Division of Health Care Finance and Policy

Student Health Program Benefit Survey User Guide

1.0 Overview

This document is a basic user guide for filing the Student Health Program (SHP) Benefit Survey using the Division of Health Care Finance and Policy's INET Web application. Filers can connect to INET through the Division's website at https://dhcfpinet.hcf.state.ma.us.

1.1 Purpose

The Division of Health Care Finance and Policy (Division) will use the SHP Benefit Survey to analyze and monitor SHPs offered by Massachusetts institutions of higher education. The information is being requested under the authority of M.G.L. c. 15A § 18 and 114.6 CMR 3.00.

1.2 INET User Registration

All users who will enter data and submit the SHP Benefit Survey must be registered for INET. If your school's form is being filled out by an outside party (i.e. an insurance broker or insurance carrier representative), please have the outside party register with INET to fill out your information.

To register with INET:

1. Type in the Division's URL: http://www.mass.gov/dhcfp
2. Navigate to the bottom right-hand corner to the "Online Services" module and click on the "INET and Report Filing Guidelines" link
3. Follow the path "INET and Reporting Filing Guidelines> INET > INET Questions and Answers > How to Register"
4. Refer to the section for "INET Non-confidential Data Security and User Agreement Forms for Provider Reporting," you will find two forms linked there: 'Non-confidential Data Security Agreement Form' and 'User Agreement for Providers.'
5. Complete, sign, and send the forms to:
   Division of Health Care Finance and Policy
   2 Boylston Street
   Boston, MA 02116-4707
   Attention: DHCFP-INET

Information from your application is put into the Division's contact management system. To ensure that you are entered correctly into the system, you may want to note in your application that you would like your INET Contact Reason to be "Web QSHIP – Student Health Insurance Program."

After a registration request is processed by the Division, the registered user will receive a Login ID via e-mail. If you have any questions about INET, please contact the Division's Help Desk at (800) 609-7232.

2.0 Filing Information

2.1 What to File

Each school will complete a SHP Benefit Survey for the SHP being offered to students during the current school year.

Schools with more than one SHP option must fill one survey for each SHP option offered to students. After reviewing the survey, the Division may determine that additional information is required from the school. Such additional information will be considered a component of the survey subject to the same processes as the initial filing data.

2.2 When to File

The SHP regulation (114.6 CMR 3.00) requires each school to file SHP benefit information with the Division. The Division has set a filing deadline of May 1 for the Benefit Survey filing.

If you will be unable to meet the deadline, please contact the Division's Help Desk at (800) 609-7232 as soon as possible.

We appreciate your promptness as your data is a key component for on-going review of the Student Health Program.

2.3 SHP Benefit Survey Questions

If you have any questions about the SHP Benefit Survey, please contact the Division's Help Desk at (800) 609-7232.

3.0 Filing Details

3.1 Assemble All Required Information

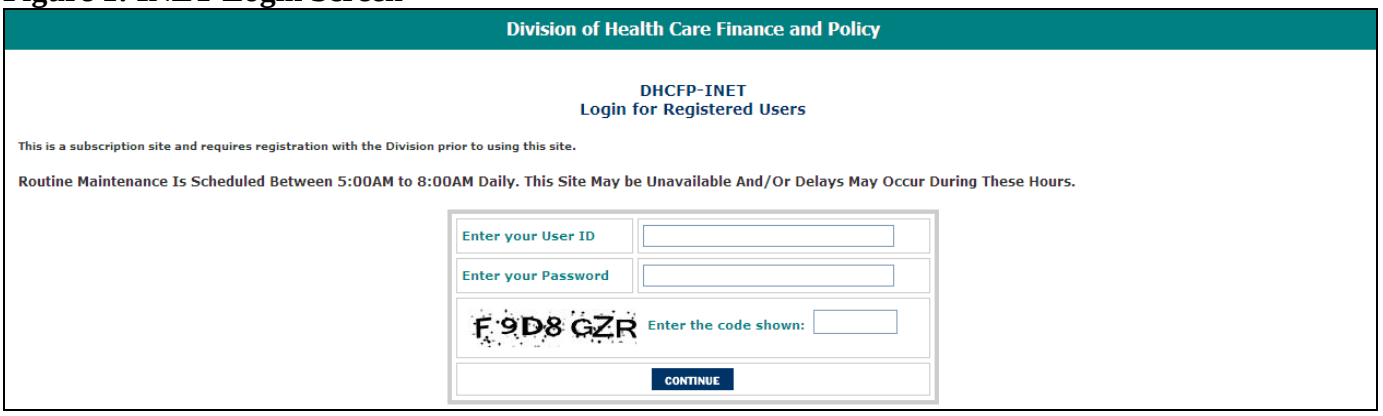
The SHP Benefit Survey asks for information regarding:

- Your SHP's insurance carrier and/ or broker;
- The number of students enrolled in your school's SHP;
- The number of covered lives (student, spouse, and dependents) enrolled in your school's SHP;
- Various policies regarding your SHP; and
- The health benefits covered by your SHP.

All information required, except the enrollment numbers, will most likely be available through your SHP's Evidence of Coverage document (aka the SHP Certificate or SHP Policy). You may need to obtain enrollment information from your insurance carrier and/ or broker.

3.2 Log into INET

Figure 1: INET Login Screen



Log into the Division's INET application (http://dhcfpinet.hcf.state.ma.us/) using the Login ID provided by the Division and Password you have chosen.

Please also make sure you type the in the exact combination of letters and numbers shown on your log-in screen in the box specified. Also, please remember to open the application in Internet Explorer to ensure that your survey works properly.

If you have any questions regarding your INET password or the SHP Benefit Survey, please call the Division's Help Desk at (800) 609-7232.

3.3 INET Main Menu

Figure 2: INET Main Menu

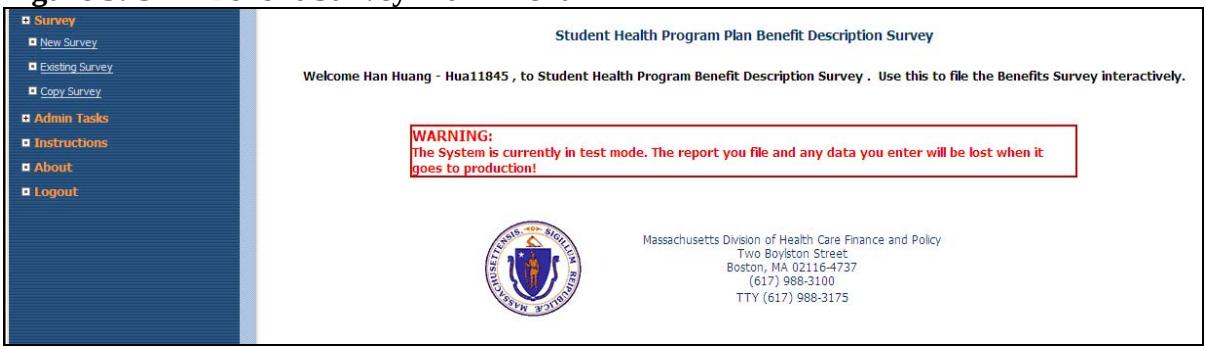
Once you have logged into INET successfully, you will be taken to the INET main menu. Click on the "Student Health Program Benefit Description Survey" menu choice to proceed with the SHP Benefit Survey.

The options listed in your INET main menu may vary from the example shown, depending on the type of data you submit to the Division. Users who submit a many data sets to the Division will have many options to choose from. However, if you only use INET to submit SHP data, you may only have the "Student Health Insurance Program" option available.

3.4 Student Health Program Benefit Survey Main Menu

The application allows you to either create a new survey or open an existing survey where you have saved, but have not yet submitted the data to the Division. You may also use the "Logout" link to return to the INET Main Menu.

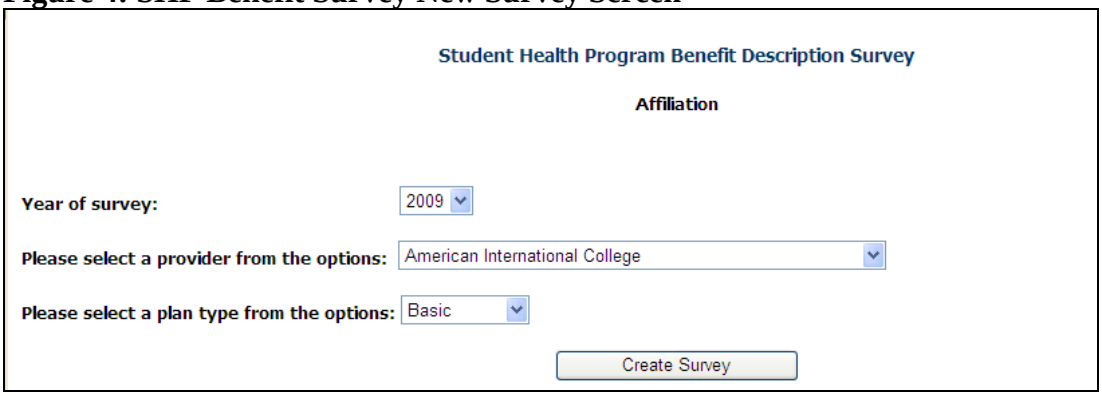
Figure 3: SHP Benefit Survey Main Menu



Creating a New Survey

To create a new survey, click on the "New Survey" link at the top of the left-hand navigation pane. This will bring you to a page that lets you pull up a new blank survey form for you to input information into.

Figure 4: SHP Benefit Survey New Survey Screen



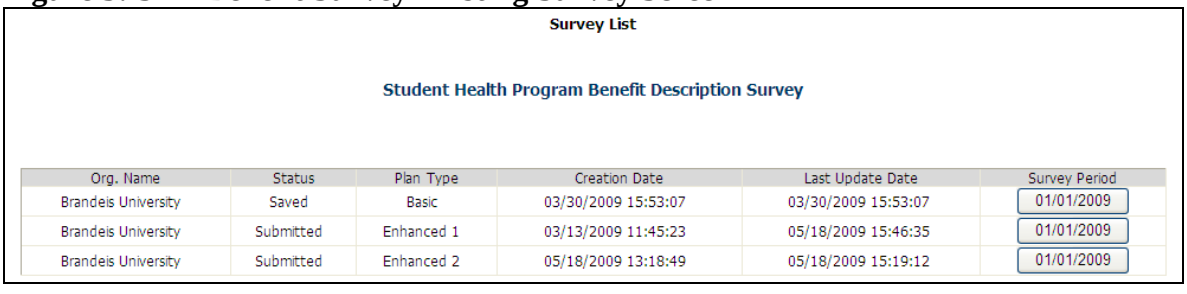
Once you have reached the page to create a new survey, please select the appropriate data in the fields shown and then click on "Create Survey". The Table 4 on page 28 in the Appendix gives a definition of the data elements required for each field.

Opening an Existing Survey

The survey does not need to be completed in one session. You may save the data you input at any time, using the "Save" function. Once you have saved your data, you can "Logout" of the survey. When you return at a later time to add more data to the survey, you would need to open an existing survey.

To open an existing survey, click on the "Existing Survey" link and select your school from the drop-down menu. This will take you to a Survey List that lists all the surveys created, saved, and/ or submitted for your school.

Figure 5: SHP Benefit Survey Existing Survey Screen



From this list, click on the button in the "Survey Period" column that corresponds to the SHP survey you would like to work on.

Please note that submitted surveys (the "Status" column indicates "Submitted" instead of "Saved") cannot be modified. If you would like to modify a submitted survey, please contact the Division's Help Desk at (800) 609-7232 for more information.

Copying an Existing Survey
Schools who offer multiple plans options for students must fill out a survey for each plan offered.

For example, your school offers a “basic” plan that all students are automatically enrolled in when they register for classes. However, your school also offers an “enhanced” plan option for students would like to pay additional money to purchase a higher level of benefits than the plan they are automatically enrolled into. You must submit an additional survey for this “enhanced” plan option.

Very often, these plans have the same basic structure as the “basic” plan with only a few enhancements. The INET application allows schools to copy information from the “basic” plan survey into the “enhanced” plan survey so that you will only have to go through and modify the benefits that differ between the two plans.

For more information on how to use this copy function, please see section “6.0 Schools With Multiple Plan Options”.

4.0 Student Health Program Benefit Survey

Once you have created a survey, you are taken to Section 1 of the SHP Benefit Survey. There, at most, four sections to fill out in this form. Inactivity for 20 minutes will cause the INET session to time out and any unsaved data will be lost.

4.1 Survey Navigation

There are 2 ways to navigate through the survey. The first is the dark blue navigation pane on the left side of the screen.

Figure 6: SHP Benefit Survey Left Navigation

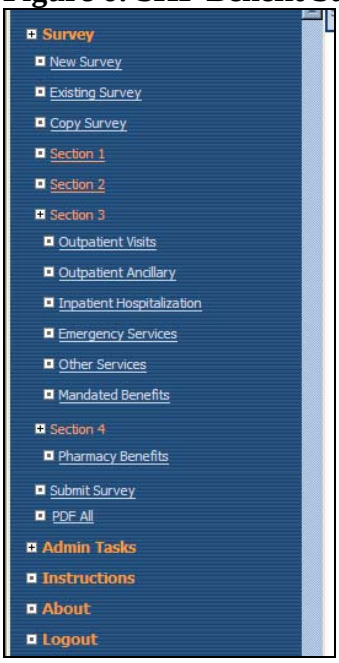


Table 1: Description of Left Navigation Links

Link	Description
New Survey	Brings you to the "Student Health Program Benefit Survey Main Menu" where you can create a new survey.
Existing Survey	Brings you to the "Student Health Program Benefit Survey Main Menu" where you can open an existing survey.
Section 1 – Section 4: Pharmacy Benefits	Takes you to the page that collects data for that particular aspect of your SHP.
Submit Survey	Allows you to submit a completed, error-free survey to the Division.
PDF All	Creates a PDF document of all the data you have saved in the survey. Please remember to save your progress before you use this function.
Logout	Allows you to exit the INET application.

Figure 7: SHP Benefit Survey Top Navigation

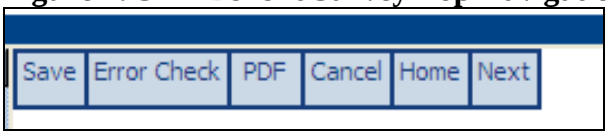


Table 2: Description of Top Navigation Buttons

Link	Description
Save	Save the data you have input at any time. The Division highly recommends that you save frequently to avoid losing data, especially since the INET application will time out after 20 minutes of inactivity.
Error Check	Check that the data you have input passes all the data edits set by the Division. You will not be able to submit the survey if there are data errors found. Please remember to save your progress before you use this function.
PDF	Create a PDF document of each section that shows the data you have saved for that section. This feature is different from the "PDF All" function in the left navigation pane which will give you a PDF of all the sections in the survey. Please remember to save your progress before you use this function.
Cancel	Discard changes made to the data inputted since the last time the data was saved.
Home	Return to the "Student Health Program Benefit Survey Main Menu" where you can either create a new survey or open up an existing survey.
Next	Advance to next section of the survey, in the order listed in the left navigation screen.

Please remember to save often. Please also note that you must save your progress before you use the "Error Check" or any "PDF" functions, as these functions only check or PDF saved data.

Special Note on Using the PDF Function

Some browsers are not configured to allow the PDF function to work properly. If you are unable to use the PDF function, please follow the steps below to correct the issue:

1. Open your Internet Explorer browser
2. Click on "Tools/ Internet Options" menu
3. Select the "Security" tab on the "Tools/ Internet Options" menu
4. Click the "Sites" button
5. Add: "https://dhcfpinet.hcf.state.ma.us" site to the trusted sites and close
6. Change the security level for the trusted site zone to "Medium-Low" and click OK
7. Close the browser and reopen the browser. Closing the browser is important for the changes to take effect the next time you open Internet Explorer.
8. Try to open the PDF.

4.2 Section 1: School and Carrier Information

Section 1 of the survey asks for information about your SHP insurance carrier and whether various SHP policies are explicitly stated in the SHP's Evidence of Coverage/ Certificate/ Policy document and/ or any of the SHP materials made available to your students.

Figure 8: Section 1 of Survey

*Required Fields

School Information	
1. Org ID	3252
2. College / University Name	Brandeis University
3. School Year for which Plan information is provided	2009 - 2010
Carrier Information	
4. Plan Name*	
5. Plan Underwriter*	Select one....
6. Plan Claims Administrator*	
7. Plan Broker*	
8. Number of Students Enrolled in This Plan*	
9. Number of Covered Lives Enrolled in This Plan*	
10. Does your Student Health Program cover routine dental services?*	
11. Does your Student Health Program cover routine vision services?*	
12. Does your Student Health Program cover prescription drug benefits?*	
13. Does your Student Health Program provide any benefits through a student health center?*	
Plan Policy	
Does your Plan specify its policies regarding:	
14. Premium refunds?*	
15. Partial year student enrollment?*	
16. Denial of claims/payments for rendered services?*	
17. Internal grievance procedure for denial of claims/ payments for rendered services?*	
18. Denial of referrals for requested services?*	
19. Internal grievance procedure for denial of referrals for requested services?*	
20. Right to file external grievances with the Massachusetts Office of Patient Protection?*	

All questions in Section 1 are required questions that must be answered. Once you have answered all the questions that apply to your SHP:

1. Click on "Save" to save your progress.

2. Click on "Error Check" to see if the data you inputted has passed all data edits. If there are errors in your data, you will get a list of the fields you need to fix before you will be able to submit your survey.
3. Fix any errors you may have, and repeat Steps 1 – 3 until there are no errors.
4. Click on "Next" to proceed to Section 2.

Please visit Table 5 on page 29 in the Appendix for a definition of the data elements required for each field.

There is often confusion among filers as to the differences between Plan Underwriter (#5), Plan Administrator (#6), and Plan Broker (#7). Information on which underwriter, administrator, and broker used for your SHP is found the end of your SHP brochure.

- Plan Underwriter – the organization that pays the bills for medical claims
- Plan Administrator – the organization that carries out the administrative functions of running a SHP
- Plan Broker – the organization that helps you choose a health plan; your insurance agent.

Example 1A: Underwriter, Administrator, Broker

26. Vision services and supplies related to eye refractions or eye examinations, eyeglasses or contact lenses or prescriptions or fitting of eyeglasses, and radial keratotomy, keratomileusis or excimer laser photo refractive keratectomy or similar type procedures or service except when due to a disease process;
27. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered); and
28. Weight management services and supplies related to weight reduction programs, weight management programs, related nutritional supplies, treatment for obesity, and surgery for removal of excess skin or fat.
29. Services and charges that are determined to be Experimental/Investigational in nature.

CLAIM PROCEDURE

1. Bills must be submitted within 90 days from the date of treatment.
2. Payment for Covered Medical Expenses will be made directly to the hospital or Physician concerned unless bill receipts and proof of payment are submitted.
3. Subsequent medical bills should be mailed promptly to Consolidated Health Plans.

All medical bills should be submitted to the Claims Administrator shown below:

Claims Administrator:
CONSOLIDATED HEALTH PLANS
195 Stafford Street
Springfield, MA 01104-3503
(413) 733-4540
Toll Free (800) 633-7867
www.chpstudent.com

Servicing Broker:
UNIVERSITY HEALTH PLANS
One Batterymarch Park
Quincy, MA 02169
Local: (617) 472-5324
Out of area: 800-437-6448
Please visit our website for more information regarding this plan at: www.universityhealthplans.com
or email us at: info@univhealthplans.com

The Plan is underwritten by:
Nationwide Life Insurance Company

For a copy of the Company's privacy notice, go to:
www.chpstudent.com

Within 45 days following receipt of the appropriate documentation, we will either 1) make payment for the services provided, 2) notify the provider or claimant in writing of the reason or reasons for nonpayment, or 3) notify the provider or claimant in writing of what additional information or documentation is necessary to complete the claim filing. If we fail to comply, We are required to pay, in addition to any reimbursement for health care services provided, interest on the benefits beginning 45 days after receipt of the properly documented claim at the rate of 1.5 percent per month, not to exceed 18 percent per year. These provisions do not apply to claims that a carrier is investigating because of suspected fraud.

There is no utilization review performed on this policy.

CLAIM APPEAL

To appeal a claim, send a letter stating the issues of the appeal to Consolidated Health Plan's Appeal Department at the above address. Include your name, phone number, address, school attended and email address, if available.

Claims will be reviewed and responded to within 60 days by Consolidated Health Plans.

Translation services are available to assist insured's, upon request, related to administrative services.

In Example 1A:
Plan Underwriter: Nationwide Life Insurance Company
Plan Administrator: Consolidated Health Plans
Plan Broker: University Health Plans

Example 1B: Underwriter, Administrator, Broker

QUESTIONS?
NEED MORE INFORMATION?

For general information on benefits, on how to enroll, or service issues, please contact:

Gallagher Koster
500 Victory Road
Quincy, MA 02171
1-800-391-9750 or 617-769-6006
Email: BayPathStudent@Kosterins.com
www.gallagherkoster.com

If you need medical attention before the ID card is received, benefits will be payable according to the Policy. You do not need an ID card to be eligible to receive benefits. Call Gallagher Koster to verify eligibility.

For information on a specific claim, or to check the status of a claim, please contact:

Pioneer Management Systems, Inc.
P.O. Box 9040
West Springfield, MA 01090
1-877-868-9060
Email: Student @Pioneerhealth.com

This Plan is Underwritten by:

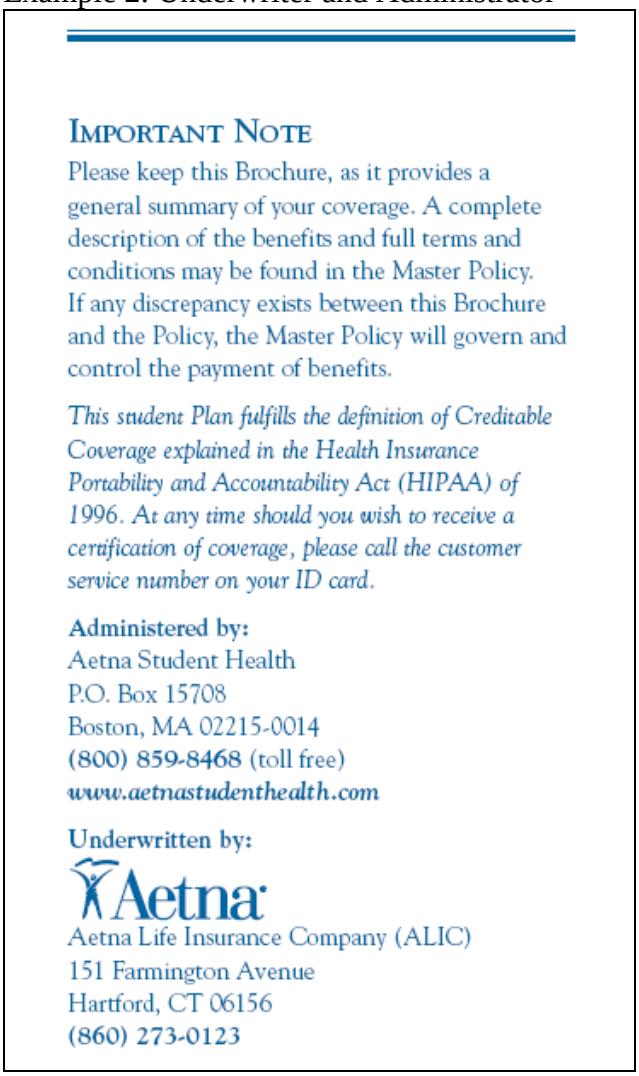
COMBINED INSURANCE

Combined Insurance Company of America
Policy Number: CUH201487

Please keep this brochure as a general summary of the insurance. The aster Policy on file at the College contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits some of which may not be included in this Brochure. If any discrepancy exists between this Brochure and the Policy, the aster Policy will govern and control the payment of benefits.

In Example 1B:
Plan Underwriter: Combined Insurance Company of America
Plan Administrator: Pioneer Management System
Plan Broker: Gallagher Koster

Example 2: Underwriter and Administrator



Important Note

Please keep this Brochure, as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policy. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits.

This student Plan fulfills the definition of Creditable Coverage explained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. At any time should you wish to receive a certification of coverage, please call the customer service number on your ID card.

Administered by:
Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014
(800) 859-8468 (toll free)
www.aetnastudenthealth.com

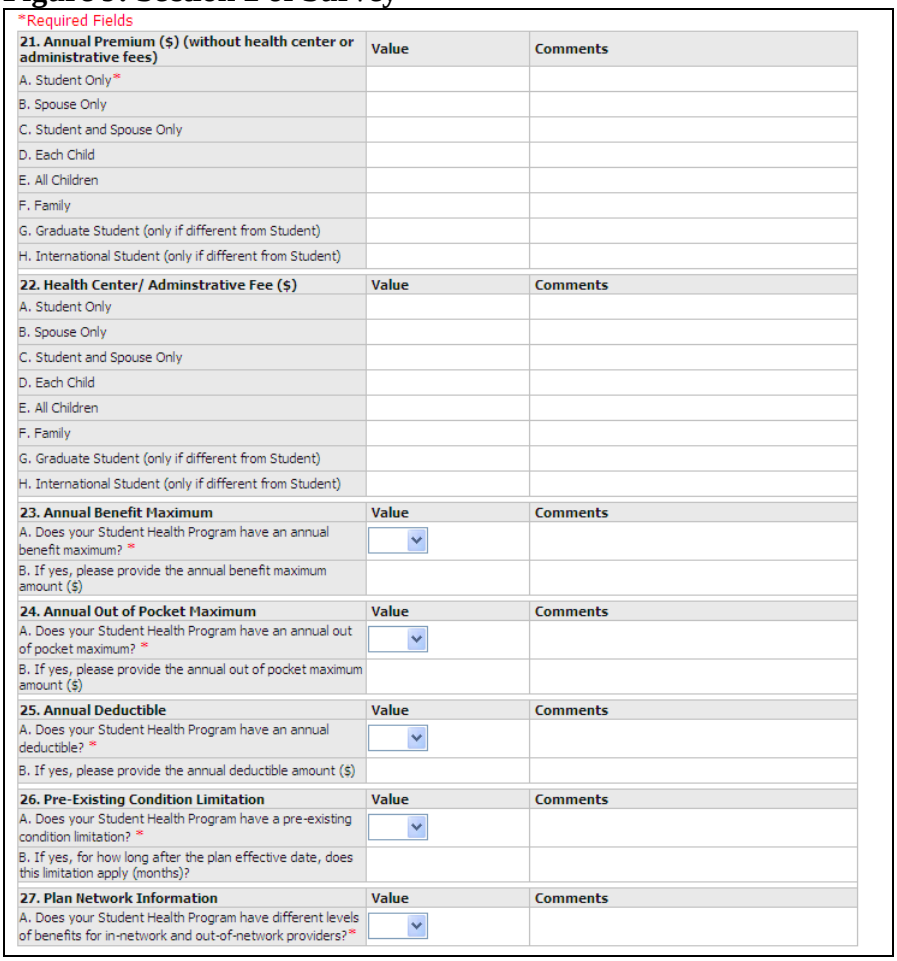
Underwritten by:
Aetna
Aetna Life Insurance Company (ALIC)
151 Farmington Avenue
Hartford, CT 06156
(860) 273-0123

In Example 2:
Plan Underwriter: Aetna Life Insurance Company
Plan Administrator: Aetna Student Health
Plan Broker: None

4.3 Section 2: Basic Plan Information

Section 2 of the survey asks for basic information about your SHP.

Figure 9: Section 2 of Survey



*Required Fields

21. Annual Premium ($) (without health center or administrative fees)	Value	Comments
A. Student Only *		
B. Spouse Only		
C. Student and Spouse Only		
D. Each Child		
E. All Children		
F. Family		
G. Graduate Student (only if different from Student)		
H. International Student (only if different from Student)		
22. Health Center/ Adminstrative Fee ($)	**Value**	**Comments**
A. Student Only		
B. Spouse Only		
C. Student and Spouse Only		
D. Each Child		
E. All Children		
F. Family		
G. Graduate Student (only if different from Student)		
H. International Student (only if different from Student)		
23. Annual Benefit Maximum	**Value**	**Comments**
A. Does your Student Health Program have an annual benefit maximum? *		
B. If yes, please provide the annual benefit maximum amount ($)		
24. Annual Out of Pocket Maximum	**Value**	**Comments**
A. Does your Student Health Program have an annual out of pocket maximum? *		
B. If yes, please provide the annual out of pocket maximum amount ($)		
25. Annual Deductible	**Value**	**Comments**
A. Does your Student Health Program have an annual deductible? *		
B. If yes, please provide the annual deductible amount ($)		
26. Pre-Existing Condition Limitation	**Value**	**Comments**
A. Does your Student Health Program have a pre-existing condition limitation? *		
B. If yes, for how long after the plan effective date, does this limitation apply (months)?		
27. Plan Network Information	**Value**	**Comments**
A. Does your Student Health Program have different levels of benefits for in-network and out-of-network providers? *		

Only fields with red stars next to them are required. Please type or select your answers from the "Value" column. If you have any comments that you think may help us better understand your SHP, please provide a short explanation in the appropriate "Comments" column.

Once you have answered all the questions that apply to your SHP:

1. Click on "Save" to save your progress
2. Click on "Error Check" to see if the data you inputted has passed all data edits. If there are errors in your data, you will get a list of the fields you need to fix before you will be able to submit your survey
3. Fix any errors you may have, and repeat Steps 1 – 3 until there are no errors
4. Click on "Next" to proceed to Section 3

Please visit Table 6 on page 31 in the Appendix for a definition of the data elements required for each field. If your premium structure does not fit into the boxes provided, please call the Division's help desk at (800) 609-7232 for assistance.

4.4 Section 3: Required Plan Benefits

Section 3 of the survey asks for information about the health benefits covered by your SHP. The benefits are organized into 6 separate pages to help facilitate data entry. The sections are: Outpatient Visits, Outpatient Ancillary, Inpatient Hospitalization, Emergency Services, Other Services, and Mandated Benefits.

You may fill out these sections in any order you choose. Clicking in each of the links in the left navigation panel will take you to each of the sections. **For each section, once you have answered all the questions that apply to your SHP:**

1. Click on "Save" to save your progress.
2. Click on "Error Check" to see if the data you inputted has passed all data edits. If there are errors in your data, you will get a list of the fields you need to fix before you will be able to submit your survey.
3. Fix any errors you may have, and repeat Steps 1 – 3 until there are no errors.
4. Click on "Next" to proceed to the next section or choose a link to go to a section you have not yet completed.

Outpatient Visits/ Outpatient Ancillary/ Inpatient Hospitalization/ Other Services
The navigation and instructions for filling out these 4 sections are the same. Each benefit has a series of questions (A – J) to answer. Please visit Tables 7 (page 33), 9 (page 37), 10 (page 38), 11 (page 38), 13 (page 39) in the Appendix for a definition of the data elements required for each field.

To fill out data:

1. Type or select your answers from the "Value" column
2. For questions with a drop-down menus in the "Qualifier" column, use this column to describe the values you provided in the "Value" column.

Example: your SHP has a co-payment of "$15 per visit."
For Question F, you would type "15" in "Value" and select "per visit" for "Qualifier".
If you have any comments that you think may help us better understand your SHP, please provide a short explanation in the appropriate "Comments" column.

Once you have answered all the questions that apply to your SHP:

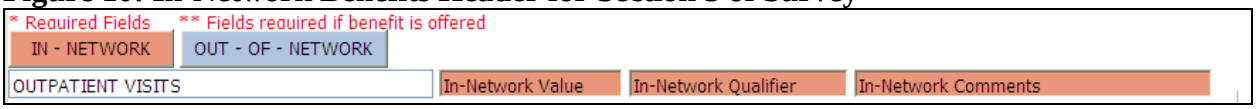
1. Click on "Save" to save your progress. Please note that if you save your data while in the "Out-of-Network" section, it will bring you back to the default "In-Network" section once the save is complete.
2. Click on "Error Check" to see if the data you inputted has passed all data edits. If there are errors in your data, you will get a list of the fields you need to fix before you will be able to submit your survey.
3. Fix any errors you may have, and repeat Steps 1 – 3 until there are no errors.
4. Click on "Next" to proceed to the next section within Section 3.

Using the In-Network and Out-of-Network Function

Some SHPs have different levels of coverage for benefits provided using an in-network and out-of-network provider. If you answered "Yes" to Question 25 in Section 2, you must fill out benefit information for both your in-network and out-of-network coverage. The sections default

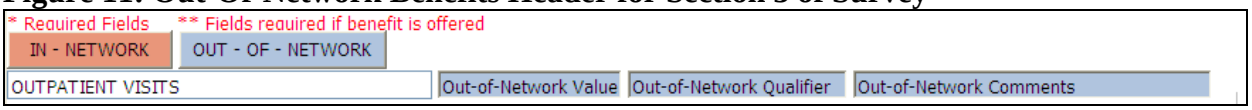
to the "In-Network" section. You will know when you are filling out "In-Network" benefits if the toolbar has the orange in-network headings.

Figure 10: In-Network Benefits Header for Section 3 of Survey



You will know when you are filling out "Out-of-Network" benefits if the toolbar has the blue out-of-network headings.

Figure 11: Out-Of-Network Benefits Header for Section 3 of Survey



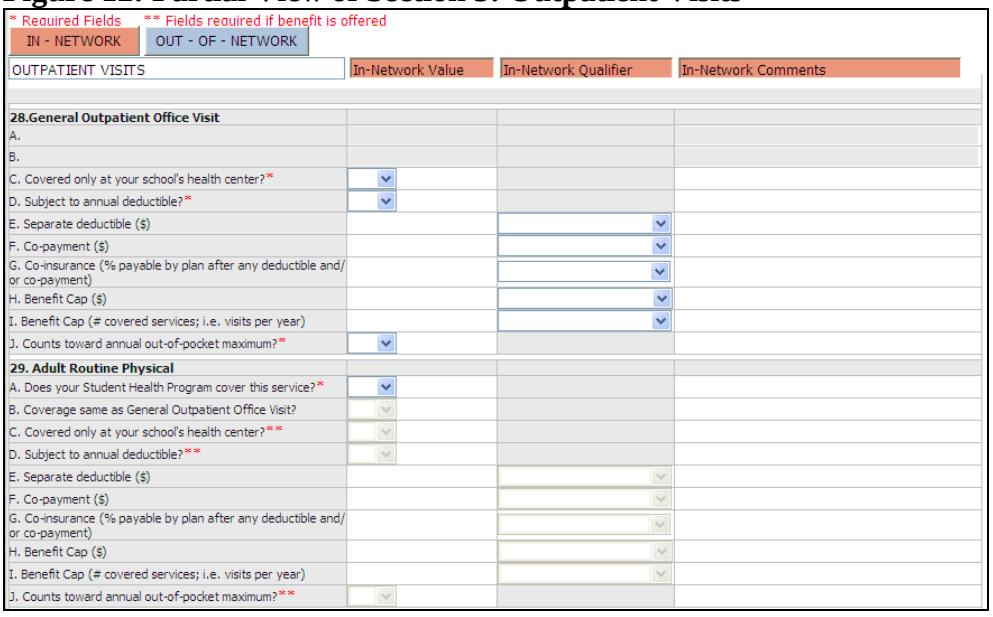
Click on the orange or blue buttons in the top of the toolbar to move between in-network and out-of-network.

Using the "General [health plan benefit]" Function

Some aspects of your SHP coverage may apply to many health benefits. For example, in the SHP coverage for "Adult Routine Visits" may be the same as "Routine GYN Visit" – both are likely to fall under the coverage for a general "Outpatient Office Visit."

To facilitate your data entry for benefit information, the first benefit you will need to provide information for in each of the 4 sections will be a "General [health benefit visit]" benefit. In the example given, you can see that question 26 is the first question of the "Outpatient Visits" section and it asks for information about a "General Outpatient Office Visit." You must answer questions C – J for this first question in all sections in order to continue.

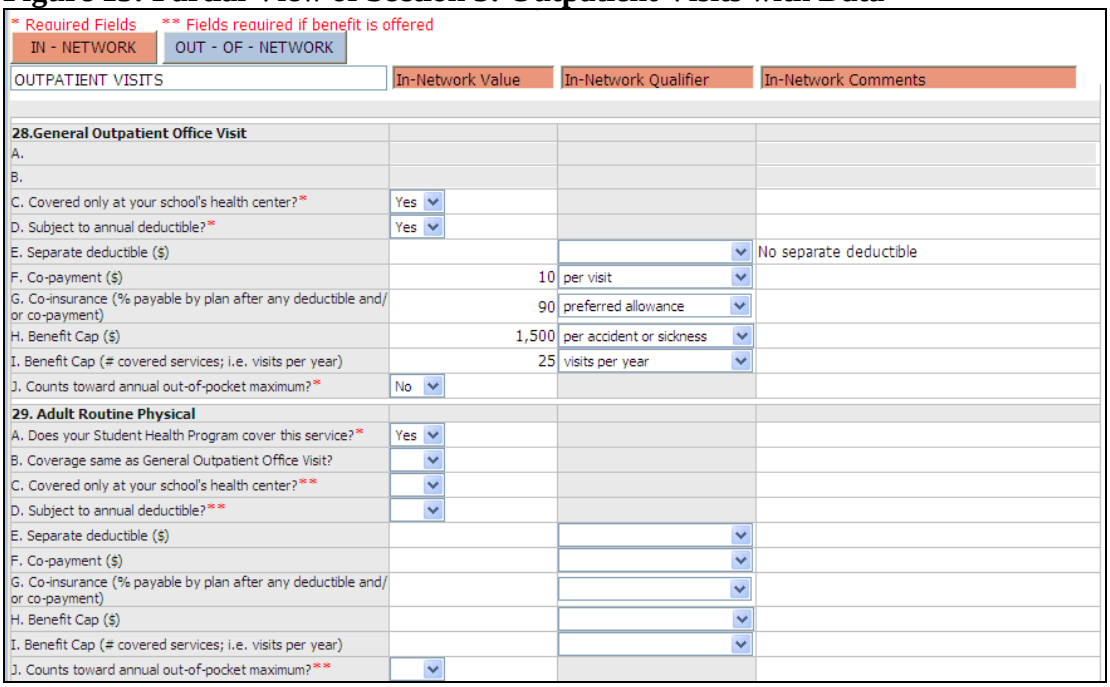
Figure 12: Partial View of Section 3: Outpatient Visits



After you fill out the information in this first question, you may move onto the next benefit. In the example, the next question is "Adult Routine Physical." For Adult Routine Physical:

Indicate whether your SHP provides coverage for this benefit. If not, then no additional data needs to be input and you can move onto the next benefit.
If your SHP offers this benefit (by selecting "Yes" to question A), then questions B – J become available to fill in data.

Figure 13: Partial View of Section 3: Outpatient Visits with Data



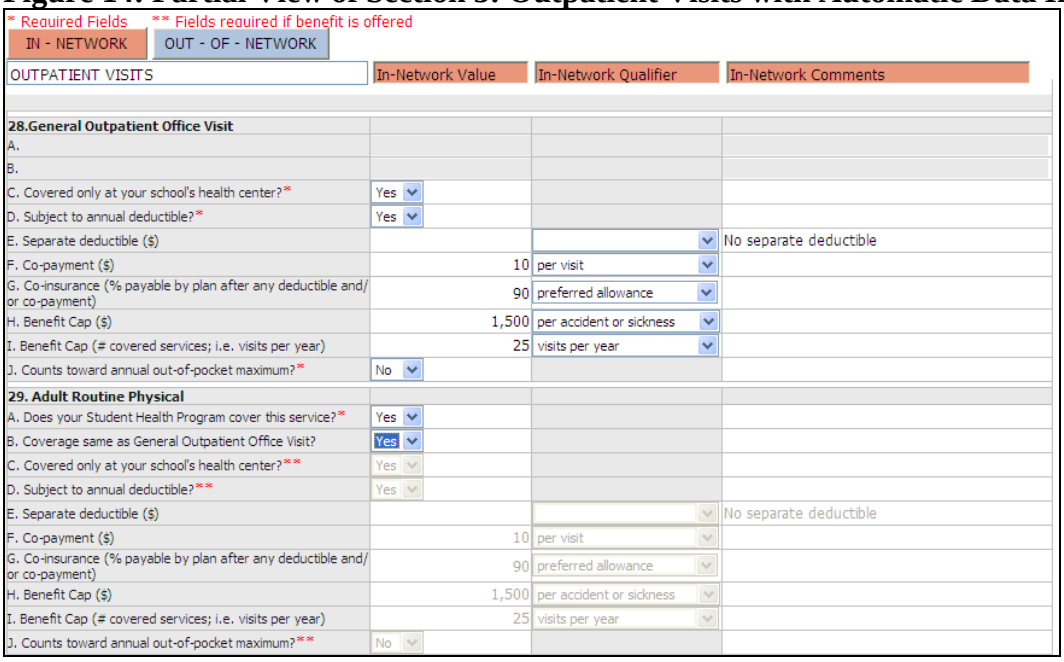
* Required Fields ** Fields required if benefit is offered

IN - NETWORK | OUT - OF - NETWORK

OUTPATIENT VISITS	In-Network Value	In-Network Qualifier	In-Network Comments
28.General Outpatient Office Visit			
A.			
B.			
C. Covered only at your school's health center?*	Yes		
D. Subject to annual deductible?*	Yes		
E. Separate deductible ($)			No separate deductible
F. Co-payment ($)	10	per visit	
G. Co-insurance (% payable by plan after any deductible and/or co-payment)	90	preferred allowance	
H. Benefit Cap ($)	1,500	per accident or sickness	
I. Benefit Cap (# covered services; i.e. visits per year)	25	visits per year	
J. Counts toward annual out-of-pocket maximum?*	No		
29. Adult Routine Physical			
A. Does your Student Health Program cover this service?*	Yes		
B. Coverage same as General Outpatient Office Visit?			
C. Covered only at your school's health center?**			
D. Subject to annual deductible?**			
E. Separate deductible ($)			
F. Co-payment ($)			
G. Co-insurance (% payable by plan after any deductible and/or co-payment)			
H. Benefit Cap ($)			
I. Benefit Cap (# covered services; i.e. visits per year)			
J. Counts toward annual out-of-pocket maximum?**			

Question B asks if the information you will be inputting for coverage of Adult Routine Physicals is the same as the information you put into the "General Outpatient Office Visit" question at the beginning of the section. If you choose "Yes", then the fields for questions C – J will self-populate with the information you put into questions C – J from "General Outpatient Visit".
If you choose "No", then you can manually fill in the fields for questions C – J.

Figure 14: Partial View of Section 3: Outpatient Visits with Automatic Data Input



* Required Fields ** Fields required if benefit is offered

IN - NETWORK | OUT - OF - NETWORK

OUTPATIENT VISITS	In-Network Value	In-Network Qualifier	In-Network Comments
28.General Outpatient Office Visit			
A.			
B.			
C. Covered only at your school's health center?*	Yes		
D. Subject to annual deductible?*	Yes		
E. Separate deductible ($)			No separate deductible
F. Co-payment ($)	10	per visit	
G. Co-insurance (% payable by plan after any deductible and/ or co-payment)	90	preferred allowance	
H. Benefit Cap ($)	1,500	per accident or sickness	
I. Benefit Cap (# covered services; i.e. visits per year)	25	visits per year	
J. Counts toward annual out-of-pocket maximum?*	No		
29. Adult Routine Physical			
A. Does your Student Health Program cover this service?*	Yes		
B. Coverage same as General Outpatient Office Visit?	Yes		
C. Covered only at your school's health center?**	Yes		
D. Subject to annual deductible?**	Yes		
E. Separate deductible ($)			No separate deductible
F. Co-payment ($)	10	per visit	
G. Co-insurance (% payable by plan after any deductible and/ or co-payment)	90	preferred allowance	
H. Benefit Cap ($)	1,500	per accident or sickness	
I. Benefit Cap (# covered services; i.e. visits per year)	25	visits per year	
J. Counts toward annual out-of-pocket maximum?**	No		

This feature is available for both the in-network and out-of-network sections of data entry. Please note that, depending on your answers to certain questions in Sections 1 and 2, you will not be required to fill out information for the following questions for each benefit:

- If Section 1, #13 (student health center) is "No" → question C is not required and can be left blank
- If Section 2, #25 (annual deductible) is "No" → question D is not required and can be left blank
- If Section 2, #24 (annual out-of-pocket maximum) is "No" → question J is not required and can be left blank
- If Section 2, #27 (plan network) is "No" → Out-Of-Network is not required and can be left blank.

The benefits for which data is required from is grouped so that the information in the "General [health benefit]" would be most applicable to the benefits in that specific section. Use Table 3 below to familiarize yourself with the benefits in each section so that you can put information in the "General [health benefit]" section that will apply to the most benefits in that section.

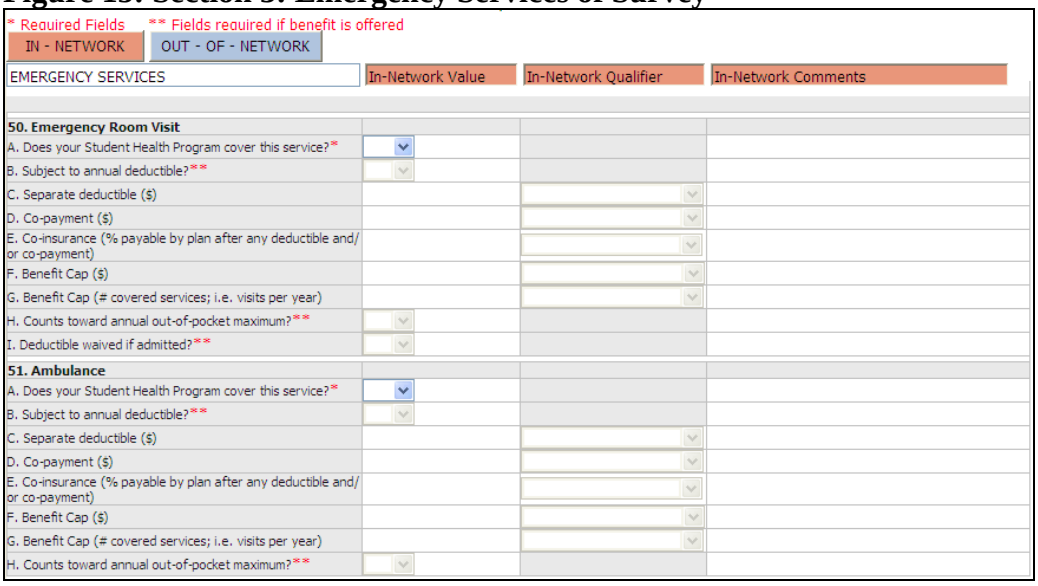
Table 3: Benefits in Each Section of Section 3

Section	Benefits
Outpatient Visits	Adult Routine Physical Routine GYN Exam Mental Health Outpatient Office Visit: Non-Biologically Based Conditions Mental Health Outpatient Office Visit: Biologically Based Conditions PCP Office Visit Specialist Office Visit Well Child Visit
Outpatient Ancillary Services	Hospital Outpatient Department Visit Outpatient Surgery – Day Unit/ Hospital Outpatient Physiotherapy Radiation and Chemotherapy Substance Abuse Outpatient Treatment
Inpatient Hospitalization Services	Inpatient Hospitalization – Physician Inpatient Hospitalization – Room and Board Inpatient Rehabilitation Inpatient Surgery Mental Health Inpatient Admission: Non-Biologically Based Conditions Mental Health Inpatient Admission: Biologically Based Conditions Substance Abuse Treatment
Other Services	Outpatient Diagnostic Laboratory Services Outpatient Diagnostic X-Ray Services Outpatient Diagnostic CT/ MRI/ PET Scan Durable Medical Equipment Christian Science Healing Practices

Emergency Services

The navigation and instructions for filling out the Emergency Services section is very similar to that shown in the "Outpatient Visits/ Outpatient Ancillary/ Inpatient Hospitalization/ Other Service" section; however there is no "General [health benefit]" question to fill out. This is because coverage for the 2 benefits in this section is not likely to be the same. Also, there is no need to fill in information for out-of-network ambulance services. Please visit Tables 8 (page 35) and 12 (page 39) in the Appendix for a definition of the data elements required for each field.

Figure 15: Section 3: Emergency Services of Survey



* Required Fields ** Fields required if benefit is offered

IN - NETWORK | OUT - OF - NETWORK

EMERGENCY SERVICES	In-Network Value	In-Network Qualifier	In-Network Comments
50. Emergency Room Visit			
A. Does your Student Health Program cover this service?*			
B. Subject to annual deductible?**			
C. Separate deductible ($)			
D. Co-payment ($)			
E. Co-insurance (% payable by plan after any deductible and/ or co-payment)			
F. Benefit Cap ($)			
G. Benefit Cap (# covered services; i.e. visits per year)			
H. Counts toward annual out-of-pocket maximum?**			
I. Deductible waived if admitted?**			
51. Ambulance			
A. Does your Student Health Program cover this service?*			
B. Subject to annual deductible?**			
C. Separate deductible ($)			
D. Co-payment ($)			
E. Co-insurance (% payable by plan after any deductible and/ or co-payment)			
F. Benefit Cap ($)			
G. Benefit Cap (# covered services; i.e. visits per year)			
H. Counts toward annual out-of-pocket maximum?**			

Once you have answered all the questions that apply to your SHP:

1. Click on "Save" to save your progress. Please note that if you save your data while in the "Out-of-Network" section, it will bring you back to the default "In-Network" section once the save is complete
2. Click on "Error Check" to see if the data you inputted has passed all data edits. If there are errors in your data, you will get a list of the fields you need to fix before you will be able to submit your survey
3. Fix any errors you may have, and repeat Steps 1 – 3 until there are no errors.
4. Click on "Next" to proceed to the next section within Section 3.

Mandated Benefits

The Division of Insurance requires certain benefits be covered for most health plans sold in the Massachusetts. Please see the "Mandatory Benefits Guide" on the Division of Insurance's website (www.mass.gov/doi) for more information.

This section asks you to select "Yes" or "No" to indicate whether your SHP covers each of these mandated benefits. There is no in-network or out-of-network for this section.

Figure 16: Section 3: Mandated Benefits of Survey

*Required Fields

58. Does your Student Health Program offer coverage for:	Value
A. Alcoholism rehabilitation?*	
B. Bone marrow transplants for treatment of breast cancer?*	
C. Cardiac rehabilitation?*	
D. Chiropractic services?*	
E. Clinical trials to treat cancer?*	
F. Contraceptive services?*	
G. Cytologic screening (pap smear)?*	
H. Diabetes-related services and supplies?*	
I. Early intervention services?*	
J. Hearing screening for newborns?*	
K. Home health care?*	
L. Hormone replacement therapy?*	
M. Hospice care?*	
N. Hypodermic syringes or needles?*	
O. Human leukocyte antigen testing?*	
P. Infertility treatment (does not apply to a diocese)?*	
Q. Lead poisoning screening?*	
R. Low protein food product for inherited amino acid and organic acid diseases (PKU)?*	
S. Mammography?*	
T. Maternity health care (including minimum maternity stay)?*	
U. Mental health care (including mental health parity)?*	
V. Nonprescription enteral formulas?*	
W. Prosthetic devices?*	
X. Preventative care for children up to age six (including specific newborn testing)?*	
Y. Off-label uses of prescription drugs to treat cancer?*	
Z. Off-label uses of prescription drugs to treat HIV/ AIDS?*	
AA. Scalp hair prostheses for cancer patients?*	
BB. Speech, hearing, and language disorders?*	

Once you have answered all the questions that apply to your SHP:

1. Click on "Save" to save your progress
2. Click on "Error Check" to see if the data you inputted has passed all data edits. If there are errors in your data, you will get a list of the fields you need to fix before you will be able to submit your survey
3. Fix any errors you may have, and repeat Steps 1 – 3 until there are no errors
4. Click on "Next" to proceed to Section 4

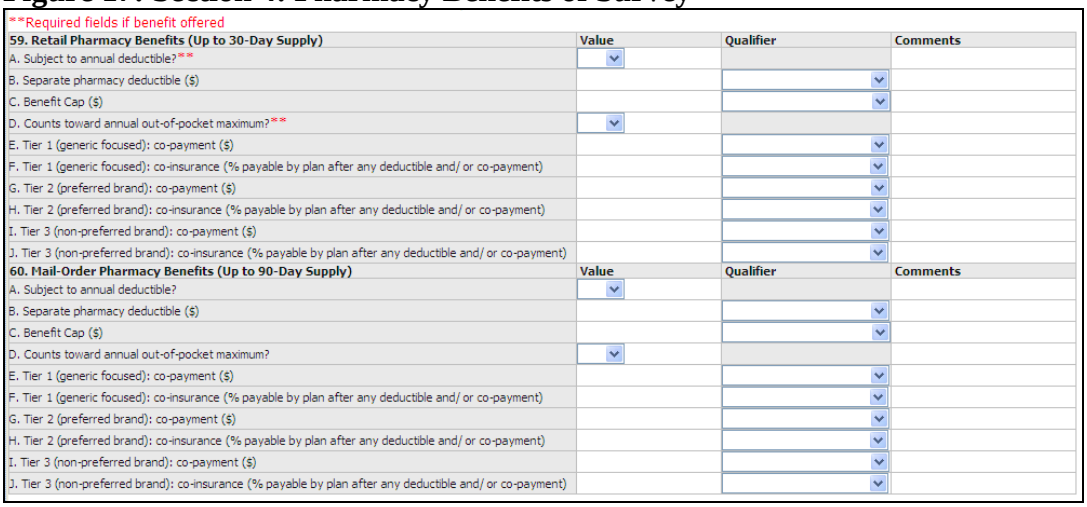
4.5 Section 4: Pharmacy Benefits

Section 4 of the survey asks for information about the pharmacy benefits covered by your SHP. SHPs are not required to offer pharmacy benefits to students, but many SHPs do. Please visit Tables 14 (page 40) and 15 (page 41) in the Appendix for a definition of the data elements required for each field. Please note that if Section 1, #10 is "No" → the pharmacy benefits section is not required and can be left blank.

Many SHPs have a different benefit structure for different types or "tiers" of drugs, generally distinguishing between "Generic", "Preferred Brand Name" and "Non-Preferred Brand Name" drugs. Health plans often require a different copayment for drugs in different tiers. Some SHPs also provide different levels of coverage depending on whether the patient receives prescriptions

at a retail pharmacy or from a mail-order pharmacy. If your SHP does not offer mail-order pharmacy benefits, please input information in just the "Retail Pharmacy Benefits" section.

Figure 17: Section 4: Pharmacy Benefits of Survey



**Required fields if benefit offered

59. Retail Pharmacy Benefits (Up to 30-Day Supply)	Value	Qualifier	Comments
A. Subject to annual deductible?**			
B. Separate pharmacy deductible ($)			
C. Benefit Cap ($)			
D. Counts toward annual out-of-pocket maximum?**			
E. Tier 1 (generic focused): co-payment ($)			
F. Tier 1 (generic focused): co-insurance (% payable by plan after any deductible and/ or co-payment)			
G. Tier 2 (preferred brand): co-payment ($)			
H. Tier 2 (preferred brand): co-insurance (% payable by plan after any deductible and/ or co-payment)			
I. Tier 3 (non-preferred brand): co-payment ($)			
J. Tier 3 (non-preferred brand): co-insurance (% payable by plan after any deductible and/ or co-payment)			
60. Mail-Order Pharmacy Benefits (Up to 90-Day Supply)	**Value**	**Qualifier**	**Comments**
A. Subject to annual deductible?			
B. Separate pharmacy deductible ($)			
C. Benefit Cap ($)			
D. Counts toward annual out-of-pocket maximum?			
E. Tier 1 (generic focused): co-payment ($)			
F. Tier 1 (generic focused): co-insurance (% payable by plan after any deductible and/ or co-payment)			
G. Tier 2 (preferred brand): co-payment ($)			
H. Tier 2 (preferred brand): co-insurance (% payable by plan after any deductible and/ or co-payment)			
I. Tier 3 (non-preferred brand): co-payment ($)			
J. Tier 3 (non-preferred brand): co-insurance (% payable by plan after any deductible and/ or co-payment)			

To fill out data:

1. Type or select your answers from the "Value" column.
2. For questions with a drop-down menus in the "Qualifier" column, use this column to describe the values you provided in the "Value" column.

Example: your SHP has a co-payment of "$15 per prescription."
For Question E, you would type "15" in "Value" and select "per rx" for "Qualifier".
If you have any comments that you think may help us better understand your SHP, please provide a short explanation in the appropriate "Comments" column.

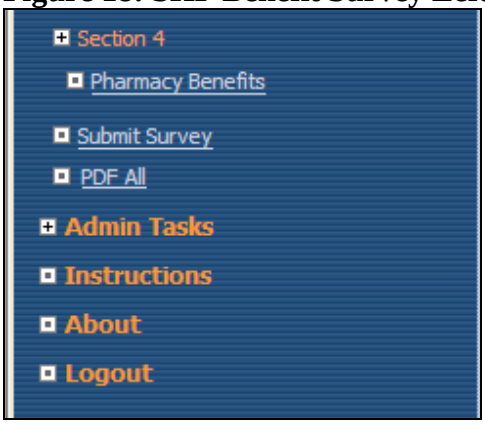
Once you have answered all the questions that apply to your SHP:

1. Click on "Save" to save your progress. Please note that if you save your data while in the "Out-of-Network" section, it will bring you back to the default "In-Network" section once the save is complete.
2. Click on "Error Check" to see if the data you inputted has passed all data edits. If there are errors in your data, you will get a list of the fields you need to fix before you will be able to submit your survey.
3. Fix any errors you may have, and repeat Steps 1 – 3 until there are no errors.
4. Click on "Next" to proceed. Since Section 4 is the last section in the survey, clicking "Next" will bring you back to Section 1.

5.0 Submitting Your Student Health Program Benefit Survey

Once you have finished inputting data into survey, you can click on the "Submit Survey" link in the left navigation pane.

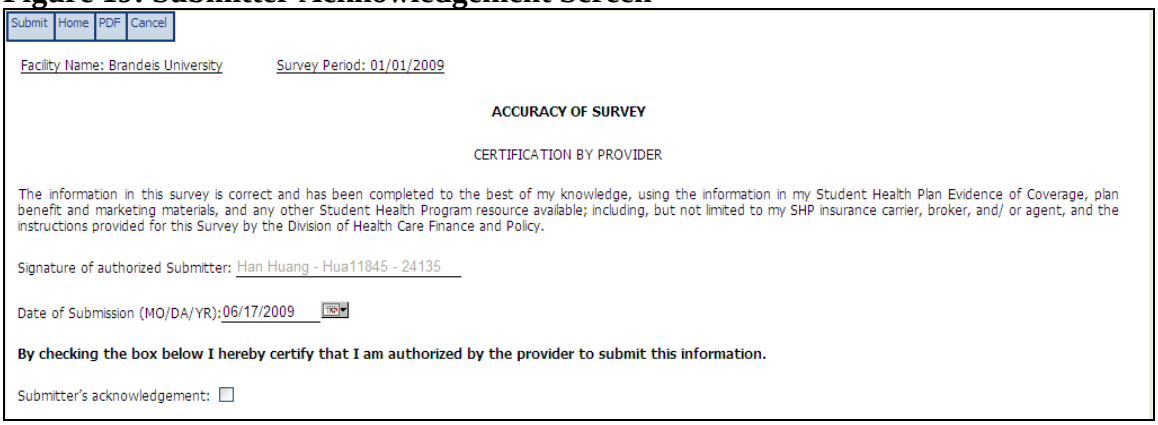
Figure 18: SHP Benefit Survey Left Navigation – Submit Survey



Once you click on the link, the application will automatically perform an error check and let you know if you have any errors in the data you input. If there are any errors, you **WILL NOT** be able to submit the survey until those errors are fixed.

If there are no errors, you will be taken to the Submitter's Acknowledgement screen.

Figure 19: Submitter Acknowledgement Screen



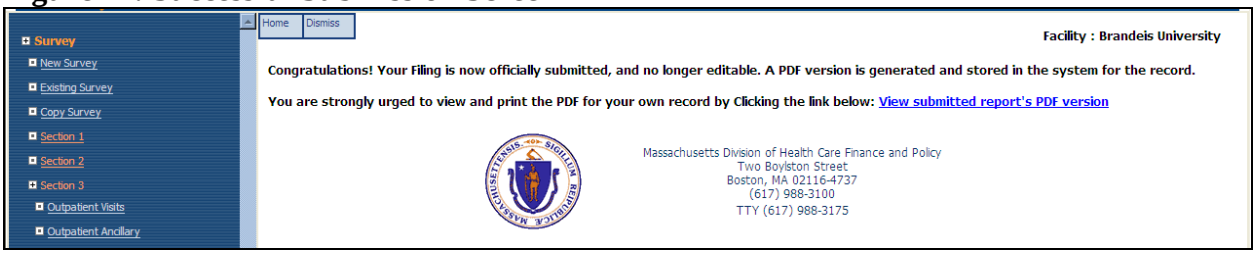
Here, you should check that the information in the electronic signature and date of submission is correct, and then check the "Submitter's Acknowledgement" box. Please note that the certification checkbox is not saved but it must be checked to submit the report. If the certification box is checked and the "Logout" link is used the certification checkbox will be unchecked when the survey is next retrieved.

Once you check the box, click the "Submit" button in the top navigation toolbar. Please note that after the survey is submitted no further changes can be made.

Figure 20: Submitter Acknowledgement Screen: Submit Button

Upon successful submission of the survey, you will see the "Successful Submission Screen". You can click on the "View Submitted Report's PDF Version" to have a complete PDF copy of the data you submitted to us. This function allows you to have a record of the information you sent to the Division.

Figure 21: Successful Submission Screen



You can now click the "Logout" link to exit INET.

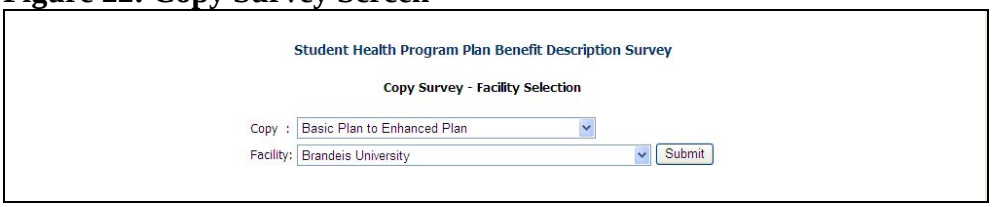
6.0 Schools With Multiple Plan Options

Please note that schools with multiple plan options available to students must fill out a survey for each plan.

The "Copy Survey" function that allows you to take the data from a submitted "Basic" survey, save it as a new "Enhanced" survey. That way, you can take the data already submitted for the Basic plan and modify only those benefits that differ from the Basic plan in the Enhanced version.

Please note that you must have submitted a "Basic" plan AND either created a new survey for the data to copy to before you can use the "Copy" function. The new survey can either be an "Enhanced" plan in the same filing year or a new "Basic" plan for a new filing year.

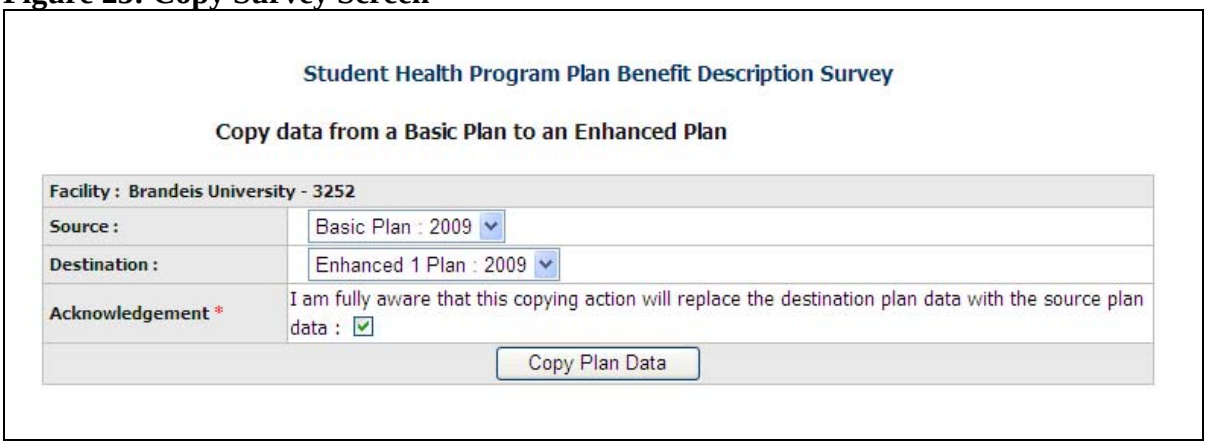
Figure 22: Copy Survey Screen



To use the "Copy Survey" function, make sure you have:

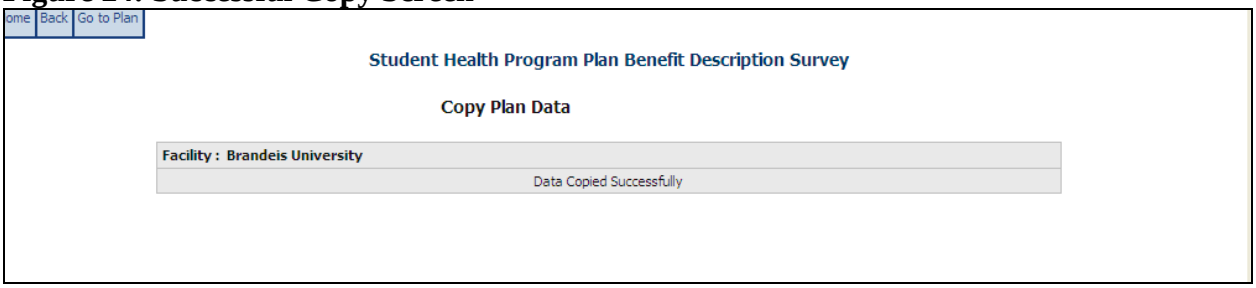
1. Submitted the survey you are planning on copying the data from.
2. Created a survey you are planning on copying the data to.
3. Click on the "Copy Survey" link in the Left Navigation. To come to the "Copy Survey Screen".
4. Choose whether you want to copy:
5. Basic Plan to Enhanced Plan – use for copying information from a Basic Plan to an Enhanced Plan for the same school year
6. Prior Year Basic Plan to Current Year Basic Plan – use for copying information from a Basic Plan you submitted in the previous year to the Basic Plan you have for the current school year
7. Note: This option is for schools who have submitted data in the prior year only. Some schools do not regularly change the plans they offer from year to year, so this function will facilitate data entry for schools whose plan only varies slightly from year to year.
8. Select your school
9. Click "Submit"
10. After the copy request is submitted, you will see a screen that ensures that you are aware of the fact that you are copying data.
11. Review and select the source data you want to copy from.
12. Review and select the destination where you want to data to copy to.
13. Check the acknowledgement box.
14. Click "Copy Plan Data".

Figure 23: Copy Survey Screen



Once you submit the request, the data will be copied and you will see a "Data copied successfully" message. You can click "Go to Plan" in the top navigation to go to the plan you copied data to and you can modify the information.

Figure 24: Successful Copy Screen

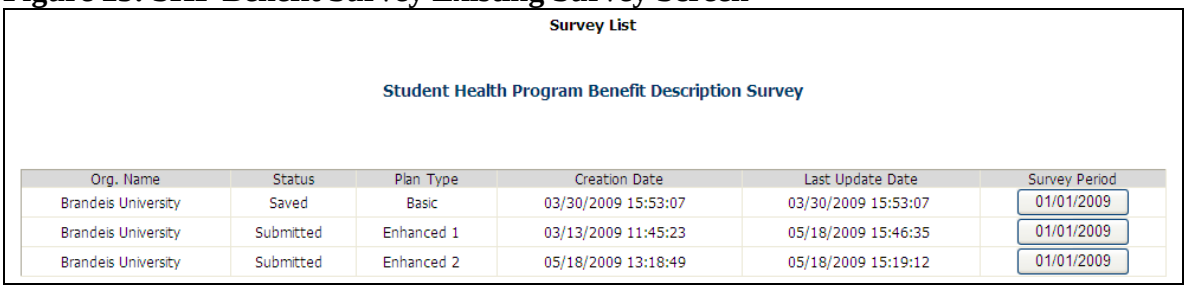


7.0 Process to View a Submitted Survey

You cannot change the content in a submitted survey unless you send the Division a "reopen request". To view a submitted survey, you need to open an existing survey, which is discussed in "3.4 Student Health Program Benefit Survey Main Menu" of this instructions manual.

Once you reach the Existing Survey Main Menu, you can click on the button in the "Survey Period" column to view (but not change) the information that you submitted. You can tell when a survey has been submitted since the "Status" column will say "Submitted" instead of "Saved".

Figure 25: SHP Benefit Survey Existing Survey Screen

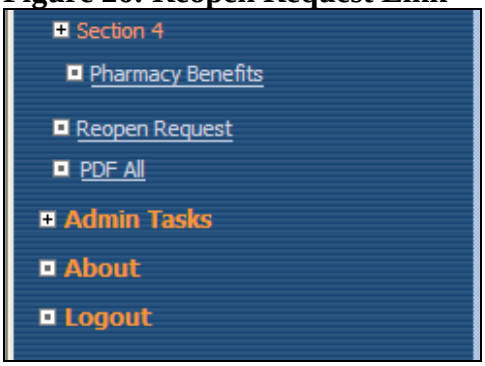


8.0 Process to Submit a Reopen Request

If you have submitted a benefit survey and want to change the data within the submission, you must submit a "Reopen Request" with the Division. Reopen requests will be reviewed and either approved or rejected by internal DHCFP staff. To help ensure timely review, an email notification is automatically generated and sent to the appropriate Division staff within 4 hours of the request.

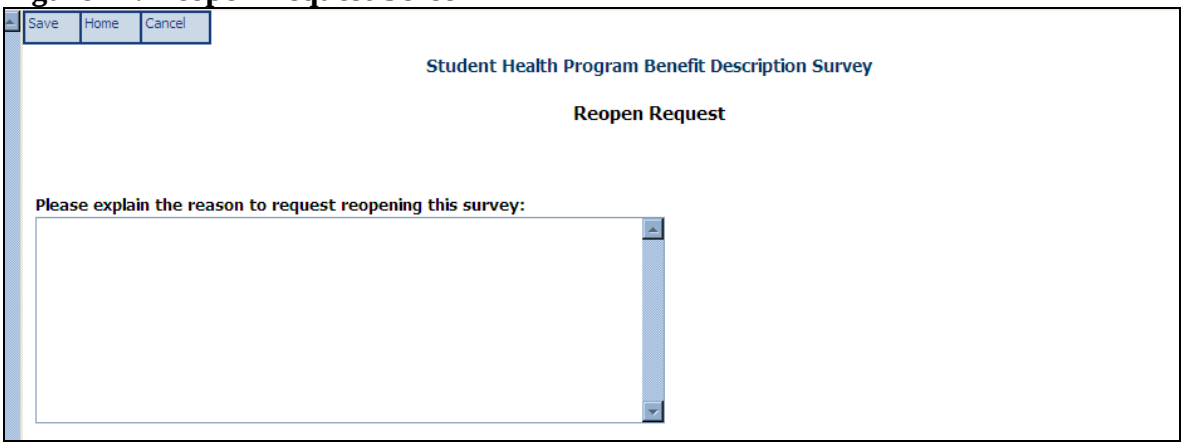
Once you have submitted a survey, a new "Reopen Request" link will appear on the left navigation pane.

Figure 26: Reopen Request Link



Click on the link and it will take you to the "Reopen Request" screen, where you can input your reason that you want to edit the information you already submitted. Once you have input your reason, you can hit the "Save" button in the top navigation bar, and then "Logout".

Figure 27: Reopen Request Screen



After receiving notification that a request to reopen was approved, the survey report will be available for editing. To make the needed corrections, you should navigate to the open an existing survey menu, which is discussed in "3.4 Student Health Program Benefit Survey Main Menu" of this instructions manual. Once you reach the Existing Survey Main Menu, you can click on the button in the "Survey Period" column to change the information that you submitted.

9.0 Appendix

The appendix provides detailed explanations and instructions about each of the fields required in each section.

Table 4: New Survey Fields

Field	Instructions
Year of survey	Select the school year you are reporting data for from the drop-down menu. Please remember that you will be filling in data for the upcoming school year, and in most cases, you will be selecting the most current year available in the drop-down menu.
Please select a provider from the options	Select the name of your school from the drop-down menu. If your school is displayed incorrectly or not listed, please contact the Division's Help Desk at (800) 609-7232.
Please select a plan type from the options below	For schools who offer only 1 SHP option, select "Basic". For schools who offer more than 1 SHP option: Select "Basic" to fill out data for the SHP option that students are automatically enrolled in when they are registered for classes. Select "Enhanced" to fill out data for any other variations of SHPs that are offered to students. For example, a school may offer students the option of purchasing a better SHP than they are enrolled in, if the student pays more for the enhanced plan. The survey allows schools to submit up to 3 enhanced SHP options. Please contact the Division's Help Desk at (800) 609-7232 if you need more than 3 plan options.

Table 5: Section 1 Fields

#	Field	Instructions
1	OrgID	Pre-populated field based on information from questions answered during survey creation.
2	College/ University Name	Pre-populated field based on information from questions answered during survey creation.
3	School year for which plan information is provided	Pre-populated field based on information from questions answered during survey creation.
4	Plan Name	Type in the name of your SHP plan
5	Plan Underwriter	Select your plan underwriter from the drop-down list. The list contains all health insurance carriers accredited by the Massachusetts Division of Insurance. If your insurance carrier is not on the list: Make sure you are looking for your insurance carrier, not agent/ broker (i.e. University Health Plans; Gallagher Koster) Select "Carrier Not Listed" Provide the name of your carrier in the comment box If you do not have an insurance carrier, select "Do not have carrier" and explain why in the comment box.
6	Plan Claims Administrator	Type in the name of the company that processes the claims for members of your SHP. This company may be different from the insurance company that underwrites your SHP, or it may be the same.
7	Plan Broker	If your school uses an insurance broker or agent, type in the name of the company used. If your school does not use an insurance broker or agent, please type "N/A".
8	Number of Students Enrolled in This Plan	Provide the number of students enrolled in your SHP (if known).
9	Number of Covered Lives Enrolled in This Plan	Provide the number of all people enrolled in your SHP (i.e. students, children, spouses), if known.
10	Does your SHP cover routine dental services?	Select either "Yes" or "No" depending on whether routine dental services are covered by your SHP. This question asks about SHP coverage, which is not the same as a dental savings programs. If routine dental services are offered as an additional benefit students can purchase, please enter this information as part of an "enhanced"

		plan and leave this information out of the "basic" plan description.
11	Does your SHP cover routine vision services?	Select either "Yes" or "No" depending on whether routine vision services are covered by your SHP. This question asks about SHP coverage, which is not the same as a vision savings programs.
12	Does your SHP cover prescription drug benefits?	Select either "Yes" or "No" depending on whether prescription drug benefits are covered by your SHP.
13	Does your SHP provide any benefits through a student health center?	Select either "Yes" or "No" depending on whether your school uses its student health center to provide any SHP benefits. If your school does not have a student health center, please select "No".
14 – 20	Does your Plan specify its policies regarding: Premium refunds? Partial year student enrollment? Denial of claims/ payments for rendered services? Internal grievance procedure for denial of claims/ payments for rendered services? Denial of referrals for requested services? Internal grievance procedure for denial of referrals for requested services? Right to file external grievances with the Massachusetts Office of Patient Protection?	Select either "Yes" or "No" depending on which these pieces of information are available in your SHP's Evidence of Coverage/ Certificate/ Policy and/ or any other SHP materials readily accessible to students. If your SHP is a PPO-type plan that does not require referrals, but does require prior authorization, for this question, please treat the prior authorization as a referral. If your SHP does not have a referral requirement, please just select "Yes," since there is no referral requirement to state; and therefore, students do not need to be notified there is one.

Table 6: Section 2 Fields

#	Field	Instructions
21: A – H	Annual Premium ($) (without health center or administrative fees)	Provide the annual premium cost for your SHP. Provide the premium costs excluding any administrative or student health center fees (i.e. the raw premium; or for some schools, the dollar amount that will be removed from the student's tuition bill as a result of waiving the SHP requirement). You must provide a premium amount for "A: Student Only." This number must be whole number. If your school offers SHP coverage to your students' spouse, dependents, or family (questions B – F), provide the additional premium cost for any of the applicable groups. If your SHP does not offer coverage to any or all of these groups, leave these fields blank. If the premium cost for a graduate student and/ or international student differs from that of a student (question A), provide the premium costs for any of the applicable groups (questions G – H), provide. If your SHP does not offer coverage to any or all of these groups, leave these fields blank.
22: A – H	Heath Center/ Administrative Fee ($)	If applicable, provide the annual administrative or student health center fees associated with your SHP, for each population group specified. This number must be whole number. If your school does not have an annual administrative or student health center fee, leave these fields blank.
23: A – B	Annual Benefit Maximum	Select "Yes" or "No", depending on whether your school's SHP has a maximum dollar amount of covered benefits available to the student for the school year. If "Yes", provide the amount of the maximum benefit (question B). If "No", leave the question blank (question B).
24: A – B	Annual Out of Pocket Maximum	Select "Yes" or "No", depending on whether your school's SHP has a maximum amount of out-of-pocket expenses for covered services that a student is responsible for during the school year.

		If “Yes”, provide the amount of the maximum benefit (question B). If “No”, leave the question blank (question B).
25: A – B	Annual Deductible	Select “Yes” or “No”, depending on whether your school’s SHP has an overall annual deductible for the health plan for the school year. If “Yes”, provide the amount of the maximum benefit (question B). If “No”, leave the question blank (question B).
26: A – B	Pre-Existing Condition Limitation	Select “Yes” or “No”, depending on whether your school’s SHP has a limit on coverage for a medical condition that has been discovered or treated within a set period before the effective date of your school’s SHP. If “Yes”, provide the number of months after the SHP effective date that the restriction applies for (question B). If “No”, leave the question blank (question B).
27	Plan Network Information	Select “Yes” or “No”, depending on whether your school’s SHP provides different levels of coverage based on whether the health provider is “in-network” or “out-of-network”. If your SHP does not clearly state that it has different networks, but does offer different levels of coverage for the same benefit depending on where the student receives care, then consider the cheaper option for the student as the “in-network” option and the more expensive option for the student as the “out-of-network” option.

Table 7: Section 3 Questions – Outpatient Visits/ Outpatient Ancillary/ Inpatient Hospitalization/ Other Services

#	Field	Instructions
A	Does your Student Health Program cover this service?	Select "Yes" or "No", depending on whether your school's SHP provides coverage for the particular benefit listed. This is a required question. If "No", questions B – J are not required.
B	Coverage same as: General Office Visit? General Ancillary Outpatient Service? General Inpatient Services? General Other Services?	Select "Yes" or "No", depending on whether the level of benefit coverage for the specified benefit is the same as the coverage you provided in the first question of each section. If "Yes", questions B – J will automatically populate with the information you provided in the specified question. If "No", fill in the appropriate answers for questions B – J.
C	Covered only at your school's health center?	Select "Yes" or "No", depending on whether your school's SHP provides coverage for the particular benefit listed only at your school's health center and not a provider outside of the school's health center. This is a required question. Note that if your answer to Section 1, #13 is "No", then this question can be left blank.
D	Subject to annual deductible?	Select "Yes" or "No", depending on whether the benefit specified is subject to your SHP's annual deductible. This is a required question. Note that if your answer to Section 2, #25 is "No", then this question can be left blank.
E	Separate Deductible ($)	Some plans may have a separate deductible, in addition to the annual deductible, for specific benefits (i.e. a separate prescription drug deductible). If applicable, provide the dollar amount for the separate deductible and select from the drop-down menu how this co-payment is applied. If you choose "Other" in the drop-down "Qualifier" menu, please provide how your SHP applies a co-payment in the "Comment" box. Otherwise, leave this blank.
F	Co-payment ($)	If applicable, provide the dollar amount for the co-payment and select from the drop-down menu how

		this co-payment is applied. If you choose "Other" in the drop-down "Qualifier" menu, please provide how your SHP applies a co-payment in the "Comment" box. Otherwise, leave this blank.
G	Co-insurance (% payable by plan after any deductible and/ or co-payment)	If applicable, provide the percentage that the insurance plan will pay for a service after any patient deductible or copayment amount and select from the drop-down menu how this co-payment is applied. If you choose "Other" in the drop-down "Qualifier" menu, please provide how your SHP applies a co-payment in the "Comment" box. Otherwise, leave this blank.
H	Benefit Cap ($)	If applicable, provide the maximum dollar amount that the plan provides for the service or benefit and select from the drop-down menu how this co-payment is applied. If you choose "Other" in the drop-down "Qualifier" menu, please provide how your SHP applies a co-payment in the "Comment" box. Otherwise, leave this blank.
I	Benefit Cap (# covered services, i.e. visits per year)	If applicable, provide the maximum number of services that the plan provides for the benefit and select from the drop-down menu how this co-payment is applied. If you choose "Other" in the drop-down "Qualifier" menu, please provide how your SHP applies a co-payment in the "Comment" box. Otherwise, leave this blank.
J	Counts toward annual out-of-pocket maximum?	Select "Yes" or "No", depending on whether the benefit specified is subject to your SHP's annual out-of-pocket maximum. This is a required question. Note that if your answer to Section 2, #24 is "No", then this question can be left blank.

Table 8: Section 3 Questions – Emergency Services

#	Field	Instructions
A	Does your Student Health Program cover this service?	Select "Yes" or "No", depending on whether your school's SHP provides coverage for the particular benefit listed. This is a required question. If "No", questions B – J are not required.
B	Subject to annual deductible?	Select "Yes" or "No", depending on whether the benefit specified is subject to your SHP's annual deductible. This is a required question. Note that if your answer to Section 2, #25 is "No", then this question can be left blank.
C	Separate Deductible ($)	Some plans may have a separate deductible, in addition to the annual deductible, for specific benefits (i.e. a separate prescription drug deductible). If applicable, provide the dollar amount for the separate deductible and select from the drop-down menu how this co-payment is applied. If you choose "Other" in the drop-down "Qualifier" menu, please provide how your SHP applies a co-payment in the "Comment" box. Otherwise, leave this blank.
D	Co-payment ($)	If applicable, provide the dollar amount for the co-payment and select from the drop-down menu how this co-payment is applied. If you choose "Other" in the drop-down "Qualifier" menu, please provide how your SHP applies a co-payment in the "Comment" box. Otherwise, leave this blank.
E	Co-insurance (% payable by plan after any deductible and/ or co-payment)	If applicable, provide the percentage that the insurance plan will pay for a service after any patient deductible or copayment amount and select from the drop-down menu how this co-payment is applied. If you choose "Other" in the drop-down "Qualifier" menu, please provide how your SHP applies a co-payment in the "Comment" box. Otherwise, leave this blank.
F	Benefit Cap ($)	If applicable, provide the maximum dollar amount that the plan provides for the service or benefit and select from the drop-down menu how this co-payment is applied. If you choose "Other" in the drop-down "Qualifier" menu, please provide how your SHP applies a co-payment in the "Comment" box. Otherwise, leave this blank.
G	Benefit Cap (# covered	If applicable, provide the maximum number of

	services, i.e. visits per year)	services that the plan provides for the benefit and select from the drop-down menu how this co-payment is applied. If you choose "Other" in the drop-down "Qualifier" menu, please provide how your SHP applies a co-payment in the "Comment" box. Otherwise, leave this blank.
H	Counts toward annual out-of-pocket maximum?	Select "Yes" or "No", depending on whether the benefit specified is subject to your SHP's annual out-of-pocket maximum. This is a required question. Note that if your answer to Section 2, #24 is "No", then this question can be left blank.
I	Deductible Waived if Admitted?	Select "Yes" or "No", depending on whether the deductible for an emergency room visit is waived if the patient is admitted. This is a required question.

Table 9: Section 3 Benefits – Outpatient Visits

#	Field	Description
29	Adult Routine Physical	A periodic visit with a medical professional (doctor, nurse practitioner, etc.) to assess a patient's overall physical health.
30	Routine GYN Exam	A periodic visit with a medical professional (doctor, nurse practitioner, etc.) to assess a patient's overall gynecological health.
31	Mental Health Outpatient Office Visit: Non-Biologically Based Conditions	Benefits for covered non-biologically based mental health services provided in an outpatient setting.
32	Mental Health Outpatient Office Visit: Biologically Based Conditions	Benefits for covered biologically based mental health services provided in an outpatient setting.
33	PCP Office Visit	Any primary care visit to a doctor's office that is not for a "routine medical office visit." In most cases, this will be akin to a "regular office visit."
34	Specialist Office Visit	A visit to a health care professional who focuses on a specific condition, illness, or part of the human body.
35	Well Child Visit	A periodic visit with a medical professional (doctor, nurse practitioner, etc.) to assess the growth, development, and health of a child.

Table 10: Section 3 Benefits – Outpatient Ancillary

#	Field	Description
37	Hospital Outpatient Department Visit	A visit during which a patient is admitted to an outpatient medical setting, rather than a hospital, for treatment or recovery
38	Outpatient Surgery – Day Unit/ Hospital	A surgical procedure that does not require an overnight stay in a hospital and is provided in an outpatient hospital or surgical day care unit setting.
39	Outpatient Physiotherapy	Specialized care to help restore functions of the body such as walking and the use of arms and legs; may include physical therapy.
40	Radiation and Chemotherapy	Specialized care using radiation and chemotherapy to treat diseases and illnesses.
41	Substance Abuse Outpatient Treatment	Benefits for covered substance abuse treatment services provided in an outpatient setting.

Table 11: Section 3 Benefits – Inpatient Hospitalization

#	Field	Description
43	Inpatient Hospitalization – Physician	Physician services for a period during which a patient is admitted to a hospital for treatment or recovery. An inpatient stay ends when the patient is discharged from an overnight stay in the hospital.
44	Inpatient Hospitalization – Room and Board	Semi-private room and board for a period during which a patient is admitted to a hospital for treatment or recovery. An inpatient stay ends when the patient is discharged from an overnight stay in the hospital.
45	Inpatient Rehabilitation	Services for a period during which a patient is admitted to a rehabilitation hospital for treatment or recovery. An inpatient stay usually involves an overnight stay in the hospital. An inpatient stay ends when the patient is discharged.
46	Inpatient Surgery	A surgical procedure that requires an overnight stay in a hospital.
47	Mental Health Inpatient Admission: Non-Biologically Based Conditions	Benefits for covered non-biologically based mental health services provided in an inpatient setting.
48	Mental Health Inpatient Admission: Biologically Based Conditions	Benefits for covered biologically based mental health services provided in an inpatient setting.
49	Substance Abuse Inpatient Treatment	Benefits for covered substance abuse treatment services provided in an inpatient setting.

Table 12: Section 3 Benefits – Emergency Services

#	Field	Description
50	Emergency Room Visit	An injury, symptom, or illness that requires immediate medical attention. An emergency room co-payment is a flat amount that a patient must pay for a covered Emergency Room visit, usually at the time the service is delivered.
51	Ambulance	Ambulance services provided for emergency situations.

Table 13: Section 3 Benefits – Other Services

#	Field	Description
53	Outpatient Diagnostic Laboratory Services	Laboratory tests (such as blood work and urine tests) that are done without a hospital admission.
54	Outpatient Diagnostic X-Ray Services	X-ray imaging tests that are done without a hospital admission.
55	Outpatient Diagnostic CT/ MRI/ PET Scan	Imaging tests, aside from x-rays, that are done without a hospital admission.
56	Durable Medical Equipment	Medical equipment used to provide care and/ or treatment for various health services and as defined by Title XVIII of the Social Security Act.
57	Christian Science Healing Practices	Health care provided in accordance with Christian Science Healing Practices.

Table 14: Section 4: Pharmacy Benefits Questions

#	Field	Instructions
A	Subject to annual deductible?	Select "Yes" or "No", depending on whether the benefit specified is subject to your SHP's annual deductible. This is a required question.
B	Separate Pharmacy Deductible ($)	Some plans may have a separate deductible, in addition to the annual deductible, for prescription drug benefits. If applicable, provide the dollar amount for the separate deductible and select from the drop-down menu how this co-payment is applied. If you choose "Other" in the drop-down "Qualifier" menu, please provide how your SHP applies a co-payment in the "Comment" box. Otherwise, leave this blank.
C	Benefit Cap ($)	If applicable, provide the maximum dollar amount that the plan provides for the service or benefit and select from the drop-down menu how this co-payment is applied. If you choose "Other" in the drop-down "Qualifier" menu, please provide how your SHP applies a co-payment in the "Comment" box. Otherwise, leave this blank.
D	Counts toward annual out-of-pocket maximum?	Select "Yes" or "No", depending on whether the benefit specified is subject to your SHP's annual out-of-pocket maximum. This is a required question.
E, G, I	Tier 1/ Tier 2/ Tier 3: Co-payment ($)	Many plans have a different benefit structure for different types or "tiers" of drugs, generally distinguishing between "Generic", "Preferred Brand Name" and "Non-Preferred Brand Name" drugs. Health plans often require a different copayment for drugs in different tiers. If applicable, provide the dollar amount for the co-payment and select from the drop-down menu how this co-payment is applied. If you choose "Other" in the drop-down "Qualifier" menu, please provide how your SHP applies a co-payment in the "Comment" box. Otherwise, leave this blank. If your pharmacy benefit does not have a tiered system, please just answer questions for "Tier 1". If your pharmacy benefit only has 2 tiers, please just answer for "Tier 1" and "Tier 2".
F, H, J	Tier 1/ Tier 2/ Tier 3: Co-insurance (% payable by	Many plans have a different benefit structure for different types or "tiers" of drugs, generally

	plan after any deductible and/ or co-payment)	distinguishing between “Generic”, “Preferred Brand Name” and “Non-Preferred Brand Name” drugs. Health plans often require a different copayment for drugs in different tiers. If applicable, provide the percentage that the insurance plan will pay for a service after any patient deductible or copayment amount and select from the drop-down menu how this co-payment is applied. If you choose “Other” in the drop-down “Qualifier” menu, please provide how your SHP applies a co-payment in the “Comment” box. Otherwise, leave this blank. If your pharmacy benefit does not have a tiered system, please just answer questions for “Tier 1”. If your pharmacy benefit only has 2 tiers, please just answer for “Tier 1” and “Tier 2”.

Table 15: Section 4: Pharmacy Benefits

#	Field	Description
59	Retail Pharmacy Benefits (Up to 30-Day Supply)	Prescriptions filled at a retail pharmacy.
60	Mail Order Pharmacy Benefits (Up to 90-Day Supply)	If applicable, prescriptions filled by a mail order pharmacy. If your SHP does not offer mail order pharmacy benefits, you can leave this section blank.