From: Toeller, Matt [mtoeller@ALCCO.COM]
Sent: Friday, September 17, 2010 6:43 PM
To: HHS HealthInsurance (HHS)
Cc: Toeller, Matt
Subject: Waiver

Attachments: Attachment 1 - 2009 ALC Basic 50 SPD.pdf; Attachment 2 - 2010 ALC Basic 50 SPD.pdf; Assisted Living Concepts PPH Act Waiver Apppdf.pdf

Mr. Mayhew,

Please accept this communication and its attachments as the Assisted Living Concepts, Inc. (ALC) application for obtaining a waiver from the annual restricted limits requirements of PHS Act Section 2711 for the ALC Basic 50 benefits plan (Plan).

If any additional information is needed to support our position, please contact me at your earliest convenience.

Regards,

Matthew J. Toeller, SPHR
Director of Benefits
Assisted Living Concepts, Inc.
W140 N8981 Lilly Road
Menomonee Falls, WI 53051
Office: 262.257.8870
Fax: 262.253.3044

Assisted Living Concepts, Inc.

September 17, 2010 via email: healthinsurance@hhs.gov

Mr. James Mayhew
Health and Human Services
Office of Consumer Information and Insurance Oversight
Office of Oversight
Room 737-F-04
200 Independence Avenue SW
Washington, DC 20201

Mr. Mayhew,

Please accept this communication as the Assisted Living Concepts, Inc. (ALC) application for obtaining a wavier from the annual restricted limits requirements of PHS Act Section 2711 for the ALC Basic 50 benefits plan (Plan).

Included is supporting documentation from ALC, Anthem Blue Cross Blue Shield National Accounts (ALC's Third Party Administrator) and Willis (ALC's benefits consultant).

The following information is provided in accordance with the memorandum dated September 2, 2010 from Steve Larsen, Director, Office of Oversight, Subject: OCIIO Sub-Regulatory Guidance (OCIIO 2010– 1): Process for Obtaining Waivers of the Annual Limits Requirements of PHS Act Section 2711:

1. The terms of the plan or policy form(s) for which a waiver is sought;
   a. Attachment 1 – 2010 ALC Basic 50 SPD
   b. Attachment 2 – 2009 ALC Basic 50 SPD

2. The number of individuals covered by the plan or policy forms(s) submitted;
   a. Appendix A – Anthem National Accounts Letter (third subsection)
      i. January 2008 – (b)(4) subscribers, (b)(4) members
      ii. January 2009 – (b)(4) subscribers, (b)(4) members
      iii. July 2010 – (b)(4) subscribers, (b)(4) members

3. The annual limit(s) and rates applicable to the plan or policy form(s) submitted;
   a. Attachment 1 and 2 – Annual limits
   b. Appendix B – 2010 Basic 50 Plan Rates

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;
   a. Appendix C – ALC's response

b. Supporting Documentation
    i. Appendix A- Anthem National Accounts Letter (first subsection)
    ii. Appendix D – Willis Projected Rates and Annual Cost
    iii. Appendix E – Willis Letter

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.
    a. Appendix F – Attestation sign by ALC, the plan administrator, by its:
        i. Chief Operation Officer
        ii. Chief Financial Officer
        iii. Director of Benefits

If any additional information is needed to support our position, please contact me at your earliest convenience.

Regards,

Matthew J. Toeller
Director of Benefits
Assisted Living Concepts, Inc.
(262) 257-8870
MToeller@alcco.com

Appendix A

Anthem National Accounts

Anthem National
Accounts
233 S. Wacker, #3800
Chicago, IL 60606

September 13, 2010

Mr. Matthew Toeller
Director of Benefits
Assisted Living Concepts, Inc.
W140 N8981 Lilly Road
Menomonee Falls, WI 53051

RE: Health Care Reform Waiver Submission - Assisted Living Concepts's Basic 50 Medical Plan

Dear Matt;

As discussed and as a part of Assisted Living Concepts' effort to obtain a waiver to maintain its $(b)(4) annual benefit maximum currently included in its Basic 50 Employee Medical Benefit plan offering, Anthem Blue Cross Blue Shield (acting as Assisted Living Concepts' third party administrator) provides the following information;

1) Expected cost increase to Assisted Living Concepts' Basic 50 Medical Plan due to removal of existing annual benefit maximum of $ - (b)(4)% above current plan cost experience. The (b)(4)% cost increase was reviewed and issued by Anthem Blue Cross Blue Shield's Underwriting and Actuary Services Department based on actuarial assumptions for the percentage of members who exceed $(b)(4) in claims costs annually and the projected total expense of those claim costs.

2) Effective Date of Assisted Living Concepts' Basic 50 Employee Medical Plan - January 1, 2005

3) Assisted Living Concepts' Basic 50 Employee Medical Benefit Plan Enrollment in 2008, 2009,and current 2010;

January 2008 - (b)(4) subscribers, (b)(4) members
January 2009 - (b)(4) subscribers, (b)(4) members
July 2010 - (b)(4) subscribers, (b)(4) members

Matt, please let me know if you have any questions with the information provided or if you need any additional information that we can help support.

Regards,

Jamon Mytty
National Account Executive
Anthem Blue Cross Blue Shield

Appendix B

Basic 50 Plan

2010
Corporate Employees

Rates	Si	l Surcharge
Total Rate	(b)(4)	
Employee Contribution		
Employer Contribution		

Field Staff Employees

Rates	Single Coverage	Employee + 1 Coverage	Family Coverage	Family Coverage W/ Spousal Surcharge
Total Rates	(b)(4)			
Employee Contribution				
Employer Contribution				

Annualized Amounts
Combined Corporate/Field
2010 Annualized

	Total	Employee/Employer %
Total Budget	(b)(4)	
Employee Contribution		
Employer Contribution		

Appendix C

Assisted Living Concepts, Inc.

Appendix C

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;*

Assisted Living Concepts' (ALC) goal has been to provide a competitive and affordable benefits package for its employees through the ALC Basic 50 benefit plan (Plan). The Plan includes a (b)(4) annual limit for medical and pharmacy coverage. This limit has been in effect since January 1, 2005. The removal of this limit would result in a significant increase in premium to participants and have the effect of significantly decreasing access to benefits for those currently covered. The actuarial projected increases in premiums would be cost prohibitive to current participants.

ALC's medical and pharmacy program is self funded and administered by Anthem Blue Cross Blue Shield. We have obtained projections from both Anthem and Willis, an independent consulting firm, of cost increases that would result from the removal of its $ (b)(4) annual limit. Attached in Appendix A you will find Anthem's projection reflecting a (b)(4)% increase in total costs and in Appendix E the Willis Group projections of a 40% increase. Both firms are ent with the actuarial methodology of evaluating the risk of the percentage of members exceeding $ (b)(4) in claims costs annually and the total expense and exposure of ALC.

Also attached in Appendix D is an exhibit from Willis that outlines the 2010 funding rates, the current employee/employer cost share, and actual employee contributions by tier (single, employee + 1 and family). In addition, the 2011 projected funding levels assuming no plan changes (inclusion of the $ (b)(4) annual limit) and then the increase with the removal of the annual limit. The projected increases are as follows:

2011 Projected Employee Cost Increase (no plan changes, with $ (b)(4) annual limit): (b)(4)
2011 Projected Employee Cost Increase (no plan changes and removal of the $51,000 annual limit): (b)(4)

Under both scenarios above, we assumed the same employer/employee cost share of the funding levels -- (b)(4) funded by ALC, (b)(4) funded by employees. The monthly employee contribution increase (from (b)(4) % to (b)(4)) due to the removal of the annual limit and the cost implications on the projected funding levels are listed below. The projections of the actual monthly employee contributions (comparing 2011 with and without the removal of the annual limit) are:

Based on the projected increase of (b)(4) % in the employee cost share, the removal of the annual limit of $ (b)(4) would result in a significant increase in premiums to participants and have the effect of significantly decreasing access to benefits for those currently covered for the 2011 benefit plan year. ALC respectfully requests that it be granted the waiver of the restricted annual limit requirements of PHS Act Section 2711 with respect to the ALC Basic 50 benefit plan.

Assisted Living Concepts, Inc.

Change in Monthly Contribution Rates (with and without the removal of the annual limit)

Single Coverage:

Average salary of Single coverage participants (corporate and field combined) is (b)(4)

Corporate Employees:	Corporate Employees:
With $ (b)(4) annual limit	Removal of $ (b)(4) annual limit
$ (b)(4) a month increase	$ (b)(4) a month increase
$ (b)(4) per month employee contribution	$ (b)(4) per month employee contribution

Field Staff Employees:	Field Staff Employees:
With $ (b)(4) annual limit	Removal of $ (b)(4) annual limit
$ (b)(4) a month increase	$ (b)(4) a month increase
$ (b)(4) per month employee contribution	$ (b)(4) per month employee contribution

Employee + 1 Coverage:

Average salary of Employee + 1 coverage participants (corporate and field combined) is $ (b)(4)

Corporate Employees:	Corporate Employees:
With $ (b)(4) annual limit	Removal of $ (b)(4) annual limit
$ (b)(4) a month increase	$ (b)(4) a month increase
$ (b)(4) per month employee contribution	$ (b)(4) per month employee contribution

Field Staff Employees:	Field Staff Employees:
With $ (b)(4) annual limit	Removal of $ (b)(4) annual limit
$ (b)(4) a month increase	$ (b)(4) a month increase
$ (b)(4) per month employee contribution	$ (b)(4) per month employee contribution

Family Coverage:

Average salary of Family coverage participants (corporate and field combined) is $ (b)(4)

Corporate Employees:	Corporate Employees:
With $ (b)(4) annual limit	Removal of $ (b)(4) annual limit
$ (b)(4) a month increase	$ (b)(4) a month increase
$ (b)(4) per month employee contribution	$ (b)(4) per month employee contribution

Field Staff Employees:	Field Staff Employees:
With $ (b)(4) annual limit	Removal of $ (b)(4) annual limit
$ (b)(4) a month increase	$ (b)(4) a month increase
$ (b)(4) per month employee contribution	$ (b)(4) per month employee contribution

Appendix D

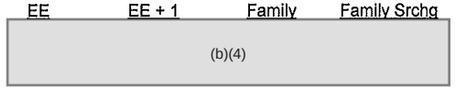
Willis

Assisted Living Concepts
Rates and Annual Cost

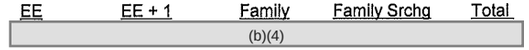
Basic 50 Plan

2010
Corporate

	EE	EE + 1	Family	Family Srchg
Rates				
Budget				
EE				
ER				

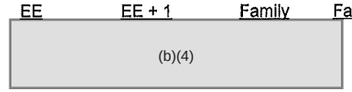


Enrollment	EE	EE + 1	Family	Family Srchg	Total

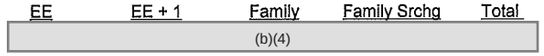


Field

	EE	EE + 1	Family	Family Srchg
Rates				
Budget				
EE				
ER				



Enrollment	EE	EE + 1	Family	Family Srchg	Total

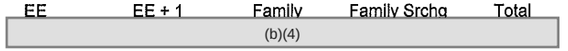


Basic 50 Plan

2011 - ER & EE Share Increase, No Other Changes
Corporate

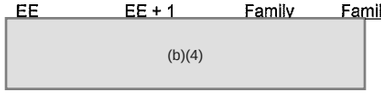
	EE	EE + 1	Family	Family Srchg
Rates				
Budget				
EE				
ER				

Enrollment	EE	EE + 1	Family	Family Srchg	Total



Field

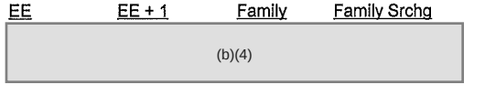
	EE	EE + 1	Family	Family Srchg
Rates				
Budget				
EE				
ER				



Enrollment	EE	EE + 1	Family	Family Srchg	Total

Change in Monthly Rates
Corporate

	EE	EE + 1	Family	Family Srchg
Rates				
Budget				
EE				
ER				



Field

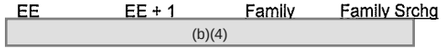
	EE	EE + 1	Family	Family Srchg
Rates				
Budget				
EE				
ER				

Basic 50 Plan

2011 - Eliminate $ (b)(4) Max, (b)(4)% Cost Increase due to Eliminating Max, EE & ER Share Increase
Corporate

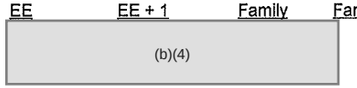
	EE	EE + 1	Family	Family Srchg
Rates				
Budget				
EE				
ER				

Enrollment	EE	EE + 1	Family	Family Srchg	Total
					136

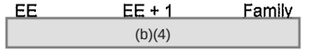


Field

	EE	EE + 1	Family	Family Srchg
Rates				
Budget				
EE				
ER				



Enrollment	EE	EE + 1	Family	Family Srchg	Total
					746

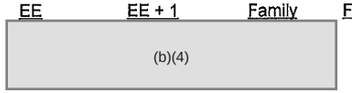


Change
Corporate

	EE	EE + 1	Family	Family Srchg
Rates				
Budget				
EE				
ER				

Field

	EE	EE + 1	Family	Family Srchg
Rates				
Budget				
EE				
ER				



Annualized Amounts

Combined Corporate/Field
2010 Annualized

	Total	%
Budget		
EE		
ER		

2011 - ER & EE Share Increase, No Other Changes

Combined Corporate/Field
2011 Annualized

	Total	%
Budget		
EE		
ER		

Change

	Total	%
Budget		
EE		
ER		

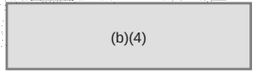
2011 - Eliminate $ (b)(4) Max, (b)(4)% Cost Increase due to Eliminating Max, EE & ER Share Increase

Combined Corporate/Field
2011 Annualized

	Total	%
Budget		
EE		
ER		

Change

	Total	%
Budget		
EE		
ER		



Appendix E

Willis

September 15, 2010

Mr. Matthew Toeller
Director of Benefits
Assisted Living Concepts, Inc.
W140 N8981 Lilly Road
Menomonee Falls, WI 53051

Re: Basic 50 Medical Plan- Impact of Increasing Annual Benefit Maximum

Assisted Living Concepts' Basic 50 Medical Plan has an annual limit of (b)(4) in paid medical claims per individual. If ALC were to increase this limit to $750,000 as required for 2011 under PPACA, we estimate the cost of the plan would increase by approximately (b)(4) The rationale for this figure is as follows.

According to Medstat, an aggregator of health claims data, on average, (b)(4)% of medical claims paid in the US exceed (b)(4) A plan with an annual maximum of (b)(4) would thus pay about (b)(4)% of all claims incurred. Removing this cap entirely would increase costs by a ratio of 100 to (b)(4), or (b)(4)% of current costs. Capping claims at $750K would remove a very small portion of these claims, perhaps (b)(4)% of all costs.

Therefore, eliminating the annual maximum entirely would increase costs by just under (b)(4)%, whereas instituting a $750,000 annual cap would increase costs only slightly less than this, and the increases required between 2012 and 2014 would exacerbate this issue.

Since eligible employees pay a percentage of the cost of coverage, employees' costs would also increase by approximately the same percentage.

This is based on an average for the United States; a specific employer's experience could be better or worse than this, but we can say with certainty that this change would entail a significant additional cost for ALC.

Kathy Dobrzynski

Kathy Dobrzynski, FSA, MAAA
Vice President and Actuary

Appendix F

Assisted Living Concepts, Inc.

Attestation

September 17, 2010

Mr. James Mayhew
Health and Human Services
Office of Consumer Information and Insurance Oversight
Office of Oversight
Room 737-F-04
200 Independence Avenue SW
Washington, DC 20201

The undersigned duly elected or appointed officers and managers of Assisted Living Concepts, Inc. (ALC), plan administrator of the ALC Basic 50 PPO Plan (Plan), hereby attest that the Plan was in force prior to September 23, 2010; and that the application of restricted annual limits to such Plan would result in a significant decrease in access to benefits for those currently covered by such Plan, or a significant increase in premiums paid by those covered by such Plan.

by 

Laurie A. Bebo
President & Chief Executive Officer
Assisted Living Concepts, Inc.

by 

John Buono
Sr. VP, Chief Financial Officer
Assisted Living Concepts, Inc.

by 

Matthew J. Toeller
Director of Benefits
Assisted Living Concepts, Inc.

Page 17 redacted for the following reason:
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(b)(4)

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(b)(4)

SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary of the Copayments and other limits when you receive Covered Services from a Provider. Please refer to the **Covered Services** section for a more complete explanation of the specific services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of this Benefit Booklet including any attachments or riders. **This Schedule of Benefits lists the Member's responsibility for Covered Services and supplies.**

Benefit Period	Calendar Year
Dependent Age Limit	To end of the calendar year in which the child attains age (b)(4), or to the end of the calendar year in which the child attains age (b)(4) if the child is: enrolled as a full-time student at an accredited school or college.

Pre-Existing Period

Late Enrollee	18 month review of 6 months before effective date. See your HR or benefits department for specifics.

Deductible		**k**
Per Person	(b)(4)	
Per Family		

Out-of-Pocket Limit	**Network**	**Non-Network**
Per Person	(b)(4)	
Per Family		

Note: The Out-of-Pocket Limit includes all percentage Coinsurance you incur in a Benefit Period. However, Mental Health/Substance Abuse Services and flat dollar amount Copayments (if applicable) do not apply toward the Out-of-Pocket Limit. Once the Member and/or family Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the Member and/or family for the remainder of the Benefit Period except for Mental Health/Substance Abuse Services Copayments and flat dollar amount Copayments (if applicable).

Network and Non-Network Deductibles, Copayments, and Out-of-Pocket Limits **are not separate and do accumulate toward each other.** The Deductible(s) apply only to Covered Services with a percentage Copayment.

Calendar Year Maximum for All Covered Services $ (b)(4)
(Network and Non-Network)

Covered Services	Copayments/Maximums	
	Network	**Non-Network**
Preventive Care		
Well Child Care (newborn to age 2)	$(b)(4) Copayment, then Covered in Full	(b)(4)% Coinsurance, subject to Deductible
Well Adult Care (ages 2 and above) Routine Exams per visit per B Period: (b)(4) exams per Benefit riod for Employee spouse (b)(4) exam per Benefit Period for Dependents.	First $(b)(4) Covered in Full after $(b)(4) Copayment	
Annual gynecological exams (b)(4) per member per Benefit Period. The gynecological exams are in addition to the (b)(4) routine exams offered annually for Employees/spouse and one annual routine exam for Dependent.	$(b)(4) Copayment	(b)(4)% Coinsurance, subject to Deductible
All Other Services	(b)(4)% Coinsurance, subject to Deductible	(b)(4)% Coinsurance, subject to Deductible
Note: Routine Hearing Exams and Routine Vision Exams are (b)(4)		

Covered Services	Copayments/Maximums	
	Network	**Non-Network**
Physician Office Services	$ (b)(4) Copayment	(b)(4) % Coinsurance, subject to Deductible
Allergy Services when billed with an Office Visit	$ (b)(4) Copayment	(b)(4) % Coinsurance, subject to Deductible
Allergy Services when not billed with an Office Visit	(b)(4) % Coinsurance, subject to Deductible	(b)(4) % Coinsurance, subject to Deductible
Inpatient Services	(b)(4) % Coinsurance, subject to Deductible	$(b)(4) Copayment, then (b)(4) % Coinsurance, subject to Deductible
Maximum Days per Benefit Period for Physical Medicine and Rehabilitation	(b)(4) Day Limits	
Maximum Days per Benefit Period for Skilled Nursing Care Facility Services	(b)(4) Day Limits	
Outpatient Facility Services	(b)(4) % Coinsurance, subject to Deductible	(b)(4) % Coinsurance, subject to Deductible
Clinic Facility Services	(b)(4) % Coinsurance, subject to Deductible	(b)(4) % Coinsurance, subject to Deductible
Therapy Services (when rendered as Physician s Office Services or Outpatient Facility Services)	(b)(4) % Coinsurance, subject to Deductible	(b)(4) % Coinsurance, subject to Deductible
NOTE: If different types of Therapy Services are performed during one Physician Office Service, or Outpatient Service, then each different type of Therapy Service performed will be considered a separate Therapy Visit. Each Therapy Visit will count against the applicable Maximum Visits listed below. For example, if both a Physical Therapy Service and a Spinal Manipulation service are performed during one Physician Office Service, or Outpatient Service, they will count as both one Physical Therapy Visit and one Spinal Manipulation Visit.		

Covered Services	Copayments/Maximums	
	Network	**Non-Network**
Maximum Visits per Benefit Period for:		
Outpatient respiratory, speech, physical and occupational therapies	Limited to a combined $ (b)(4) per person, per calendar year Network and Non-Network combined.	
Chiropractic Care	(b)(4) Covered	
Other Therapy Services (when rendered as Physician s Office Services or Outpatient Facility Services)	Network Copayment based on setting where Covered Services are received	Non-Network Copayment based on setting where Covered Services are received
Diagnostic Services	When rendered as Physician Office Services or Outpatient Services the Copayment is based on the setting where Covered Services are received.	
Emergency Room Services (If admitted directly from the Emergency Room, the Emergency Room Copayment for that visit is waived). (ER Copayment does not apply on Accidental Injury Claims.)	$(b)(4) Copayment then (b)(4) % Coinsurance, subject to Deductible	$(b)(4) Copayment then (b)(4) % Coinsurance, subject to Deductible
Urgent Care Center Services	$(b)(4) Copayment	(b)(4) % Coinsurance, subject to Deductible
Ambulance Services	(b)(4) % Coinsurance, subject to Deductible	(b)(4) % Coinsurance, subject to Deductible
Home Care Services	(b)(4) % Coinsurance, subject to Deductibl	(b)(4) % Coinsurance, subject to Deductible
Maximum Visits per Benefit Period	(b)(4) Visits	
Hospice Services	(b)(4) % Coinsurance, subject to Deductible	(b)(4) % Coinsurance, subject to Deductible

Covered Services	Copayments/Maximums	
	Network	**Non-Network**
Medical Supplies, Durable Medical Equipment and Appliances	(b)(4) % Coinsurance, subject to Deductible	(b)(4) % Coinsurance, subject to Deductible
NOTE: Physician office Copayments are applied rather than the Network Copayment listed above if medical supplies, Durable Medical Equipment or appliances are obtained in a Network Physician s office.		
Maternity Services	(b)(4) % Coinsurance, subject to Deductible	(b)(4) % Coinsurance, subject to Deductible
Physician Office Services	$(b)(4) Copayment First prenatal visit is subject to Office Visit Copayment	(b)(4) % Coinsurance, subject to Deductible
Infertility Services	(b)(4) Covered	(b)(4) Covered
Mental Health Services		
Inpatient Services	(b)(4) % Coinsurance, subject to Deductible	$(b)(4) Copayment, then (b)(4) % Coinsurance, subject to Deductible
Maximum Days per Benefit Period	(b)(4) Days	
Outpatient Services	$(b)(4) Copayment	(b)(4) % Coinsurance, subject to Deductible
Maximum Days per Benefit Period	(b)(4) Visits	
Physician Office Services	$(b)(4) Copayment	(b)(4) % Coinsurance, subject to Deductible

Covered Services	Copayments/Maximums	
	Network	Non-Network
Substance Abuse Services		
Inpatient Services	(b)(4) % Coinsurance, subject to Deductible	$(b)(4) Copayment, then (b)(4) % Coinsurance, subject to Deductible
Maximum Days per Benefit Period	(b)(4) Days	
Outpatient Services	$(b)(4) Copayment	(b)(4) % Coinsurance, subject to Deductible
Maximum visits per Benefit Period	(b)(4) Visits	
Physician Office Services	$(b)(4) Copayment	(b)(4) % Coinsurance, subject to Deductible,
Human Organ and Tissue Transplant Services		
Human Organ Transplants	(b)(4) % Coinsurance, subject to Deductible	(b)(4) % Coinsurance, subject to Deductible
Tissue Transplants	(b)(4) % Coinsurance, subject to Deductible	(b)(4) % Coinsurance, subject to Deductible
Transportation Lodging and Meals	(b)(4) Covered	(b)(4) Covered

Prescription Drugs	
Days Supply: Days Supply may be less than the amount shown due to Prior Authorization, Quantity Limits, and/or age limits and Utilization Guidelines.	
Retail Pharmacy (Network and Non-Network)	(b)(4) Days
Mail Service	(b)(4) Days
Network Retail Pharmacy Prescription Drug Copayment:	
Generic Formulary Drugs	(b)(4) % or $ (b)(4) Copayment, whichever is greater, per Prescription Order
Brand Name Formulary Drugs	(b)(4) % or $ (b)(4) Copayment, whichever is greater, per Prescription Order
Generic Non-Formulary Drugs	(b)(4) % or $ (b)(4) Copayment, whichever is greater, per Prescription Order
Brand Name Non-Formulary Drugs	(b)(4) % or $ (b)(4) Copayment, whichever is greater, per Prescription Order
Our Mail Service Program Prescription Drug Copayment:	
Generic Formulary Drugs	% or $ Copayment, whichever is greater, per Prescription Order
Brand Name Formulary Drugs	% or $ Copayment, whichever is greater, per Prescription Order
Generic Non-Formulary Drugs	% or $ Copayment, whichever is greater, per Prescription Order
Brand Name Non-Formulary Drugs	% or $ Copayment, whichever is greater, per Prescription Order
Non-Network Retail Pharmacy Prescription Drug Copayment/Coinsurance:	
Generic Formulary Drugs	% or $ Copayment, whichever is greater, per Prescription Order
Brand Name Formulary Drugs	% or $ Copayment, whichever is greater, per Prescription Order
Generic Non-Formulary Drugs	% or $ Copayment, whichever is greater, per Prescription Order
Brand Name Non-Formulary Drugs	% or $ Copayment, whichever is greater, per Prescription Order

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SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary of the Copayments and other limits when you receive Covered Services from a Provider. Please refer to the **Covered Services** section for a more complete explanation of the specific services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of this Benefit Booklet including any attachments or riders. **This Schedule of Benefits lists the Member's responsibility for Covered Services and supplies.**

Benefit Period	Calendar Year
Dependent Age Limit	To the end of the calendar year in which the child attains age (b)(4) or to the end of the calendar year in which the child attains age (b)(4) if the child is: enrolled as a full-time student at an accredited school or college.

Pre-Existing Period

Late Enrollee	18 month review of 6 months before effective date. See your HR or benefits department for specifics.

Deductible	**Network**	**Non-Network**
Per Person	(b)(4)	
Per Family		

Out-of-Pocket Limit		
Per Person	(b)(4)	
Per Family		

Note: The Out-of-Pocket Limit includes all percentage Coinsurance you incur in a Benefit Period. However, Deductibles, Mental Health/Substance Abuse Services and flat dollar amount Copayments (if applicable) do not apply toward the Out-of-Pocket Limit. Once the Member and/or family Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the Member and/or family for the remainder of the Benefit Period except for Deductibles, Mental Health/Substance Abuse Services Copayments and flat dollar amount Copayments (if applicable).

Network and Non-Network Deductibles, Copayments, and Out-of-Pocket Limits **are not separate and do accumulate toward each other.** The Deductible(s) apply only to Covered Services with a percentage Copayment.

Calendar Year Maximum for All Covered Services $ (b)(4)
(Network and Non-Network)

Covered Services	**Copayments/Maximums**	
	Network	**Non-Network**
Preventive Care		
Well Child Care (newborn to age 2)	$(b)(4) Copayment, then Covered in Full	(b)(4)% Coinsurance, subject to Deductible
Well Adult Care (ages 2 and above) Routine Exams per visit per Benefit Period: (b)(4) exams per Benefit Period for Employee spouse (b)(4) exam per Benefit Period for Dependents.	First $(b)(4) Covered in Full after $(b)(4) Copayment	
Annual gynecological exams (b)(4) per member per Benefit Period. The gynecological exams are in addition to the (b)(4) routine exams offered annually for Employees/spouse and one annual routine exam for Dependent.	$(b)(4) Copayment	(b)(4)% Coinsurance, subject to Deductible
All Other Services	(b)(4)% Coinsurance, subject to Deductible	(b)(4)% Coinsurance, subject to Deductible
Note: Routine Hearing Exams and Routine Vision Exams are (b)(4)		

Covered Services	Copayments/Maximums	
	Network	**Non-Network**
Physician Office Services		
Primary Care Physician (PCP)	$ Copayment	(b)(4) % Coinsurance, subject to Deductible
Specialist Physician Care (SPC)	$(b)(4) Copayment	(b)(4) % Coinsurance, subject to Deductible
Allergy Services when billed with an Office Visit	$ Copayment	(b)(4) % Coinsurance, subject to Deductible
Allergy Services when not billed with an Office Visit	(b)(4) % Coinsurance, subject to Deductible	(b)(4) % Coinsurance, subject to Deductible
Inpatient Services	(b)(4) % Coinsurance, subject to Deductible	$(b)(4) Copayment, then (b)(4) % Coinsurance, subject to Deductible
Maximum Days per Benefit Period for Physical Medicine and Rehabilitation	(b)(4) Day Limits	
Maximum Days per Benefit Period for Skilled Nursing Care Facility Services	(b)(4) Day Limits	
Outpatient Facility Services	(b)(4) % Coinsurance, subject to Deductible	(b)(4) % Coinsurance, subject to Deductible
Clinic Facility Services	(b)(4) % Coinsurance, subject to Deductible	(b)(4) % Coinsurance, subject to Deductible
Therapy Services (when rendered as Physician s Office Services or Outpatient Facility Services)	(b)(4) % Coinsurance, subject to Deductible	(b)(4) % Coinsurance, subject to Deductible
NOTE: If different types of Therapy Services are performed during one Physician Office Service, or Outpatient Service, then each different type of Therapy Service performed will be considered a separate Therapy Visit. Each Therapy Visit will count against the applicable Maximum Visits listed below. For example, if both a Physical Therapy Service and a Spinal Manipulation service are performed during one Physician Office Service, or Outpatient Service, they will count as both one Physical Therapy Visit and one Spinal Manipulation Visit.		

Covered Services	Copayments/Maximums	
	Network	**Non-Network**
Maximum per Benefit Period for:		
Outpatient respiratory, speech, physical and occupational therapies	Limited to a combined $ (b)(4) per person, per calendar year Network and Non-Network combined.	
Chiropractic Care	(b)(4) Covered	
Other Therapy Services (when rendered as Physician s Office Services or Outpatient Facility Services)	Network Copayment based on setting where Covered Services are received	Non-Network Copayment based on setting where Covered Services are received
Diagnostic Services	(b)(4) % Coinsurance, subject to Deductible	(b)(4) % Coinsurance, subject to Deductible
Emergency Room Services (If admitted directly from the Emergency Room, the Emergency Room Copayment for that visit is waived). (ER Copayment does not apply on Accidental Injury Claims.)	$(b)(4) Copayment then (b)(4) % Coinsurance, subject to Deductible	$(b)(4) Copayment then (b)(4) % Coinsurance, subject to Deductible
Urgent Care Center Services	$(b)(4) Copayment	(b)(4) % Coinsurance, subject to Deductible
Ambulance Services	(b)(4) % Coinsurance, subject to Deductible	(b)(4) % Coinsurance, subject to Deductible
Home Care Services	(b)(4) % Coinsurance, subject to Deductible	(b)(4) % Coinsurance, subject to Deductible
Maximum Visits per Benefit Period	(b)(4) Visits	
Hospice Services	(b)(4) % Coinsurance, subject to Deductible	(b)(4) % Coinsurance, subject to Deductible

Covered Services	Copayments/Maximums	
	Network	**Non-Network**
Medical Supplies, Durable Medical Equipment and Appliances	(b)(4) % Coinsurance, subject to Deductible	(b)(4) % Coinsurance, ect to Deductible
NOTE: Physician office Copayments are applied rather than the Network Copayment listed above if medical supplies, Durable Medical Equipment or appliances are obtained in a Network Physician s office.		
Maternity Services	(b)(4) % Coinsurance, subject to Deductible	(b)(4) % Coinsurance, subject to Deductible
Physician Office Services	$(b)(4) Copayment First pre al visit is subject to Office Visit Copayment	(b)(4) % Coinsurance, subject to Deductible
Infertility Services Diagnosis of infertility covered but treatment is not.	(b)(4) % Coinsurance, subject to Deductible	(b)(4) % Coinsurance, subject to Deductible
Mental Health/Substance Abuse Services	Copayments/Coinsurance based on setting where Covered Services are received	Copayments/Coinsurance based on setting where Covered Services are received
Coverage for the treatment of Behavioral Health and Substance Abuse Services is provided in compliance with federal law.		
Human Organ and Tissue Transplant Services		
Human Organ Transplants	(b)(4) % Coinsurance, subject to Deductible	(b)(4) % Coinsurance, subject to Deductible
Tissue Transplants	(b)(4) % Coinsurance, subject to Deductible	(b)(4) % Coinsurance, subject to Deductible
Transportation, Lodging and Meals	(b)(4) Covered	(b)(4) Covered

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From: Botwinick, Alexandra (HHS/OCIIO)
Sent: Tuesday, October 12, 2010 4:48 PM
To: 'mtoeller@ALCCO.COM'
Subject: Waiver Approval Letter
Mr. Toeller,

Thank you for submitting an application for a Waiver of the Annual Limits Requirements of the PHS Act Section 2711 for Assisted Living Concepts. 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
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 January 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

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.

From: Toeller, Matt [mtoeller@ALCCO.COM]
Sent: Tuesday, October 12, 2010 4:56 PM
To: Botwinick, Alexandra (HHS/OCIIO)
Subject: RE: Waiver Approval Letter with attachment

Please disregard my last email. Thank you for resending.

Matt

Matthew J. Toeller, SPHR
Director of Benefits & Compensation
Office: 262.257.8870

From: Botwinick, Alexandra (HHS/OCIIO) [mailto:Alexandra.Botwinick@hhs.gov]
Sent: Tuesday, October 12, 2010 3:50 PM
To: Toeller, Matt
Subject: FW: Waiver Approval Letter with attachment

Mr. Toeller,

Thank you for submitting an application for a Waiver of the Annual Limits Requirements of the PHS Act Section 2711 for Assisted Living Concepts. 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
alexandra.botwinick@hhs.gov

From: Botwinick, Alexandra (HHS/OCIIO)
Sent: Tuesday, October 12, 2010 4:48 PM
To: 'mtoeller@ALCCO.COM'
Subject: Waiver Approval Letter

Mr. Toeller,

Thank you for submitting an application for a Waiver of the Annual Limits Requirements of the PHS Act Section 2711 for Assisted Living Concepts. 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
alexandra.botwinick@hhs.gov