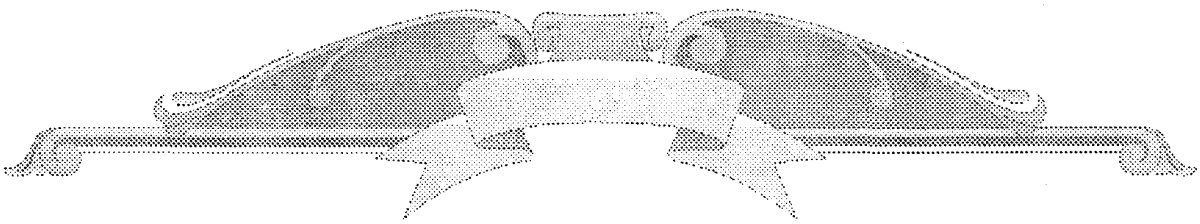
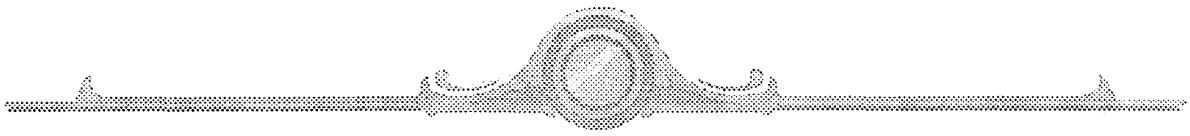


1994 National Employer Health Insurance Survey

Self Administered Questionnaires



Dear Data User:

This document includes two self administered questionnaires (SAQ's) that were used in the 1994 National Employer Health Insurance Survey (NEHIS) by employers who were unable to complete the interview using the primary mode of data collection, Computer Assisted Telephone Interviewing (CATI), or who preferred to complete a mail questionnaire. The first questionnaire , the Establishment Questionnaire, contains questions about the characteristics of the establishment and the employees that work there, for example, whether or not the establishment offers health insurance, other company locations, number of full time, part time, temporary and seasonal employees, eligibility requirements, enrollment, and number and types (HMO, PPO, Conventional) of plans offered. The Plan Questionnaire obtains detailed information, such as premiums, deductibles, coinsurance rates, and services covered, for each plan offered by the establishment.

Efforts were made to design the NEHIS SAQ in such a way as to maximize response and to minimize respondent burden. Therefore, these questionnaires are missing a few data items that are contained in the NEHIS CATI questionnaire and do not include most of the probe or follow-up questions . The NEHIS SAQ, however, is complete in the sense that it contains the main data items from the NEHIS CATI questionnaire that are analytically relevant to health care researchers and policy makers.

The NEHIS Staff

OMB No: 0920-0341; Approval Expires: December 31, 1994

National Employer Health Insurance Survey

conducted for

The United States Department of Health and Human Services

Establishment Questionnaire

Please answer each of the questions that apply to this location. This Establishment Questionnaire has questions about the business establishment or location of your organization. Also enclosed are several Plan Questionnaires. Please complete the Establishment Questionnaire and a Plan Questionnaire for each health insurance plan your company or organization offered at the location below as of the most recent plan year ending before April 1, 1994.

Instructions are in shaded boxes like this. Explanations of the questions are in italics. Instructions for returning the questionnaire are on the back of this booklet.

Please answer questions in this questionnaire for the location shown below:

A. Offering Health Benefits to Employees

A1.	**Did your organization or business offer a group health insurance plan for employees at the location on the label as of December 31, 1993?** *Answer "Yes" even if you offered a group health insurance plan only to some employees.*	Yes | | No | |

A2.	**Did any of your employees receive health insurance coverage through a union as of December 31, 1993?** *Do not include any employees who may have been covered by their spouses' union plans.*	Yes | | No | |
	If "Yes" to A2:	
A3.	**Did your organization or business contribute to this coverage?**	Yes | | No | |

A4.	**Did any of your employees receive health insurance coverage through a professional or trade association as of December 31, 1993?** *Do not include any employees who may have been covered by their spouses' union plans.*	Yes | | No | |
	If "Yes" to A4:	
A5.	**Did your organization or business contribute to this coverage?**	Yes | | No | |

*If you answered "Yes" to A1, A3, **OR** A5, your business or organization is considered as offering health benefits to employees.*

If you answered "No" to A3 or A5, please enter the information requested for the the union or association below. Please provide infromation for other organizations on a separate sheet.

Name of union or association:

Name of contact person:

Address:

Telephone Number: ( ) -

Number of employees at this location covered by this group:

If your busines or organization does not offer health benefits to employees, please answer question A5. Otherwise, go on to Section B.

A5. Has your business or organization offered health insurance as a benefit to employees in the past five years?	Yes | | No | |
If "Yes" to A5: **A6. When did you last offer a health insurance benefit?**	**Month:** **Year:**

If the date in A6 is May 1993 or later, please answer the remaining questions about your health benefits as of that date.

Please go on to Section B.

B. Locations and Employees Nationwide

B1.	**Does your company or organization have branches or locations in the United States other than the one shown on the label?**	Yes | | No | |

If "No" to B1, GO TO SECTION C. Otherwise, please continue with Section B.

B2.	**Including the location shown on the label, how many branches or locations did your business or organization have . . .** **a. nationwide (in the United States)?** **b. in the state shown on the label?**	

B3.	**Including those at the location shown on the label, at the end of 1993 how many employees did your business or organization have ...** **a. nationwide (in the United States)?** **b. in the state shown on the label?**	

B4.	**Is your business or organization . . .**	**for profit?** | | **not for profit?** | |
	If "for profit": **B4a. What kind of ownership does your business have?**	**Corporation** | | **S Corporation** | | **Partnership** | | **Sole proprietorship** | | **Other (What?)** | |

B5.	**How long has your company or organization been in existence?** *Enter either a number of years or the year your business or organization started.*	**Years:** **Since**

C. Employees at Location

C1.	**What was the total number of employees on December 31, 1993, at the location on the label on the front of the questionnaire?** *Include all full- and part-time employees as well as the owner, if he or she works at this location. Include all employees on the payroll from this location as of December 31, 1993, but do not include persons working under personal service contracts or hired from a temporary agency such as Kelly Services.*	employees

If the answer to any question below is "None," enter "0."	Full-time	Part-time
C2a. **How many of the employees in C1 were considered full-time, and how many part-time?**		
C2b. **How many of these full-time and part-time employees were *eligible* for health benefits through your company or organization as of December 31, 1993?**		
C2c. **How many of these full-time and part-time employees were actually *enrolled* in a health insurance plan through your company or organization?**		
C2d. **How many of these full-time and part-time employees were considered *temporary* or *seasonal* on December 31, 1993?** *Temporary or seasonal employees are those hired on a short-term basis, but do not include those employed by an agency such as Manpower.*		
C2e. **How many of these temporary or seasonal employees were *eligible* for health benefits through your company or organization as of December 31, 1993?**		
C2f. **How many of these temporary or seasonal employees were actually *enrolled* in a health insurance plan through your company or organization?**		

C3.	**How many hours per week does an employee have to work to be considered full-time?**	hours/week

C4.	**How many of your employees at this location were union members as of December 31, 1993?** *You may enter either a number of employees or a percentage. If none, please enter "0."*	Number: OR percent

		Hourly	Salaried
C5a.	**Please enter the number of hourly (wage) and salaried employees as of December 31, 1993.** *Count employees on commission as salaried. Count those earning wages plus tips as hourly.* **In each column, please enter the number of employees in that category who earned . . .**		
C5b.	**Less than $5.00 per hour or less than $10,000 per year.** *Comparable rates are $200 per week or $800 per month.*		
C5c.	**at least $5.00 but less than $15.00 per hour, or at least $10,000 but less than $30,000 per year?** *Comparable rates are $200-$600 per week and $800-$2400 per month.*		
C5d.	**$15.00 per hour or more, or $30,000 per year or more?** *Comparable rates are $600 per week or more and $2400 per month or more.*		

C6.	**What was the total annual payroll for 1993 for this location including both hourly and salaried workers?**	$
	C6a. Was that for the calendar year, the fiscal year, or for some other period?	Calendar year | | Fiscal year | | Other period | |-> What?

C7.	**In 1993, how much did your company or organization spend on all your health insurance plans for this location?** *Please include all premiums (including employee contributions) and claims your company paid for all employees, as well as for any former employees or retirees that were covered. Please also include premiums paid by employees and any other costs such as administrative costs, stop-loss coverage or reinsurance. You may enter either a dollar amount or a percentage of total payroll.*	$ OR (percent of payroll)

D. Eligibility for Health Plan

If your company or organization did not offer health benefits, please skip to the last page of this questionnaire.

D1.	**As of December 31, 1993, did new employees have to work for a certain length of time before they became eligible for your health insurance plan?** *Do not include a waiting period your plan may have had for pre-existing conditions.*	Yes | | No | |
	If "Yes" to D1: **D2. What was this waiting period?** *Please enter a number of days, weeks, or months, or check a box if the waiting period varied or was the first day of the next month or pay period.*	Days: Weeks: Months: Varied | | First day of next month or pay period | |

D3.	**Did employees have to work a certain number of hours per week, per month, or per year to be eligible for your health insurance plan?**	Yes | | No | |
	If "Yes" to D3: **D4. How many hours?** *Enter the number of hours next to the appropriate period.*	**per week:** **per month:** **per year:**

D5.	**Were retirees *65 or older eligible* for your health insurance coverage other than through COBRA or other continuation of benefits laws?**	Yes | | No | |

D6.	**Were retirees *under 65 eligible* for your health insurance coverage other than through COBRA or other continuation of benefits laws?**	Yes | | No | |

D7.	**In what month does your health insurance plan year . . .** *The beginning of the plan year is the beginning of the period when the plan calculates deductibles and other benefits. It may also be the time, just after "open season," when an employee can change plans or elect coverage previously declined.*	begin? end?

The "plan year" that the questionnaire will ask about is the most recent plan year that ended before April 1, 1994. For example, if your plan year is the same as the calendar year, the "plan year" is January 1, 1993, through December 31, 1993. If your plan year begins in July and ends in June, the questionnaire plan year is July 1, 1992, through June 30, 1993. If your plan year begins in October and ends in September, the questionnaire plan year is October 1, 1992, through September 30, 1993. The questions below call this period "plan year 1993."

	If your plan year is not the same as the calendar year:	
D8.	**How many employees did your company or organization have at this location on the last day of plan year 1993?**	

D9.	**At the end of plan year 1993, did your company or organization offer employees ...**		
	a.	**paid vacation?**	Yes | | No | |
	b.	**paid sick leave?**	Yes | | No | |
	c.	**long-term disability insurance?**	Yes | | No | |
	d.	**life insurance?**	Yes | | No | |
	e.	**a retirement or pension plan such as a 401K or 403B plan?**	Yes | | No | |
	f.	**a flexible spending account?** *(That is, an account in which employees use pretax dollars to pay their share of health insurance costs or to buy other benefits. A flexible spending account may be offered along with a "cafeteria plan," but is not the same thing.)*	Yes | | No | |

E. Health Insurance Plans

Please list below all health insurance plans your company or organization offered in plan year 1993. Please include:

- all HMO, PPO, or conventional health insurance plans;
- each high and low option plan separately;
- any plans that cover just dental care, vision care, or prescription drugs;
- any plans employees obtain through a union or through a professional or trade association;
- any plan that you may obtain through a multi-employer trust (MET), multi-employer welfare association (MEWA), or other pooling arrangement.

List of plans offered in plan year 1993. If you offered more than 10 plans, please include additional plan names on a separate sheet.

Plan 1. _____

Plan 2. _____

Plan 3. _____

Plan 4. _____

Plan 5. _____

Plan 6. _____

Plan 7. _____

Plan 8. _____

Plan 9. _____

Plan 10. _____

Please write the name of each plan you offered in plan year 1993 on the cover of a Plan Questionnaire and complete the questionnaire for that plan. Shown on the next page are the definitions of the different kinds of health insurance plans for question F1 of the Plan Questionnaire.

Plan Type Definitions for Question F1 on Plan Questionnaire

1. **Health Maintenance Organization (HMO) or Exclusive Provider Organization (EPO).** An HMO offers comprehensive health care from a specified set of providers, who may be employees of or under contract to the HMO. Care from providers outside the HMO is only covered in emergencies or when the patient is referred by an HMO provider.

2. **Preferred Provider Organization (PPO).** In a PPO, the covered person may seek care from a provider associated with the plan (preferred provider) or a provider outside the plan (non-preferred provider). Typically, the patient pays more when s/he sees a non-preferred provider.

3. **Conventional Health Insurance.** Under conventional health insurance, the covered person seeks care from his/her own choice of providers on a fee-for-service basis. Either the patient or the provider then submits a claim.

4. **"Combination Plans" (Including, Point-of Service HMO, POS, or Open-ended HMO).** A "combination plan" has elements of an HMO and of a PPO or conventional plan. Plan benefits are greater if members choose providers within the HMO or PPO.

5. **Dental Insurance (Dental Only Plan).** A dental only plan covers only dental care, including checkups, cleaning, and fillings, as well as more involved procedures.

6. **Vision Care Plan.** A vision care plan covers only eye examinations, eye care, and eyeglasses.

7. **Prescription Drug Plan**A prescription drug plan covers only drugs prescribed by a physician. The plan may have co-payments or a deductible. It may require covered persons to use particular pharmacies or a mail-order drug service.

8. **Long-term Care Insurance.** Long-term care insurance covers all forms of care, both institutional and noninstitutional, required by people with chronic health conditions.

9. **Dread Disease Plan (Cancer Plan, Stroke Plan).** Dread disease plans cover only medical services associated with a particular condition and usually pay a set amount per day.

10. **Extra Cash Plan (Hospital Indemnity Insurance).** Extra cash plans typically pay the covered person a set amount per day when s/he is hospitalized. They do not specifically cover the costs of any health care services.

The following kinds of insurance are not counted for this survey. Please do not list them or complete plan questionnaires for them.

A. **Administrative Plan (Administrative Services Only (ASO) or Administrative Services Contract (ASC)).** In an administrative plan, the employer purchases from a commercial carrier or Blue Cross/Blue Shield services such as claims adjudication, member services, and management information reporting. Usually the employer bears the full risk of the cost of health claims (other than that covered by a separate stop-loss arrangement).

B. **Disability Insurance.** Disability insurance pays all or a part of an employee's salary (and possibly medical care costs) if the employee becomes unable to work due to physical or mental disability.

C. **Life Insurance.** Life insurance pays a cash benefit in the event of the covered person's death (or serious injury, in some cases).

OMB No: 0920-0341; Approval Expires: December 31, 1994

National Employer Health Insurance Survey

conducted for

The United States Department of Health and Human Services

Plan Questionnaire

Please complete a Plan Questionnaire for each health insurance plan your company or organization offered at the location below as of the most recent plan year ending before April 1, 1994.

Instructions are in shaded boxes like this. Explanations of the questions are in italics. Instructions for returning the questionnaire are on the back of this booklet.

Please answer questions in this questionnaire for the location shown below:

Name of Health Insurance Plan:

F. Plan Costs and Enrollment

Please complete this Plan Questionnaire for the plan shown on the cover.

F1.	**What kind of plan is it?** *Please mark one box only. See definitions in Section E of the Establishment Questionnaire.*	HMO |__| PPO |__| Conventional plan |__| Combination plan |__| Dental only plan |__| Vision only plan |__| Prescription plan |__|

If your company or organization has only one location, please skip to Question F3.

F2.	**The next question is about the number of employees and other persons enrolled in this plan as of the end of the plan year. We would prefer you answer for the location on the label on the cover of the Establishment Questionnaire. Please mark whether you can report the number of employees enrolled for this location only, only for the firm as a whole, or only for some other group of locations.**	This location |__| Firm as a whole |__| Some other group |__|

F3.	**How many people were enrolled in this plan (at this location) as of the end of the plan year in the following categories:** *(that is, at the end of the most recent plan year that ended before April 1, 1994) If none, enter "0."*	
	a. employees?	_____
	b. dependents of employees?	_____
	c. former employees covered through COBRA, or state continuation of benefits laws?	_____
	d. dependents of former employees?	_____
	e. retirees *65 or older*?	_____
	f. retirees *under 65?*	_____
	g. dependents of retirees?	_____

F4.	**Did this plan offer family coverage?**	Yes |__| No |__|

F5.	**Were you self-insured for this plan, or were you fully insured by the insurance company that wrote the plan?** *If you were self-insured, it means that your company or organization would bear the financial responsibility for employees' medical claims.*	Self-insured |__| Fully insured |__| Don't know |__|

If your company or organization has only one location, please check here |__| *and skip to the next Instruction Box.*

F6.	**The next question is about the total costs or premiums for this plan in the last plan year. We would prefer you answer for the location on the mailing label. Please mark whether you can report the total costs or premiums for this location only, only for the firm as a whole, or only for some other group of locations.**	This location |__| Firm as a whole |__| Some other group |__|

If you answered "Self-insured" in Question F5, please go on with Question F7. If you answered "Fully insured" or "Don't know" in Question F5, please skip to Question F15.

	Self-insured plans only:	
F7.	**What were the following costs for this plan in the most recent plan year that ended before April 1, 1994?**	*Please record below the appropriate costs* ***for the entire plan year.***
	a. total annual premiums (for the company or location, not per employee) for stop-loss coverage or reinsurance? *Stop-loss coverage protects self-insured firms from very large claims for an individual, or a large amount of total claims. If your plan did not have stop-loss coverage in this plan year, enter "0."*	$_____ (premium for stop-loss)
	b. benefits paid for claims incurrred in the plan year?	$_____ (benefits)
	c. administration or claims processing costs?	$_____ (administrative costs)
	d. total plan costs including all above costs?	$_____ (total plan costs)

	Self-insured plans only:	
F8.	**Who administered this plan in the most recent plan year ending before April 1, 1994?**	Blue Cross/Blue Shield |__| An insurance company |__| A third party administrator (TPA) |__| Your own firm |__| Someone else |__|-> Who?_____

	Self-insured plans only:	
F9.	**Did your company or organization calculate a "premium equivalent," or cost per covered employee, in the most recent plan year that ended before April 1, 1994?** *For self-insured firms, a "premium equivalent" is the amount the firm would expect to pay if it was insured by someone else. The premium equivalent is usually equal to the amount of claims, administration costs, and stop-loss premiums on a per-employee basis.*	Yes |__| No |__|
	If "No" to Question F9: **How much did employees contribute for . . .**	
	a. single coverage?	$_____per month
	b. family coverage?	$_____per month

If you answered "No" or "Don't know" to Question F9, please skip to the Benefits section (Section G).
If you answered "Yes" to Question F9, please go on with Question F10.

F10.	**In the most recent plan year that ended before April 1, 1994, did the premium equivalent include the costs of processing claims, or did it cover medical claims only?**	Included processing |__| Medical claims only |__|

F11a.	**What was the premium equivalent (for single coverage) per employee per month?**	$_____ per month
F11b.	**What part of the premium equivalent (for single coverage) was contributed by the *employee*?**	$_____ per month OR _____ percent
F11c.	**What part of the premium equivalent (for single coverage) was contributed by the *employer*?**	$_____ per month OR _____ percent

If this plan did not offer family coverage, please skip to the Benefits section (Section G).

F12. Did your company or organization calculate one premium equivalent, or different premium equivalents for single and family coverage?	One premium equivalent |__| Different for single and family |__|

If this plan had only one premium equivalent amount for single and family coverage (Question F12), please skip to the Benefits section (Section G). If the amounts were different for single and family coverage, please go on with Question F13.

F13. Did you have different premium equivalents for different family sizes or compositions? *For example, you may have calculated different premium evuivalents for a family of two, a family of three, and so on.*	Yes (Different) |__| No |__|

F14a. What was the premium equivalent for family coverage (for a family of four, including a spouse) per employee per month?	$_____ per month
F14b. What part of the premium equivalent (for family coverage) was contributed by the *employee*?	$_____ per month OR _____ percent
F14c. What part of the premium equivalent (for family coverage) was contributed by the *employer*?	$_____ per month OR _____ percent

Self-insured plans skip to the Benefits section (Section G).

	Fully-insured plans only:	
F15.	**What were the following costs for this plan in the most recent plan year that ended before April 1, 1994:**	
	a. total premiums for the year? *Please enter the total premiums for the year for all employees together (at this location).*	$_____
	b. benefits paid for claims incurred in the plan year?	$_____
	c. administration or claims processing costs? *Please enter either as a dollar amount or a percentage of premiums.*	$_____ OR _____% of premium

	Fully-insured plans only:	
F16.	**What is the name of the insurance company that wrote the policy for this plan?**	Blue Cross/Blue Shield |__| Aetna |__| Cigna |__| Metropolitan |__| Travelers |__| Prudential |__| Other |__|-> Who?_____

	Fully-insured plans only:	
F17.	**What is the policy number for this plan?** *The policy number may be used to request some general information about the plan from your insurance company.*	_____

F18a. Including both what the employer and the employee paid, what was the total monthly premium for an employee with single coverage per employee?	$_____ per month
F18b. What part of the total monthly premium (for single coverage) was contributed by the *employee*?	$_____ per month OR _____ percent
F18c. What part of the total monthly premium (for single coverage) was contributed by the *employer*?	$_____ per month OR _____ percent

If this plan did not offer family coverage, please skip to the Benefits section (Section G). If the plan did offer family coverage, please go on with Question F19.

F19. In the most recent plan year that ended before April 1, 1994, was the premium for family coverage the same as the premium for single cverage?	Yes (same premium) |__| No (different premiums) |__|

If this plan had the same premium for single and family coverage ("Yes" to Question F19), please skip to the Benefits section (Section G). If the plan had different premiums for single and family coverage, please go on with Question F20.

F20. Did this plan have different premiums for different family sizes or compositions? *For example, there may have been different premiums for a family of two, a family of three, and so on.*	Yes (Different) |__| No |__|

F21a. Including both what the employer and the employee paid, what was the total monthly premium for family coverage (for a family of four, including a spouse)?	$_____ per month
F21b. What part of the total monthly premium for family coverage was contributed by the *employee*?	$_____ per month OR _____ percent
F21c. What part of the total monthly premium for family coverage was contributed by the *employer*?	$_____ per month OR _____ percent

G. Benefits

G1. Please enter below the annual deductibles, if any, for this plan in the most recent plan year that ended before April 1, 1994? *A deductible is the amount the employee must pay for medical services before the plan begins to pay anything.*	*Please use both columns if the plan covered both preferred and non-preferred providers, or both providers in the plan and outside the plan. Otherwise, use the first column only.*	
	Preferred (In plan) Providers	Non-preferred (Out-of-plan) Providers
a. What was the deductible for inpatient services (stays in a hospital) for an individual with single coverage? *If none, enter "0" and go to d.*	$_____	$_____
If an amount other than 0 entered in a: **b. Was that inpatient deductible per stay or for the year?**	Per stay |__| For the year |__|	Per stay |__| For the year |__|
If "for the year" entered in b. **c. Did the same deductible apply to outpatient services (doctor visits)?**	Yes |__| No |__|	Yes |__| No |__|
Unless "No" entered in c. **d. What was the deductible for outpatient services (doctor visits) for an individual with single coverage?**	$_____	$_____

G2. What was the maximum deductible to be paid by the family in the year? *Please enter the number of people, the dollar amount, or both, as appropriate.*	Number of people meeting individual deductible _____ Dollar amount $_____

G3. **Please enter below the coinsurance rates or copayment amounts, if any, for this plan in the most recent plan year that ended before April 1, 1994.** *Coinsurance or copayment refers to the employee's share of the cost for a covered service, after the deductible has been met but before the maximum out-of-pocket expense has been reached.*

a. **What was the coinsurance rate for basic inpatient services (stays in the hospital)?**

0% or None |__|
10% or "90-10" |__|
15% or "85-15" |__|
20% or "80-20" |__|
25% or "75-25" |__|
30% or "70-30" |__|
50% or "50-50" |__|
Rate varied |__|
Other rate |__|->

What?_____

b. **How much did an employee have to pay when he or she saw a doctor?** *After the deductible had been met, but before the maximum out-of-pocket expense had been met. If the plan had different rates for preferred and non-preferred providers, or doctors in the plan and doctors not in the plan, please enter here the rate for preferred providers or doctors in the plan.*

$_____
OR
0% or Nothing |__|
10% or "90-10" |__|
15% or "85-15" |__|
20% or "80-20" |__|
25% or "75-25" |__|
30% or "70-30" |__|
50% or "50-50" |__|
Rate varied |__|
Other rate |__|->

What?_____

If the plan had different rates or copayment amounts for preferred and non-preferred providers, or for providers in and out of the plan:

c. **How much did an employee have to pay when he or she saw a non-preferred provider, or a doctor outside the plan?**

$_____
OR
0% or Nothing |__|
10% or "90-10" |__|
15% or "85-15" |__|
20% or "80-20" |__|
25% or "75-25" |__|
30% or "70-30" |__|
50% or "50-50" |__|
Rate varied |__|
Other rate |__|->

What?_____

G4.	**What was the maximum amount that this plan would pay over an employee's lifetime?** *Do not include limits that apply only to mental health, or only to certain diseases such as cancer or AIDS.*	$_____ OR No lifetime limit |__|

G5.	**Did this plan have a waiting period for pre-existing conditions for employees or their dependents?** *During such a waiting period, employees would be covered for new conditions, but not for pre-existing conditions.*	Yes |__| No |__|
	If there was a waiting period:	
a.	**How long was the waiting period for coverage of pre-existing conditions?** *If the waiting period differed depending on whether the employee was in treatment for the condition or not, please enter the waiting period for "in treatment."*	_____ days _____ months _____ years OR Never covered |__| Period varied |__|
	If there was a waiting period:	
b.	**Did the waiting period differ according to whether the employee was in treatment or not?**	Yes |__| No |__|

G6.	**Could this plan refuse to cover employees or their dependents who had particular health problems or conditions?** *That is, could the plan refuse to cover an employee* ***at all****, regardless of what the medical expenses were for?*	Yes (could refuse) |__| No |__|
	If the plan could refuse coverage:	
a.	**How many active employees or dependents were refused coverage at the end of the most recent plan year that ended before April 1, 1994?** *If none, please enter "0."*	_____ employees _____ dependents

G7.	**Which of the following services were covered by this plan in the most recent plan year ending before April 1, 1994?**	
	a. adult routine physical examinations?	Yes |__| No |__|
	b. routine mammography screening?	Yes |__| No |__|
	c. routine Pap smears?	Yes |__| No |__|
	d. childhood immunizations?	Yes |__| No |__|
	e. well-baby care, or checkups for children under one year of age?	Yes |__| No |__|
	f. checkups for children 1 to 4 years of age?	Yes |__| No |__|
	g. checkups for children 5 to 13 years of age?	Yes |__| No |__|

G8.	**Did this plan cover outpatient prescription drugs (that is, drugs prescribed by a doctor outside of a hospital)?** *If prescription drugs were not covered, please skip to Question G9.*	Yes |__| No |__|
	a. What was the dollar limit for outpatient prescription drug coverage in a year?	$_____ OR No dollar limit |__|
	b. Did this plan require that generic drugs be purchased if available?	Yes |__| No |__|

G9.	**In the most recent plan year that ended before April 1, 1994, did this plan cover routine dental care?** *Routine dental care includes such things as cleanings, checkups and fillings.* *If routine dental care was not covered, please skip to Question G10.*	Yes |__| No |__|
	a. Did this plan cover orthodontic care other than that required by accident or injury?	Yes |__| No |__|

G10.	**In the most recent plan year that ended before April 1, 1994, did this plan cover routine eye examinations?** *If routine eye examinations were not covered, please skip to Question G11.*	Yes |__| No |__|
	a. Were eyeglasses or contact lenses covered? *Please answer "Yes" for any coverage, even if limited.*	Yes |__| No |__|

G11.	**In the most recent plan year that ended before April 1, 1994, was care in a nursing home covered under this plan?** *If care in a nursing home was not covered, please skip to Question G12.*	Yes |__| No |__|
	a. What was the limit on the number of days or dollar amount that would be covered for care in a nursing home? *Please enter all types of limits that apply.*	_____ days per year _____ days per stay $_____ per day (per diem) $_____ per year No limit |__|

G12. **In the most recent plan year that ended before April 1, 1994, were personal care services in the home covered under this plan?** *"Personal care services in the home" include help a person may receive at home with activities of daily living, such as bathing, eating, and dressing. Such help may be provided by nurse's aides or other paid professionals.*	Yes |__| No |__|

G13. **In the most recent plan year that ended before April 1, 1994, was home health care covered under this plan?** *"Home health care" includes care by registered nurses (R.N.), licensed practical nurses (L.P.N.), home health aides, or various kinds of therapists given to a person in his or her home.* *If home health care was not covered, please skip to Question G14.*	Yes |__| No |__|
a. **What was the limit on the number of visits or dollar amount that would be covered for home health care?** *Please enter all types of limits that apply.*	_____ visits per year $_____ per year No limit |__|

G14. **In the most recent plan year that ended before April 1, 1994, did this plan cover *inpatient* mental health services?** *If inpatient mental health services were not covered, please skip to Question G15.*	Yes |__| No |__|
a. **What was the limit on the number of days or dollar amount that would be covered for inpatient mental health services?** *Please enter all types of limits that apply. Do not include a separate deductible or coinsurance rate that may apply to mental health benefits.*	_____ days per stay _____ days per year _____ days for lifetime $_____ per stay $_____ per year $_____ for lifetime No limit |__|

G15. In the most recent plan year that ended before April 1, 1994, did this plan cover *outpatient* mental health services? *If outpatient mental health services were not covered, please skip to Question G16.*	Yes |__| No |__|
a. What was the limit on the number of visits or dollar amount that would be covered for outpatient mental health services? *Please enter all types of limits that apply. Do not include a separate deductible or coinsurance rate that may apply to mental health benefits.*	Limits same as inpatient |__| ***(Do not re-enter limits)*** _____ visits per year _____ visits for lifetime $_____ per year $_____ for lifetime No limit |__|

16.	**In the most recent plan year that ended before April 1, 1994, did this plan cover *inpatient substance abuse* services (including either alcohol or drug abuse treatment)?** *If inpatient substance abuse services were not covered, please skip to Question G17.*	Yes |__| No |__|
	a. What was the limit on the number of days or dollar amount that would be covered for inpatient substance abuse treatment? *Please enter all types of limits that apply. Do not include a separate deductible or coinsurance rate that may apply to substance abuse benefits.*	Limits same as mental health |__| ***(Do not re-enter limits)*** _____ days per stay _____ days per year _____ days for lifetime $_____ per stay $_____ per year $_____ for lifetime No limit |__|

G17. In the most recent plan year that ended before April 1, 1994, did this plan cover *outpatient* substance abuse treatment? *If outpatient substance abuse services were not covered, please go to next plan. If no other plan, please go to instructions for returning the questionnaires, on the back of the Establishment Questionnaire.* **a. What was the limit on the number of visits or dollar amount that would be covered for outpatient substance abuse treatment?** *Please enter all types of limits that apply. Do not include a separate deductible or coinsurance rate that may apply to substance abuse benefits.*	Yes |__| No |__| Limits same as already reported |__| ***(Do not re-enter limits)*** _____ visits per year _____ visits for lifetime $_____ per year $_____ for lifetime No limit |__|

Please go on to the next plan. If there is no other plan, please go to the instructions for returning the questionnaires, on the back of the Establishment Questionnaire.

Thank you very much for completing this questionnaire. Please return all completed questionnaires in the postpaid envelope that came with the package, or mail to:

National Employer Health Insurance Survey
Westat, Inc., WB-220
1650 Research Blvd.
Rockville, MD 20850