"/>
Tier 3 - Non-formulary (Non-preferred)	<input type="text"/>	<input type="text"/>

---

143. Please identify the mail order prescription plan's co-payment or coinsurance requirements:

Note: Leave field blank if it is N/A

Note: Please fill in only the % or \$ column. If your prescription copay is a percent, but has a dollar amount cap, please fill out the dollar amount cap only.

	Dollar (\$)	Percent (%)
Tier 1 - Generic	<input type="text"/>	<input type="text"/>
Tier 2 - Formulary (Preferred)	<input type="text"/>	<input type="text"/>
Tier 3 - Non-formulary (Non-preferred)	<input type="text"/>	<input type="text"/>

(Go to Question 146)

144. Please identify the retail prescription plan's co-payment or coinsurance requirements:

Note: Leave field blank if it is N/A

Note: Please fill in only the % or \$ column. If your prescription copay is a percent, but has a dollar amount cap, please fill out the dollar amount cap only.

	Dollar (\$)	Percent (%)
Tier 1 - Generic	<input type="text"/>	<input type="text"/>
Tier 2 - Formulary (Preferred)	<input type="text"/>	<input type="text"/>
Tier 3 - Non-formulary (Non-preferred)	<input type="text"/>	<input type="text"/>
Tier 4 - Specialty / Biologic	<input type="text"/>	<input type="text"/>

---

145. Please identify the mail order prescription plan's co-payment or coinsurance requirements:

Note: Leave field blank if it is N/A

Note: Please fill in only the % or \$ column. If your prescription copay is a percent, but has a dollar amount cap, please fill out the dollar amount cap only.

	Dollar (\$)	Percent (%)
Tier 1 - Generic	<input type="text"/>	<input type="text"/>
Tier 2 - Formulary (Preferred)	<input type="text"/>	<input type="text"/>
Tier 3 - Non-formulary (Non-preferred)	<input type="text"/>	<input type="text"/>
Tier 4 - Specialty / Biologic	<input type="text"/>	<input type="text"/>

146. Does the prescription drug plan exclude any specific drug class from coverage (e.g., cosmetic, hair-loss drugs, fertility or sexual dysfunction drugs, and/or weight-control drugs)?

Yes  No

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147. Does the prescription drug plan feature any prior authorization requirement?

*Note: Prior authorization procedures are often established to require pharmacy benefit management approval for certain classes of drugs or to limit drug access to patients with a certain condition or history.*

Yes  No

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148. Does the prescription drug plan feature any step therapy (or fail-first) requirement?

*Note: Step therapy programs limit access to certain drugs unless other drug therapies have been tried first.*

Yes  No

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149. Is there a penalty associated with using a formulary or brand-name drug when a generic drug is available? (e.g. insured person pays difference between the cost of the generic and brand drug)

*Note: For example, if a patient chooses a brand-name drug when a generic drug is available, they could be charged for the difference in price between the brand-name and generic drug in addition to the generic drug co-payment.*

Yes  No

---

150. Does the prescription drug plan have a mandatory mail-order requirement for maintenance medications?

Yes  No

## DENTAL INSURANCE

151. Does the employer offer any type of dental insurance coverage?

Yes  No

(Go to Question 162 if answered no in question 151)

152. Is the cost for dental insurance included in the medical insurance premium as reported earlier in the survey?

Yes  No

(Go to Question 159 if answered yes in question 152)

153. How many employees were eligible to participate in this dental plan as of January 1, 2017?

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154. How many employees were enrolled in this dental plan as of January 1, 2017?

	Quantity of Employees Enrolled
Employees choosing a single plan:	<input type="text"/>
Employees choosing a single and child plan:	<input type="text"/>
Employees choosing a single and spouse plan:	<input type="text"/>
Employees choosing a single plus one plan:	<input type="text"/>
Employees choosing a single and family plan:	<input type="text"/>

---

155. How many total **employees plus dependents** are covered by this dental plan as of January 1, 2017?

**Note:** This number should be greater than the sum of the responses in the previous question.

**Example:** Employee plus 3 children = 4

Note: This can be found on your renewal development statement from the insurance company.

---

156. In the spaces provided below, please identify the dental plan's monthly premium for employer and employees. If there is one dental rate for all enrollees, please fill in "composite" rate only. Enter "0" if employee does not contribute to the premium.

Note: Employer Monthly Premium + Employee Monthly Premium = Total Monthly Premium

Note: Column A + Column B = Column C

Note: If more than one dental insurance plan is offered, please complete the questions in this section as they pertain to the dental insurance plan with the largest number of enrollees.

Not applicable

	MONTHLY		
	Employer +	Employee =	Total
Single: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Single and Child: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Single and Spouse: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Single plus One: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Family: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Composite: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>

157. Is this dental insurance plan fully-insured or self-insured?

- Fully-insured
- Self-insured
- Other

158. Please provide the name of your dental insurance plan administrator:

159. What is the network deductible on the plan (e.g. \$100)? If the dental plan has no deductible, please mark N/A.

Not applicable

	Single	Family
Network	<input type="text"/>	<input type="text"/>
Non-Network (if applicable)	<input type="text"/>	<input type="text"/>

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160. Please identify the network coinsurance (e.g., 80%) that the dental plan covers, associated with the following benefits:

*Note: Response should be greater than 50%*

*Mark N/A if not applicable*

Not applicable

Diagnostic and Preventive Services: (% plan covers)

Oral surgery services: (% plan covers)

Major restorative services: (% plan covers)

Orthodontic services: (% plan covers)

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161. What is the annual maximum dental benefit/limit per covered person?

*Numbers only may be entered*

Not applicable

**VISION PLAN**

162. Does the employer offer any type of vision insurance coverage?

- Yes  No

(Go to Question 171 if answered no in question 162)

163. Is the cost for vision insurance included in the medical or dental insurance premium as reported earlier in the survey?

*Choose one of the following answers*

- Vision is included in the medical premium (Go to Question 170)
- Vision is included in the dental premium (Go to Question 170)
- Vision insurance is purchased in a separate plan

164. How many employees were eligible to participate in this vision plan as of January 1, 2017?

165. How many employees were enrolled in this vision plan as of January 1, 2017?

	Quantity of Employees Enrolled
Employees choosing a single plan:	<input type="text"/>
Employees choosing a single and child plan:	<input type="text"/>
Employees choosing a single and spouse plan:	<input type="text"/>
Employees choosing a single plus one plan:	<input type="text"/>
Employees choosing a family plan:	<input type="text"/>

166. How many total **employees plus dependents** were enrolled in this vision plan as of January 1, 2017?

**Note:** This number should be greater than the sum of the responses in the previous question.

**Example:** Employee plus 3 children = 4

167. In the spaces provided below, please identify the vision plan's monthly premium for employer and employees. If there is one vision rate for all enrollees, please fill in "composite" rate only.

Note: *Employer Monthly Premium + Employee Monthly Premium = Total Monthly Premium*

Note: *If more than one vision insurance plan is offered by the organization, please complete the questions in this section as they pertain to the vision insurance plan with the largest number of enrollees.*

Not applicable

	MONTHLY		
	Employer +	Employee =	Total
Single: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Single and Child: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Single and Spouse: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Single plus One: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Family: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Composite: (Per Employee)	<input type="text"/>	<input type="text"/>	<input type="text"/>

---

168. Is this vision insurance plan fully-insured or self-insured?

Choose one of the following answers

- Fully-insured
  - Self-insured
  - Other
- 

169. Please provide the name of your vision plan administrator:

170. How often are each of the benefits reimbursed under the organization's vision insurance plan?

	<b>Biannually (Twice a year)</b>	<b>Annually (once a year)</b>	<b>Biennially (once every two years)</b>	<b>The benefit is not covered</b>
Vision examination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Single vision lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bifocal lenses	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trifocal lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact lenses (Elective instead of glasses)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Contact lenses (necessary)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## LIFE INSURANCE

### 171. Does the employer offer life insurance benefits?

Please select 'no' if life insurance is offered, but the employee is responsible for paying the premiums

- Yes  No

(Go to Question 176 if answered no in question 171)

### 172. Which of the following best describes how your life insurance plan is calculated?

Choose one of the following answers

- One face value for all employees
- Face value varies by department or job class (e.g. police, administrative, certified)
- Face value varies with salary (i.e. value is a percent of salary) (Go to Question 174)
- Other

### 173. Please enter the face value of the policy for the largest group of employees? (Example: Employer offers \$25,000 in life insurance coverage)

Note: If the face value varies by job class, please give the amount that applies to the largest number of employees.

\$

### 174. Please enter the employer's monthly premium rate for life insurance per \$1,000 of coverage in cents:

(Example: Employee pays \$1.10 per month for \$20,000 in coverage would be  $1.10 / 20 = \$0.055$ )

Note: Response is usually less than \$1.00

Note: The rate is usually in cents (i.e. enter .05 if the cost of life insurance is five cents per employee per month of coverage).

\$

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### 175. Does the employer offer (or include in life insurance policy) accidental death and dismemberment coverage?

- Yes  No

**END OF SURVEY QUESTIONS**

176. What county is your organization located in?

177. Please provide the following information

First Name:

Last Name:

Email Address:

Phone Number:

Employer Name:

Employer Address:

Employer City:

Employer Zip:

178. Please use this space to provide us with any additional information and/or comments.

*Optional: Comments appreciated!*

This completes the survey. Please use the link sent to your email account to access the online survey to submit your answers. If you have any questions please contact us.

Thank you!