From: Sacher, Eric [Eric.Sacher@dishnetwork.com]
Sent: Monday, September 13, 2010 11:57 AM
To: HHS HealthInsurance (HHS)
Subject: Waiver

Attachments: DISH Network Waiver.pdf; HCR HHS Waiver 9.03.2010.pdf

HHS,

Please find a waiver application for DISH Network attached to this email. If you require any additional information to review/process this waiver, please let me know.

Thank you,

Eric Sacher
Manager of Benefits
DISH Network L.L.C - Headquarters
9601 S. Meridian Blvd.
Englewood, CO 80112
(ph) 303.723.3191
eric.sacher@dishnetwork.com
www.dishnetwork.com

DISH Network
Restricted Annual Maximum Waiver Application

Employer: DISH Network LLC
Plan Name: Minimum Coverage Plan
Plan Administrator: DISH Network LLC
Contact information: Aaron LaPoint, Vice President of Human Resources
9601 South Meridian BLVD
Englewood, CO 80112
303-723-1371

Required application contents:

1. **Terms of the plan or policy form(s) for which a waiver is sought**

   DISH Network currently offers two self-funded medical plan options to all benefits eligible employees: a comprehensive, high-deductible medical PPO plan ("Consumer Choice Plan," "CCP") and a limited benefit medical plan ("Minimum Coverage Plan," "MCP"). Both plans have been offered since 3/1/2006 and both plans fill different needs for DISH employees.

   The MCP includes both an annual ((b)(4)) and a lifetime ((b)(4)) limit and, as a result has substantially lower costs, and lower monthly employee contribution levels. The plan has a low ((b)(4) single/(b)(4) family) deductible and offers (b)(4)% coinsurance up to the annual maximum. It also provides enrollees with access to the substantial discounts offered through the CIGNA PPO network.

   All full time employees are eligible for both plans. A summary of the highlights of the plan designs offered to DISH Network employees is provided in Attachment A.

2. **Number of individuals covered by plan or policy forms(s) submitted**

   As of July, 2010, (b)(4) employees are enrolled in the MCP ((b)(4) with dependent coverage) and (b)(4) are enrolled in the CCP. The number of employees enrolled in the MCP has grown steadily since the plan's inception, currently standing at (b)(4)% of enrollees, further reinforcing the fact that many individuals see value in the plan.

3. Annual limit(s) and rates applicable to the plan or policy form(s) submitted

Annual: $ (b)(4)
Lifetime: $ (b)(4)

	Monthly Accrual Rates	Monthly Employee Contributions
Employee Only	$ (b)(4)	$ (b)(4)
Employee Plus One	$	$
Employee Plus Family	$	$

4. Why compliance would result in significant decrease in access to or increase in premiums paid for benefits for those covered?

To change the current MCP provisions to comply with the restricted annual maximum limitations would increase the underlying cost of the MCP significantly. This would mean that the projected cost of the MCP would be higher than the CCP and, as a result, the MCP employee premium contributions would have to be even higher than the current CCP contributions in order for the plan to continue to be offered. Therefore, if not approved for a waiver, the MCP would simply have to be eliminated and just the CCP would be offered, given the magnitude of the cost impact to DISH Network and employees related to compliance.

Since compliance with the restricted annual maximum requirements would require an increase to plan costs per enrollee even beyond the current CCP, the only viable option is to eliminate the MCP. In doing so, however, the plan costs are expected to significantly increase. To illustrate the cost difference between the current MCP and CCP, please see the claims summary attached as Attachment B. For 3/2009 – 2/2010, the average claims cost per employee per month for the MCP was (b)(4) compared to (b)(4) during that same time period for the CCP. The results for 3/2010 – 7/2010 are similar. Should the MCP be eliminated and all MCP enrollees move to the CCP, we would expect their claim costs to double and be similar to the current CCP experience due to the higher level of coverage in the CCP.

Thus, if the MCP is not granted a waiver and has to be eliminated, this would result in displacement of current coverage for (b)(4) employees. These employees would either face an increase in their monthly premium contributions of roughly (b)(4)% if they move to the CCP (assuming current contributions on the CCP remain in place) or loss of coverage entirely since the cost of obtaining an individual plan on the open market would be substantially higher than their current MCP contribution requirement (assuming that they are even medically qualified to do so).

The MCP has satisfied a need for the DISH Network population by providing a low-cost, limited coverage plan and the elimination of this plan prior to the establishment of the insurance exchange with subsidy assistance would have a significant impact on

this population. For these covered employees and their families, their costs would significantly increase if they are forced to move to the CCP and for those who are unable to afford to move to the CCP, loss of coverage is the likely outcome.

5. **I hereby certify the following to be completely true:**

- The plan was in place prior to September 23, 2010

- The application of restricted annual limits to this plan would result in a significant increase in premiums paid by those covered or a significant decrease in access (due to those who would drop coverage entirely rather than pay higher premiums).

9/12/10

Plan Administrator — Date

Attachment A

DISH Network 2010 Medical Plan Highlights

	Consumer Choice Plan (CCP)		Minimum Coverage Plan (MCP)
	In-Network	**Out-of-Network**	**In-Network Only**
Primary Care Physician Required?			
Deductible (Medical/Rx combined)			
Employee Only			
Employee+One/Family			
Coinsurance			
Out-of-Pocket Maximum (includes deductible)			
Employee Only			
Employee+One/Family			
Plan Maximum			
Annual (per person)			
Lifetime (per person)			
Plan Network			
Preventive Visit			
Other Office Visit			
Specialist Visit			
Urgent Care			
Emergency Room			
Outpatient Hospital			
Inpatient Hospital			
Pharmacy:			
Retail			
Generic			
Formulary Brand			
Non-Formulary Brand			
Mail Order			
Generic			
Formulary Brand			
Non-Formulary Brand			
May Contribute to an HSA			

(b)(4)

Attachment B

DISH Network 2009/2010 Experience Data

2009/2010	Medical	Rx	Total	Total Enrollment	PEPM	Claims Ratio vs MCP
MCP	(b)(4)					
CCP						

2010/2011*	Medical	Rx	Total	Avg Enrollment	PEPM	Claims Ratio vs MCP
MCP	(b)(4)					
CCP						

**Data through July 2010*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Consumer Information and
Insurance Oversight
Washington, DC 20201

Date: September 3, 2010

From: Steve Larsen, Director, Office of Oversight

Title: Insurance Standards Bulletin Series--INFORMATION

Subject: OCIIO Sub-Regulatory Guidance (OCIIO 2010 - 1): Process for Obtaining Waivers of the Annual Limits Requirements of PHS Act Section 2711

Markets: Group and Individual

I. Purpose

Section 2711(a)(2) of the Public Health Service Act (PHS Act)[1], as added by the Patient Protection and Affordable Care Act (Affordable Care Act), requires the Secretary to impose restrictions on the imposition of annual limits on the dollar value of essential health benefits (as defined in section 1302(b) of the Affordable Care Act)[2] for any participant or beneficiary in a new or existing group health plan or a new policy in the individual market for plan or policy years beginning on or after September 23, 2010 and prior to January 1, 2014. Specifically, the Secretary is granted the authority to determine what constitutes a "restricted annual limit" that can still be imposed under such plans or policies prior to January 1, 2014.

The interim final regulations published on June 28, 2010 (codified at 26 CFR §54.9815-2719T; 29 CFR §2590.715-2719; and 45 CFR §147.126) established such restricted annual limits. The regulations also provided that these restricted annual limits may be waived by the Secretary of Health and Human Services (HHS) if compliance with the interim final regulations would result in a significant decrease in access to benefits or a significant increase in premiums. The preamble to those regulations further provided that guidance from HHS regarding the scope and process for applying for such a waiver would be issued in the near future. This memorandum constitutes that guidance.

[1] The Affordable Care Act adds section 715(a)(1) to the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) to the Internal Revenue Code (the Code) to incorporate the provisions of part A of title XXVII of the PHS Act, which includes PHS Act section 2711, into ERISA and the Code, and make them applicable to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans.

[2] The interim final regulations under PHS Act section 2711 defined "essential health benefits" by cross-reference to section 1302(b) of the Affordable Care Act and applicable regulations. Regulations under section 1302(b) of the Affordable Care Act have not yet been issued. The preamble to the interim final regulations provides that, for plan years (in the individual market, policy years) beginning before the issuance of regulations defining "essential health benefits", the Departments of Health and Human Services, Labor and the Treasury (the Departments) will take into account good faith efforts to comply with a reasonable interpretation of the term "essential health benefits."

DISH NET:000007

II. Background

Section 2711 and the interim final regulations (26 CFR §54.9815-2719T; 29 CFR §2590.715-2719; and 45 CFR §147.126) allow the imposition of "restricted annual limits" on essential health benefits for plan years for group health plans and group health insurance coverage, and for policy years for new non-grandfathered individual health insurance coverage, beginning before January 1, 2014. No annual limits on essential health benefits are permitted with respect to plan or policy years beginning on or after January 1, 2014, except in the case of grandfathered individual market policies. Group health plans and health insurance coverage that meet the definition of an excepted benefit pursuant to section 2791 of the PHS Act, section 732 of ERISA, or section 9831 of the Internal Revenue Code are not governed by this Memorandum.

As set forth in the interim final regulations, the restricted annual limits on the dollar value of essential health benefits cannot be lower than:

- For plan or policy years beginning on or after September 23, 2010 but before September 23, 2011, $750,000;
- For plan or policy years beginning on or after September 23, 2011 but before September 23, 2012, $1.25 million; and
- For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014, $2 million.

A class of group health plans and health insurance coverage, generally known as "limited benefit" plans or "mini med" plans, often has annual limits well below the restricted annual limits set out in the interim final regulations. These group plans and health insurance coverage often offer lower-cost coverage to part-time workers, seasonal workers, and volunteers who otherwise may not be able to afford coverage at all. In order to ensure that individuals with certain coverage, including coverage under limited benefit or mini-med plans, would not be denied access to needed services or experience more than a minimal impact on premiums, the interim final regulations contemplated a waiver process for plan or policy years beginning prior to January 1, 2014 for cases in which compliance with the restricted annual limit provisions of the interim final regulations "would result in a significant decrease in access to benefits" or "would significantly increase premiums." This waiver process does not impact any State law requirement addressing annual benefit limits in group health plans, or group and individual health insurance coverage.

III. The Waiver Process

A group health plan or health insurance issuer may apply for a waiver from the restricted annual limits set forth in the interim final regulations if such plan or the coverage offered by such issuer was offered prior to September 23, 2010 for the plan or policy year beginning between September 23, 2010 and September 23, 2011 by submitting an application not less than 30 days before the beginning of such plan or policy year, or in the case of a plan or policy year that begins before November 2, 2010 not less than 10 days before the beginning of such plan or policy year. The application must include:

1. The terms of the plan or policy form(s) for which a waiver is sought;

2. The number of individuals covered by the plan or policy form(s) submitted;

3. The annual limit(s) and rates applicable to the plan or policy form(s) submitted;

4. A brief description of why compliance with the interim final regulations would result in a significant decrease in access to benefits for those currently covered by such plans or policies, or significant increase in premiums paid by those covered by such plans or policies, along with any supporting documentation; and

5. An attestation, signed by the plan administrator or Chief Executive Officer of the issuer of the coverage, certifying 1) that the plan was in force prior to September 23, 2010; and 2) that the application of restricted annual limits to such plans or policies would result in a significant decrease in access to benefits for those currently covered by such plans or policies, or a significant increase in premiums paid by those covered by such plans or policies.

The plan administrator or Chief Executive Officer should retain documents in support of this application for potential examination by the Secretary.

HHS will process complete waiver applications within 30 days of receipt, except that complete applications submitted for plan or policy years beginning before November 2, 2010 will be processed no later than 5 days in advance of such plan or policy year.

A waiver approval granted under the process set forth in this memorandum applies only for the plan or policy year beginning between September 23, 2010 and September 23, 2011. A group health plan or health insurance issuer must reapply for any subsequent plan or policy year prior to January 1, 2014 when this waiver expires in accordance with future guidance from HHS. HHS may modify this waiver approval process after reviewing the information provided in connection with the waiver process set forth in this memorandum and other relevant information.

A group health plan or health insurance issuer that provides coverage that would meet the above criteria and that wishes to obtain a waiver of the restricted annual limit requirements should apply for such waiver by submitting the items referenced above within the timeframe described above to HHS, Office of Consumer Information and Insurance Oversight, Office of Oversight, attention James Mayhew, Room 737-F-04, 200 Independence Ave. SW, Washington, DC 20201 or emailing the items to healthinsurance@hhs.gov (use "waiver" as the subject of the email).

Where to get more information:

If you have any questions regarding this Bulletin, please contact the Office of Consumer Information and Insurance Oversight at (301) 492 4100 or email at healthinsurance@hhs.gov (use "waiver" as the subject of the email).

DISH NET:000009

From: Gary, Lapreea (HHS/OCIIO)
Sent: Thursday, September 30, 2010 11:24 AM
To: Botwinick, Alexandra (HHS/OCIIO)
Cc: Andrews, Jane (HHS/OCIIO)
Subject: RE: Dish

Not sure of where you are noting this but please note that I left a message for Mr. LaPoint today at 11:22am EST.

Thank you,

Lapreea R. Gary
U.S. Department of Health & Human Services
Office of Consumer Information & Insurance Oversight
Division of Enforcement
(301) 492-4167
Lapreea.Gary@hhs.gov

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW:
This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

From: Botwinick, Alexandra (HHS/OCIIO)
Sent: Thursday, September 30, 2010 11:15 AM
To: Gary, Lapreea (HHS/OCIIO)
Subject: RE: Dish

I don't think so

Alexandra Botwinick

Office of Oversight
HHS/OCIIO
(301) 492-4177
alexandra.botwinick@hhs.gov

From: Gary, Lapreea (HHS/OCIIO)
Sent: Thursday, September 30, 2010 11:07 AM
To: Botwinick, Alexandra (HHS/OCIIO)
Subject: Dish
Importance: High

Hey-did the guy from Dish ever email you back with their renewal date?

Lapreea R. Gary
U.S. Department of Health & Human Services
Office of Consumer Information & Insurance Oversight
Division of Enforcement
(301) 492-4167
Lapreea.Gary@hhs.gov

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This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

From: Andrews, Jane (HHS/OCIIO)
Sent: Thursday, September 30, 2010 11:24 AM
To: Gary, Lapreea (HHS/OCIIO)
Cc: Botwinick, Alexandra (HHS/OCIIO); Pham, Erica (HHS/OCIIO)
Subject: There is one more blank effective date, that we should check on effective dates for

Lapreea – I remember the fellow from the Dish Network asking if we had received his app. I believe I talked with him and told him we have received it. I may have asked his effective date. Please work with Alex to see if she can remember or find the e-mail where he would have sent his effective date. I believe you have established the effective dates for all the other "blank effective dates" except for hearing back from one.

Thanks.

12	**DISH Network**	Minimum Coverage Plan	9/13/2010		Aaron LaPoint, VP of HR (303) 723-1371
16	**Grace Living Centers**		9/14/2010		Terri Kirk [Terri.Kirk@GraceLivingCenters.com]
		Integrity Standard Plan	9/14/2010		
		Integrity Plus Plan	9/14/2010		
		Integrity Premium Plan	9/14/2010		
		Integrity Medallion Plan	9/14/2010		
24	**Cigna**		9/17/2010		[Mary.Fischer-McKee@cignavoluntary.com]
26	**Health Markets**		9/17/2010		Dew, Susan [Susan.Dew@healthmarkets.com]
30	**SBU Real Estate**		9/21/2010		Kayde Campbell [kcampbell@etmg.us]

Jane W. Andrews
OCIIO
7501 Wisconsin Ave
Bethesda, MD 20814
301-492-4122 (desk)

(b)(6) (Blackberry)

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This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

From: Sacher, Eric [Eric.Sacher@dishnetwork.com]
Sent: Thursday, September 23, 2010 4:09 PM
To: Botwinick, Alexandra (HHS/OCIIO)
Subject: RE: Waiver Application

Ms. Botwinick,

Our 2011-2012 benefit plan year will begin March 1st, 2011. Thank you for your quick response.

Regards,

Eric Sacher
Manager of Benefits
DISH Network L.L.C - Headquarters
9601 S. Meridian Blvd.
Englewood, CO 80112
(ph) 303.723.3191
eric.sacher@dishnetwork.com
www.dishnetwork.com

From: Botwinick, Alexandra (HHS/OCIIO) [mailto:Alexandra.Botwinick@hhs.gov]
Sent: Thursday, September 23, 2010 1:39 PM
To: Sacher, Eric
Subject: Waiver Application
Importance: High

Mr. Sacher,

Thank you for your submission. Could you please confirm your policy's effective date?

Sincerely,

Alexandra Botwinick

Office of Oversight
HHS/OCIIO
alexandra.botwinick@hhs.gov

From: Botwinick, Alexandra (HHS/OCIIO)
Sent: Friday, October 08, 2010 1:49 PM
To: 'Sacher, Eric'
Subject: RE: Waiver Application

Mr. Sacher,

You application is complete and I am in the processes of reviewing it. I will let you know if I require any further information.

You will receive the decision via e-mail early next week prior to the 13th. Thank you for your patience in this matter.

Please let me know if I can be of further assistance. Have a nice weekend.

Sincerely,

Alexandra Botwinick

Office of Oversight
HHS/OCIIO
alexandra.botwinick@hhs.gov

From: Sacher, Eric [mailto:Eric.Sacher@dishnetwork.com]
Sent: Thursday, October 07, 2010 5:22 PM
To: Botwinick, Alexandra (HHS/OCIIO)
Subject: RE: Waiver Application

Ms. Botwinick,

I wanted to ensure that you all had everything that you needed regarding our waiver submission. October 13th will make 30 days from our waiver submission and I wanted to double check with you. Our policy's effective date is March 1st 2011.

Will decisions be issued via mail, email, or some other way?

Thank you for your assistance,

Eric Sacher
Manager of Benefits
DISH Network L.L.C - Headquarters
9601 S. Meridian Blvd.
Englewood, CO 80112
(ph) 303.723.3191
eric.sacher@dishnetwork.com
www.dishnetwork.com

From: Botwinick, Alexandra (HHS/OCIIO) [mailto:Alexandra.Botwinick@hhs.gov]
Sent: Thursday, September 23, 2010 1:39 PM
To: Sacher, Eric
Subject: Waiver Application
Importance: High

Mr. Sacher,

Thank you for your submission. Could you please confirm your policy's effective date?

Sincerely,

Alexandra Botwinick

Office of Oversight
HHS/OCIIO
alexandra.botwinick@hhs.gov

DISH NET:000016

From: Botwinick, Alexandra (HHS/OCIIO)
Sent: Friday, October 08, 2010 4:12 PM
To: 'Eric.Sacher@dishnetwork.com'
Subject: Waiver Approval Letter

Attachments: March 1 Acceptance Letter .pdf
Mr. Sacher,

Thank you for submitting an application for a Waiver of the Annual Limits Requirements of the PHS Act Section 2711 for Dish Network. HHS has reviewed your application and made its determination. Please see the attached letter.

Please confirm receipt of this letter by replying to this e-mail with a copy to OCIIOOversight@hhs.gov.

Please let me know if I can be of further assistance.

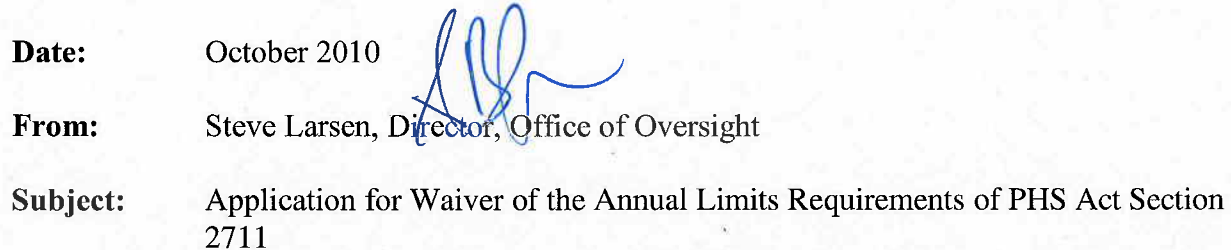
Sincerely,

Alexandra Botwinick

Office of Oversight
HHS/OCIIO
(301) 492-4177
alexandra.botwinick@hhs.gov

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Consumer Information and
Insurance Oversight
Washington, DC 20201



Date: October 2010

From: Steve Larsen, Director, Office of Oversight

Subject: Application for Waiver of the Annual Limits Requirements of PHS Act Section 2711

Dear Waiver Applicant:

Section 2711(a)(2) of the Public Health Service Act (PHS Act), as added by the Patient Protection and Affordable Care Act (Affordable Care Act), requires the Secretary to impose restrictions on the imposition of annual limits on the dollar value of essential health benefits (as defined in section 1302(b) of the Affordable Care Act) for any participant or beneficiary in a new or existing group health plan or a new policy in the individual market for plan or policy years beginning on or after September 23, 2010 and prior to January 1, 2014. Specifically, the Secretary is granted the authority to determine what constitutes a "restricted annual limit" that can still be imposed under such plans or policies prior to January 1, 2014.

The interim final regulations published on June 28, 2010 (codified at 26 CFR § 54.9815-2719T; 29 CFR § 2590.715-2719; and 45 CFR §147.126) established such restricted annual limits. The regulations also provided that these restricted annual limits may be waived by the Secretary of Health and Human Services (HHS) if compliance with the interim final regulations would result in a significant decrease in access to benefits or a significant increase in premiums. Pursuant to the regulation, HHS issued guidance on September 3 regarding the scope and process for applying for a waiver.

The Office of Consumer Information and Insurance Oversight, Office of Insurance Oversight received and processed your application for the plan(s) or policy(ies) year beginning March 1, 2011. We have determined that your application has met the criteria to obtain a waiver of the restricted annual limits requirements because compliance with the interim final regulations would result in a significant decrease in access to benefits for those currently covered by such plans or policies, or a significant increase in premiums paid by those covered by such plans or policies. To the extent you make any change to your benefit package after March 23, 2010, you must determine whether the change(s) will trigger loss of grandfathering status pursuant to 45 CFR §147.140(g)(1).

An approval of your request for waiver of the restricted annual limits requirements granted under this process applies only to the annual limit(s) provided in your application for the plan or policy year beginning between September 23, 2010 and September 23, 2011. This waiver only applies to the annual limits requirements in Section 2711 of the ACA and does not apply to any other requirement of the Affordable Care Act, ERISA, the IRS Code or the PHS Act. Further, a group

DISH NET:000018

health plan or health insurance issuer must reapply for any subsequent plan or policy year prior to January 1, 2014 when this waiver expires in accordance with future guidance from HHS. HHS may modify this waiver approval process memorandum and other relevant information.

If you have any questions regarding this letter, please email OCIIOOversight@hhs.gov.

DISH NET:000019

From: Botwinick, Alexandra (HHS/OCIIO)
Sent: Friday, October 15, 2010 1:37 PM
To: 'Eric.Sacher@dishnetwork.com'
Subject: Second Request For Confirmation of Receipt of Approval Letter

Importance: High
Good Afternoon,

The e-mail you received containing the Approved Waiver of the Annual Limits Requirements of PHS Act Section 2711 instructed you to confirm receipt of the e-mail and attached Approval Letter. Please e-mail back to confirm receipt as soon as possible.

Sincerely,

Alexandra Botwinick

Office of Oversight
HHS/OCIIO
alexandra.botwinick@hhs.gov

From: Sacher, Eric [Eric.Sacher@dishnetwork.com]
Sent: Friday, October 15, 2010 1:41 PM
To: Botwinick, Alexandra (HHS/OCIIO)
Subject: RE: Second Request For Confirmation of Receipt of Approval Letter

Ms. Botwinick,

We have received the approval letter that you are referring to below.

Thank you for your help!

Eric Sacher
Manager of Benefits
DISH Network L.L.C - Headquarters
9601 S. Meridian Blvd.
Englewood, CO 80112
(ph) 303.723.3191
eric.sacher@dishnetwork.com
www.dishnetwork.com

From: Botwinick, Alexandra (HHS/OCIIO) [mailto:Alexandra.Botwinick@hhs.gov]
Sent: Friday, October 15, 2010 11:37 AM
To: Sacher, Eric
Subject: Second Request For Confirmation of Receipt of Approval Letter
Importance: High

Good Afternoon,

The e-mail you received containing the Approved Waiver of the Annual Limits Requirements of PHS Act Section 2711 instructed you to confirm receipt of the e-mail and attached Approval Letter. Please e-mail back to confirm receipt as soon as possible.

Sincerely,

Alexandra Botwinick

Office of Oversight
HHS/OCIIO
alexandra.botwinick@hhs.gov

DISH Network
Restricted Annual Maximum Waiver Application

Employer: DISH Network LLC
Plan Name: Minimum Coverage Plan
Plan Administrator: DISH Network LLC
Contact information: Aaron LaPoint, Vice President of Human Resources
9601 South Meridian BLVD
Englewood, CO 80112
303-723-1371

Required application contents:

1. **Terms of the plan or policy form(s) for which a waiver is sought**

   DISH Network currently offers two self-funded medical plan options to all benefits eligible employees: a comprehensive, high-deductible medical PPO plan ("Consumer Choice Plan," "CCP") and a limited benefit medical plan ("Minimum Coverage Plan," "MCP"). Both plans have been offered since 3/1/2006 and both plans fill different needs for DISH employees.

   The MCP includes both an annual (b)(4) and a lifetime (b)(4) limit and, as a result has substantially lower costs, and lower monthly employee contribution levels. The plan has a low ((b)(4) single/(b)(4) family) deductible and offers (b)(4)% coinsurance up to the annual maximum. It also provides enrollees with access to the substantial discounts offered through the CIGNA PPO network.

   All full time employees are eligible for both plans. A summary of the highlights of the plan designs offered to DISH Network employees is provided in Attachment A.

2. **Number of individuals covered by plan or policy forms(s) submitted**

   As of July, 2010, (b)(4) employees are enrolled in the MCP ((b)(4) with dependent coverage) and (b)(4) are enrolled in the CCP. The number of employees enrolled in the MCP has grown steadily since the plan's inception, currently standing at (b)(4)% of enrollees, further reinforcing the fact that many individuals see value in the plan.

3. **Annual limit(s) and rates applicable to the plan or policy form(s) submitted**

Annual: (b)(4)
Lifetime: (b)(4)

	Monthly Accrual Rates	Monthly Employee Contributions
Employee Only	(b)(4)	(b)(4)
Employee Plus One	(b)(4)	(b)(4)
Employee Plus Family	(b)(4)	(b)(4)

4. **Why compliance would result in significant decrease in access to or increase in premiums paid for benefits for those covered?**

To change the current MCP provisions to comply with the restricted annual maximum limitations would increase the underlying cost of the MCP significantly. This would mean that the projected cost of the MCP would be higher than the CCP and, as a result, the MCP employee premium contributions would have to be even higher than the current CCP contributions in order for the plan to continue to be offered. Therefore, if not approved for a waiver, the MCP would simply have to be eliminated and just the CCP would be offered, given the magnitude of the cost impact to DISH Network and employees related to compliance.

Since compliance with the restricted annual maximum requirements would require an increase to plan costs per enrollee even beyond the current CCP, the only viable option is to eliminate the MCP. In doing so, however, the plan costs are expected to significantly increase. To illustrate the cost difference between the current MCP and CCP, please see the claims summary attached as Attachment B. For 3/2009 – 2/2010, the average claims cost per employee per month for the MCP was (b)(4), compared to (b)(4) during that same time period for the CCP. The results for 3/2010 – 7/2010 are similar. Should the MCP be eliminated and all MCP enrollees move to the CCP, we would expect their claim costs to double and be similar to the current CCP experience due to the higher level of coverage in the CCP.

Thus, if the MCP is not granted a waiver and has to be eliminated, this would result in displacement of current coverage for (b)(4) employees. These employees would either face an increase in their monthly premium contributions of roughly (b)(4)% if they move to the CCP (assuming current contributions on the CCP remain in place) or loss of coverage entirely since the cost of obtaining an individual plan on the open market would be substantially higher than their current MCP contribution requirement (assuming that they are even medically qualified to do so).

The MCP has satisfied a need for the DISH Network population by providing a low-cost, limited coverage plan and the elimination of this plan prior to the establishment of the insurance exchange with subsidy assistance would have a significant impact on

this population. For these covered employees and their families, their costs would significantly increase if they are forced to move to the CCP and for those who are unable to afford to move to the CCP, loss of coverage is the likely outcome.

5. **I hereby certify the following to be completely true:**

- The plan was in place prior to September 23, 2010

- The application of restricted annual limits to this plan would result in a significant increase in premiums paid by those covered or a significant decrease in access (due to those who would drop coverage entirely rather than pay higher premiums).

9/12/10

Plan Administrator Date

Attachment A

DISH Network 2010 Medical Plan Highlights

	Consumer Choice Plan (CCP)		Minimum Coverage Plan (MCP)
	In-Network	Out-of-Network	In-Network Only
Primary Care Physician Required?			
Deductible (Medical/Rx combined)			
Employee Only			
Employee+One/Family			
Coinsurance			
Out-of-Pocket Maximum (includes deductible)			
Employee Only			
Employee+One/Family			
Plan Maximum			
Annual (per person)			
Lifetime (per person)			
Plan Network			
Preventive Visit			
Other Office Visit			
Specialist Visit			
Urgent Care			
Emergency Room			
Outpatient Hospital			
Inpatient Hospital			
Pharmacy:			
Retail			
Generic			
Formulary Brand			
Non-Formulary Brand			
Mail Order			
Generic			
Formulary Brand			
Non-Formulary Brand			
May Contribute to an HSA			

(b)(4)

Attachment B

DISH Network 2009/2010 Experience Data

2009/2010	Medical	Rx	Total	Total Enrollment	PEPM	Claims Ratio vs MCP
MCP	(b)(4)					
CCP						

2010/2011	Medical	Rx	Total	Avg Enrollment	PEPM	Claims Ratio vs MCP
MCP	(b)(4)					
CCP						

**Data through July 2010*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Consumer Information and
Insurance Oversight
Washington, DC 20201

Date: September 3, 2010

From: Steve Larsen, Director, Office of Oversight

Title: Insurance Standards Bulletin Series--INFORMATION

Subject: OCIIO Sub-Regulatory Guidance (OCIIO 2010 - 1): Process for Obtaining Waivers of the Annual Limits Requirements of PHS Act Section 2711

Markets: Group and Individual

I. Purpose

Section 2711(a)(2) of the Public Health Service Act (PHS Act)[1], as added by the Patient Protection and Affordable Care Act (Affordable Care Act), requires the Secretary to impose restrictions on the imposition of annual limits on the dollar value of essential health benefits (as defined in section 1302(b) of the Affordable Care Act)[2] for any participant or beneficiary in a new or existing group health plan or a new policy in the individual market for plan or policy years beginning on or after September 23, 2010 and prior to January 1, 2014. Specifically, the Secretary is granted the authority to determine what constitutes a "restricted annual limit" that can still be imposed under such plans or policies prior to January 1, 2014.

The interim final regulations published on June 28, 2010 (codified at 26 CFR §54.9815-2719T; 29 CFR §2590.715-2719; and 45 CFR §147.126) established such restricted annual limits. The regulations also provided that these restricted annual limits may be waived by the Secretary of Health and Human Services (HHS) if compliance with the interim final regulations would result in a significant decrease in access to benefits or a significant increase in premiums. The preamble to those regulations further provided that guidance from HHS regarding the scope and process for applying for such a waiver would be issued in the near future. This memorandum constitutes that guidance.

[1] The Affordable Care Act adds section 715(a)(1) to the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) to the Internal Revenue Code (the Code) to incorporate the provisions of part A of title XXVII of the PHS Act, which includes PHS Act section 2711, into ERISA and the Code, and make them applicable to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans.

[2] The interim final regulations under PHS Act section 2711 defined "essential health benefits" by cross-reference to section 1302(b) of the Affordable Care Act and applicable regulations. Regulations under section 1302(b) of the Affordable Care Act have not yet been issued. The preamble to the interim final regulations provides that, for plan years (in the individual market, policy years) beginning before the issuance of regulations defining "essential health benefits", the Departments of Health and Human Services, Labor and the Treasury (the Departments) will take into account good faith efforts to comply with a reasonable interpretation of the term "essential health benefits."

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II. Background

Section 2711 and the interim final regulations (26 CFR §54.9815-2719T; 29 CFR §2590.715-2719; and 45 CFR §147.126) allow the imposition of "restricted annual limits" on essential health benefits for plan years for group health plans and group health insurance coverage, and for policy years for new non-grandfathered individual health insurance coverage, beginning before January 1, 2014. No annual limits on essential health benefits are permitted with respect to plan or policy years beginning on or after January 1, 2014, except in the case of grandfathered individual market policies. Group health plans and health insurance coverage that meet the definition of an excepted benefit pursuant to section 2791 of the PHS Act, section 732 of ERISA, or section 9831 of the Internal Revenue Code are not governed by this Memorandum.

As set forth in the interim final regulations, the restricted annual limits on the dollar value of essential health benefits cannot be lower than:

- For plan or policy years beginning on or after September 23, 2010 but before September 23, 2011, $750,000;
- For plan or policy years beginning on or after September 23, 2011 but before September 23, 2012, $1.25 million; and
- For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014, $2 million.

A class of group health plans and health insurance coverage, generally known as "limited benefit" plans or "mini med" plans, often has annual limits well below the restricted annual limits set out in the interim final regulations. These group plans and health insurance coverage often offer lower-cost coverage to part-time workers, seasonal workers, and volunteers who otherwise may not be able to afford coverage at all. In order to ensure that individuals with certain coverage, including coverage under limited benefit or mini-med plans, would not be denied access to needed services or experience more than a minimal impact on premiums, the interim final regulations contemplated a waiver process for plan or policy years beginning prior to January 1, 2014 for cases in which compliance with the restricted annual limit provisions of the interim final regulations "would result in a significant decrease in access to benefits" or "would significantly increase premiums." This waiver process does not impact any State law requirement addressing annual benefit limits in group health plans, or group and individual health insurance coverage.

III. The Waiver Process

A group health plan or health insurance issuer may apply for a waiver from the restricted annual limits set forth in the interim final regulations if such plan or the coverage offered by such issuer was offered prior to September 23, 2010 for the plan or policy year beginning between September 23, 2010 and September 23, 2011 by submitting an application not less than 30 days before the beginning of such plan or policy year, or in the case of a plan or policy year that begins before November 2, 2010 not less than 10 days before the beginning of such plan or policy year. The application must include:

1. The terms of the plan or policy form(s) for which a waiver is sought;

2. The number of individuals covered by the plan or policy form(s) submitted;

3. The annual limit(s) and rates applicable to the plan or policy form(s) submitted;

4. A brief description of why compliance with the interim final regulations would result in a significant decrease in access to benefits for those currently covered by such plans or policies, or significant increase in premiums paid by those covered by such plans or policies, along with any supporting documentation; and

5. An attestation, signed by the plan administrator or Chief Executive Officer of the issuer of the coverage, certifying 1) that the plan was in force prior to September 23, 2010; and 2) that the application of restricted annual limits to such plans or policies would result in a significant decrease in access to benefits for those currently covered by such plans or policies, or a significant increase in premiums paid by those covered by such plans or policies.

The plan administrator or Chief Executive Officer should retain documents in support of this application for potential examination by the Secretary.

HHS will process complete waiver applications within 30 days of receipt, except that complete applications submitted for plan or policy years beginning before November 2, 2010 will be processed no later than 5 days in advance of such plan or policy year.

A waiver approval granted under the process set forth in this memorandum applies only for the plan or policy year beginning between September 23, 2010 and September 23, 2011. A group health plan or health insurance issuer must reapply for any subsequent plan or policy year prior to January 1, 2014 when this waiver expires in accordance with future guidance from HHS. HHS may modify this waiver approval process after reviewing the information provided in connection with the waiver process set forth in this memorandum and other relevant information.

A group health plan or health insurance issuer that provides coverage that would meet the above criteria and that wishes to obtain a waiver of the restricted annual limit requirements should apply for such waiver by submitting the items referenced above within the timeframe described above to HHS, Office of Consumer Information and Insurance Oversight, Office of Oversight, attention James Mayhew, Room 737-F-04, 200 Independence Ave. SW, Washington, DC 20201 or emailing the items to healthinsurance@hhs.gov (use "waiver" as the subject of the email).

Where to get more information:

If you have any questions regarding this Bulletin, please contact the Office of Consumer Information and Insurance Oversight at (301) 492 4100 or email at healthinsurance@hhs.gov (use "waiver" as the subject of the email).

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