Self-Funded Medical Financial Assumptions and Caveats

City of Round Rock

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For purposes of this document, Aetna [1]may be referred to using 'we', 'our' or 'us' and City of Round Rock may be referred to using 'you' or 'your'.

We have made every effort to respond to City of Round Rock's request in a manner that reflects our existing and expected business practices for the period January 1, 2019 continuing through December 31, 2021. If you decide to establish a business relationship with us, we'll send you a Letter of Understanding confirming agreed upon benefits, services and fees. Then you'll need to enter into an administrative services agreement (the "Agreement") with us.

Fee Guarantee Period

We have provided a fee guarantee for each of the first three periods from January 1, 2019 through December 31, 2021 (each, a "Guarantee Period"). We have also included performance guarantees in this proposal.
We are also willing to offer two additional years (January 1, 2022 through December 31, 2022 and January 1, 203 through December 31, 2022) at 3% increase for each year.

Underwriting Caveats

Your pricing considers all of the multiple products, programs and services you have with us and/or are included in this proposal and will be in effect for the full 12 months of the plan year. Pricing for some programs and services are amortized over a 12-month period. Therefore fees will not be reduced if termination occurs prior to the end of the plan year. We require notice to properly terminate before the plan year ends in accordance with the Termination provision in your Agreement. Otherwise, you may be charged for the cost until that notice is met.

If any of the changes outlined below occur, we may adjust your Guaranteed Fees. If this happens, you'll be required to pay any difference between the fees collected and the new fees calculated back to the start of the Guarantee Period. If fees are adjusted, the caveats below will be based on the new assumptions.

[1] Aetna is providing this proposal on behalf of itself and Banner Health and Aetna Health Insurance Company Banner|Aetna), Texas Health + Aetna Health Insurance Company (Texas Health Aetna), Innovation Health Insurance Company (Innovation Health), Sutter Health and Aetna Administrative Services, LLC (Sutter Health|Aetna), Allina Health and Aetna Insurance Company (Allina Health|Aetna).

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During the Guarantee Period we may adjust your Guaranteed Fees if:

1. for any product:

    a. There is a 15 percent change in enrolled employees by product or jurisdiction. We assumed 403 employees in Aetna Choice POSII and 425 employees in Aetna Open Access Aetna Select.

2. Maximum account structure exceeds 60 units per product. Account structure determines the reporting format. During the installation process, we'll work with you to finalize the account structure and determine which report formats will be most meaningful. Maximum total account structure includes Experience Rating Groups (ERGs), controls, suffixes, billing and claim accounts.

3. A material change in the plan of benefits is initiated by you or by legislative or regulatory action.

4. A material change in the claim payment requirements or procedures, claim fiduciary option, account structure, or any other change materially affecting the manner or cost of paying benefits is initiated by you or by legislative or regulatory action.

5. You terminate the Agreement and we incur charges for maintaining plan structure to report and/or process runoff claims.

6. You change or terminate the National Advantage™ Program (NAP), Facility Charge Review (FCR) or Itemized Bill Review (IBR) programs.

7. There are any changes to the programs and services we offer you.

8. You terminate any of our other products not addressed within this financial package including, but not limited to, Dental products
9. And/or Pharmacy products.

10. If additional products are not sold, or if additional products terminate during the multi-year guarantee period, any applicable bundled product fee credits will be removed. You place the products, programs and services included in this multi-year fee guarantee out to bid with an effective date prior to January 1, 2022 (end of multi-year Guarantee Period), and then this guarantee is no longer valid.

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11. Legislation, regulation or requests of government authorities result in material changes to plan benefits, we reserve the right to collect any material fees, costs, assessments, or taxes due to changes in the law even if no benefit or plan changes are mandated.

If any of the conditions outlined above occur, then any performance guarantees may be changed or terminated based on the caveats outlined in those guarantee documents.

We're relying on information from you and your representatives in establishing the fees and terms of this proposal. If any of this information is inaccurate and has an impact on the cost of the programs, we reserve the right to adjust our fees and terms upon the receipt of corrected information.

Allowance

- **Wellness Allowance** – We're including a wellness allowance of up to $10,000. You can use this to pay for reasonable wellness-related programs or activities you received from third-party vendors incurred during the January 1, 2019 through December 31, 2019 plan year. This allowance may be used for programs or activities such as wellness fairs, biometric screenings, onsite flu vaccinations, etc. These funds will be available as of the effective date of the guarantee period. We'll pay wellness-related expenses directly to the vendor only after you send us the proper documentation outlining the expenses you have incurred. Our preferred method of payment is directly to the vendor. Payment will be made once expenses are incurred and invoice(s) provided. On an exception basis, we can reimburse you directly. In the event the exception is granted, we'll require you to submit detailed paid receipts from the vendor. Documentation must be submitted within 60 days following the close of the plan year, otherwise you forfeit the funds. Expenses must be for wellness-related programs or activities that are designed to promote the health and wellbeing of plan participants, or to educate participants about healthy lifestyles and choices. Acceptable documentation includes, but is not limited to:

  - Vendor invoice(s) summarizing level of work completed, hourly rate and hours spent; and

  - Invoices or other documentation summarizing any other miscellaneous expenses incurred (such as travel and other business expenses related to service rendered)

  A wellness allowance of up to $10,000 is available in the second and third Guarantee Periods, as well as outlying fourth and fifth years. Please note, the allowance of $10,000 is available for each year and is forfeited at the end of each year if not fully utilized (it does not get rolled over for a cumulative amount).

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We assume the funding of any wellness budget is either at the request of your Plan Administrator acting in its fiduciary capacity or for the exclusive benefit of your Plan. Any wellness-related allowance amounts we pay you directly to offset or reimburse you for any expense or costs you reimbursed a vendor for directly, must comply with these conditions. We suggest you seek appropriate accounting and legal counsel for all payments to ensure they comply with applicable accounting principles and law.

If you terminate your medical plan with us in whole or in part (defined as a 50 percent or greater membership reduction from the membership we assumed in this proposal) prior to the end of the Guarantee Period, December 31, 2019 you will be responsible for remitting payment for any allowance amounts used. Payment will be due to us within 31 days of the invoice.

If you terminate your medical plan with us in whole or in part (defined as a 50 percent or greater membership reduction from the membership we assumed in this proposal) prior to the end of the multi-year Guarantee Period, December 31, 2021 you will be responsible for remitting payment for any allowance amounts used. Payment will be due to us within 31 days of the invoice.

- Late Payment

We'll assess a late payment charge if you don't provide funds on a timely basis to cover benefit payments and/or fail to pay service fees on a timely basis as outlined in the Agreement. The current charges are:

- late funds to cover benefit payments (e.g., late wire transfers after 24-hour request): 12 percent annual rate

- late payments of service fees after 31 day grace period: 12 percent annual rate

We reserve the right to collect any incurred late payment charges through a claim wire billing account on a monthly basis provided there are no other special payment arrangements in-force to fund any incurred late payment charges. We'll notify you in writing to obtain approval prior to billing any late payment charges through the claim wire billing account.

We'll notify you of any changes in late payment interest rates. The late payment charges described in this section are without limitation to any other rights or remedies available to us under the Agreement or at law or in equity for failure to pay.

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Underwriting Assumptions

- Our quotation assumes our standard Agreement provisions and claim settlement practices apply unless otherwise stated.

- The attached financial exhibit outlines the products, programs and services we offer.

- **Participation Requirement** – A minimum of 250 enrolled employees is required to administer the proposed products on a self-funded basis.

- **Plan Design** – The products offered are subject to the terms of our Benefit Review document.

- **Claim Fiduciary (Option 4)** – Our proposal assumes we'll provide mandatory Level I (benefit review and determination of claims) and Level II (deciding appeals and final claims determination) appeals. We'll also write the letter to the member to communicate the appeal decision. We'll defend any lawsuit originating during or after completion of the first two levels of appeal. You'll act as claim fiduciary for all voluntary appeals after Level I and Level II appeals are exhausted. The fee included for this service assumes a member-to-employee ratio range of 2.10 to 2.50.

    - We'll act as claim fiduciary for all Level I (benefit review and determination of claims) appeals. You assume claim fiduciary responsibility for all Level II (deciding appeals and final claims determination) appeals.

- **External Review** – We've included external review in our proposal. External view uses outside vendors who coordinate a medical review through their network of outside physician reviewers. When you retain claim fiduciary responsibility, we pass through the actual vendor charges on a direct-charge basis.

- **Non-ERISA** – For a non-ERISA plan, the risks and responsibilities are different from those under ERISA plans, since the ERISA preemption and ERISA standard of performance do not apply. Our charge for non-ERISA plans must take into account the additional liability risk as compared to known risks under an ERISA plan.

- **Eligibility Transmission** – Our proposal assumes we'll receive eligibility information weekly or biweekly, from your locations and/or by your designated vendor. Our preferred method of submission is via electronic connectivity. We don't charge for the first four Electronic Reporting (ELRs)/segments whether associated with one transmission or by multiple methods. Costs associated with more than four

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ELRs/segments or with any custom programming necessary to accept your eligibility information and/or information coming from a designated vendor aren't included in this proposal and will be assessed separately. During the installation, we'll review all available methods of submitting eligibility information and identify the approach that best meets your needs or the needs of your designated vendor.

- **Third-Party Audits** – We don't typically charge to recoup internal costs associated with a third-party audit. We reserve the right to recover these expenses if significant time and materials are required.

- **Mental Health/Substance Abuse Benefits** – Our quotation assumes that mental health/substance abuse benefits are included.

- **Prescription Drug Benefits** – Our quotation assumes that prescription drug benefits are included.

- **Additional Products, Programs and Services** – Costs for special services rendered that are not included or assumed in the pricing guarantee will be billed through the claim wire, on a single claim account, when applicable, to separately identify charges. Additional charges that are not collected through the claim wire during the year will either be direct-billed or reconciled in conjunction with the year-end accounting and may result in an adjustment to the final administration charge. For example, you will be subject to additional charges for customized communication materials, as well as costs associated with custom reporting, booklet and SPD printing, etc. The costs for these types of services will depend upon the actual services performed and will be determined at the time the service is requested.

Banking

We've assumed that you provide funds through City of Round Rock-pushed ACH wire transfer for drafts clearing the bank issued under the self-funded arrangement assumed in this proposal.

When claims have accumulated to more than $20,000, a request will be sent to you and/or your bank requesting funds for the total claims from the previous day(s). For most customers, this will mean daily claim wire transfers. In addition, there will be a month end close out request on the first banking day of each subsequent month.

Our standard banking arrangement is to request funds when claims have accumulated to more than $20,000. In this arrangement, a wire request is sent to you and/or your bank

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requesting funds for the total claims from the previous day(s). For most customers, this would mean daily claim wire transfers.

In place of this arrangement, we will request funds for claims on a specific day of the week. In addition, there will be a month end close out request on the first banking day of each subsequent month.

The proposed banking arrangement is subject to change based on results of a credit risk evaluation. We will complete an evaluation upon notification of sale.

We've assumed you'll use no more than three primary banking lines which are shared across all self-funded products, excluding Flexible Spending Accounts (FSAs). Additional wire lines and customized banking arrangements will result in an adjustment to the proposed pricing.

Compensation

The quoted fees don't include consultant compensation.

Disclosure Statement – We have various programs for compensating agents, brokers and consultants. If you'd like information about compensation programs for which your agent, broker, or consultant is eligible; payments (if any) which we have made to your agent, broker, or consultant; or other material relationships your agent, broker, or consultant may have with us, you may contact your agent, broker, or consultant or your Aetna account representative. Information about our programs for compensating agents, brokers, or consultants is also available at **www.aetna.com**.

Billing Information

- **Advance Notification of Fee Change** – We'll notify you of any fee change within 31 days of the fee change.

- **Claim Wire Billing Fees** – Claim wire billing fees refers to the portion of the total administrative expenses that are charged through the claim wire as the services are rendered, and are subject to any future fee increases. Fees charged through the claim wire include those described on the Fee Schedule as well as those fees that the parties may subsequently agree to add to the claim wire from time to time. Programs or services that are charged through the claim wire are excluded from the monthly PEPM Administrative Fees as illustrated on the attached financial exhibit(s) and will not appear on the monthly billing statement. Claim wire charges will appear in the claim detail

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report separated by unique Claim Reporting System (CRS) draft accounts and other monthly reports provided to you.

- **Enhanced Clinical Review Program** – Our Enhanced Clinical Review Program can limit the financial impact of high tech imaging, diagnostic cardiac, sleep management, cardiac implantable devices, interventional pain, and hip and knee arthroplasties by coordinating information provided by the ordering doctor. The information is reviewed by board-certified physicians and registered nurses, to maximize savings on these high cost services. Our Enhanced Clinical Review Program is projected to reduce unnecessary utilization by approximately 12 to 15 percent. You will be charged a $0.70 per-member-per-month (PMPM) fee through the claim wire on behalf of your subscribers and covered dependents for participation in this program under your PPO-based plan. We charge you fees based upon those members who fall into service areas where the program is available.

  These fees are billed through a claim wire billing account and will be outlined on your monthly claim detail reports.

  We'll calculate the fee and send you a direct bill after services are rendered on a monthly basis.
- **Teladoc** – Teladoc offers members access to quality, affordable General Medical, Behavioral Health, Caregiver and Dermatology services.

  - **General Medical:** Members can receive care for routine common illnesses with a telephone or online video consultation. Teladoc offers a low cost alternative to more expensive emergency room and urgent-care centers when the member's PCP is unavailable. Telephone consults are available in 49 states (not available in ID), and video consults are available in all 50 states. Arkansas and Delaware require a member's first Teladoc visit to be by video; after the requirement is met, the member will be able to choose phone or video for subsequent visits. Consultations are available seven days a week, 24 hours a day.

  - **Caregiver:** Members can add a non-member care recipient onto their existing Teladoc account to initiate a three-way visit between a physician, caregiver and care recipient. This is a direct to consumer service through Teladoc, available only to access the general medical services. You cannot purchase Caregiver without the General Medical services.

  - **Behavioral Health:** Members can speak with a Behavioral Health provider via an online video consultation. Consultations are available seven days a week, 7 am to 9

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pm local time. You cannot purchase Behavioral Health without the General Medical services.

- **Dermatology:** Members can work with a Dermatologist through 'store and forward' technology where the member provides pictures and a questionnaire to the provider via Teladoc and receive communication back. There is no actual video or telephone appointment. You cannot purchase Dermatology without the General Medical services.

Program	Administration Fee PEPM	Per Consult Claim Charge*
General Medical	$0.95	$40
Behavioral Health	$0.15	$160 for the first Behavioral Health consultation with a psychiatrist $90 for all subsequent Behavioral Health consultations with a psychiatrist; and $80 for each Behavioral Health consultation with a Masters level therapist other than a psychiatrist
Caregiver	No cost	$45 paid directly to Teladoc at the time of visit
Dermatology	No cost	$75

*While this is the total cost that is charged to the member for a consult (depending on the provider level), what a member actually pays depends on how you choose to setup and implement Teladoc. In general, the member will pay a copay amount and the remaining balance (of the provider level consult fee) is billed to you, where applicable.

Unless we hear from you, all of the Teladoc programs noted above will be included as part of our standard offering. Teladoc per consult claim charges are billed through the claim wire and will be outlined on your monthly claim detail reports.

- Claim and Member Services

- **Run-In Claim Processing** – Our proposal excludes run-in claim processing from the prior carrier (claims incurred before the effective date of the plan).

- **Runoff Claims Processing** – The expenses associated with processing runoff claims following cancellation are covered for one year.

Medical Explanation of Benefits (EOB) Suppression – Unless required by state law, we don't produce paper EOBs for members registered through our member website. In addition, we don't produce EOBs for claims when there is no member liability. EOBs are always available electronically through our secure member website.

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- **Care Management Center** – Our National Accounts Care Management Solutions Teams (NACMST) will administer your care management services.

- **Care Management Center** – Our Aetna One Advocate team will administer your care management services.

- **Alternate Office Processing (AOP)** – We regularly use both internal and external claim adjudication services to meet service requirements of our business. These services may be located inside or outside of the United States. Our quality standards and controls apply to all claims regardless of where they're processed. Standard pricing assumptions are in effect based on type of product, auto-adjudication, plan design, and customer specific requirements. We may adjust fees based on the above factors and/or where you wish to limit use of Alternate Office Processing (AOP).

- **Subcontractors** – The work to be performed by us under the Services Agreement may, at our discretion, be performed directly by us or wholly or in any part through a subsidiary, an affiliate, or under a contract with an organization of our choosing. We'll remain liable for Services under the Services Agreement. Upon request, we shall provide a written list of Tier 1 subcontractors. Tier 1 subcontractors are defined as a subset of our suppliers for whom a portion of the Services provided may include direct member contact or significant access to Plan Participant-identifiable data. Not all of our suppliers on the list provided are utilized in providing services to all customers or plan participants. We shall make an updated Tier 1 Subcontractor list available to you, for informational purposes, as requested by you but no more frequently than once annually during the term of the Services Agreement. For the avoidance of doubt, neither our obligation to provide, nor your right to receive, a Tier 1 Subcontractor list under this paragraph shall constitute your right to pre-approve any of our subcontractors or a right to require us to terminate any agreements (or services under any agreements) with any of our suppliers.

- **Claims Subrogation** – We have an agreement with Rawlings & Associates to provide comprehensive subrogation services. A contingency fee of 37.5 percent is retained upon recovery for self-funded customers.

- **Contracted Services** – Cotiviti- We utilize external vendors for claim recovery on:

  - Coordination of Benefits (primary and secondary review)
  - Retroactive Terminations
  - Medical Bill and Hospital Bill Audits
  - Workers Compensation (California, Florida, New York, Ohio and Texas)

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- DRG and Implant Audits

A contingency fee of 37.5 percent is charged for the claim recoveries. These fees are primarily to support vendor costs and our internal administrative costs associated with these programs.

- **Third Party Claim and Code Review Program** – We utilize external vendors for claim recovery on:
  - Payer liability (e.g. member eligibility verification, COB)
  - Coding compliance (e.g. payment policy adherence, duplicate claims)
  - Contract compliance (e.g. provider contract adherence)
  - Clinical appropriateness (e.g. clinical feasibility and appropriateness of claim, chart review verification of claim)

  A contingency fee of 37.5 percent is charged for the claim recoveries. These fees are primarily to support vendor costs and our internal administrative costs associated with these programs.

- **Specialty Pharmaceutical Rebates** – We'll retain (as compensation for our efforts in administering the Preferred Specialty Pharmaceutical Program) all specialty pharmaceutical rebates earned on drug claims that we administer and pay through the medical benefit rather than the pharmacy benefit.

Value Based Contracting

1. Introduction
   We have a variety of different value-based contracting (VBC) arrangements with many of our Network Providers. These arrangements compensate providers to improve indicators of value such as, effective population health management, efficiency and quality care.

2. Contracting Models
   We have VBC arrangements ranging from bundled payments and pay-for-performance approaches to more advanced forms of collaborative arrangements that include integrated technology and case management, aligned incentives and risk sharing. Our VBC models include:

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(A) Pay for Performance (P4P). Under P4P programs, we work together with providers (doctors and hospitals) to develop and agree to a set of quality and efficiency measures and their performance impacts their total compensation.

(B) Bundled Payments. In a Bundled Payment model, a single payment is made to doctors or health care facilities (or jointly to both) for all services associated with an episode-of-care. Bundled payment rates are determined based on the total expected costs for a particular treatment, including pre- and post-treatment services, and are set to incentivize efficient medical treatment.

(C) Patient Centered Medical Home (PCMH). In a PCMH, a primary care doctor leads a clinical team that oversees the care of each patient in a practice. The medical practice receives data about their patients' quality and costs of care in order to improve care delivery. Financial incentives can be earned based upon performance on specific quality and efficiency measures.

(D) Accountable Care Organizations (ACOs). In an ACO, we team up with systems of doctors, hospitals and other health care providers to help these organizations manage risk, improve clinical care management, and implement data and technology to connect providers, health plans and patients. The ACO arrangements include financial incentives for the organization to improve the quality of patient care and health outcomes, while controlling costs.

We will continue to evolve our value-based contracting arrangements over time. We employ a broad spectrum of different reimbursement arrangements with providers to advance of the goals of improving the quality of patient care and health outcomes, while controlling costs.

3. Value-Based Contracting Example Calculations
   A customers' financial responsibility under many VBC arrangement is determined based on provider performance, using an allocation method appropriate for each particular performance program. These methods include: percentage of allowed claims dollars; number of members; percentage of member months.

   Examples

   A. **P4P.** Percentage of allowed claims dollars:
      Achieving agreed upon clinical and efficiency performance goals by comparing performance year end to performance year baseline or an industry standard.

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i. Provider earns $100,000 performance-based compensation for the 12-month period January to December;

ii. All plan sponsors combined, incurred $8,500,000 in claims with the provider for the 12-month period January to December;

iii. Plan sponsor incurred $150,000 in claims with the provider for the 12-month period January to December;

iv. Plan sponsor's share of claims costs is ($150,000/$8,500,000) = 1.7647%. Formula: (Plan sponsor incurred claims/All plan sponsors incurred claims);

v. Plan sponsor's share of the $100,000 performance-based compensation is 1.7647% * $100,000) = $1,764.70, which would be processed as a claim through ordinary self-funded banking channels.

B. **PCMH and ACO.** Percentage of member months:
Achieving agreed upon clinical and efficiency goals as measured by performance year end to performance year baseline or an industry standard.

i. Provider earns $100,000 performance-based compensation for the 12-month period January to December;

ii. All plan sponsors combined, had 100,500 member months with the provider for the 12-month period January to December;

iii. Plan sponsor had 9,500 member months (for 850 unique members) attributed to the provider for the 12-month period January to December;

iv. Plan sponsor's share of the member months is (9,500/100,500) = 9.4527%. Formula: (Plan sponsor member months/All plan sponsors member months);

v. Plan sponsor's share of the $100,000 performance-based compensation is (9.4527% * $100,000) = $9,452.73, which would be processed as a claim through ordinary self-funded banking channels.

C. **PCMH and ACO.** Number of Members:
In addition to Example B above, a quarterly Accountable Care Payment (ACP) may be made to the provider to fund activities necessary to meet the financial and clinical objectives. These are paid quarterly either during, or after the end of

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each quarter. The financial impact is considered in the total financial package negotiated with the provider.

i. We determine the attributed patients for the provider for the quarter April through June;

ii. Plan sponsor had 850 members attributed to the provider for the quarter April through June;

iii. ACP and FFS payments are incorporated into the final analysis of provider performance against the medical claims target;

iv. We apply the agreed upon rate to the attributed patients; i.e. $2.00 per-member, per-month (PMPM) = $6.00 per quarter per member, to determine funding to the provider;

v. Plan sponsor's calculated share is $5,100 ($6.00 * 850), which would be processed as a claim through ordinary self-funded banking channels.

4. General
We will process any payments in accordance with the terms of each VBC arrangement. In each of the VBC models, self-funded plan sponsors reimburse us for any payment attributable to their plan when the payments are made. Each customer's results will vary. It is possible that payments paid to a particular provider or health system may be required even if the plan sponsor's own population did not experience the same financial or qualitative improvements. It is also possible that payments will not be paid to a provider even if the customer's own population did experience financial and quality improvements. A report of VBC charges to a plan sponsor will be available on a quarterly basis.

Upon request, we will provide additional information regarding our VBC arrangements.

Network Services

- **Primary Care Physician Referrals** – Because of certain provider contractual arrangements with some Independent Provider Associations (IPAs) and medical groups, we'll permit specific exemptions to the requirement that a member obtain a referral from their primary care physician (PCP) before receiving care from other providers.

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- **California Primary Care Physician Referrals** – Given the unique nature of the health care system in California, referral registration for members in California is generally not required. The delegated model in place in the state already encourages providers to make appropriate referral decisions for our members. We believe this decision is in the best interests of plan sponsors, members and providers. However, please note that referral registration is required in California in the event that the servicing provider is not in the same network area (e.g., Los Angeles, Northern California, San Diego and Central Valley) as the member or the member's PCP. In addition, PCP selection is required. Par provider claims for members that do not select a PCP will be processed at the par non-authorized level.

- **Network Provider Arrangements** – Certain network providers require payment of claims that might otherwise be denied, such as those not medically necessary or experimental or investigational (but does not require payment for services you expressly exclude from coverage, such as for cosmetic surgery). We will charge you for these claims in order to be able to continue providing members with access to services on an in-network basis. You agree to comply with such applicable provisions of our network provider contracts.

- **Out-of-Network Program and Reimbursement** – We have several programs to help you and your members save money when receiving care out-of-network. Outlined below is the out-of-network program we have included in this proposal.

  National Advantage™ Program including the Contracted Rates, Facility Charge Review and Itemized Bill Review

  The National Advantage Program (NAP) includes three parts, Contracted Rates, Facility Charge Review (FCR) and Itemized Bill Review (IBR). The Contracted Rates part offers access to contracted rates for many medical claims from non-network providers, including claims for emergency services and claims by hospital-based specialists such as anesthesiologists and radiologists who do not contract with insurers.

  National Advantage Program fees

  We'll retain 50 percent of savings from the Contracted Rates National Advantage Program. We retain the same percentage of savings from the FCR and IBR components of the National Advantage Program. These fees are in addition to the per-employee, per-month administrative service fees.

  We'll retain 50 percent of savings from the National Advantage Program. We retain the same percentage of savings from the FCR and IBR components of the National Advantage Program. We're agreeable to capping the amount of the National Advantage Program retained savings that are charged during the calendar year at $100,000 per

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individual claim. The NAP charge limit is based upon the calendar year in which the NAP fees are billed to the claim wire (i.e., recorded date). These fees are in addition to the per-employee, per-month administrative service fees.

How NAP fees are charged

Fees for the program are charged as a percentage of savings achieved by NAP. Fees are credited back to you if savings are subsequently reduced or eliminated. Savings are generally defined as the difference between the reference price and the NAP priced amount, where the reference price is typically defined as:

a. For facility services, the amount billed by the provider.

b. For most professional services, the lesser of the amount billed by the provider or the 80th percentile of the applicable FAIR Health database or other reference database reasonably comparable to FAIR Health.

c. For a professional service paid using an Ad Hoc Rate negotiated by Aetna for an Involuntary Out-of-Network claim, the amount billed by the provider.

d. For claims reviewed under Itemized Bill Review, the in-network rate prior to removal of any non-payable charges identified through the claim review.

The FCR rate will be set as your plan rate for non-par, voluntary facility claims. Your Summary Plan Description will need to reflect this.

- **Institutes of Excellence™ Transplant Network** – As part of our National Transplant Program, a registered nurse is assigned to each member to assist with every phase of the transplant process, from evaluation through post-transplant recovery. The nurse coordinates care and assists your employees in accessing covered treatment through our contracted Institutes of Excellence (IOE) transplant network. The program also features dedicated claims and member services staff for special handling of patient claims and benefits issues. The IOE transplant network is our national network of facilities for transplants and transplant related services. Hospitals that are selected to participate in our IOE transplant network have met enhanced quality thresholds for volumes and outcomes. The charge is on a per transplant basis, whether or not an IOE facility is used. The charge is based on your specific utilization. Billing is through the claim wire process at the rate of $2,500 when a member is wait-listed for a transplant and $7,500 when a member's transplant procedure is complete.

Reporting and Data Transfers

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- **Aetna Informatics® Reporting and Consulting** – In addition to our electronic tool, Aetna Health Information Advantage, you'll receive 5 hours of support for report generation and/or consulting services for customer data housed in Aetna Health Information Advantage.

- **Data Integration (Set-up)** – Our proposal assumes one historical medical and one historical pharmacy data integration feed. For an additional fee, historical medical and pharmacy data integration feeds may be added.

- **Data Integration (On-Going)** – Options and pricing for integrating claims data from an external vendor into one or more of our systems will vary depending on the scale of your integration needs.

- **Claims History Transfer (set up)** – These files are used to administer deductible and internal maximums. There is no cost associated with receiving claim history files electronically from the prior carrier for initial implementation. There will be a charge for files received in a format other than electronically; costs are based on the complexity and format of the data.

- **States' All payer Claims database (APCD) reporting** – Certain state regulations require insurance carriers to supply data relating to their fully insured products to that state's all payer claims database (APCD). As a result of a recent US Supreme Court ruling, and as a TPA for your self-funded plan, we are no longer required to submit self-funded plan health care claims data to states with APCDs.

  However, in some states, the law indicates that providing the data for self-funded plans is voluntary. In these circumstances, we won't provide your self-funded plan data to these states unless you inform us in writing that you wish us to do so.

  New Hampshire:
  Many states have passed laws requiring disclosure of health care claims data to all payer claims databases (APCDs). The data is used by the states for a variety of analytical purposes. You can find more information on APCDs at the APCD Council website at http://www.apcdcouncil.org/.

  In 2016, the U.S. Supreme Court ruled in Gobeille v. Liberty Mutual Insurance Co., that the Employee Retirement Income Security Act of 1974 (ERISA) prevents states from requiring self-insured plan sponsors to submit data to APCDs. As a result of this ruling, Aetna will not automatically submit your self-funded plan data to any state APCDs. If you wish to have your plan's date submitted to state APCDs, you will need to affirmatively opt in to this process by notifying your account manager. Please read the

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New Hampshire Department of Insurance specific message to companies with a business location including a branch location in New Hampshire.

Legislative & Regulatory Requirements

We believe this proposal to be compliant with all applicable state and federal laws, including health care reform.

- **Employer Reporting Requirements** – Under Internal Revenue Code (IRC) Section 6055 health insurance issuers, certain employers, government agencies and other entities that provide Minimum Essential Coverage (MEC) to individuals must report to the IRS information about the type and period of coverage and furnish related statements to covered individuals. This information is used by the IRS to administer the individual shared responsibility provision and by individuals to show compliance with the individual shared responsibility provision.

  IRC Section 6056 requires applicable large employers (those having employed an average of 50 or more full-time employees during the preceding calendar year) to report to the IRS information about the health care coverage they have offered and also furnish applicable statements to employees. The purpose is to allow the IRS to enforce the employer responsibility provisions.

  Self-funded employers will be responsible for collecting and reporting the information to both the IRS and their employee pursuant to their obligations under both Sections 6055 and 6056s. For the collection, they may use a combined form for their 6055 and 6056 reporting. Entities must file their 6055 and 6056 requirements with the IRS no later than February 28 of the year following coverage (if filing on paper) or March 31 if filing electronically. A statement must be furnished to individuals by January 31 of the year succeeding the calendar year to which the return relates.

- **Support for SBC Draft Documents** – At your request and expense, we'll provide assistance in connection with the preparation of draft Summary of Benefits and Coverage (SBC) documents subject to your direction, review and final approval. If we develop draft SBCs, they will be based on the benefits information you provide. We'll include plan design information in the draft SBC relating to products or services administered under your Agreement with us as well as any additional pharmacy or behavioral health carve out information you or your delegates provide. SBCs are not required for "retiree-only plans" as defined by the Affordable Care Act (ACA) and we won't be supporting generation of SBCs for "retiree-only plans."

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You are responsible for reviewing and approving any SBCs with your legal counsel. We have no responsibility or liability for the content or distribution of any of your SBCs, regardless of the role we have played in the preparation of the documents. The production of SBCs will not be subject to Service or Performance Guarantees.

The SBC must include statements about whether the plan or coverage provides minimum essential coverage (MEC) and if the coverage meets minimum value (MV) requirements.

Under the ACA, minimum value and minimum essential coverage determinations are your responsibility. We will include the MV and MEC statements in SBCs; however, we won't make the final MV or MEC determinations. We'll review the minimum value standard for the plans based on the minimum value calculator criteria provided by the Department of Health and Humans Services (HHS). We'll provide the SBC in editable format so you can update MV and MEC statements within the document to reflect your determination for each plan. We don't provide legal or tax advice, and suggest you consult with your legal and tax consultants when making determinations. We don't have responsibility or liability regarding the MV or MEC evaluation, regardless of the role we may have played in reviewing/producing the SBC documents.

- **Health Care Reform Disclosure** – We believe this proposal is intended to be compliant with healthcare reform.

  Under the federal health care reform legislation, health plans existing prior to the enactment of the Affordable Care Act may be "grandfathered" and not subject to **some** of the mandated benefits and reform provisions. Changes in your benefit design as well as your contribution strategy may affect grandfathering**.** You're required to notify us if your contribution rate changes for a grandfathered plan at any point during the plan year.

  We assume your plans are non-grandfathered.

  Except for specific and limited scenarios described as transitional rules in the health care reform legislation, if a plan's grandfathered status has been lost, it cannot be regained. If, after reviewing the grandfathering rules with your benefit consultant or counsel, you determine that your coverage could be or is grandfathered, and you want to retain grandfathered status, you should contact your Account Executive for further instructions.

- **Retiree Only Plan Status Certification** – Guidance issued by the Internal Revenue Service (IRS), and the U.S. Department of Labor (DOL), and Department of Health and

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Human Services (HHS) has indicated that "retiree only" plans are exempt from the benefit mandates under the ACA (Retiree only plans are subject to certain ACA fees and assessments). In order to demonstrate the establishment of a retiree only plan, a plan should maintain, separately from the plan for current (i.e., active) employees, a separate plan document and Summary Plan Description (SPD) and file a separate Form 5500. If you have a retiree only plan, and want to be considered exempt, please submit a retiree only certification form and required documentation to us.

The benefits and fees within this proposal are subject to change pending any required approvals or future guidance from state or federal regulatory agencies. If you have questions, please contact your Account Executive.
We reserve the right to modify products, services, rates and fees, in response to legislation, regulation or requests of government authorities resulting in changes to plan benefits and to recoup any material fees, costs, assessments, or taxes due to changes in the law even if no benefit or plan changes are mandated.

- **ACA Taxes and Fees – Notice of Self-Funded Group Health Plan's Financial Liability** – Any taxes or fees (assessments) related to the Affordable Care Act that apply to self-funded benefit plans will be your obligation.