Achieving health performance together

An Aetna Proposal for

State of Nebraska State Purchasing Bureau Solicitation Number: RFP 6102 Z1
TECHNICAL PROPRIETARY

August 2019

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Table of Contents

Executive Summary

Proposal Requirements
- Form A Bidder Contact Sheet
- Section I Procurement Procedure
- Section II Terms and Conditions
- Section III Contractor Duties
- Section IV Payment
- Section V Project Description and Scope of Work
- Request for Proposal for Contractual Services Form
- Confidential Information Disclosure

Questionnaire
- 6102 Z1, Attachment A Bidder Questionnaire

Plan Design
- Benefit Review Document
- WellNebraska Plan Choice POS II Plan Design - Incentive
- WellNebraska Plan Choice POS II Plan Design - Without Incentive
- Consumer Focused Plan HDHP Aetna Choice POS AHF HSA Plan Design
- Regular Plan Choice POS II Plan Design

Network Information – *Provided on CD ROM*
- Medical Provider Disruption
- Aetna Choice POS II GeoAccess
- Aetna Choice POS II AHF GeoAccess
- GeoAccess_Aetna_Pharmacy_Management2in5
- GeoAccess_Aetna_Pharmacy_Management2in20
- GeoAccess_CVS_Minute_Clinics_2in5
- GeoAccess_CVS_Minute_Clinics_2in20
- APM National Retail Network Disruption
- Aetna Standard Formulary Disruption

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Exhibits

- Implementation Solutions
- State Insurance License
- Certificate of Good Standing
- Litigation History Response
- Legal Deviations

Samples and Brochures – Provided on CD ROM

- 2019 Aetna Standard Formulary
- Account Team Resumes
- Aetna Financial Statements
- APM Sample Reports
- Centers of Excellence
- Clinical DUR Programs
- MASTER SERVICES AGREEMENT (MSA) - 5.15.19
- Prospective DUR Clinical Programs
- References
- Sample Administrative Services Agreement
- Sample Communication Materials
- Sample Reporting Package
- Aetna Disaster Recovery Plan
- Starter Drug Fill List
- Subcontractor Listing

We have provided Network Information as well as Samples & Brochures on CD-ROM.

Aetna's commitment to the State of Nebraska

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Collaboration and partnership with Aetna in the Nebraska community

We are invested in you and your community. We are transforming the consumer experience and this begins with creating a new front door to health care. With CVS, we can now improve the experience of our members. This means improved engagement, improved health outcomes and lower total health care costs.

Delivering for you:

- We are local. We live and work where you do.
- Dedicated Public and Labor sector, with more than 1,300 employees*** focused on meeting the unique Public and Labor needs
- We partner with quality, local health systems to drive collaborative care and access to high-quality care.
- Providing member-centric benefits for the state of Nebraska families no matter where they are on their health journey, so they can achieve their best health and live their best lives.

Investing in Nebraska

Since 1997, Aetna Foundation has contributed $11M in affordable housing and community investment†

We have over 1,200 employees and their families calling Nebraska home.

Community partner

In Nebraska, Aetna employees have volunteered more than 15K hours, valued at $380K††.

* As of April 2018.
** As of January 2019.
*** Aetna employees as of December 31, 2018.
†Affordable Housing Investments have generally been in the form of low income housing tax credit investments.
††Commercial medical membership as of September 30, 2018.
1 http//www.Nebraska.gov/

Personalizing support one member at a time

When we understand each individual, and where they are on their personal health journey, we can provide the right support at the right time. And by supporting the whole person, your people can live healthier lives.

Our proprietary tools help us find people in need of the most care and proactively reach out to them. In other words, we help find and address issues early, before health matters escalate.

Being proactive helps us encourage members to visit their provider for a check up. If plan members do not have a provider, we work with them to find a quality local resource and make an appointment. Plan members can build a relationship through one-on-one nurse support and take advantage of integrated digital care that extends to their entire family.

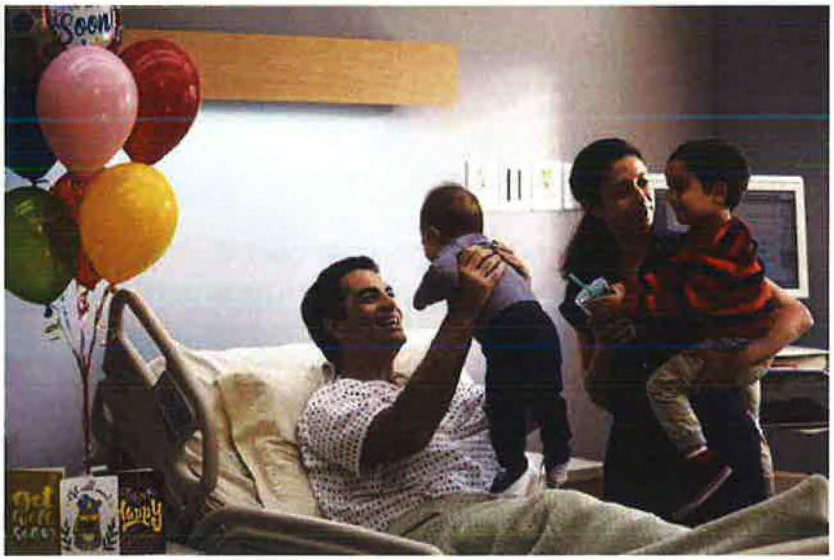
Personal care plans with health actions make it easier to manage her health. We've seen solid outcomes from our efforts:

- $5.71 – $20.02 PMPM savings[2]
- 96 percent member satisfaction[3]
- 10-18 percent identified[4]

Supporting care management with powerful resources

Personal Health Record

Our Personal Health Record (PHR) is a secure, online tool that allows eligible members to easily track and use important health information. PHRs make it easy to share this information with doctors, and deliver alerts and reminders to help members stay healthy and make more informed decisions.



2 Aetna In Touch Care (AITC) ranges across all programs, 2016. Results vary based on the program offered.
3 Survey of members who were enrolled in self-insured commercial plans with AITC Solutions during 2017.
4 Aetna In Touch Care (AITC) ranges across all programs, 2016. Results vary based on the program offered

Working with Nebraska's providers to offer the highest quality of care at an affordable rate

We work closely with **Catholic Health Initiatives (CHI)** to provide a product model ACO that delivers convenient access to high-quality care where members live and work.[5]

Nebraska Health Network (NHN) is another value based network in the Nebraska footprint that is available to your employees. Combined with CHI and NHN, you have convenient access, affordability and doctors they know and trust, your people can get the help and support they need, *when they need it*. Locally based accountable care helps members achieve healthier outcomes and helps you achieve higher levels of engagement.

Giving you more local touchpoints with CVS-Aetna

National strength, local presence

Positioned squarely behind our local support is our broad national network. It provides even more resources for your people. And because all health care is local, we immerse ourselves in your community. We tap into key demographic insights and expand beyond the doctor's office and emergency room to create care communities. We facilitate health wherever it's needed, like fitness centers and meal delivery services.

Paying for value, not volume with value-based care

You value innovation and forward thinking. So do we. Which is why our value-based contracting started with collaborations, advanced to the patient-centered medical home and now includes accountable care organization (ACO) plan designs. These are some of the most advanced and efficient systems in the country. And because they focus on value instead of volume, physicians and clinical staff are rewarded for healthy outcomes, rather than the number of patients they see. These full coordination models can lead to greater engagement and increased savings.

~45K

clinical professionals at CVS and Aetna, including pharmacists, nurse practitioners, community liaisons and social workers[7]

9,500

CVS and Aetna customer service staff to support our members[7]

24

CVS Pharmacy® locations in Nebraska[8]

1.2M

health care professionals[9]

690K

primary care doctors and specialists[9]

5 https://www.chihealth.com/

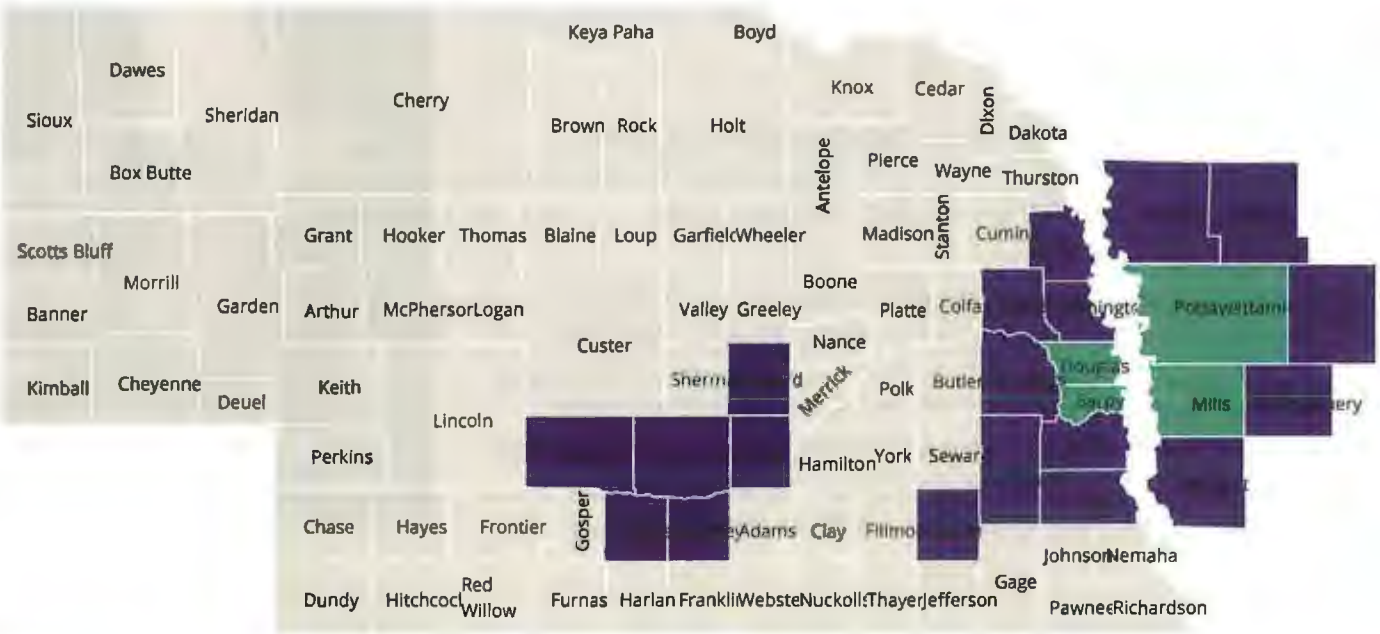
6 Based on the assumption that Aetna Whole Health℠ plan rates are 13 – 16 percent lower than broad network Aetna plans in the market. For illustrative purposes only. Actual results may vary.

7 CVS Health® and Aetna enterprise analytics 2018.

8 Aetna internal data, November 2018.

9 Aetna Facts. Information as of December 31, 2017. www.aetna.com/about-us/aetna-facts-and-subsidiaries/aetna-facts.html.

Aetna's commitment to Value Based Care in Nebraska



Catholic Health Initiative

Catholic Health Initiative & Nebraska Health Network

CHI - Serving **residents of Nebraska**, southwest Iowa and northern Kansas.

800+ PCP's

28 hospitals

150+ locations

13%-16% estimated savings[6]

72% of employees have access to CHI

Nebraska Health Network (NHN)- Serving **residents of Nebraska** and Iowa

425+ PCPs

10 hospitals

10% estimated savings[6]

Enhanced medical and pharmacy experience

We see pharmacy as more than simply dispensing drugs. With integrated pharmacy and medical benefits, you have greater insights to help your employees get and stay healthy through our:

- Seamless collaboration with providers
- Infusion site-of-care neutrality that directs members to low-cost care
- Earlier targeting and greater engagement of high-risk members, particularly through trusted interactions with CVS pharmacists
- Data sharing that enables more precise forecasting and risk projection

We've generated an average savings of $120K per member per year on infusion treatments.†††

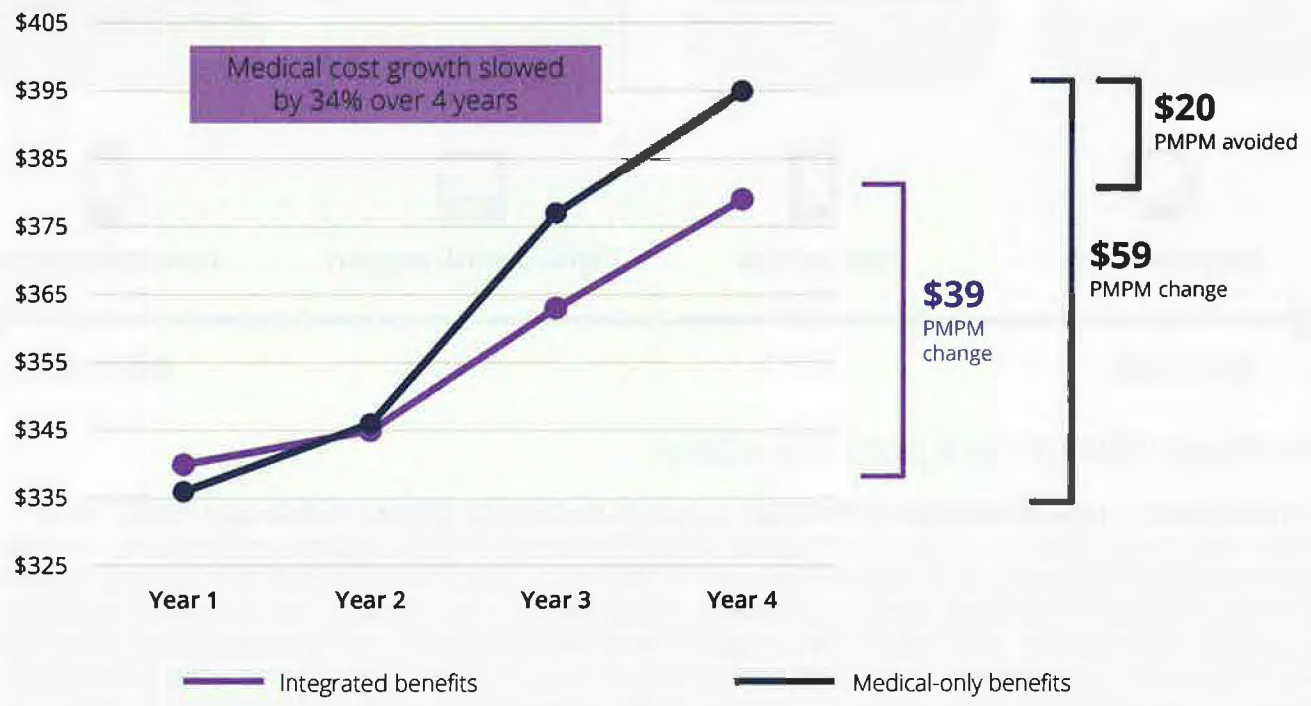
Strength in numbers

Our benefits work best when they're offered together. That's because we can make the most of real-time data to coordinate care and claims payment. And an overall view of benefits helps us better understand member needs. By integrating pharmacy benefits you can achieve $27 - $117 PMPM avoided in medical costs.[10]

Automated refill reminders and streamlined mail ordering can help medication adherence.

You get more with integration

Impact of integrating Aetna Pharmacy with medical, 2012–2015, PMPM[10]

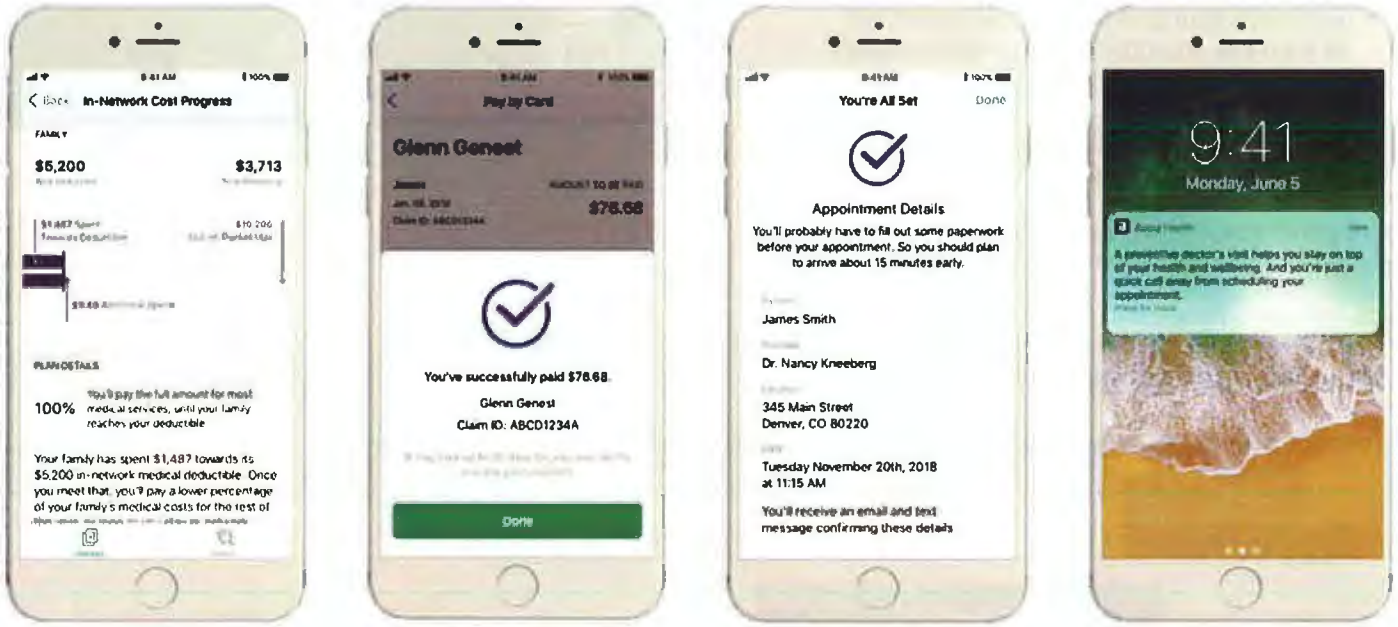


†††Aetna Site of Care program analysis, 2016.
10 Demonstrating the Value of Pharmacy & Medical Benefits Integration. Aetna, April 2017.

Bringing health care to you when you need it

It is our mission to keep healthy people healthy and to help those at risk reach their best health. So what makes us different? We do it *on the member's terms*. Our Aetna Health℠ platform provides members with an on-the-go, self-service single access point for personalized, real-time health information. We've packaged all of your digital tools, programs and resources neatly into one comprehensive experience. This includes personalized visuals and graphics that prompt member interest. It houses a health assessment, online health coaching programs and decision-support tools.

By helping your employees quickly and easily find a doctor, estimate costs, view claims and more, we help them manage every aspect of their health. With our integrated digital approach, we make health care more accessible. This leads to a better experience, improved outcomes and lower costs.



Personal touch **Self-service** **Digital health support** **Innovative tools**

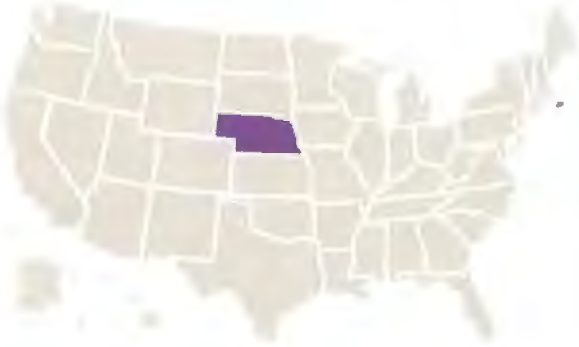
Live contact Self-service

Convenient quality care *from anywhere*

Your members can take advantage of 24/7/365 access to doctors by phone, mobile and video. These providers help resolve common physical and behavioral health issues by diagnosing illnesses, providing referrals and writing prescriptions as needed. In fact, only six percent of Teladoc™ consults require any follow-up visit, compared to 20 percent of ER visits.[10] Best of all, Teladoc is seamlessly integrated with our member website and the Aetna Health app through a single sign-on, so it's easy to get started. If a member searches for non-emergency symptoms, Teladoc displays in the search results. He or she can schedule and launch a consultation with Teladoc without leaving the app or website. This integrated approach helps improve outcomes, increase productivity and reduce your costs.

NOTE: Information is not based on actual member data.
Apple, the Apple logo, iPad, iPod, iPod touch and iPhone are trademarks of Apple Inc., registered in the U.S. and other countries.
App Store is a service mark of Apple Inc.
11 Study: Telehealth Expands Access to Health Care. Accessed on February 11, 2019.

Strong team support for the State of Nebraska



Think of your account team as an extension of your human resources department. We'll be by your side, every step of the way, helping you maximize the value of your benefits package.

Aetna account managers are creative thinkers, finding innovative ways to help you achieve your goals. A consultative relationship like ours supports your benefits strategy. And it helps you work proactively to engage your employees, improve outcomes and protect your bottom line.

Joining Nebraska state employees where they work

We are committed to providing the State of Nebraska with higi stations for 2020 and beyond. We will work with you to decide how to strategically place these machines to maximize the benefit for your members.

Higi stations measure:

- Blood Pressure
- Pulse
- Weight
- Height (self reported)
- Body Mass Index (BMI)

Monitoring these statistics together is key to early detection of hypertension, diabetes and other treatable health conditions. Higi stations are just one tool, of many, that help State of Nebraska members to get and stay healthy.

Let us show you how we can promote and preserve the health of your people with access to high-quality local care, one-to-one nurse support, integrated medical and pharmacy and strong savings opportunities.

Why Aetna?

It's all about you. We understand your goals and your population. We engage your members, help ease your administrative burden, and always find new and innovative ways to protect your bottom line.

Form A Bidder Contact Sheet

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Form A
Bidder Contact Sheet
Request for Proposal Number 6102 Z1

Form A should be completed and submitted with each response to this RFP. This is intended to provide the State with information on the bidder's name and address, and the specific person(s) who are responsible for preparation of the bidder's response.

Preparation of Response Contact Information	
Bidder Name:	Aetna Life Insurance Company
Bidder Address:	151 Farmington Avenue Hartford, CT 06156
Contact Person & Title:	Tami Polsonetti
E-mail Address:	PolsonettiT@aetna.com
Telephone Number (Office):	800-872-3862
Telephone Number (Cellular):	Not applicable
Fax Number:	860-273-3382

Each bidder should also designate a specific contact person who will be responsible for responding to the State if any clarifications of the bidder's response should become necessary. This will also be the person who the State contacts to set up a presentation/demonstration, if required.

Communication with the State Contact Information	
Bidder Name:	Aetna Life Insurance Company
Bidder Address:	151 Farmington Avenue Hartford, CT 06156
Contact Person & Title:	Michael Boden
E-mail Address:	mwboden@aetna.com
Telephone Number (Office):	402-618-7097
Telephone Number (Cellular):	402-618-7097
Fax Number:	866-602-1247

Section I Procurement Procedure

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Section I Procurement Procedure

I. PROCUREMENT PROCEDURE

A. GENERAL INFORMATION

The RFP is designed to solicit proposals from a qualified Bidder to provide Administrative Support Services for the State of Nebraska Employee Health Care Benefits Plans. Annual Open Enrollment for the State of Nebraska occurs in the month of May.

Proposals shall conform to all instructions, conditions, and requirements included in the RFP. Bidders should carefully examine all documents, schedules, and requirements in this RFP, and respond to each requirement in the format prescribed. Proposals may be found non-responsive if they do not conform to the RFP.

Noted.

B. PROCURING OFFICE AND COMMUNICATION WITH STATE STAFF AND EVALUATORS

Procurement responsibilities related to this RFP reside with the State Purchasing Bureau. The point of contact (POC) for the procurement is as follows:

Name:	Julie Schiltz/Teresa Fleming, Buyers
Agency:	State Purchasing Bureau
Address:	1526 K Street, Suite 130
	Lincoln, NE 68508
Telephone:	402-471-6500
E-Mail:	as.materielpurchasing@nebraska.gov

From the date the RFP is issued until the Intent to Award is issued, communication from the Bidder is limited to the POC listed above. After the Intent to Award is issued, the Bidder may communicate with individuals the State has designated as responsible for negotiating the contract on behalf of the State. No member of the State Government, employee of the State, or member of the Evaluation Committee is empowered to make binding statements regarding this RFP. The POC will issue any clarifications or opinions regarding this RFP in writing. Only the Buyer can modify the RFP, answer questions, render opinions, and only the SPB or awarding agency can award a contract. Bidders shall not have any communication with, or attempt to communicate or influence any evaluator involved in this RFP.

Section I Procurement Procedure

The following exceptions to these restrictions are permitted:

1. Contact made pursuant to pre-existing contracts or obligations;
2. Contact required by the schedule of events or an event scheduled later by the RFP POC; and
3. Contact required for negotiation and execution of the final contract.

The State reserves the right to reject a bidder's proposal, withdraw an Intent to Award, or terminate a contract if the State determines there has been a violation of these procurement procedures.

Noted.

C. SCHEDULE OF EVENTS

The State expects to adhere to the procurement schedule shown below, but all dates are approximate and subject to change.

ACTIVITY		DATE/TIME
1.	Release RFP	May 31, 2019
2.	Last day to submit written questions 1st Round	June 23, 2019
3.	State responds to written questions through RFP "Addendum" and/or "Amendment" to be posted at: http://das.nebraska.gov/materiel/purchasing.html	July 03, 2019
4.	Last day to submit written questions 2nd Round	July 14, 2019
5.	State responds to written questions through RFP "Addendum" and/or "Amendment" to be posted at: http://das.nebraska.gov/materiel/purchasing.html	July 19, 2019
6.	Proposal opening Location: State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508	August 08, 2019 2:00 PM Central Time
7.	Review for conformance to RFP requirements	August 08, 2019
8.	Evaluation period	August 14, 2019 through September 12, 2019
9.	"Oral Interviews/Presentations and/or Demonstrations" (if required)	TBD
10.	Post "Intent to Award" to at: http://das.nebraska.gov/materiel/purchasing.html	September 18, 2019
11.	Contract finalization period	September 18, 2019 through November 01, 2019
12.	Contract award	November 01, 2019
13.	Contractor start date	November 01, 2019
14.	Plan start date	July 01, 2020

Noted.

Section I Procurement Procedure

D. WRITTEN QUESTIONS AND ANSWERS

Questions regarding the meaning or interpretation of any RFP provision must be submitted in writing to the State Purchasing Bureau and clearly marked "RFP Number 6102 Z1; Administrative and Support Services for the State of Nebraska Employee Health Care Benefit Plans Questions". The POC is not obligated to respond to questions that are received late per the Schedule of Events.

Bidders should present, as questions, any assumptions upon which the Bidder's proposal is or might be developed. Proposals will be evaluated without consideration of any known or unknown assumptions of a bidder. The contract will not incorporate any known or unknown assumptions of a bidder.

It is preferred that questions be sent via e-mail to as.materielpurchasing@nebraska.gov, but may be delivered by hand or by U.S. Mail. It is recommended that Bidders submit questions using the following format.

RFP Section Reference	RFP Page Number	Question

Written answers will be posted at http://das.nebraska.gov/materiel/purchasing.html per the Schedule of Events.

Noted.

E. PRICES

Prices submitted on the cost proposal form shall remain fixed for the initial three (3) years of the contract. Any request for a price increase subsequent to the initial three (3) years of the contract shall not exceed three and a half percent (3.5%) of the previous Contract period. Increases will be cumulative across the remaining periods of the contract. Requests for an increase must be submitted in writing to the State Purchasing Bureau a minimum of six (6) months prior to the end of the current contract period. Documentation may be required by the State to support the price increase. The State reserves the right to deny any requested price increase. No price increases are to be billed to any State Agencies prior to written amendment of the contract by the parties.

Section I Procurement Procedure

The State shall receive fixed discounts throughout the initial contract period in addition to the optional periods. If further discounts are achieved, those discounts shall be passed on to the State. Discounts less than the fixed discounts in the initial contract shall not be allowed.

Noted

F. SECRETARY OF STATE/TAX COMMISSIONER REGISTRATION REQUIREMENTS (Statutory)

The Contractor must be authorized to transact business in the State of Nebraska and comply with all Nebraska Secretary of State Registration requirements. The bidder who is the recipient of an Intent to Award may be required to certify that it has complied and produce a true and exact copy of its current (within ninety (90) calendar days of the intent to award) Certificate or Letter of Good Standing, or in the case of a sole proprietorship, provide written documentation of sole proprietorship and complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html. This must be accomplished prior to execution of the contract.

Confirmed. We have provided a current Certificate of Good Standing from the CT Secretary of State's office with our RFP submission.

G. ETHICS IN PUBLIC CONTRACTING

The State reserves the right to reject bids, withdraw an intent to award or award, or terminate a contract if a bidder commits or has committed ethical violations, which include, but are not limited to:

1. Offering or giving, directly or indirectly, a bribe, fee, commission, compensation, gift, gratuity, or anything of value to any person or entity in an attempt to influence the bidding process;
2. Utilize the services of lobbyists, attorneys, political activists, or consultants to influence or subvert the bidding process;
3. Being considered for, presently being, or becoming debarred, suspended, ineligible, or excluded from contracting with any state or federal entity:
4. Submitting a proposal on behalf of another Party or entity; and

Section I Procurement Procedure

5. Collude with any person or entity to influence the bidding process, submit sham proposals, preclude bidding, fix pricing or costs, create an unfair advantage, subvert the bid, or prejudice the State.

The Bidder shall include this clause in any subcontract entered into for the exclusive purpose of performing this contract.

Bidder shall have an affirmative duty to report any violations of this clause by the Bidder throughout the bidding process, and throughout the term of this contract for the successful Bidder and their subcontractors.

Noted.

H. DEVIATIONS FROM THE REQUEST FOR PROPOSAL

The requirements contained in the RFP become a part of the terms and conditions of the contract resulting from this RFP. Any deviations from the RFP in Sections II through VI must be clearly defined by the bidder in its proposal and, if accepted by the State, will become part of the contract. Any specifically defined deviations must not be in conflict with the basic nature of the RFP, requirements, or applicable state or federal laws or statutes. "Deviation", for the purposes of this RFP, means any proposed changes or alterations to either the contractual language or deliverables within the scope of this RFP. The State discourages deviations and reserves the right to reject proposed deviations.

Noted.

I. SUBMISSION OF PROPOSALS

Bidders should submit one proposal marked on the first page: "ORIGINAL". If multiple proposals are submitted, the State will retain one copy marked "ORIGINAL" and destroy the other copies. The Bidder is solely responsible for any variance between the copies submitted. Proposal responses should include the completed Form A, "Bidder Contact Sheet". Proposals must reference the RFP number and be sent to the specified address. Please note that the address label should appear as specified in Section I B. on the face of each container or bidder's bid response packet. If a recipient phone number is required for delivery purposes, 402-471-6500 should be used. The RFP number should be included in all correspondence.

Section I Procurement Procedure

Emphasis should be concentrated on conformance to the RFP instructions, responsiveness to requirements, completeness, and clarity of content. If the bidder's proposal is presented in such a fashion that makes evaluation difficult or overly time consuming the State reserves the right to reject the proposal as non-conforming.

By signing the "Request for Proposal for Contractual Services" form, the bidder guarantees compliance with the provisions stated in this RFP.

The State shall not incur any liability for any costs incurred by bidders in replying to this RFP, in the demonstrations and/or oral presentations, or in any other activity related to bidding on this RFP.

The Technical and Cost Proposals should be packaged separately (loose-leaf binders are preferred) on standard 8 ½" by 11" paper, except that charts, diagrams and the like may be on fold-outs which, when folded, fit into the 8 ½" by 11" format. Pages may be consecutively numbered for the entire proposal, or may be numbered consecutively within sections. Figures and tables should be numbered and referenced in the text by that number. They should be placed as close as possible to the referencing text. The Technical Proposal should not contain any reference to dollar amounts. However, information such as data concerning labor hours and categories, materials, subcontracts and so forth, shall be considered in the Technical Proposal so that the bidder's understanding of the scope of work may be evaluated. The Technical Proposal shall disclose the bidder's technical approach in as much detail as possible, including, but not limited to, the information required by the Technical Proposal instructions.

Noted.

J. BID PREPARATION COSTS

The State shall not incur any liability for any costs incurred by Bidders in replying to this RFP, including any activity related to bidding on this RFP.

Noted.

Section I Procurement Procedure

K. FAILURE TO COMPLY WITH REQUEST FOR PROPOSAL

Violation of the terms and conditions contained in this RFP or any resultant contract, at any time before or after the award, shall be grounds for action by the State which may include, but is not limited to, the following:

1. Rejection of a bidder's proposal;
2. Withdrawal of the Intent to Award;
3. Withdrawal of the Award;
4. Termination of the resulting contract;
5. Legal action; and
6. Suspension of the bidder from further bidding with the State for the period of time relative to the seriousness of the violation, such period to be within the sole discretion of the State.

Noted.

L. BID CORRECTIONS

A bidder may correct a mistake in a bid prior to the time of opening by giving written notice to the State of intent to withdraw the bid for modification or to withdraw the bid completely. Changes in a bid after opening are acceptable only if the change is made to correct a minor error that does not affect price, quantity, quality, delivery, or contractual conditions. In case of a mathematical error in extension of price, unit price shall govern.

Noted.

Section I Procurement Procedure

M. LATE PROPOSALS

Proposals received after the time and date of the proposal opening will be considered late proposals. Late proposals will be returned unopened, if requested by the bidder and at bidder's expense. The State is not responsible for proposals that are late or lost regardless of cause or fault.

Noted.

N. PROPOSAL OPENING

The opening of proposals will be public and the bidders will be announced. Proposals **WILL NOT** be available for viewing by those present at the proposal opening. Vendors may contact the State to schedule an appointment for viewing proposals after the Intent to Award has been posted to the website. Once proposals are opened, they become the property of the State of Nebraska and will not be returned.

Noted.

Section I Procurement Procedure

O. REQUEST FOR PROPOSAL/PROPOSAL REQUIREMENTS

The proposals will first be examined to determine if all requirements listed below have been addressed and whether further evaluation is warranted. Proposals not meeting the requirements may be rejected as non-responsive. The requirements are:

1. Original Request for Proposal for Contractual Services form signed using an indelible method;
2. Clarity and responsiveness of the proposal;
3. Completed Corporate Overview (Attachment A Bidder Questionnaire);
4. Completed Sections II through VI;
5. Completed Technical Approach (Attachment A Bidder Questionnaire); and
6. Completed State Cost Proposal Template.

Noted.

P. EVALUATION COMMITTEE

Proposals are evaluated by members of an Evaluation Committee(s). The Evaluation Committee(s) will consist of individuals selected at the discretion of the State. Names of the members of the Evaluation Committee(s) will not be published prior to the intent to award.

Any contact, attempted contact, or attempt to influence an evaluator that is involved with this RFP may result in the rejection of this proposal and further administrative actions.

Noted.

Q. EVALUATION OF PROPOSALS

All proposals that are responsive to the RFP will be evaluated. Each evaluation category will have a maximum point potential. The State will conduct a fair, impartial, and comprehensive evaluation of all proposals in accordance with the criteria set forth below. Areas that will be addressed and scored during the evaluation include:

1. Corporate Overview:
2. Technical Approach; and,
3. Cost Proposal.

Neb. Rev. Stat. §73-107 allows for a preference for a resident disabled veteran or business located in a designated enterprise zone. When a state contract is to be awarded to the lowest responsible bidder, a resident disabled veteran or a business located in a designated enterprise zone under the Enterprise Zone Act shall be allowed a preference over any other resident or nonresident bidder, if all other factors are equal.

Resident disabled veterans means any person (a) who resides in the State of Nebraska, who served in the United States Armed Forces, including any reserve component or the National Guard, who was discharged or otherwise separated with a characterization of honorable or general (under honorable conditions), and who possesses a disability rating letter issued by the United States Department of Veterans Affairs establishing a service-connected disability or a disability determination from the United States Department of Defense and (b)(i) who owns and controls a business or, in the case of a publicly owned business, more than fifty percent of the stock is owned by one or more persons described in subdivision (a) of this subsection and (ii) the management and daily business operations of the business are controlled by one or more persons described in subdivision(a) of this subsection. Any contract entered into without compliance with this section shall be null and void.

Section I Procurement Procedure

Therefore, if a resident disabled veteran or business located in a designated enterprise zone submits a proposal in accordance with Neb. Rev. Stat. §73-107 and has so indicated on the RFP cover page under "Bidder must complete the following" requesting priority/preference to be considered in the award of this contract, the following will need to be submitted by the vendor within ten (10) business days of request:

1. Documentation from the United States Armed Forces confirming service;
2. Documentation of discharge or otherwise separated characterization of honorable or general (under honorable conditions);
3. Disability rating letter issued by the United States Department of Veterans Affairs establishing a service-connected disability or a disability determination from the United States Department of Defense; and
4. Documentation which shows ownership and control of a business or, in the case of a publicly owned business, more than fifty percent of the stock is owned by one or more persons described in subdivision (a) of this subsection; and the management and daily business operations of the business are controlled by one or more persons described in subdivision (a) of this subsection.

Failure to submit the requested documentation within ten (10) business days of notice will disqualify the bidder from consideration of the preference.

Evaluation criteria will be released with the RFP.

Noted.

Section I Procurement Procedure

R. ORAL INTERVIEWS/PRESENTATIONS AND/OR DEMONSTRATIONS

The State may determine after the completion of the Technical and Cost Proposal evaluation that oral interviews/presentations and/or demonstrations are required. Every bidder may not be given an opportunity to interview/present and/or give demonstrations; the State reserves the right, in its discretion, to select only the top scoring bidders to present/give oral interviews. The scores from the oral interviews/presentations and/or demonstrations will be added to the scores from the Technical and Cost Proposals. The presentation process will allow the bidders to demonstrate their proposal offering, explaining and/or clarifying any unusual or significant elements related to their proposals. Bidders' key personnel, identified in their proposal, may be requested to participate in a structured interview to determine their understanding of the requirements of this proposal, their authority and reporting relationships within their firm, and their management style and philosophy. Only representatives of the State and the presenting bidder will be permitted to attend the oral interviews/presentations and/or demonstrations. A written copy or summary of the presentation, and demonstrative information (such as briefing charts, et cetera) may be offered by the bidder, but the State reserves the right to refuse or not consider the offered materials. Bidders shall not be allowed to alter or amend their proposals.

Once the oral interviews/presentations and/or demonstrations have been completed, the State reserves the right to make an award without any further discussion with the bidders regarding the proposals received.

Any cost incidental to the oral interviews/presentations and/or demonstrations shall be borne entirely by the bidder and will not be compensated by the State.

Noted.

Section I Procurement Procedure

S. BEST AND FINAL OFFER

If best and final offers (BAFO) are requested by the State and submitted by the bidder, they will be evaluated (using the stated BAFO criteria), scored, and ranked by the Evaluation Committee. The State reserves the right to conduct more than one Best and Final Offer. The award will then be granted to the highest scoring bidder. However, a bidder should provide its best offer in its original proposal. Bidders should not expect that the State will request a best and final offer.

Noted.

T. REFERENCE AND CREDIT CHECKS

The State reserves the right to conduct and consider reference and credit checks. The State reserves the right to use third parties to conduct reference and credit checks. By submitting a proposal in response to this RFP, the bidder grants to the State the right to contact or arrange a visit in person with any or all of the bidder's clients. Reference and credit checks may be grounds to reject a proposal, withdraw an intent to award, or rescind the award of a contract.

Confirmed.

U. AWARD

The State reserves the right to evaluate proposals and award contracts in a manner utilizing criteria selected at the State's discretion and in the State's best interest. After evaluation of the proposals, or at any point in the RFP process, the State of Nebraska may take one or more of the following actions:

1. Amend the RFP;
2. Extend the time of or establish a new proposal opening time;
3. Waive deviations or errors in the State's RFP process and in bidder proposals that are not material, do not compromise the RFP process or a bidder's proposal, and do not improve a bidder's competitive position;
4. Accept or reject a portion of or all of a proposal;
5. Accept or reject all proposals;
6. Withdraw the RFP;
7. Elect to rebid the RFP;

Section I Procurement Procedure

8. Award single lines or multiple lines to one or more bidders; or,
9. Award one or more all-inclusive contracts.

The RFP does not commit the State to award a contract. Once intent to award decision has been determined, it will be posted at:
http://das.nebraska.gov/materiel/purchasing.html

Grievance and protest procedure is available at:
http://das.nebraska.gov/materiel/purchasing.html

Any protests must be filed by a bidder within ten (10) business days after the intent to award decision is posted.

Noted.

Section II Terms and Conditions

aetna™

Section II Terms and Conditions

II. TERMS AND CONDITIONS

Bidders should complete Sections II through IV as part of their proposal. Bidder is expected to read the Terms and Conditions and should initial either accept, reject, or reject and provide alternative language for each clause. The bidder should also provide an explanation of why the bidder rejected the clause or rejected the clause and provided alternate language. By signing the RFP, bidder is agreeing to be legally bound by all the accepted terms and conditions, and any proposed alternative terms and conditions submitted with the proposal. The State reserves the right to negotiate rejected or proposed alternative language. If the State and bidder fail to agree on the final Terms and Conditions, the State reserves the right to reject the proposal. The State of Nebraska is soliciting proposals in response to this RFP. The State of Nebraska reserves the right to reject proposals that attempt to substitute the bidder's commercial contracts and/or documents for this RFP.

The bidders should submit with their proposal any license, user agreement, service level agreement, or similar documents that the bidder wants incorporated in the Contract. The State will not consider incorporation of any document not submitted with the bidder's proposal as the document will not have been included in the evaluation process. These documents shall be subject to negotiation and will be incorporated as addendums if agreed to by the Parties.

If a conflict or ambiguity arises after the Addendum to Contract Award have been negotiated and agreed to, the Addendum to Contract Award shall be interpreted as follows:

1. If only one Party has a particular clause then that clause shall control;
2. If both Parties have a similar clause, but the clauses do not conflict, the clauses shall be read together;
3. If both Parties have a similar clause, but the clauses conflict, the State's clause shall control.

Noted. Our Administrative Service Agreement will be the highest level of priority and would govern in the event of a conflict. Aetna is willing to work with the State of Nebraska to include any additional provisions the State would require in a contract between the parties.

Section II Terms and Conditions

A. GENERAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		tp	

The contract resulting from this RFP shall incorporate the following documents:

1. Request for Proposal and Addenda;
2. Amendments to the RFP;
3. Questions and Answers;
4. Contractor's proposal (RFP and properly submitted documents);
5. The executed Contract, and Addendum One to Contract (if applicable) ; and,
6. Amendments/Addendums to the Contract.

These documents constitute the entirety of the contract.

Unless otherwise specifically stated in a future contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to the executed Contract with the most recent dated amendment having the highest priority, 2) executed Contract and any attached Addenda, 3) Amendments to RFP and any Questions and Answers, 4) the original RFP document and any Addenda, and 5) the Contractor's submitted Proposal.

Any ambiguity or conflict in the contract discovered after its execution, not otherwise addressed herein, shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

We can agree as long as the Administrative Services Contract between the parties is at the highest level of priority and governs in the event of any conflict between these documents. Further, any of Aetna's responses to the listed documents take precedence over the initially submitted copies of these documents. The order of precedence would be as follows:

Section II Terms and Conditions

1. ASC Agreement
2. Aetna's response to the RFP, Notice of Intent of Contract, etc.
3. Any change the customer makes to the RFP.

B. NOTIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
tp			

Contractor and State shall identify the contract manager who shall serve as the point of contact for the executed contract.

Noted. Michael Boden is the Account Representative.

C. GOVERNING LAW (Statutory)

Notwithstanding any other provision of this contract, or any amendment or addendum(s) entered into contemporaneously or at a later time, the parties understand and agree that, (1) the State of Nebraska is a sovereign state and its authority to contract is therefore subject to limitation by the State's Constitution, statutes, common law, and regulation; (2) this contract will be interpreted and enforced under the laws of the State of Nebraska; (3) any action to enforce the provisions of this agreement must be brought in the State of Nebraska per state law; (4) the person signing this contract on behalf of the State of Nebraska does not have the authority to waive the State's sovereign immunity, statutes, common law, or regulations; (5) the indemnity, limitation of liability, remedy, and other similar provisions of the final contract, if any, are entered into subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity; and, (6) all terms and conditions of the final contract, including but not limited to the clauses concerning third party use, licenses, warranties, limitations of liability, governing law and venue, usage verification, indemnity, liability, remedy or other similar provisions of the final contract are entered into specifically subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity.

Section II Terms and Conditions

The Parties must comply with all applicable local, state and federal laws, ordinances, rules, orders, and regulations.

Agreed.

D. BEGINNING OF WORK

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
tp			

The bidder shall not commence any billable work until a valid contract has been fully executed by the State and the successful Contractor. The Contractor will be notified in writing when work may begin.

Noted and Agreed.

E. CHANGE ORDERS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
tp			

The State and the Contractor, upon the written agreement, may make changes to the contract within the general scope of the RFP. Changes may involve specifications, the quantity of work, or such other items as the State may find necessary or desirable. Corrections of any deliverable, service, or work required pursuant to the contract shall not be deemed a change. The Contractor may not claim forfeiture of the contract by reasons of such changes.

Section II Terms and Conditions

The Contractor shall prepare a written description of the work required due to the change and an itemized cost sheet for the change. Changes in work and the amount of compensation to be paid to the Contractor shall be determined in accordance with applicable unit prices if any, a pro-rated value, or through negotiations. The State shall not incur a price increase for changes that should have been included in the Contractor's proposal, were foreseeable, or result from difficulties with or failure of the Contractor's proposal or performance.
No change shall be implemented by the Contractor until approved by the State, and the Contract is amended to reflect the change and associated costs, if any. If there is a dispute regarding the cost, but both parties agree that immediate implementation is necessary, the change may be implemented, and cost negotiations may continue with both Parties retaining all remedies under the contract and law.

Noted.

F. NOTICE OF POTENTIAL CONTRACTOR BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
tp			

If Contractor breaches the contract or anticipates breaching the contract, the Contractor shall immediately give written notice to the State. The notice shall explain the breach or potential breach, a proposed cure, and may include a request for a waiver of the breach if so desired. The State may, in its discretion, temporarily or permanently waive the breach. By granting a waiver, the State does not forfeit any rights or remedies to which the State is entitled by law or equity, or pursuant to the provisions of the contract. Failure to give immediate notice, however, may be grounds for denial of any request for a waiver of a breach.

Noted.

Section II Terms and Conditions

G. BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
	tp		

Either Party may terminate the contract, in whole or in part, if the other Party breaches its duty to perform its obligations under the contract in a timely and proper manner. Termination requires written notice of default and a thirty (30) calendar day (or longer at the non-breaching Party's discretion considering the gravity and nature of the default) cure period. Said notice shall be delivered by Certified Mail, Return Receipt Requested, or in person with proof of delivery. Allowing time to cure a failure or breach of contract does not waive the right to immediately terminate the contract for the same or different contract breach which may occur at a different time. In case of default of the Contractor, the State may contract the service from other sources and hold the Contractor responsible for any excess cost occasioned thereby.

The State's failure to make payment shall not be a breach, and the Contractor shall retain all available statutory remedies and protections.

Noted. Unless otherwise agreed or required by law, either party can cancel by sending a written notice to the other at least 31 days in advance. We can terminate the arrangement sooner under certain circumstances. These include the enactment of new laws or regulations that do not allow us to write such a plan or the failure of the customer to pay amounts owed when due, or within any applicable grace period. Termination requirements are the same regardless if the plan terminates on or off anniversary.

Section II Terms and Conditions

H. NON-WAIVER OF BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
tp			

The acceptance of late performance with or without objection or reservation by a Party shall not waive any rights of the Party nor constitute a waiver of the requirement of timely performance of any obligations remaining to be performed.

Noted.

I. SEVERABILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
tp			

If any term or condition of the contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the contract did not contain the provision held to be invalid or illegal.

Noted.

Section II Terms and Conditions

J. INDEMNIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
	tp		

1. **GENERAL**

The Contractor agrees to defend, indemnify, and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all third party claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State for personal injury, death, or property loss or damage, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Contractor, its employees, Subcontractors, consultants, representatives, and agents, resulting from this contract, except to the extent such Contractor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

Your Indemnification language is generally acceptable. However, we wish to clarify the following:

(1) Aetna can agree to indemnify the State of Nebraska on a comparative negligence theory, but we are not prepared to indemnify the State for 100% of a loss if Aetna is only partially at fault. As such, the words "that portion of" should be inserted before "any and all third claims" in the first line.

(2) Consistent with the last comment, a standard of care should be introduced so that Aetna would only be liable for conduct deemed to be negligent. We are prepared to discuss other formulations of the standard of care, but we do not believe it is appropriate to omit the standard of care altogether in this paragraph.

Section II Terms and Conditions

(3) Neither the State of Nebraska nor Aetna is responsible for the health care delivered by health care providers, whether network or non-network. The indemnification obligation set forth above would not apply to any portion of any claim, demand or legal action caused by the acts or omissions of health care providers with respect to Members.

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2. **INTELLECTUAL PROPERTY**

The Contractor agrees it will, at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Contractor or its employees, Subcontractors, consultants, representatives, and agents; provided, however, the State gives the Contractor prompt notice in writing of the claim. The Contractor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Contractor has indemnified the State, the Contractor shall, at the Contractor's sole cost and expense, promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Contractor, and the State may receive the remedies provided under this RFP.

Aetna can agree to indemnify the State of Nebraska for all costs, expenses, judgments, and damages that the City may have to pay or incur, and would like to clarify that this obligation of indemnification will not apply where the State has modified or misused the equipment, hardware or software and the claim of infringement, is based on the modification or misuse.

Section II Terms and Conditions

3. **PERSONNEL**
The Contractor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel, including subcontractor's and their employees, provided by the Contractor.

Noted and agreed.

4. **SELF-INSURANCE**
The State of Nebraska is self-insured for any loss and purchases excess insurance coverage pursuant to Neb. Rev. Stat. § 81-8,239.01 (Reissue 2008). If there is a presumed loss under the provisions of this agreement, Contractor may file a claim with the Office of Risk Management pursuant to Neb. Rev. Stat. §§ 81-8,829 – 81-8,306 for review by the State Claims Board. The State retains all rights and immunities under the State Miscellaneous (Section 81-8,294), Tort (Section 81-8,209), and Contract Claim Acts (Section 81-8,302), as outlined in Neb. Rev. Stat. § 81-8,209 et seq. and under any other provisions of law and accepts liability under this agreement to the extent provided by law.

Noted.

5. The Parties acknowledge that Attorney General for the State of Nebraska is required by statute to represent the legal interests of the State, and that any provision of this indemnity clause is subject to the statutory authority of the Attorney General.

Noted.

Section II Terms and Conditions

K. ATTORNEY'S FEES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		tp	

In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Parties agree to pay all expenses of such action, as permitted by law and if order by the court, including attorney's fees and costs, if the other Party prevails.

We agree to pay attorney fees under our obligation of indemnification, but we would look to the court to determine which party is responsible for attorney fees in all other matters.

Section II Terms and Conditions

L. PERFORMANCE BOND

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
tp			

The Contractor will be required to supply a bond executed by a corporation authorized to contract surety in the State of Nebraska, payable to the State of Nebraska, which shall be valid for the life of the contract to include any renewal and/or extension periods. The amount of the bond must be $1,500,000.00. The bond will guarantee that the Contractor will faithfully perform all requirements, terms and conditions of the contract. Failure to comply shall be grounds for forfeiture of the bond as liquidated damages. Amount of forfeiture will be determined by the agency based on loss to the State. The bond will be returned when the service has been satisfactorily completed as solely determined by the State, after termination or expiration of the contract.

Noted.

M. ASSIGNMENT, SALE, OR MERGER

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
tp			

Either Party may assign the contract upon mutual written agreement of the other Party. Such agreement shall not be unreasonably withheld.

Section II Terms and Conditions

The Contractor retains the right to enter into a sale, merger, acquisition, internal reorganization, or similar transaction involving Contractor's business. Contractor agrees to cooperate with the State in executing amendments to the contract to allow for the transaction. If a third party or entity is involved in the transaction, the Contractor will remain responsible for performance of the contract until such time as the person or entity involved in the transaction agrees in writing to be contractually bound by this contract and perform all obligations of the contract.

Noted.

N. CONTRACTING WITH OTHER NEBRASKA POLITICAL SUB-DIVISIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
tp			

The Contractor may, but shall not be required to, allow agencies, as defined in Neb. Rev. Stat. §81-145, to use this contract. The terms and conditions, including price, of the contract may not be amended. The State shall not be contractually obligated or liable for any contract entered into pursuant to this clause. A listing of Nebraska political subdivisions may be found at the website of the Nebraska Auditor of Public Accounts.

Aetna's fees/premiums quoted are unique to the State of Nebraska and cannot be extended. We would be pleased to work with other governmental entities to determine whether these terms can be extended to them, but each case would need to be individually underwritten.

Section II Terms and Conditions

O. FORCE MAJEURE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
tp			

Neither Party shall be liable for any costs or damages, or for default resulting from its inability to perform any of its obligations under the contract due to a natural or manmade event outside the control and not the fault of the affected Party ("Force Majeure Event"). The Party so affected shall immediately make a written request for relief to the other Party, and shall have the burden of proof to justify the request. The other Party may grant the relief requested; relief may not be unreasonably withheld. Labor disputes with the impacted Party's own employees will not be considered a Force Majeure Event.

Noted.

P. CONFIDENTIALITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
tp			

All materials and information provided by the Parties or acquired by a Party on behalf of the other Party shall be regarded as confidential information. All materials and information provided or acquired shall be handled in accordance with federal and state law, and ethical standards. Should said confidentiality be breached by a Party, the Party shall notify the other Party immediately of said breach and take immediate corrective action.

Section II Terms and Conditions

It is incumbent upon the Parties to inform their officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable by 5 U.S.C. 552a (m)(1), provides that any officer or employee, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

Noted.

Q. EARLY TERMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
tp			

The contract may be terminated as follows:

1. The State and the Contractor, by mutual written agreement, may terminate the contract at any time.

2. The State, in its sole discretion, may terminate the contract for any reason upon thirty (30) calendar day's written notice to the Contractor. Such termination shall not relieve the Contractor of warranty or other service obligations incurred under the terms of the contract. In the event of termination the Contractor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.

3. The State may terminate the contract immediately for the following reasons:
   a. if directed to do so by statute;
   b. Contractor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business;

Section II Terms and Conditions

c. a trustee or receiver of the Contractor or of any substantial part of the Contractor's assets has been appointed by a court;

d. fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Contractor, its employees, officers, directors, or shareholders;

e. an involuntary proceeding has been commenced by any Party against the Contractor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) the Contractor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Contractor has been decreed or adjudged a debtor;

f. a voluntary petition has been filed by the Contractor under any of the chapters of Title 11 of the United States Code;

g. Contractor intentionally discloses confidential information;

h. Contractor has or announces it will discontinue support of the deliverable; and,

i. In the event funding is no longer available.

Unless otherwise agreed or required by law, either party can cancel by sending a written notice to the other at least 30 days in advance. We can terminate the arrangement sooner under certain circumstances. These include the enactment of new laws or regulations that do not allow us to write such a plan or the failure of the customer to pay amounts owed when due, or within any applicable grace period. Termination requirements are the same regardless if the plan terminates on or off anniversary.

Section II Terms and Conditions

R. CONTRACT CLOSEOUT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
tp			

Upon contract closeout for any reason the Contractor shall within 30 days, unless stated otherwise herein:

1. Transfer all completed or partially completed deliverables to the State;
2. Transfer ownership and title to all completed or partially completed deliverables to the State;
3. Return to the State all information and data, unless the Contractor is permitted to keep the information or data by contract or rule of law. Contractor may retain one copy of any information or data as required to comply with applicable work product documentation standards or as are automatically retained in the course of Contractor's routine back up procedures;
4. Cooperate with any successor Contactor, person or entity in the assumption of any or all of the obligations of this contract;
5. Cooperate with any successor Contactor, person or entity with the transfer of information or data related to this contract;
6. Return or vacate any state owned real or personal property;
7. Return all data in a mutually acceptable format and manner;
    a. Contractor must provide, at no additional cost to the State, up to five (5) files of historical data, for three (3) previous contract years, to any new vendor(s) selected by the State immediately following notification of termination and must be complete within ninety (90) days of notification.
    b. Contractor must agree to include a clause to the effect that, upon contract termination, the cost of any work required by a new Contractor to bring records in unsatisfactory condition up to date shall be the obligation of Contractor and Contractor shall reimburse such expenses.

Section II Terms and Conditions

8. All records (including the provisions of service, participant and data processing documents) shall become the property and be provided to the State of Nebraska at no additional cost to the State; and,
9. All records that are the property of the State will be returned to the State within thirty (30) days.

Nothing in this Section should be construed to require the Contractor to surrender intellectual property, real or personal property, or information or data owned by the Contractor for which the State has no legal claim.

Noted.

Section III Contractor Duties

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Section III Contractor Duties

III. CONTRACTOR DUTIES

A. INDEPENDENT CONTRACTOR / OBLIGATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
	tp		

It is agreed that the Contractor is an independent contractor and that nothing contained herein is intended or should be construed as creating or establishing a relationship of employment, agency, or a partnership.

The Contractor is solely responsible for fulfilling the contract. The Contractor or the Contractor's representative shall be the sole point of contact regarding all contractual matters.

The Contractor shall secure, at its own expense, all personnel required to perform the services under the contract. The personnel the Contractor uses to fulfill the contract shall have no contractual or other legal relationship with the State; they shall not be considered employees of the State and shall not be entitled to any compensation, rights or benefits from the State, including but not limited to, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

By-name personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State. Replacement of these personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

All personnel assigned by the Contractor to the contract shall be employees of the Contractor or a subcontractor, and shall be fully qualified to perform the work required herein. Personnel employed by the Contractor or a subcontractor to fulfill the terms of the contract shall remain under the sole direction and control of the Contractor or the subcontractor respectively.

Section III Contractor Duties

With respect to its employees, the Contractor agrees to be solely responsible for the following:

1. Any and all pay, benefits, and employment taxes and/or other payroll withholding;
2. Any and all vehicles used by the Contractor's employees, including all insurance required by state law;
3. Damages incurred by Contractor's employees within the scope of their duties under the contract;
4. Maintaining Workers' Compensation and health insurance that complies with state and federal law and submitting any reports on such insurance to the extent required by governing law; and
5. Determining the hours to be worked and the duties to be performed by the Contractor's employees.
6. All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination alleged against the Contractor, its officers, agents, or subcontractors or subcontractor's employees)

If the Contractor intends to utilize any subcontractor, the subcontractor's level of effort, tasks, and time allocation should be clearly defined in the bidder's proposal. The Contractor shall agree that it will not utilize any subcontractors not specifically included in its proposal in the performance of the contract without the prior written authorization of the State.

The State reserves the right to require the Contractor to reassign or remove from the project any Contractor or subcontractor employee.

Contractor shall insure that the terms and conditions contained in any contract with a subcontractor does not conflict with the terms and conditions of this contract.

The Contractor shall include a similar provision, for the protection of the State, in the contract with any Subcontractor engaged to perform work on this contract.

We use a variety of vendors to perform specific services and we require those vendors to meet all of our performance standards. Aetna is responsible for performance of all work under this agreement if done by Aetna or any one of Aetna's vendors. Because we subcontract on behalf of an entire book of business, we cannot agree to your specific language in our agreements.

Section III Contractor Duties

In lieu of proactively providing notice of a new or a change in subcontractors, Aetna can offer to provide the Tier 1 and Tier 2 subcontractor lists on a frequency requested by the client (not to exceed once/month). If clients note a new subcontractor on the lists, they can have the opportunity to discuss/object to Aetna's use of such subcontractor.

B. BUSINESS ASSOCIATE AGREEMENT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
tp			

Contractor will execute and be in full compliance with Attachment B Business Associate Agreement (BAA) with the State. Contractor acknowledges that it is compliant with the Electronic Data Interchange ("EDI"), Privacy and Security Rules of the Health Insurance Portability and Accountability Act ("HIPAA"), and will execute the appropriate Business Associate Agreement ("BAA") as provided by the State.

Agreed. We have included a signed copy of the Agreement with our RFP submission.

C. EMPLOYEE WORK ELIGIBILITY STATUS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
tp			

Section III Contractor Duties

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of an employee.

If the Contractor is an individual or sole proprietorship, the following applies:

1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html

   The completed United States Attestation Form should be submitted with the RFP response.

2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.

3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

Noted. Aetna complies with all state and federal requirements to verify a person's eligibility and authorization to work in the U.S. and does not knowingly employ anyone in the U.S. that is not authorized to work in the U.S.

Section III Contractor Duties

D. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION (Statutory)

The Contractor shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Contractors of the State of Nebraska, and their Subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensation, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §48-1101 to 48-1125). The Contractor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The Contractor shall insert a similar provision in all Subcontracts for services to be covered by any contract resulting from this RFP.

Noted. Aetna complies with all federal and state laws, regulations and executive orders requiring equal employment opportunity and affirmative action for women, minorities, veterans and people with disabilities. Aetna fully complies with Executive Order 11246 which requires government contractors to comply with Equal Employment Opportunity (EEO) laws and affirmative action regulations. Aetna's Equal Employment Opportunity and Anti-Harassment policies prohibit discrimination and harassment against individuals based on: race, color, ethnicity, sex, pregnancy, national origin, citizenship, ancestry, religion, age, disability, veteran status, military status, sexual orientation, gender identity and/or expression, marital or family status, genetic information.

Section III Contractor Duties

E. COOPERATION WITH OTHER CONTRACTORS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
tp			

Contractor may be required to work with or in close proximity to other contractors or individuals that may be working on same or different projects. The Contractor shall agree to cooperate with such other contractors or individuals, and shall not commit or permit any act which may interfere with the performance of work by any other contractor or individual. Contractor is not required to compromise Contractor's intellectual property or proprietary information unless expressly required to do so by this contract.

Noted.

Section III Contractor Duties

F. PERMITS, REGULATIONS, LAWS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
tp			

The contract price shall include the cost of all royalties, licenses, permits, and approvals, whether arising from patents, trademarks, copyrights or otherwise, that are in any way involved in the contract. The Contractor shall obtain and pay for all royalties, licenses, and permits, and approvals necessary for the execution of the contract. The Contractor must guarantee that it has the full legal right to the materials, supplies, equipment, software, and other items used to execute this contract.

Noted.

G. OWNERSHIP OF INFORMATION AND DATA / DELIVERABLES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
	tp		

The State shall have the unlimited right to publish, duplicate, use, and disclose all information and data developed or obtained by the Contractor on behalf of the State pursuant to this contract.

Section III Contractor Duties

All eligibility and claims records are the sole property of the State, and must be made available upon request to the State and its representatives. Selling of the State's data to ANY outside entities must be approved in advance, reported on a monthly basis and all income derived must be disclosed and shared per agreement with the State. Even if Contractor has not "sold" the data, they are NOT free to use the data for analyses that they publish or provide at a fee to outside industries.

The State shall own and hold exclusive title to any deliverable developed as a result of this contract. Contractor shall have no ownership interest or title, and shall not patent, license, or copyright, duplicate, transfer, sell, or exchange, the design, specifications, concept, or deliverable.

Aetna can agree if the Goods or Services are Customized, which means (i) based on the Customer's written specifications, (ii) paid for separately by the Customer to Aetna, and (iii) pursuant to a written statement of work signed by both parties.

H. INSURANCE REQUIREMENTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
	tp		**We have provided revisions and clarifications in the deviation grid with our RFP submission.**

The Contractor shall throughout the term of the contract maintain insurance as specified herein and provide the State a current Certificate of Insurance/Acord Form (COI) verifying the coverage. The Contractor shall not commence work on the contract until the insurance is in place. If Contractor subcontracts any portion of the Contract the Contractor must, throughout the term of the contract, either:

1. Provide equivalent insurance for each subcontractor and provide a COI verifying the coverage for the subcontractor;
2. Require each subcontractor to have equivalent insurance and provide written notice to the State that the Contractor has verified that each subcontractor has the required coverage; or,

Section III Contractor Duties

3. Provide the State with copies of each subcontractor's Certificate of Insurance evidencing the required coverage.

The Contractor shall not allow any Subcontractor to commence work until the Subcontractor has equivalent insurance. The failure of the State to require a COI, or the failure of the Contractor to provide a COI or require subcontractor insurance shall not limit, relieve, or decrease the liability of the Contractor hereunder.

In the event that any policy written on a claims-made basis terminates or is canceled during the term of the contract or within one (1) year of termination or expiration of the contract, the contractor shall obtain an extended discovery or reporting period, or a new insurance policy, providing coverage required by this contract for the term of the contract and one (1) year following termination or expiration of the contract.

If by the terms of any insurance a mandatory deductible is required, or if the Contractor elects to increase the mandatory deductible amount, the Contractor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

Notwithstanding any other clause in this Contract, the State may recover up to the liability limits of the insurance policies required herein.

1. **WORKERS' COMPENSATION INSURANCE**
The Contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the Contractor shall require the Subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the Subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. **The policy shall include a waiver of subrogation in favor of the State. The COI shall contain the mandatory COI subrogation waiver language found hereinafter.** The amounts of such insurance shall not be less than the limits stated hereinafter. For employees working in the State of Nebraska, the policy must be written by an entity authorized by the State of Nebraska Department of Insurance to write Workers' Compensation and Employer's Liability Insurance for Nebraska employees.

Section III Contractor Duties

2. **COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE**

The Contractor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Contractor and any Subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Contractor or by any Subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

The Commercial General Liability Insurance shall be written on an **occurrence basis**, and provide Premises/Operations, Products/Completed Operations, Independent Contractors, Personal Injury, and Contractual Liability coverage. **The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory. The COI shall contain the mandatory COI liability waiver language found hereinafter.** The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned, and Hired vehicles.

Section III Contractor Duties

REQUIRED INSURANCE COVERAGE	
COMMERCIAL GENERAL LIABILITY	
General Aggregate	$2,000,000
Products/Completed Operations Aggregate	$2,000,000
Personal/Advertising Injury	$1,000,000 per occurrence
Bodily Injury/Property Damage	$1,000,000 per occurrence
Medical Payments	$10,000 any one person
Damage to Rented Premises (Fire)	$300,000 each occurrence
Contractual	Included
Independent Contractors	Included
If higher limits are required, the Umbrella/Excess Liability limits are allowed to satisfy the higher limit.	
WORKER'S COMPENSATION	
Employers Liability Limits	$500K/$500K/$500K
Statutory Limits- All States	Statutory - State of Nebraska
Voluntary Compensation	Statutory
COMMERCIAL AUTOMOBILE LIABILITY	
Bodily Injury/Property Damage	$1,000,000 combined single limit
Include All Owned, Hired & Non-Owned Automobile liability	Included
Motor Carrier Act Endorsement	Where Applicable
UMBRELLA/EXCESS LIABILITY	
Over Primary Insurance	$5,000,000 per occurrence
PROFESSIONAL LIABILITY	
Professional liability (Medical Malpractice)	$10,000,000 per occurrence
Qualification Under Nebraska Excess Fund	$20,000,000 Aggregate
All Other Professional Liability (Errors & Omissions)	$1,000,000 Per Claim / Aggregate
COMMERCIAL CRIME	
Crime/Employee Dishonesty Including 3rd Party Fidelity	$2,000,000
CYBER LIABILITY	
Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties	$20,000,000
MANDATORY COI SUBROGATION WAIVER LANGUAGE	
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."	
MANDATORY COI LIABILITY WAIVER LANGUAGE	
"Commercial General Liability & Commercial Automobile Liability policies shall name the State of Nebraska as an Additional Insured and the policies shall be primary and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory as additionally insured."	

If the mandatory COI subrogation waiver language or mandatory COI liability waiver language on the COI states that the waiver is subject to, condition upon, or otherwise limit by the insurance policy, a copy of the relevant sections of the policy must be submitted with the COI so the State can review the limitations imposed by the insurance policy.

Section III Contractor Duties

3. **EVIDENCE OF COVERAGE**

The Contractor shall furnish the Contract Manager, with a certificate of insurance coverage complying with the above requirements prior to beginning work at:

Administrative Services
Attn: Wellness & Benefits Administrator
1526 K Street, Suite 110
Lincoln, NE 68508

These certificates or the cover sheet shall reference the RFP number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Contractor shall be responsible for all reasonable costs properly attributable thereto.

Reasonable notice of cancellation of any required insurance policy must be submitted to the contract manager as listed above when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

4. **DEVIATIONS**

The insurance requirements are subject to limited negotiation. Negotiation typically includes, but is not necessarily limited to, the correct type of coverage, necessity for Workers' Compensation, and the type of automobile coverage carried by the Contractor.

Section III Contractor Duties

I. ANTITRUST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
tp			

The Contractor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

Noted.

J. CONFLICT OF INTEREST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
tp			

By submitting a proposal, bidder certifies that no relationship exists between the bidder and any person or entity which either is, or gives the appearance of, a conflict of interest related to this Request for Proposal or project.

Bidder further certifies that bidder will not employ any individual known by bidder to have a conflict of interest nor shall bidder take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its contractual obligations hereunder or which creates an actual or appearance of conflict of interest.

Section III Contractor Duties

If there is an actual or perceived conflict of interest, bidder shall provide with its proposal a full disclosure of the facts describing such actual or perceived conflict of interest and a proposed mitigation plan for consideration. The State will then consider such disclosure and proposed mitigation plan and either approve or reject as part of the overall bid evaluation.

Confirmed. Pursuant to a search of our records, no employee has disclosed an affiliation of any sort with the State of Nebraska.

K. STATE PROPERTY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
tp			

The Contractor shall be responsible for the proper care and custody of any State-owned property which is furnished for the Contractor's use during the performance of the contract. The Contractor shall reimburse the State for any loss or damage of such property; normal wear and tear is expected.

Noted.

Section III Contractor Duties

L. SITE RULES AND REGULATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
tp			

The Contractor shall use its best efforts to ensure that its employees, agents, and Subcontractors comply with site rules and regulations while on State premises. If the Contractor must perform on-site work outside of the daily operational hours set forth by the State, it must make arrangements with the State to ensure access to the facility and the equipment has been arranged. No additional payment will be made by the State on the basis of lack of access, unless the State fails to provide access as agreed to in writing between the State and the Contractor.

Noted.

Section III Contractor Duties

M. ADVERTISING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
tp			

The Contractor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its services are endorsed or preferred by the State. Any publicity releases pertaining to the project shall not be issued without prior written approval from the State.

Noted.

N. NEBRASKA TECHNOLOGY ACCESS STANDARDS (Statutory)

Contractor shall review the Nebraska Technology Access Standards, found at https://nitc.nebraska.gov/standards/2-201.pdf and ensure that products and/or services provided under the contract are in compliance or will comply with the applicable standards to the greatest degree possible. In the event such standards change during the Contractor's performance, the State may create an amendment to the contract to request the contract comply with the changed standard at a cost mutually acceptable to the parties.

Aetna can agree, so long as both parties mutually agree on fees and Aetna has the right to approve changes that have a material impact.

Section III Contractor Duties

O. DISASTER RECOVERY/BACK UP PLAN

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
tp			

The Contractor shall have a disaster recovery and back-up plan, of which a copy should be provided upon request to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue services as specified under the specifications in the contract in the event of a disaster.

Noted. We have included a copy of our Disaster Backup and Recovery Plan with our RFP submission.

P. DRUG POLICY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
tp			

Contractor certifies it maintains a drug free work place environment to ensure worker safety and workplace integrity. Contractor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

Confirmed. Aetna's Drug and Alcohol policy complies with all the requirements of federal and various state Drug Free Workplace Acts.

Section IV Payment

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Section IV Payment

IV. PAYMENT

A. **PROHIBITION AGAINST ADVANCE PAYMENT (Statutory)**
Payments shall not be made until contractual deliverable(s) are received and accepted by the State.

Noted.

B. **TAXES (Statutory)**
The State is not required to pay taxes and assumes no such liability as a result of this solicitation. Any property tax payable on the Contractor's equipment which may be installed in a state-owned facility is the responsibility of the Contractor.

Noted.

C. **INVOICES**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		tp	At this time, invoices are not provided online. Invoices are not provided in an excel. Summary style invoices are provided with the ability of the State to adjust the number covered based on enrollment transactions. The State can self-bill or send their own payment support by providing this detail with their payment. Some additional information may be required or requested to be omitted due to personal health information.

Section IV Payment

			Discrepancies will be addressed with the customer after each months reconciliation; however, will not be provided in the same format as an invoice. Again, with summary style invoicing the customer can make adjustments. Invoices for fees are produced on a monthly basis separate from claims with a due date prior to the coverage effective date. For example, an invoice may produce 4/26 for coverage period 5/1-5/31 with a due date of 5/1 and grace period until 5/31.

Invoices for payments must be provided on a secure website with sufficient detail to support payment. The terms and conditions included in the Contractor's invoice shall be deemed to be solely for the convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been previously agreed to by the State as an amendment to the contract.

The Contractor's invoice(s) and detail will be posted on a monthly basis. The detail for the monthly invoice(s) will be provided in an Excel file and will contain the following information: Invoice Number, Invoice Date, Record Count, Agency, Plan, Tier, Employee Name, Coverage Dates, Social Security Number, ASO Fee Amount, Coverage Type, and Benefit Group. If applicable, it is acceptable for the Contractor to provide both the medical and pharmacy fees into one amount per employee. The Contractor will provide one invoice for the current monthly membership, then reconcile the membership every month, and provide another invoice for any adjustments for prior periods for any untimely membership terminations or additions.

Administrative Services Only (ASO) fees for medical and pharmacy benefits are required to be invoiced separately, from claims, and only after deliverables are received, meaning that administrative services must be billed after performance of the services, not in advance of provision of the services.

Section IV Payment

D. CLAIMS REIMBURSEMENT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
		tp	The State will use our SAMP account and can be requested daily. Notification will be just an aggregate amount no details that is provided by a separate report. Funding is expected to be initiated same day. We have two reports available that provide member level detail for recorded claims, the CDR (claim detail reporting) and TOW (Time of Wire). The CDR is a report that shows recorded items on a monthly basis. The TOW is a report that is provided for each funding request that is created. We do not have a daily report available – unless the State would receive requests daily. We have provided comments below on the requested reporting elements: **a.** Customer ID – Confirmed. **b.** Contract Number – Confirmed. **c.** Plan ID – Confirmed. **d.** Bank Account Number – The CDR does not include banking specific information. The TOW reports are set up at the wireline level. We do not have access to bank account info, but we do have the report by wireline which is how we group claims for the State requests. **e.** Transaction Date – Confirmed for claim incurred date. **f.** Transaction ID – Confirmed. **g.** Transaction Amount Check/Item Number – Confirmed.

Section IV Payment

			h. Employee Name – Confirmed. i. Dependent Name – The CDR does not include claimant name. The TOW includes claimant name. The Claimant's name is only available consistently for adjudicated claims; non claim items may or may not have the claimant name. j. Employee Social Security Number – This is not available on either report standardly. If the State requires this information we can provide an exception. k. Plan Code – We do not have plan level details on the report. l. Issue Date – The check issued date is included in both reports. m. Date of Service – The date of service is included in both reports. n. Work Date – If this is the date of adjudication, we do not have this in either reports. o. Book Month – Confirmed.

The Contractor will set up a bank account and have the capability for ACH. The Contractor will maintain and reconcile the bank account. The Contractor will be required to prefund the bank account, with their money. The Contractor will process the approved claims payments out of this account. Only after the approved payments have cleared this bank account, may the Contractor request reimbursement from the State. On a daily basis, the Contractor will e-mail a reimbursement notification to the State indicating the amount of the payments that have cleared the bank account the previous business day. The notification will also include other information for the bank account, i.e. customer number, ABA number, Bank Account number, etc. The State will provide reimbursement to the bank account, via ACH transfer, within three business days of receipt of the reimbursement notification request and the supporting detail. The bank account will be dedicated to the State of Nebraska. The ASO fees will be paid to a different bank account.

Section IV Payment

The daily claims reimbursement detail, which supports the reimbursement notification, will be posted to the Contractors secure website on a daily basis by 8:00 AM Central Time.

1. The daily cleared claims reimbursement request detail will be provided in an Excel format and will contain the following fields but not limited to:

   a. Customer ID
   b. Contract Number
   c. Plan ID
   d. Bank Account Number
   e. Transaction Date
   f. Transaction ID
   g. Transaction Amount Check/Item Number
   h. Employee Name
   i. Dependent Name
   j. Employee Social Security Number
   k. Plan Code
   l. Issue Date
   m. Date of Service
   n. Work Date
   o. Book Month

E. INSPECTION AND APPROVAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
tp			Agreed. Inspections shall be subject to mutual agreement as to nature, scope, format, structure and cost as applicable.

Final inspection and approval of all work required under the contract shall be performed by the designated State officials.

Section IV Payment

The State and/or its authorized representatives shall have the right to enter any premises where the Contractor or Subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

F. PAYMENT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
tp			Premium/fee payments are billed and due prior to the coverage effective date with a grace period of 31 days.

State will render payment to Contractor when the terms and conditions of the contract and specifications have been satisfactorily completed on the part of the Contractor as solely determined by the State. (Neb. Rev. Stat. Section 73-506(1)) Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408). The State may require the Contractor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any services provided by the Contractor prior to the Effective Date of the contract, and the Contractor hereby waives any claim or cause of action for any such services.

G. LATE PAYMENT (Statutory)

The Contractor may charge the responsible agency interest for late payment in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408).

We reserve the right to assess late payment fees.

Section IV Payment

H. SUBJECT TO FUNDING / FUNDING OUT CLAUSE FOR LOSS OF APPROPRIATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
tp			Agreed.

The State's obligation to pay amounts due on the Contract for a fiscal years following the current fiscal year is contingent upon legislative appropriation of funds. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal year(s) for which such funds are not appropriated. The State will give the Contractor written notice thirty (30) calendar days prior to the effective date of termination. All obligations of the State to make payments after the termination date will cease. The Contractor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Contractor be paid for a loss of anticipated profit.

Section IV Payment

I. RIGHT TO AUDIT (First Paragraph is Statutory)

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
	tp		We welcome independent audits of relevant records and documentation by the State and their representatives, provided no audit interferes with our business operations or the confidential interests of our company or another party. We have assumed for the purpose of this contract that an "audit" is defined as performing a review of claim transactions for the purpose of assessing the accuracy of benefit determinations and shall be subject to a mutual agreement as to nature, scope, format, structure and cost. We work from established audit guidelines that are accepted in this industry and we are confident we can meet your needs in this important area as well.

The State shall have the right to audit the Contractor's performance of this contract upon a 90 days' written notice. Contractor shall utilize generally accepted accounting principles, and shall maintain the accounting records, and other records and information relevant to the contract (Information) to enable the State to audit the contract. The State may audit and the Contractor shall maintain, the Information during the term of the contract and for a period of five (5) years after the completion of this contract or until all issues or litigation are resolved, whichever is later. The Contractor shall make the Information available to the State at Contractor's place of business or a location acceptable to both Parties during normal business hours. If this is not practical or the Contractor so elects, the Contractor may provide electronic or paper copies of the Information. The State reserves the right to examine, make copies of, and take notes on any Information relevant to this contract, regardless of the form or the Information, how it is stored, or who possesses the Information. Under no circumstance will the Contractor be required to create or maintain documents not kept in the ordinary course of contractor's business operations, nor will contractor be required to disclose any information, including but not limited to product cost data, which is confidential or proprietary to contractor.

Section IV Payment

The Parties shall pay their own costs of the audit unless the audit finds a previously undisclosed overpayment by the State. If a previously undisclosed overpayment exceeds one-half of one percent (.5%) of the total contract billings, or if fraud, material misrepresentations, or non-performance is discovered on the part of the Contractor, the Contractor shall reimburse the State for the total costs of the audit. Overpayments and audit costs owed to the State shall be paid within ninety days of written notice of the claim. The Contractor agrees to correct any material weaknesses or condition found as a result of the audit.

Section V Project Description and Scope of Work

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Section V Project Description and Scope of Work

V. PROJECT DESCRIPTION AND SCOPE OF WORK

A. PROJECT OVERVIEW

The State of Nebraska ("State") employs approximately 16,400 individuals and 12,845 are enrolled in health plans. These employees are primarily located throughout the State of Nebraska. The State allows both Union and non-Union employees to be enrolled in one of the three (3) State health plans. The State currently has the following self-insured medical plan designs:

1. Regular Plan
2. Consumer Focused Health Plan (with Health Savings Account Eligibility)
3. WellNebraska (with or without incentive)

The WellNebraska (with or without incentive) Plan Option allows any employee who is eligible to enroll in the WellNebraska Health Plan. However, employees and spouses (if applicable) who choose this option and who have met qualifications for wellness incentives through the State's WellNebraska program will benefit from reduced premiums and lower out-of-pocket costs for certain benefits.

The State currently has Contract 77103 O4 for Administrative and Support Services for the State of Nebraska Employee Health Care Benefits and Pharmacy Benefit Plans. This includes the administration of the Health Savings Account program and a Specialty Pharmacy Program.

Through the passage of Legislative Bill 1119, the Nebraska Legislature introduced the Direct Primary Care (DPC) Pilot Program Act, which allows for the establishment of the Direct Primary Care Pilot Program. The program, established within the Nebraska State Insurance Program, shall include at least two direct primary care health plans. These are plans, which include direct primary care services offered by a participating provider and health care coverage for medical specialists, hospitals, pharmacy and other medical coverage. Under the legislation, the non-direct primary health care coverage must include at least one high-deductible coverage option and one low deductible coverage option to provide major medical coverage to supplement the direct primary care services. The final bill was passed in the Nebraska Legislature and approved by the Governor of Nebraska on April 13, 2018. Please refer to Nebraska State Statute 84-1618 through 84-1627.

Section V Project Description and Scope of Work

Information about the current health plans offered to plan members is available at: http://das.nebraska.gov/benefits.html

Health Plans (Plan Options: Regular, Consumer Focused, and WellNebraska) and Pharmacy Benefits can be found at: http://das.nebraska.gov/Benefits/Active/healthplan-about.html

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Confirmed.

B. MEDICAL AND PHARMACY BENEFIT ADMINISTRATION FILES

In order to receive the Medical Administration and Pharmacy Benefit Administration files below, a signed Non-Disclosure Agreement (NDA) Attachment C must be emailed to JSlutzky@segalco.com. Data will NOT be released until the Bidder submits a signed agreement. Upon receipt of the signed NDA, the Bidder will receive the data via Segal's Secure File Transfer (SFT) server. Bidders must register to use the SFT site in order to obtain the data.

Medical Administration files are:

1. Census data for active employees, COBRA participants and pre-65 retirees;
2. Claims data for the most recent 12 month period;
3. Enrollment data for the most recent 36 month period;
4. Large loss information for the most recent 36 month period;

Pharmacy Benefit Administration files are:

1. Census data for active employees, COBRA participants and pre-65 retirees;
2. Claims data for the most recent 12-month period.

Confirmed.

C. ENROLLMENT

Following is a table representing State employee participation in each health plan by tier and is not an exact match to the Census Data:

Plan/Tier	Regular PPO	Wellness PPO with incentive	High Deductible Health Plan (CFHP)	Wellness without incentive	Total
Employee Only	1,723	3,380	676	168	5,947
Employee/Spouse	759	1,204	156	58	2,177
Employee/Child(ren)	403	1,211	152	92	1,858
Family	675	1,843	244	101	2,863
Total	3,560	7,638	1,228	419	12,845

Confirmed.

D. PROJECT OBJECTIVES

The objectives for the medical administration component are to obtain, related to the specified scope of services, employee and State staff satisfaction with the Contractor, assistance with controlling expenditures through negotiated provider reimbursement schedules, and emerging provider reimbursement methodologies. The Contractor shall perform the following services:

1. Provide complete administrative and support services for the medical administration including but not limited to:
    a. Access to nationwide network of providers with uniform quality of care and services;
    b. Cost effective contracting arrangements that can be demonstrated to represent direct savings to the State;
    c. Comprehensive set of medical management services
    d. Show strong financial stability
    e. Demonstrate innovative and quality-oriented medical claims administration
    f. Provide excellent communication services

Section V Project Description and Scope of Work

g. Provide superior account service to the State and excellent customer support to members

h. Provide seamless implementation of the program for the State and its members

i. Account Executive to be available at any time by phone or email and in-person meeting a minimum of once per week. Including but not limited to weekly in-person meetings, quarterly and annual reviews, open enrollment on-site meetings and additional contacts as needed.

Confirmed.

The objectives for the prescription benefit administration component are to obtain secure competitive pricing and fees for pharmacy benefit management services while maintaining and enhancing the quality of the pharmacy benefit plan and maximizing employee satisfaction. In addition, the State seeks clinical and utilization management programs that will be effective in reducing costs and waste while ensuring the highest quality patient care.

2. Provide complete administrative and support services for the prescription drug administration - including, but not limited to:

   a. Claims Adjudication
   b. Member Enrollment and Eligibility Maintenance
   c. ID Card Production and Distribution
   d. Patient and Provider Education
   e. Systematic Prospective, Concurrent and Retroactive Drug Utilization Review
   f. Account Management Services (including standard/custom reporting and online systems)
   g. Member Services (including call center, website and portal)
   h. Formulary Management and Rebate Sharing
   i. Clinical and Utilization Management Programs
   j. Network Pharmacy Management

Section V Project Description and Scope of Work

k. Mail Service Pharmacy
l. Specialty Pharmacy Program
m. Ability to share claims data with other State healthcare and data analytics vendors as needed

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Confirmed.

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3. Provide information about emerging trends in the pharmacy benefits industry and how they may be applied to the State's pharmacy benefits within the constraints of the State's ability to change plan design and employee contribution structures.

We expect 2020 trends to increase from 2019 trends due to continuing increased pressure from specialty drugs and reduced opportunities from generic launches:

- Generic – With generic AWP/inflation trend having minimal impact in recent years, generic trend is driven largely by utilization and drug mix. Generic trend in the past has helped offset brand cost trend; however, with fewer generic products in the pipeline than in the past, there is reduced opportunity to move brand market share to lower cost generics.

- Brand – While brand utilization trend remains negative, overall brand drug trend is pressured by AWP inflation driven by unregulated manufacturer price increases. Egregious pricing actions in particular can place significant pressure on brand cost trend.

- Specialty – Specialty trend continues to be pressured by a robust pipeline and manufacturers increasing prices at greater rates. Increasing spend on specialty products is further driven by increased utilization due to direct-to-consumer advertising, expanded indications, and new approvals of specialty drugs.

Section V Project Description and Scope of Work

What actions are we taking to manage future trends?

We offer multiple solutions to help support pharmacy trend management. These include our managed formulary options, additional formulary offerings such as our formulary exclusion list, our choose generics programs and quarterly formulary changes in order to quickly respond to market changes. Other solutions include regular monitoring and reporting of pharmacy fraud, waste and abuse; and employment of cost management strategies such as value based contracting and regular review of rebates to ensure best contracting.

- Formulary control – Formulary exclusions provide opportunity for extra savings for you and choice for members. Some high-cost drugs are exceedingly promoted to your employees. You can exclude these drugs from coverage to better control crowded drug classes.

- Generics – You can control pharmacy costs with Choose Generics. Your employees will pay the difference in costs if they choose brand drugs when generics are available. Employers can save an estimated 2.5% - 3.5% when implementing a generics first strategy.

- Trend monitoring – We use routine monitoring of various pharmacy dashboards and reporting to identify potential drivers of pharmacy trends in order to address these through quarterly formulary actions, rebate and value based contracting, or other cost management strategies
  - Weekly/Monthly reporting is used to monitor egregious and high impact manufacturer drug price increases
  - Monitoring of our monthly fraud, waste and abuse dashboard is used to identify potential gaming of the system as well as outlier pharmacies and physicians that can drive significant cost
  - Regular monitoring of trend dashboards in order to identify potential trend drivers at a class or drug level

Section V Project Description and Scope of Work

4. Provide an integrated system for processing retail, mail order and specialty pharmacy claims.

Confirmed.

5. Promptly process and fill all prescriptions submitted by the State's plan members. The Contractor must provide all prescription fulfillment and processing services for all covered members.

Confirmed.

6. Load all current Prior Authorizations, open mail order refills, open specialty refills, claim history files, and accumulator files that exist for current members from the existing Pharmacy Benefit Manager (PBM) at no charge to the State no later than the date of implementation of management by the Contractor. (No charge includes no charges being deducted from the implementation allowance for file loading or IT.)

Confirmed.

7. Mail order service notifying individual participating members and the State or its designee prior to substituting products that will result in a higher member copayment.

Confirmed.

Section V Project Description and Scope of Work

E. SUBROGATION REQUIREMENT

Contractor shall enforce the State's right to seek recovery based on subrogation or other theories from third parties, or other insurance carriers, who have caused injury or illness to a covered person or damages to the plan, except when said third party is the State of Nebraska. Contractor shall provide subrogation recovery service at no additional charge to the State. Contractor may engage a subcontractor to perform specialized services for recovery of funds or discovery of overpayment or fraud. If any subrogation services are subcontracted by contractor, approval of subcontractors and contract terms must be obtained from the State prior to contractor entering into an agreement with any such subcontractor(s). Such subcontractors may be reimbursed based on a reasonable basis other than percent of recovery, but cost of such subcontractors shall be the responsibility of contractor and shall not be deducted from the subrogated amount. The Contractor shall obtain the approval of the State for any subrogation claim that is less than 100% of the State's loss, and shall obtain the State's approval of all settlements. In the event that the State is a party to litigation regarding any such claims, settlement or release of such claims must be approved by the State. This authority regarding recoveries from third parties or their carriers includes participation in consolidated or class action lawsuits alleging such injuries, if authorized by the State. Any recovery from consolidated or class action suits will be apportioned among all insured and self-insured plans or pools in like manner. The proration may be based on number of covered persons, number of injured persons, claims volume, or any other basis determined by contractor and approved by the State. Recoveries made in the same plan year as the original claim payments are made, will be applied to the State's claims liability by immediate credit to the State. Recoveries made in subsequent years will be credited in total to the State's claim liability at the time recovery is made. The State agrees to cooperate with all such recovery efforts.

Subrogation services will not incur an increase to the billed administrative fee. However, subrogation does result in the retention of 37.5% of recovered amounts. We charge the fee to your account through the claims reporting process. The result on the claims detail report is a credit for the gross recovery costs.

Section V Project Description and Scope of Work

F. MEDICAL PLAN DESIGN

At a minimum, the Contractor must duplicate the plan design and level of coverage presently offered to the State's covered member population.

Please refer to the Benefit Review Document provided in the Plan Design section of the proposal response.

G. PLAN REQUIREMENTS

1. There will be no restrictions or benefit limitations for pre-existing conditions applied to any members or their dependents under the plan.

   Confirmed.

2. The plan will contain the "birthday rule" and will have group-to-group coordination of benefits provision. The birthday rule applies when two parents cover the same dependent children under two different health plans, the parent whose birthday falls earliest in the calendar year will be considered as the primary carrier for the dependent children.

   Confirmed.

3. The Contractor shall provide services to all present members (active employees, COBRA participants, early retirees, and eligible dependents) enrolled on the program effective date.

   Confirmed.

Section V Project Description and Scope of Work

4. Members who are not actively at work due to disablement on program effective date will be covered.

Confirmed.

5. The Contractor must perform a semi-annual, and/or as requested, Comparison Analysis and Strategic review. This analysis and plan should include, but not be limited to, identifying how the State of Nebraska's expenses and policies compare to other states, large employers, and innovative concepts for modifications to existing programs, the addition of new programs and or recommendations for changes in the State's policies on how to improve the State's performance and specific methods to reduce costs.

Confirmed.

6. Provide reports and claim analyses that meet the needs of the State including, but not limited to:

   a. Key Performance Indicators developed by the State
   b. Ad Hoc reports
   c. Benchmarking against peer state clients

Confirmed.

Section V Project Description and Scope of Work

7. Responsible for the provision of all levels of full and fair review of claims, claim denials and appeals made by members as mandated by the federally regulated appeals process. Determination of payment or denial of claims or of appealed claims shall be made by Contractor following appropriate analysis and review. The State may submit to the Contractor any request it receives for a review of a claim that has been denied so that Contractor may provide a full and fair review of the claim in compliance with the Patient Protection and Affordable Care Act (PPACA) appeals process. The State reserves the right to uphold, overturn or modify any denied claim(s) by Contractor.

Confirmed.

8. Design communications materials as mutually agreed by the Parties to be necessary to communicate the program to members and for use by the State in developing summary plan descriptions, or other program materials.

Confirmed.

9. Advise and assist the State in the preparation of forms and other documentation necessary to fulfill reporting and disclosure requirements.

Confirmed.

10. Provide final Summary Plan Documents (SPD), written and electronic, including SPD language for any clinical programs to be implemented, to the State prior to the Open Enrollment period and subsequent open enrollments.

Confirmed.

Section V Project Description and Scope of Work

11. The State will neither recognize the appointment of any agent, general agent or broker nor authorize any payment or remuneration of any kind by the Contractor to a party not approved in writing by the State.

Confirmed.

12. Provide guidance and written documentation within thirty (30) days upon request, on the PPACA and any future issues as related to health care reform, including but not limited to data comparison, analytics, strategic development, timelines, compliance, impact studies and implementation as they pertain to the State's experience.

We are committed to helping customers understand the impact of the Affordable Care Act (ACA) and other key legislative and regulatory developments.

We provide communications and resources directly to self-funded customers to inform them of new and existing resources we have developed to comply with the requirements of the law.

Our website can help members, consumers, employers and brokers understand health care reform and related developments. The website also highlights our vision on issues critical to the ongoing transformation of the health care system. Our account teams are available to customers as resources for health care reform issues.

We provide general information that may be helpful to customers as they work through changes required by health care reform. We can't provide legal, compliance or tax advice. We'll work with each customer in this area through appropriate personnel.

We advise customers to seek their own legal counsel concerning the effect of health care reform regulations on their plans.

Section V Project Description and Scope of Work

13. Absorb any programming or other administrative costs to meet any existing or future requirements of PPACA at no additional cost to the State.

Confirmed.

14. Administer the plans in compliance with the insurance laws of the State of Nebraska and all Federal regulations.

Confirmed.

15. Monitor Federal regulations and State legislation affecting the delivery of medical and prescription drug benefits under the plan and report to the State on those issues in a timely fashion prior to the effective date of any mandated plan changes.

Confirmed. Our legal department monitors, lobbies and analyzes legislation, and advises our business areas with respect to their legal obligations. When appropriate, we will advise you of developments through your account management team. The State should consult with your own legal counsel regarding any changes that may affect their plan.

16. Will not release any information related to the State of Nebraska health plans or claims in detail or in aggregate unless authorized by the Director of Administrative Services.

Confirmed. We can agree with this provision provided we retain the ability to use the data in accordance with HIPAA.

Section V Project Description and Scope of Work

17. Provide immediate on-line real-time manual eligibility updates for urgent requests by the State's staff.

Confirmed.

18. Attend an annual performance or "stewardship" meeting within 180 days after contract year-end at which time the Contractor will, as directed by the State, summarize activities and performance for the year ended.

Confirmed.

19. Assign a dedicated Account Executive who shall be accountable and responsible to the State for proactive management of all aspects of the Contractor's performance to the State and its members. The Contractor shall not change assignment of the Account Executive without written notice provided to the State with a minimum of fourteen (14) business days prior to such change. The State reserves the right to request assignment of a new Account Executive and the Contractor shall make such change within 30 calendar days of receipt of written notice from the State.

Confirmed. We strive to make sure you are completely satisfied with the assigned team and the services they provide.

We continually welcome your feedback on the account team. We address any concerns quickly and efficiently so that potential issues don't have the chance to escalate.

Section V Project Description and Scope of Work

20. Provide an Account Executive available by phone conference within two (2) hours after a request by the State and at no additional cost to the State.

Confirmed.

21. Provide dedicated staff in the following specialties:

    a. Implementation Manager: Responsible for development and execution of implementation plan. Coordinates with the State, internal and other external resources. The Implementation Manager shall be dedicated to the State during the implementation process. Three (3) years of experience as an Implementation Manager and experience with groups 15,000 and larger are also required.

Mary Anderson

    b. Account Executive: Responsible for overall account relationship including strategic planning in relation to plan performance, consultative services, recommendations for benefit design and cost containment opportunities, overseeing contractual services under the contract with the State, and managing all other Contractor's staff working on this account. Has overall responsibility for waste, fraud and abuse oversight and control. The Account Executive will be located in Nebraska and will be dedicated to the State account. The Account Executive will have a minimum five (5) years of experience as an Account Executive and have previously served as an Account Executive for at least one (1) year for a group of at least 15,000 members.

Confirmed. The account executive assigned to the State of Nebraska account is Tim Redmond. We have provided his resume in our proposal response.

Section V Project Description and Scope of Work

c. Clinical Pharmacist: Pharmacist with oversight and management of all clinical aspects of the State's plans; attends all clinical meetings; prepares clinical agenda; tracks new drugs in the market; reviews all prior authorization criteria with the State and customizes as necessary; provides all web PDL posting documents; provides Vendor P&T committee feedback; performs clinical research as needed. Must be dedicated to the State and in good standing with the Nebraska Board of Pharmacy. Must have a minimum 3 years' experience in a PBM and/or managed care pharmacy environment with direct responsibility for developing, implementing and maintaining clinical pharmacy programs.

Confirmed.

Kim Haywood, Pharm.D
Manager, Clinical Account Executives
Nebraska State Board of Pharmacy – Licensed Pharmacist Number 12661
Omaha, NE

Kim is the Manager of Clinical Account Executives within Aetna Pharmacy Management and is responsible for providing clinical program consultation to Aetna customers by recommending strategies that promote cost-effective therapies, enhance quality of care and optimize pharmacy spend.

Kim obtained a Bachelor's degree from the University of Nebraska at Omaha and a Doctor of Pharmacy degree from the University of Nebraska Medical Center. She has been a member of the Academy of Managed Care Pharmacy since 2007 and has held adjunct faculty positions at Metropolitan Community College in Omaha and University of Missouri-Kansas City School of Pharmacy.

Section V Project Description and Scope of Work

d. Operations Director: Responsible for all claims operations and reporting, including overseeing the file transfer process of eligibility data, interfaces between vendors, reporting, and data sharing. Monitors provider coding and claims submission patterns for potential waste, fraud and abuse. Three (3) years of experience as an Operations Director and experience with groups 15,000 and larger are also required.

Confirmed. The operations director assigned to the State of Nebraska account is Jessica Casselman. We have provided her resume in our proposal response.

e. Network Manager: Responsible for monitoring and assisting in resolving provider contract disputes, monitors and reports to the State on network access. Monitors State utilization and is proactive in expanding networks as needed to adjust to changes in member demand, access needs and/or gaps in care. Monitors provider coding and claims submission patterns for potential waste, fraud and abuse. Facilitates the expansion and increased awareness of tiered networks and centers-of-excellence. Three (3) years of experience as a Network Manager and experience with groups 15,000 and larger are also required.

Confirmed. The network manager assigned to the State of Nebraska account is Greg Killinger. We have provided his resume in our proposal response.

f. Member Services Manager: Responsible for all customer service functions and reporting. Three (3) years of experience as a Member Services Manager and experience with groups 15,000 and larger are also required.

Confirmed. The member services managers assigned to the State of Nebraska account are Shelly Geiger and Rita Pfeifer. We have provided their resumes in our proposal response.

Section V Project Description and Scope of Work

22. Participate in an Annual Vendor Summit to discuss strategic opportunities for the State's overall health management program.

Confirmed.

23. Provide data feeds (ex. eligibility file) to the State's vendor partners such as ASI COBRA, as requested. The cost for providing data feeds must be included in the Contractor's administrative fees.

Confirmed.

24. Provide an annual score card so the State can assess Contractor's performance.

Confirmed. Recognizing that customer satisfaction begins with our own organizational accountability, we contract with Acturus to conduct our nationwide Client Satisfaction Survey (previously called the Account Executive Survey). They are an independent market research firm located in Farmington, CT. They conduct the survey annually to measure how well we are meeting customer expectations. It includes a sample of Public & Labor customers.

The survey focuses on several areas:

- Overall satisfaction with our product offerings
- Access and responsiveness of our account management staff
- Likelihood of customer renewing their contract with us
- Customer satisfaction with product value and our customer service

Section V Project Description and Scope of Work

We use survey results to help us:

- Develop strategies
- Deploy resources
- Plan professional development activities

Through these results, we continue to provide the State with the best products and service possible.

25. Administer run-out claims for 12 months following termination of the contract. The cost of run-out administration must be included in your proposed administration fees.

Confirmed.

26. Provide complete banking arrangements for claims processing, including the printing and issuing of checks and electronic funds transfer.

Confirmed.

27. Participate in-person during the annual Human Resource Information Group (HRIG) in April of each year. In addition to the HRIG, the Contractor is required to participate in the informational meetings across the State directly following the HRIG. If requested by other State agencies, the Contractor may participate in agency specific health fair(s).

Confirmed.

Section V Project Description and Scope of Work

28. Integrate with the State's eligibility systems.

Our system does not integrate with other systems. However, we can accept eligibility in our standard layout, as described in this proposal.

29. Accept electronic transfer of eligibility data in a format indicated by the State and acknowledge receipt of the file.

Confirmed. We can receive and process enrollment and change data in the following formats:

- Industry ANSI 834 format
- Our proprietary 2000-byte format
- Our Consolidated Eligibility Format (CEF) file

We will evaluate any customization to standard formats on a case-by-case basis. If approved, charges to establish and support the customization generally do apply.

30. Implement eligibility updates within 24 hours of receipt.

Once we upload the eligibility file to our mainframe system, we automatically notify the State's assigned eligibility consultant to review an edit of the file online. Within 48 hours the eligibility consultant reviews the file, if there are no other data quality concerns, we update the system. Updated information appears in our eligibility and claims system immediately. Eligibility files that are not submitted in the proper format do not automatically proceed to the edit stage and the eligibility consultant is notified by our data center of the problem. The eligibility consultant is responsible for working with the State to resolve any errors/data quality/formatting issues that may arise.

Section V Project Description and Scope of Work

31. Maintain eligibility records for all participants.

Confirmed.

32. Maintain eligibility reconciliations between Contractor files and the State's eligibility files.

Confirmed.

33. Upon request, Contractor will provide HEDIS reports or State specific utilization data for health plans for State members.

Confirmed.

H. REQUESTED PHARMACY BENEFIT CONTRACTUAL TERMS

1. The State has the right to complete a mid-contract term market check, that may start as soon as the second quarter of the second Contract year, conducted by an independent third party (of the State's choosing) to ensure the State is receiving appropriate current pricing terms competitive with the industry (as compared to other PBMs) based on its volume and membership, and will improve pricing in the event that the State's contract terms are less than current. The State will have the right to terminate without penalty if the pricing terms are not industry competitive.

Confirmed. We agree to the Market Check provisions as stated below and in our Pharmacy Service and Fee Schedule.

During the second quarter of the second contract year and at the State's reasonable request, Aetna may review the financial terms of the State compared to financial offering presented to similar employers in the marketplace as deemed appropriate. The parties agree for the purpose of this market check that Aetna will compare, among other things, the following factors to determine whether the State is entitled to such revised pricing terms:

(i) The aggregate pricing terms of such applicable customers of comparable size, inclusive of the program savings, the retail pricing for brand and generic drugs, pricing for specialty drugs, administrative fees, rebates and guarantees

(ii) The services provided by Aetna to such customers and

(iii) The plan design of such customers, which may include plan formulary, brand/generic utilization information, in addition to mail and retail utilization information, available to Aetna.

If the State and Aetna agree to any revisions to the financial terms because of this review:

(i) The agreement shall be amended and

(ii) Shall be effective July 1 of the contract year following agreement on such revisions, provided that the parties agree on final pricing not less than 120 days prior to the first day of the contract year as to which the revisions are to apply.

Section V Project Description and Scope of Work

The State must sign a legal document and return it to Aetna, 90 days prior to pricing effective date.

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2. Contractor will implement new pricing within 90 days of completion of the market check or signature of contract. Acceptance of the new pricing will apply for the remainder of the Initial Term and will not result in renewal of the contract, unless requested by the State. The financial guarantees for any partial contractual year that results from the implementation of new pricing will still be guaranteed, reconciled and the Contractor will still make payments for any shortfalls for those partial contractual years with less than 12 months and those contractual years with over 12 months.

Confirmed as follows. If The State and Aetna agree to any revisions to the financial terms because of this review:

(i) The agreement shall be amended and

(ii) Shall be effective July 1 of the contract year following agreement on such revisions, provided that the parties agree on final pricing not less than 120 days prior to the first day of the contract year as to which the revisions are to apply.

The State must sign a legal document and return it to Aetna, 90 days prior to pricing effective date.

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3. Contractor will do quarterly face-to-face meetings with the State to discuss plan performance, present utilization and financial results, etc. at Contractor's expense. At a minimum, the State expects that the Account Executive and the Clinical Pharmacist attend these meetings.

Confirmed.

Section V Project Description and Scope of Work

4. Contractor will provide biweekly (every 2 weeks) and/or monthly data transmissions to at least five chosen vendors at no charge, and two full, annual electronic claims files, in the National Council for Prescription Drug Programs (NCPDP) format, at no charge. Contractor will also interact/exchange data with all vendors as needed at no additional charge.

   Confirmed.

5. The State will have the ability to adjust "refill-too-soon" limits at both retail and mail without any modifications to the guaranteed pricing.

   Confirmed.

6. Contractor will ensure all future edits required as a result of plan design changes implemented by the State or its designee, and uploads therefore, shall be completed, after testing, by the Contractor within 30 days of request/advisory by the State or its designee.

   Confirmed.

7. Minimum Brand and Minimum Generic Discount Guarantees for both mail and retail shall be defined as follows:

   a. Aggregate Discounted Ingredient Cost prior to application of plan specific copayments will be the basis of the calculation.

      Confirmed.

Section V Project Description and Scope of Work

b. Aggregate AWP will be from a single, nationally recognized price source for all claims.

Confirmed. We use Medi-Span as our sole source of pricing.

c. Dispensing Fees are not included in the Aggregate Ingredient Cost.

Confirmed.

d. Zero balance due claims or zero amount claims will be included in the guaranteed measurement for AWP, ingredient cost, achieved discounts or dispensing fee calculations at the discounted cost before copay.

Confirmed. Zero balance claims are included at the actual contracted rate and not at a 100 percent discount.

e. All guarantee measurements shall be calculated prior to the copayment being applied. Entire dollar-for-dollar shortfalls, prior to the application of copayments, will be reimbursed to the State without any adjustments to remove zero balance due or excess copayment claims.

Confirmed.

f. Both the Aggregate Ingredient Cost and Aggregate AWP from the actual date of claim adjudication will be used.

Confirmed.

Section V Project Description and Scope of Work

g. Aggregate AWP will be the date sensitive, 11-digit National Drug Code (NDC) of the actual product dispensed at retail, mail and specialty.

Confirmed.

h. Non-MAC, MAC, single-source, and multiple source generic products are to be included in the generic guarantee measurement (regardless of the exclusivity period and/or number of manufacturers) and excluded from brand guarantee measurement.

Confirmed.

i. Compounds, OTC claims, and claims with ancillary charges will be excluded from the guarantee measurements for retail and mail order components.

Confirmed.

j. The financial guarantee measurement must exclude the savings impact from Drug Utilization Review programs, formulary programs, utilization management programs, and coupon and/or copay assistance programs.

Confirmed.

Section V Project Description and Scope of Work

k. Measurement will be performed annually via independent audit utilizing date-sensitive AWP derived from a single, nationally recognized price source for all claims.

Confirmed.

l. Over performance or surpluses in one financial/pricing guarantee shall not be used to offset under-performance or shortfalls in any other financial/pricing guarantee.

Confirmed for Discount and Dispensing Fee guarantees.

Rebate guarantees will be measured individually by component and reconciled in the aggregate on an annual basis. We may use a surplus in one or more component Rebate guarantees to offset shortages in other component Rebate guarantees.

m. Repackaging or reporting a different package size than that actually obtained from the original manufacture or wholesaler is prohibited.

Confirmed.

8. Contractor must provide upon request any algorithms, hierarchy or other logic employed to define a prescription drug as generic or brand.

Confirmed.

Section V Project Description and Scope of Work

I. HIPAA COMPLIANCE

The Contractor shall provide the State an annual HIPAA training seminar to comply with the annual education and training requirements as defined by HIPAA at no cost to the State. In addition, the Contractor must provide an annual review of the State's HIPAA policies and make recommendations for the State to maintain compliance with HIPAA policies and guidelines at no cost to the State.

We do not provide HIPAA training to our customers. As a covered entity, we are obligated under HIPAA to only provide training to our workforce.

In addition, the State requires the following with respect to HIPAA Compliance:

1. Contractor personnel/staff have completed initial HIPAA training.

   Confirmed.

2. Contractor personnel/staff will continue to complete HIPAA training on an annual basis.

   Confirmed.

3. Contractor is currently in and will maintain full compliance with HIPAA's:

   a. Administrative simplification standards relating to electronic data transfers.

      Confirmed.

Section V Project Description and Scope of Work

b. Regulations protecting the privacy of individually identifiable health information.

Confirmed.

4. Contractor must be able to accept standard, HIPAA-compliant enrollment data electronically.

Confirmed.

5. Contractor has conducted a HIPAA assessment, including compliance with HITECH Act and the Omnibus Final Rule.

Confirmed.

6. Contractor has written Information Security Policy and Procedures, and that these policies apply to the systems, processes and personnel directly related to the work included in this contract and not for other subcontractor's or lines of business.

Confirmed.

Section V Project Description and Scope of Work

7. In the event of a privacy violation or data breach, the Contractor must notify the State immediately and the impacted members to a breach.

We have policies, procedures and technologies in place to protect member and other non-public data from unauthorized use and disclosure. Unfortunately, despite our best efforts, privacy breaches do occur from time to time.

Our standard is to research breaches with urgency and to promptly notify self-funded customers as soon as possible upon determining that a privacy breach has compromised their members' protected health information (PHI). We often notify customers within days of the breach.

The HIPAA breach notification regulation requires the Business Associate (Aetna in this instance) to notify the self-funded customer within 60 days of discovery of a breach. We include 30 days in our agreements to account for the rare instance when an incident requires extensive analysis in order to identify impacted members and customers. Be assured that we have a process in place to ensure potential breaches are researched as expeditiously as possible.

8. In the event of a privacy violation or data breach, the Contractor shall provide any required remedies to resolve the violation/breach.

We have a comprehensive incident response plan to handle any potential data security breach. We follow a rigorous process to immediately halt any ongoing breach and to mitigate the impact of the event to our customers. This includes notifying members, customers and regulators as required under applicable state and federal laws and taking other steps such as offering free credit monitoring when a member's financial information is exposed.

We address the root cause of the breach to strengthen controls, where necessary, to prevent a reoccurrence. Corrective actions may include:

- Making system enhancements
- Updating applicable workflows or procedures
- Creating new training and/or holding refresher training with impacted departments

Section V Project Description and Scope of Work

- Employee sanctions
- Vendor termination

9. Contractor must hold the State harmless for any HIPAA Violations made by the Contractor and its Network Providers.

Neither the State of Nebraska nor Aetna is responsible for health care providers, whether network or non-network. The indemnification obligation would not apply to any portion of any claim, demand or legal action caused by the acts or omissions of health care providers with respect to Members.

J. GENERAL PLAN INFORMATION AND REQUIREMENTS

1. Contractor will not render or administer services (including wellness) offshore, and all work performed will be in the contiguous United States.

Confirmed.

K. MEMBER SERVICES

1. The State requires that the Contractor provide an Account Executive and a backup account staff member that will handle ALL service matters related to the operation of the program.

Confirmed. Tim Redmond will be the Account Executive who manages the State's account. An entire team will also be designated to the State will support Tim.

Section V Project Description and Scope of Work

A core account management team that consists of the following individuals to support you:

- Tim Redmond - *Account Executive*

  Tim works with you to create your benefit program strategy and gather the right resources within our company to support it. Tim has overall responsibility for our partnership with you.

- Penny Pollard – *Plan Sponsor Liaison*

  Penny will act as a single point-of-contact to your HR staff for claim and benefit related issues. Penny will maintain an on-going relationship with your HR staff to meet your changing needs. Penny will be responsible for reporting and analysis of your service experience.

- Hunter Williams – *Account Manager*

  Hunter is your day-to-day contact. He is responsible for building and maintaining a strong relationship with you. That means communicating with you on a regular basis, overseeing operational services for you, connecting all areas of Aetna to ensure commitments are kept and managing day-to-day services to make sure we provide you with quality service.

- Dominique McLin – *Pharmacy Strategic Account Executive (SAE)*

  Dominique acts as your financial and strategic lead for the pharmacy benefit. She works with the account team to present consultative benefit design and program strategy to find ways to decrease drug spend and increase pharmacy plan value.

  Dominique has been in the insurance industry for over 20 years, with 16 years of that time spent at Aetna in various departments. Most recently, Dominique was an Account Executive for National Accounts in our St. Louis, MO office. Her responsibilities included working with her customers to develop and implement an overall benefits strategy based on the customer's unique objectives and business challenges.

Section V Project Description and Scope of Work

- Karen Conroy – *Pharmacy Account Manager*

  Karen has over 25 years of experience in the pharmacy industry and has been with Aetna for six years. She works with customers in the Central Mid-America region providing ongoing day-to-day support for product implementation, open enrollment, issue resolution, reporting and more. Prior to Aetna, she worked at Coventry Health Care, Truman Medical Center and Humana in a variety of pharmacy roles. Karen will oversee the servicing and continuity of your pharmacy benefits program.

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2. The State requires the Contractor to respond to all State inquiries within one (1) business day.

Confirmed.

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3. The State requires that the Contractor's Account team for this account will attend all quarterly and account meetings at the Contractor's expense.

Confirmed.

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4. Contractor will dedicate a Customer Service unit to the State.

We are proposing a designated customer service unit that is dedicated to our Public and Labor business segment.

Section V Project Description and Scope of Work

5. Contractor to provide a dedicated toll-free number to the State. This line must be dedicated solely for the use of State members. The minimum hours for customer service operation must be from Monday through Friday, 8:00 a.m. to 6:00 p.m., CT.

Confirmed.

6. Contractor shall have a process in place to handle after-hours calls.

For inquiries outside of normal business hours, members have the option of using Aetna Voice Advantage, our self-service telephone system or our member website.

Pharmacy after-hours calls

In addition to normal business hours, members can receive pharmacy benefit support 24 hours a day, 7 days a week, through the following channels:

- Teams of representatives available to help answer questions at any time
- Personal online access 24/7 on **aetna.com**
- Interactive voice response (IVR) service 24/7, using phone keypad or speech recognition

CSRs are empowered to function as member advocates by engaging members and educating them on how to maximize their prescription benefit. We provide the CSR teams and supervisors with customer-specific training so they will fully understand the State's pharmacy benefits.

Section V Project Description and Scope of Work

7. For the 24-Hour Nurse Line program, staff must be available 24-hours a day, 365 days a year.

Confirmed.

8. Contractor shall utilize a dedicated call tracking and documentation system. This system must be able to produce State-specific Customer Service statistics.

Confirmed.

9. Contractor shall comply with the Internal Claims and Appeals and External Review requirements under the PPACA. Contractor shall provide the appeals procedures for denied claims or authorizations and time frames that a member would follow.

Confirmed.

10. Contractor must mail hard-copy provider directories to current and prospective members within two (2) business days of request.

Confirmed. If a member contacts our call center and provides the search criteria, the CSR will print and mail a customized directory based on their specifications.

11. Contractor will develop a mutually agreeable member satisfaction survey that will be provided to each State employee member and collect and report the results on an annual basis at no additional cost to the State.

Confirmed.

12. Contractor shall have in place a State of Nebraska specific website by Feb 1, 2020, through which members can, at a minimum, access and view eligibility, plan benefits, pharmacy and formulary information, locate a pharmacy, price a prescription specific to the State's plan design, order a mail order refill, track a mail order shipment, and order a replacement card. This website will be linked to the State's home page at http://das.nebraska.gov/Benefits/Active.html.

Confirmed.

L. DATA ANALYTICS TOOL

Contractor shall provide a data analytics tool to the State. If the Contractor does not have the capability to provide a data analytics tool, the State will allow the Contractor to subcontract this service. Contractor must comply with the following minimum requirements of the data analytics tool are as follows:

1. State access to develop and run ad hoc reports on each of the plan options offered by the State.

Confirmed.

2. Ability to import medical, pharmacy, wellness, and other third party health data.

Confirmed.

Section V Project Description and Scope of Work

3. Ability to identify members with gaps in care according to generally accepted disease management protocols.

Confirmed.

4. Ability to allow the State staff to perform ad hoc queries on the data.

Confirmed.

5. At a minimum, the State requires your data analytics tool have the ability to stratify data by common variables used in the plan such as but not limited to:

   a. Health Plan type/ Option
   b. Member Status (Active, Early Retiree, Retiree)
   c. Relationship (Employee, Spouse, Dependent)
   d. Network Indicator
   e. Place of Service (Inpatient, Outpatient, Emergency Room, Physician's office, etc.)
   f. Major Diagnostic Category
   g. Diagnosis Related Group
   h. Member ID
   i. Provider ID
   j. Date of Service
   k. Date of Payment

Confirmed.

Section V Project Description and Scope of Work

6. At a minimum, the State requires your data analytics tool to have the ability to calculate measures commonly used in the plan such as but not limited to:

   a. Admissions
   b. Readmissions (7,15,30 days)
   c. Urgent Care Visits
   d. Other Facilities
   e. Avoidable Admissions
   f. Inpatient Days
   g. Emergency Room Visits
   h. Office Visits
   i. Preventive Screens
   j. Total number of claims
   k. Net Payment
   l. Healthcare Reimbursement Amount
   m. Copayment Amount
   n. Coinsurance Amount
   o. Deductible Amount

   Confirmed.

7. Contractor must have the ability to report claims based on volume, cost, and location.

   Confirmed.

8. The State requires access to the data analytics tool to produce executive level and ad hoc reports as well as extracts. The State would either need data to be sent by the Data Analytics vendor or access to the system online to pull the reports and data needed to review the analytics.

   Confirmed.

9. The State requires training on all tools made available to staff for reporting purposes at no cost to the State.

Confirmed.

M. CLAIMS PROCESSING

1. The State requires the minimum hours for claims administration operation be from Monday through Friday, 8:00 a.m. to 6:00 p.m. Central Time.

Confirmed.

2. Contractor shall credit overpaid claims upon identification within 7 – 10 business days of discovery of overpayment. This does not include actual recovery of funds that were the result of Contractor error.

Confirmed. We identify overpayments through claim audits, file reviews, telephone calls, correspondence and unsolicited refunds.

When we identify an overpayment, we refer the information to our recovery area to review and begin the collection procedures. As part of those procedures we determine the cause, to whom the overpayment was made and the most effective way to recover the overpayment. We do not typically pursue overpayments where the aggregate amount is under $15 for provider and $25 for member and cannot pursue claims which are beyond 24 months from the payment date.

Section V Project Description and Scope of Work

Overpayment collection

We generally attempt to collect overpayments by requesting a lump sum reimbursement. Our recovery staff makes a minimum of two attempts at recovery, usually in the form of letters to the overpaid party requesting reimbursement of the overpayment. We use the Overpayment Tracking system for tracking and to ensure appropriate handling and credit to you.

In many circumstances, we may withhold the overpayment amount (minus debit) from future payments to the provider to the extent permitted by law, contract and system capabilities.

If these efforts are unsuccessful, we refer the matter to our overpayment recovery vendor. We report recoveries to our Cost Containment/Operational Accounting areas who then creates a credit to you.

We credit your plan for any amounts recovered. The credit is applied against normal claim funding requests once recovered and appears on your next monthly claim detail report. For any items recovered, the contingency fee appears as an offset. Any amounts we fail to recover remain charged to your plan.

In addition to our internal recovery efforts, we also collaborate with several national third-party vendors who receive claims data feeds from us and utilize their systems to search for potential overpayments. These companies data mine based upon their expertise including COB, retroactive terminations and hospital audits to determine if a recovery opportunity may exist. If we identify a recovery opportunity, the vendor pursues the overpayment on behalf of us. Once collected, they forward that information to our Cost Containment/ Operational Accounting areas for credit to your account. Vendors have their own contingency fee rate.

Our responsibility for overpayment recovery is governed by the specific terms of your Master Services Agreement.

Section V Project Description and Scope of Work

3. Contractor shall provide quality assurance and internal audit procedures and programs. The Contractor must provide the State with most recent SOC 1 Type 2 audit report for the specific entity proposing to the State as well as an annual audit report on the State's claims.

Confirmed.

4. The State requires claims history be maintained on-line for a minimum of ten (10) years.

Confirmed.

5. Contractor must comply with State Coordination of Benefits (COB) requirements. COB questionnaires shall be sent to all members on an annual basis. No claims shall be paid until the COB questionnaire is completed and returned by the member.

Confirmed.

6. Contractor's claims system must have the capability to process network, non-network, and out-of-area claims on the same system.

Confirmed.

Section V Project Description and Scope of Work

7. Contractor must indicate in their annual report to the State how COB savings are calculated.

Confirmed.

8. The Contractor must be able to load, audit and insure clean eligibility data at least fifteen (15) business days prior to program effective date. New cards for members must be issued ten business (10) days prior to program effective date to allow such cards to be issued.

Confirmed.

9. The State requires that claim payments to providers are reimbursed after checks or electronic transfer of funds are completed, not when they are issued.

Confirmed.

10. The State reserves the right to accept or decline the following at no additional cost to the State:

    a. designated service centers
    b. designated claims processors
    c. proposed changes to claims processing systems

Because of the large investments that we make in facilities and personnel, we cannot agree in advance to extensive changes in those areas. Typically, we do not permit customers to determine who in our staff supervises or processes claims. In the event significant problems occur, we will work with the State and our customer service center to address and resolve any issues.

Section V Project Description and Scope of Work

N. BEHAVIORAL HEALTH

1. Contractor must offer a comprehensive behavioral health network that includes a variation of providers such as Psychiatrists (MDs), Psychologists, Therapists, Counselors, Social Workers, etc.

Confirmed.

2. Contractor must ensure that behavioral health providers are accepting new patients.

Confirmed. Approximately 99.8 percent of our behavioral health providers are accepting new patients.

3. Contractor must create a clinically integrated delivery system that coordinates behavioral health services to improve the quality of care.

Confirmed. Our behavioral health care management staff works with the member from the initial point of contact, and can easily act as facilitators with our medical programs. We use our case management system to maintain a 360-degree view of the member's physical, behavioral health, social and cultural needs so our case managers can access information to identify benefits and processes for referring members for physical health services.

We work collaboratively with medical providers, medical care managers, other medical/disease management vendors, EAP providers and the community. This offers a holistic approach to the treatment process.

If the member requires basic triage and referral services, the case manager provides the member with the access phone number to our patient management department and warm transfers the member.

Section V Project Description and Scope of Work

When a member requires more intense medical services, the case manager will contact a medical case manager and refer the member. Behavioral health clinicians serve as trainers, mentors and support for medical teams regarding mental and behavioral health issues. They collaborate and consult on the care of the co-morbid population through consultation and case conferencing, offering full integration of services. The behavioral health case manager will also collaborate with this team to coordinate ongoing treatment services and discharge and follow-up plans. The collaboration occurs with the member's full knowledge and involvement.

Another major driver of our integrated approach is the use of our data warehouse to identify members that would benefit from behavioral health services or outreach. The data includes the vast array of information that we have and the analytics that Aetna and Aetna Behavioral Health have developed to identify members at risk.

If a member prefers to call their Aetna health plan number as the initial point of contact, our nurses screen the caller to identify the following behavioral health issues:

- Anxiety
- Alcohol dependency
- Eating disorders
- Bipolar screening
- Depression

A nurse addresses those calls they identify as "routine" issues – such as feeling stressed, overwhelmed, irritable, nervous, anxious or worried. To help our care management nurses support these members, we have a behavioral health specialist on each team. The behavioral health specialist provides support/ guidance to the nurse in coordinating the member's care. Those members we identify with needs that are more complex we refer to appropriate resources included in the member's benefit plan. This ensures the member is receiving holistic care regardless of how the member contacts us.

O. ELIGIBILITY/MEMBERSHIP

1. Contractor must follow the specified eligibility rules established by the State.

Confirmed.

2. Contractor must have the capability to receive electronic membership files and to maintain eligibility files and transmit and receive updates from the State electronically.

Confirmed.

3. Contractor must accept the electronic eligibility file in place as of the effective date of this contract and any subsequent files on a regular basis.

Confirmed.

4. The State determines eligibility for current members and all dependents. All participant and dependent additions or terminations will be processed by the State and sent to Contractor. The State will require the Contractor to complete monthly membership reconciliation and COB.

Confirmed.

5. Contractor must provide a real-time, on-line capability for the State to add, delete, or change member status.

Confirmed.

6. Contractor must provide dependent eligibility verification.

    a. Contractor must provide the services for complete dependent eligibility audits of the dependent(s) enrolled on employee health plans as indicated below. If the Contractor does not have the capability to perform dependent eligibility audits, the State will allow the Contractor to subcontract this service with a third party.

        i. Dependent eligibility audit of dependents added for coverage on the employee's health plan during our annual Open Enrollment period, prior to them having access to coverage July 1 of each year. The State has approximately 200 employees each year that enroll new dependents in one of the State's health plans during each annual Open Enrollment period.

        ii. Regular dependent eligibility audits of dependents for new hires, prior to them having access to coverage in one of the State's health plans. The State currently hires approximately 1200 employees each year that enroll in one of the State's health plans with dependents.

        iii. Regular dependent eligibility audits of dependents of employees that have life status changes, prior to them having access to coverage in one of the State's health plans. The State has approximately 200 employees each year that experience life status change events and enroll new dependents in one of the State's health plans. Twice a year perform random dependent eligibility audits of dependents currently enrolled in one of the State's health plans. Each random dependent eligibility audit must be performed on 5% of the employees currently enrolled with dependents in one of the State's health plans.

We have included an allowance of $100,000 to cover the cost of coordinating Dependent Verification services with Aon.

P. WEB ACCESS

1. For Administration testing purposes, Contractor shall have an interactive website operational by February 1, 2020.

Confirmed.

2. Contractor shall provide established standards for web access for Administrative Services employees managing the health plans and State of Nebraska plan members. Any material available through web access must also be made available by hard copy. Contractor must be able to provide the below capabilities at a minimum.

    a. Member capabilities, including health plan information and tools available to improve health status:

        i. Request additional or replacement ID cards
        ii. Print ID cards directly from site
        iii. Access historical health data
        iv. Provider directories
        v. Provider selection where users enter search criteria
        vi. Claim status review
        vii. Plan design
        viii. Ability to email member services
        ix. Customizable health content tools
        x. Tools available to evaluate cost and/or quality of healthcare providers
        xi. On-line access to claim processing status and appeals by the member
        xii. Applications for mobile devices

    b. Ability to customize web site for the State
    c. Ability to hot link to the State's site

Section V Project Description and Scope of Work

d. Employer/actuarial consultant inquiry capabilities
e. Security/privacy issues
f. Future plans/timeframes for enhancements

Confirmed.

Q. MEDICAL PROVIDER NETWORK

1. Contractor shall notify the State immediately if the network or any part thereof, loses any accreditation, licenses or liability insurance coverage, security or bonding.

Confirmed.

2. Contractor's network for the State must be accredited by an organization such as National Committee for Quality Assurance (NCQA), Joint Commission on Accreditation of Health Care Organizations (JCAHO), etc.

Confirmed. We are accredited by NCQA.

3. The State requires that when a member or dependent enrollee is admitted in one of the Contractor's network facilities at the time the group contract terminates, the normal/usual discount still applies for the entire period of admittance, as if the program had not terminated.

Confirmed.

Section V Project Description and Scope of Work

4. The network of locations that can provide medical services must be in areas where our employees, retirees and COBRA participants live. Urban/Suburban must be 1 within 20 miles and Rural must be 1 within 35 miles for the following provider types:

   a. Facilities:

      i. Hospitals
      ii. Ambulatory Surgical Center
      iii. Urgent Care facilities
      iv. Imaging Centers
      v. Inpatient Behavioral Health Faculties

   b. Primary Care:

      i. General/Family Practitioner
      ii. Internal Medicine
      iii. Family Medicine
      iv. General Medicine OB/GYN
      v. Pediatrician

   c. Specialists:

      i. Endocrinologist
      ii. Urologist
      iii. Cardiologist
      iv. Dermatologist
      v. Allergist
      vi. Psychologist/Psychiatrist
      vii. General Surgeon
      viii. Hematologist/Oncologist
      ix. Chiropractor

Please refer to the GeoAccess reports included in the Network Information section of the proposal response.

Section V Project Description and Scope of Work

R. QUALITY ASSURANCE

1. Contractor is required to have a quality assurance program in place.

Confirmed.

2. In addition to the requirements under Section IV. Payment, H. Subject to Funding/Funding out Clause for Loss of Appropriations, the State reserves the right to conduct a clinical audit of claims processing services upon reasonable advance notice. Should the State undertake said audit, the Contractor shall, at no additional cost to the State, supply to the State the materials and resources necessary for the audit.

Confirmed.

We welcome independent audits of relevant records and documentation by the State and their representatives, provided no audit interferes with our business operations or the confidential interests of our company or another party. We have assumed for the purpose of this contract that we define an "audit" as performing a review of claim transactions for assessing the accuracy of benefit determinations and shall be subject to a mutual agreement as to nature, scope, format, structure and cost. We work from established audit guidelines that are accepted in this industry and we are confident we can meet your needs in this important area as well.

S. UTILIZATION MANAGEMENT/CASE MANAGEMENT

Utilization management (UM) is the evaluation of the appropriateness, medical need and efficiency of health care services, procedures and facilities according to established criteria or guidelines and under the provisions of an applicable health benefits plan. It includes new activities or decisions based upon the analysis of a case. It describes proactive procedures, including discharge planning, concurrent planning, pre-certification and clinical case appeals. It also covers proactive processes, such as concurrent clinical reviews and peer reviews, as well as appeals introduced by the provider, payer or patient.

Case management (CM) is a managed care technique focusing on delivering personalized services to patients to improve their care. It is a method of managing the provision of health care to members with chronic medical conditions. The goal is to coordinate the care to improve both continuity and quality of care and lower costs.

1. Contractor must have a comprehensive CM Program that addresses short-term and complex long-term care.

Confirmed.

2. Contractor shall have the ability to integrate their medical management services that include, but are not limited to, precertification, CM, disease management, Nurse Line, behavioral health, and substance abuse.

Confirmed.

3. Contractor must maintain a process to include individuals in the UM/CM program once paid claims exceeds $50,000.

Confirmed.

Section V Project Description and Scope of Work

4. Contractor's UM program will also include a requirement for evaluating the appropriateness of services according to mutually agreeable criteria, and integrating proactive processes surrounding discharge planning, concurrent planning, pre-certification and clinical case appeals.

Confirmed.

T. DISEASE MANAGEMENT

The State requires the Contractor to have a Disease Management (DM) service that is more than a managed care health service. An effective DM program requires 'whole system' implementation with a range of activities relevant to the context, clinical professionals willing to act as partners or coaches and on-line resources that are verifiable. This is performed with knowledge sharing through centralized medical records plus knowledge building and a medical community integral to the concept of DM. It is a population health strategy as well as an approach to personal health. It is a method of managing the provision of health care to members with high-cost medical conditions. The objective is to reduce healthcare costs and/or improve quality of life for individuals by preventing or minimizing the effects of diseases, usually a chronic condition, through knowledge, skills, enabling a sense of control over life (despite symptoms of the disease) and integrative care.

1. Increase member engagement and participation in targeted DM programs offered to members and educate members on how to manage and control their condition(s).

Confirmed. The Aetna In Touch Care℠ program is an innovative, industry leading care management program that helps your employees and their families easily and successfully navigate the health system. Our program is an alternative to having separate case management and disease management programs. We are offering this program as a buy-up option.

Aetna In Touch Care finds the members who need help most, engages them in meaningful and personalized ways, and helps them manage their health on their terms. From identification to nurse engagement, our entire process is member centric.

Section V Project Description and Scope of Work

It includes three primary functions:

- Find – Our algorithms identify at-risk members by comparing member data against the latest medical knowledge. Our goal is to identify potential health issues before they become a major problem. Once identified, we can reach out to offer those members with an appropriate level of support.
- Engage – Our nurses connect with members using techniques, such as motivational interviewing and preference-based outreach, to engage members into taking action.
- Help – Digital and nurse support options allow members to personalize the way they receive help as they strive to reach their best health.

2. Improve the DM program participants' key clinical indicators.

Confirmed. If the State elects the buy-up option, Aetna In Touch Care Solutions.

3. Provide accurate and detailed reporting of the State's DM program activities and outcomes.

Confirmed. If the State elects the buy-up option, Aetna In Touch Care Solutions.

4. Assist with strategic planning to provide proactive ideas and plans each year to enhance the program.

Confirmed.

5. Provide extensive communications and outreach to engage and educate the membership through personalized, multi-modal, segmented communication rooted in evidence based medicine (EBM) and behavioral science.

Confirmed.

U. STANDARD MEDICAL REPORTING

State must have the ability to access a portal to create and download reports. These reports must be provided at minimum but not limited to:

1. Daily Reporting

The State requires a daily reporting of claims paid in a format acceptable to meet State requirements for Contractor reimbursement; such format shall be determined during contract finalization with the specified Contractor. The following are required data fields for daily reporting and should not include Personal Health Information (PHI):

a. Policy/Group/Plan Number
b. Claim Number
c. Payee
d. Provider Name
e. Claim Expense Incurred Date
f. Claim Payment Date
g. Claim Process Date
h. Claim Billed Amount
i. Claim Allowed Amount
j. Claim Paid Amount

Confirmed.

Section V Project Description and Scope of Work

2. Monthly reporting shall contain the following information including but not limited to:

   a. Paid claims
   b. Administrative/Network Fees (if applicable)
   c. Monthly enrollment counts
   d. Reconciliation of claim drafts to paid claims
   e. ASO reconciliation of monthly PEPM Administrative Fees
   f. Membership (Census) report
   g. Large Loss Report
   h. EPR and Rx Executive Summary

Confirmed.

3. Quarterly Reports

   a. Appeals Reports
   b. Workers Comp Report
   c. Performance Guarantees (Service Report)
   d. Health Plan Review Report
   e. Medical/Rx Rebate report

We can provide all of the reports listed above except the Workers Comp Report.

4. Annual Reports

   a. General claim utilization reports by major line of coverage identifying:

      i. Claims submitted
      ii. Claims eligible
      iii. Deductible and coinsurance application
      iv. Payment reductions due to network negotiated rates
      v. Reasonable and Customary cutbacks and savings
      vi. COB savings
      vii. Ineligible expenses
      viii. Net benefits paid by major line of coverage

Section V Project Description and Scope of Work

Confirmed.

5. Consultative Reports
   a. Reports that analyze utilization of healthcare services of plan members:
      i. Identifies opportunities for plan design or care management interventions.

Confirmed.

6. Claim utilization report will show separate experience for:
   a. Members
   b. Dependents
   c. COBRA Participants
   d. Retirees

Confirmed. During the installation process, we work with the State to set up a reporting account structure that will be most meaningful for analysis.

7. Employee contested claims separated by denial reason.

Reports to address claim denial reasons are available for the State. However, the reports do not show all claims denied or a subset of claims denied for a specific reason. The reports are available on a fee-for-service basis. We are unable to identify whether a claim is employee contested.

Section V Project Description and Scope of Work

8. Claim lag report.

Confirmed. We provide an estimate of claims reserves in our annual accounting package based on customer-specific runoff, claim patterns and our book-of-business factors. We also provide a monthly Claim Detail report to help the State perform your own lag study.

For an additional charge, we can provide the State with specific claim lag reports by product. The charge varies by requested report complexity.

9. Network savings reports for each network offered.

Confirmed. Our Provider Network Experience reports include network savings and utilization metrics for current and prior periods. The reports show the value of our network discounts based on the use of network providers by your members and our book of business comparisons.

10. Most utilized hospitals and physicians reports.

Confirmed.

11. A year-end financial accounting for the program within 90 calendar days after fiscal year end.

At the end of each contract period, we provide a look-back at the year to determine an overall financial balance. The package includes detailed and summary exhibits of service fee payments, claims and reserve charges and administrative expenses. We provide the accounting 120 days after the end of the policy period. The reports are available electronically, usually in Microsoft Word format.

Section V Project Description and Scope of Work

12. Ad Hoc Reporting Capability – both online and paper formats.

Confirmed. Ad hoc reports will be delivered in an agreed upon format.

13. Any reports should be delivered through an encrypted, secure email system.

Confirmed.

V. PHARMACY BENEFITS REPORTING

1. Contractor must provide the following pharmaceutical reports at a minimum quarterly;

   a. Eligibility Report which shows accuracy of updates and changes

   b. Paid Claims Summary (Ingredient cost, day's supply, dispensing fees, taxes, copay totals by month, total number of claims, eligible charges and claim payments for each category)

   c. Detail Claim Listing (Utilization and Ingredient cost by individual claimant, listing the Drug name and dosage, submitted charge, allowable charge, paid)

   d. Cost Sharing Report (Amounts determined to be ineligible, amounts applied to copays and coinsurance, and amounts adjusted for COB)

   e. Detailed Utilization Report (# of prescriptions submitted by single source brand, multi-source brand and generic drugs, including average AWP, Ingredient cost per Rx, Dispensing fee, and average day's supply)

   f. Top Drug Report (detail of cost and utilization by top drug products)

   g. High Amount Claimant report

   h. Therapeutic Interchange Report detailing success rates and cost impacts of Contractor initiated interchanges

   i. Drug Utilization Review activity and Savings Report by type of edit

   j. Member compliance and adherence to therapy

Section V Project Description and Scope of Work

k. Formulary Savings and Rebate report

l. Prior Authorization and other clinical program reporting

m. Specialty Rx reporting

n. Pharmacy cost and utilization reporting

We will provide an extensive package of standard reports to the State to meet your information needs. Customized reports are available upon request from Aetna Informatics®. We will assign a business consultant to respond to tailored information and analytic needs. We quote charges and delivery dates for customized or ad hoc reports in advance.

Please refer to the *APM Sample Reports.zip* file included with this proposal in the Samples and Brochures section for your review.

W. REBATE AND FORMULARY MANAGEMENT

1. Guaranteed rebates per brand will be based on all brand prescriptions dispensed, not only on formulary prescriptions dispensed.

Confirmed.

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2. Rebates are guarantees on a minimum (i.e., not fixed) basis, and the Contractor will pass through 100% of the rebates through to the State.

Confirmed.

Section V Project Description and Scope of Work

3. Over-performance of minimum rebate guarantees will not be used to offset performance guarantee shortfalls in other areas.

Confirmed that we will not use over-performance of minimum rebate guarantees to offset Discount and Dispensing shortfalls.

4. Rebates will not be withheld for execution of any contract amendments. No annual renewals/amendments signatures for payment of rebates through the initial contract period.

Confirmed.

5. Contractor will reconcile rebate guarantees to verify that the State is receiving the guaranteed rebates and provide rebate payments and reports listing detailed rebate utilization and calculations to the State quarterly, within sixty (60) calendar days of the quarter's close, without a request being made by the State.

Rebate guarantees will be measured individually by component and reconciled in the aggregate on an annual basis within one hundred eighty (180) days following the end of the Plan year based on actual rebates and an estimate for any residual payments not received at the time of the reconciliation. Any payment will be received within 30 days of receipt of the reconciliation.

The State will receive quarterly rebate statements without request. Rebate allocations will be made within 180 days from the end of each calendar quarter, with payments issued to customers in the month following allocation.

We have included a sample quarterly rebate statement for your review. We would be happy to discuss to make sure it suites your needs.

Section V Project Description and Scope of Work

6. Contractor will provide the annual rebate report within 180 days of the end of each contract year. Any shortfall between the actual result and the minimum rebate guarantees will be paid, dollar-for-dollar, to the State within 180 calendar days of the end of the contract year.

Confirmed.

7. All rebate revenue earned by the State will be paid to the State regardless of its contract status as a client. Lag rebates will continue to be paid to the State after contract expiration or termination until 100% of earned rebates are paid.

Confirmed.

8. Contractor must produce an auditable quarterly report demonstrating pass-through rebates.

Confirmed.

9. Contractor must provide written notification to the State or its designee at least 90 days in advance when a formulary drug is targeted to be moved to or from the preferred/formulary drug list. Contractor must provide a detailed disruption and financial impact analysis at the same time. No greater than two percent (2%) of participants will be disrupted by any formulary deletions or all deletions in total, on an annual basis.

Confirmed with exception. We cannot guarantee that no greater than two percent (2%) of participants will be disrupted by any formulary deletions or all deletions in total, on an annual basis.

Section V Project Description and Scope of Work

10. Contractor must send timely notification letters to members and their prescribing physicians of drug formulary changes or other changes where there is a negative impact on the member at no additional fee.

Confirmed.

11. Contractor must remove drugs from coverage or the formulary at most two times per year and no greater than two percent (2%) of participants will be disrupted by any formulary deletions or all deletions in total, on an annual basis.

Confirmed.

12. Contractor will not withhold any financial recoveries from audits performed on the contracted pharmacy network including mail order and specialty pharmacies. Any recoveries will be disclosed and credited to the State.

Confirmed. We will pass on 100% of recoveries we receive.

13. Contractor must not remove any participating network pharmacies that impact greater than two percent (2%) of the State's prescriptions without communicating to the State at least sixty (60) days in advance of the scheduled change. If the change is not agreeable to the State, the State will have the right to terminate the contract without penalty.

Confirmed.

Section V Project Description and Scope of Work

14. Contractor must offer improved pricing terms to the State if greater than two percent (2%) of members are impacted by proposed changes to the participating pharmacy network.

Confirmed.

15. If requested by the State, the Contractor agrees to grandfather the current formulary (preferred) list and respective copayments for up to 90 days following the contract effective date with no impact on the minimum rebate guarantees.

Confirmed.

16. With the exception of FDA recalls or other safety issues, the Contractor must limit new drug exclusions from coverage to twice per year (typically July 1 and January 1) and only upon 60 day advanced notification to affected members.

We conduct an annual review of the proposed formulary to ensure that we represent the most favorable therapies and may exclude specific drugs at that time. In addition, we conduct quarterly reviews and may exclude products that have experienced egregious price inflation (such as hyperinflation) at that time. We make reasonable efforts to provide advanced communication to you for exclusions.

We send member notifications 30 to 45 days prior to the effective date in order to provide awareness of the upcoming change and action steps needed to address the transition, for example notifying their physician of the change.

Section V Project Description and Scope of Work

X. PHARMACY NETWORK ACCESS AND MANAGEMENT

1. Contractor must utilize their broadest network.

Confirmed. We have quoted our National Retail Pharmacy network which includes over 67,000 pharmacies in every state and the U.S. Territories.

2. In the event that the contract for a participant's network pharmacy (or pharmacy chain) terminates for any reason, the Contractor will notify plan participants, in writing, with at least 45 days advance notice (or as much time as is feasible if the terminating Pharmacy gives the Contractor less than 45 days' notice). For the purposes of this requirement, plan participant shall mean a member who has had a prescription filled within the last 30 calendar days or a member has an active refill on file with the affected pharmacy.

We generally do not provide notification when a pharmacy leaves any of our retail networks or when the pharmacy experiences a change in status. However, we'd be happy to provide notification if the impact to your membership is greater than 5 percent.

You and your members may use our online Pharmacy Locator tool at **aetna.com** or the Aetna mobile App to determine whether a pharmacy participates in our network. We update Pharmacy Locator weekly so the most current network information is available. In addition, the member may call Member Services to find a conveniently located retail pharmacy in our network.

Section V Project Description and Scope of Work

3. Contractor must have the following.

Provider Type	Urban/Suburban Enrollees	Rural Enrollees
Pharmacies	2 in 5 miles	2 in 20 miles

Confirmed.

4. Contractor must be responsive to requests by the State to recruit additional pharmacies for the network, on a general, regional, or specific basis.

Confirmed.

5. Contractor must have a network of retail pharmacies that have agreed to discount their charges for 90-day supplies of maintenance medications.

Confirmed.

6. Contractor must apply MAC pricing to Retail Pharmacy 90-Day Network. The MAC price must be the same MAC as the Retail Network or better on an individual drug basis.

Confirmed.

Section V Project Description and Scope of Work

7. Contractor will notify the State prior to any anticipated major changes to the network. The State reserves the right to accept or decline proposed changes to the network and set the effective date of such changes.

Confirmed.

8. Contractor must pass through 100% of State-related audit recoveries identified through internal daily and ongoing retail network pharmacy audit compliance procedures.

Confirmed.

9. Contractor must implement measures to recover overpayments made to pharmacies or members and employ a mechanism to ensure the State receives credit for these overpayments. Details of threshold recovery levels will be finalized at the time of contract award.

Confirmed. In the event of overpayments or billing errors, pharmacists can often reverse and resubmit claims online. The ability to do this depends on both the situation and on how much time elapsed since the dispensing date. If pharmacists cannot reverse claims online, they can call the Pharmacy Help Line to initiate a manual adjustment.

Section V Project Description and Scope of Work

Y. MAIL ORDER

1. Contractor must ensure prescriptions purchased via mail order will never be more expensive than those obtained via retail pharmacies.

We agree that the overall guaranteed Mail Order discounts are equal to or more favorable than the overall minimum Retail discounts. We are not providing a guarantee on a drug-by-drug basis.

2. Contractor will not repackage prescriptions or otherwise change the NDC for any prescription or OTC products dispensed at mail order.

Confirmed.

3. Contractor will communicate via a telephone call or email any delays beyond two (2) days in the delivery of prescriptions to the member.

Confirmed.

4. Contractor will send prescription orders to members that do not provide appropriate payments with their prescription order, up to three (3) times the plans highest copayment for each enrollee. After the ceiling is reached, the Contractor may implement standard accounts receivable policies and procedures.

Confirmed.

Section V Project Description and Scope of Work

5. Contractor will arrange and pay for a short-term retail supply of a delayed or incorrectly processed mail order prescription caused by your organization. In addition, Contractor must not to charge the State's members for expedited delivery of the mail order prescription if the prescription delay is caused by Contractor's organization.

Confirmed.

6. In the event of a natural disaster or national emergency, Contractor will continue to fill all prescription requests, proactively obtaining any necessary overrides to facilitate this process, and provide members with expedited delivery to convenient locations.

Confirmed.

7. Contractor will assure that 100% of mail order prescriptions will be imaged and entered when received at mail service (including Specialty prescriptions). Contractor must electronically track 100% of all mail order prescriptions (Including Specialty) throughout the filling process, on a timely basis, from the point of prescription is received until it is shipped to the member.

Confirmed.

8. Within 24 hours, Contractor must contact prescribers and/or members via a telephone call or email for 100% of incomplete mail order prescriptions (including Specialty) that require additional information.

Confirmed.

Section V Project Description and Scope of Work

9. Contractor must provide both email and telephone voicemail capabilities to communicate to members their mail order has been received and the date the order has been shipped to members.

Confirmed. Members can also track orders via our website or through our telephone IVR system.

10. Contractor must have the capability to accept early refill orders and suspend or "queue" these orders in your system until the earliest refill date for processing.

Confirmed.

11. Contractor must have the capability to accept major credit cards and store credit card number(s) by member account for future mail order prescriptions. Contractor must have the capability to advise members thirty (30) days in advance of the date their credit card number is going to expire.

Confirmed.

12. If requested, Contractor must provide members with checks for monies owed to them instead of maintaining credits at your mail facility.

Confirmed.

Section V Project Description and Scope of Work

13. The State shall have the right to advise you in writing to change the floor limit for all members or just those with unpaid balances after 120 days of dispensing.

Confirmed.

14. Contractor cannot require the State of Nebraska to mandate use of the mail pharmacies.

Confirmed.

15. Contractor will disclose any limits on the number of days' supply that can be filled through the Contractor's mail order facilities, such as controlled substances.

Confirmed.

Z. SPECIALTY PHARMACY

1. Contractor must provide 24 hour, 7 day a week patient education support and access to pharmacists and nurses with experience in designated therapies.

Confirmed.

2. Contractor must provide specialty condition/disease specific management protocols and access to in-home nursing services where applicable.

Confirmed. We provide clinical support to members taking specialty drugs through two integrated nursing teams: pharmacy operations nurses and Specialty Health Care Management℠ nurses. Members can call Aetna Specialty Pharmacy® and speak with a nurse or pharmacist 24 hours a day, 7 days a week.

Pharmacy Operations nurses

Our pharmacy operation nurses proactively manage the following disease states:

- Hemophilia
- Immune Deficiencies (IVIG)
- Lysosomal Storage Diseases (Enzymes)
- Pulmonary Arterial Hypertension
- Certain Oncology Drugs

While these nurses proactively manage certain disease states, it is important to note that we support *every* member who fills a drug through Aetna Specialty Pharmacy. When we receive a specialty drug order, a pharmacy service representative contacts the member to confirm delivery and offer the opportunity to speak with a nurse. Once connected to the member (either proactively or on request), our pharmacy operations nurses provide the following general specialty drug support to members:

- Review and confirm dose
- Provide additional education and self-injection training
- Coordinate home infusions

Section V Project Description and Scope of Work

- Coordinate home health care
- Determine supplies to send with medication
- Outreach to ensure refills are available when needed
- Refer members to Behavioral Health services if they screen positive
- Screening for copay concerns

If members have major concerns or adherence issues for an applicable disease state, our pharmacy operations nurses refer them to our Specialty Health Care Management area for additional support.

Specialty Health Care Management nurses

Our Specialty Health Care Management program is an enhanced care management solution that we offer on an opt-in basis to all members using Aetna Specialty Pharmacy. All members receive written information about the program and steps on how to enroll with each prescription order.

In addition, the nurse team will outreach to members with the conditions below who are new to therapy or Aetna Specialty Pharmacy:

- Crohn's and Colitis
- Hepatitis C
- HIV/AIDS
- Multiple Sclerosis
- Oncology
- Osteoporosis
- Rheumatoid Arthritis (includes Psoriatic Arthritis and Ankylosing Spondylitis)

We integrate this program with our medical and behavioral health solutions. What this means for you is that we can increase member engagement in medical disease management, case management, behavioral health and wellness programs, including Registered Dieticians.

Because we offer these programs internally, our nurses can see all programs that may benefit members. We can see what programs members are participating in and additional programs that may benefit them. Based on the programs offered, the nurse may loop in these areas to act as a consultant in supporting the member.

Section V Project Description and Scope of Work

3. Contractor must demonstrate ability to ensure patient adherence to drug therapy.

Confirmed. We track member adherence to their specialty drug regimen for many disease states that require the use of specialty drugs. Following are adherence rates for common disease states in 2018 based on medication possession ratio (MPR).

- Autoimmune – 89.81%
- Multiple Sclerosis – 92.64%
- Transplant – 93.36%
- Psoriasis – 89.65%
- Oral Oncolytic – 94.04%
- HIV / AIDS – 95.66%
- Asthma – 86.25%
- Growth Hormone – 88.04%
- Neurological Neuromuscular – 93.67%
- Hyperlipemia – 92.30%
- Hepatitis – 97.41%
- Osteoarthritis – 91.58%
- Osteoporosis – 95.30%
- Pulmonary Arterial Hypertension – 94.25%

4. Contractor must demonstrate adherence to drug therapy prescribing guidelines including required genetic testing, if applicable, prior to initiation of treatment.

Confirmed.

AA. PHARMACY FEES

1. Contractor will guarantee the quoted fees until the scheduled implementation date through the entire contract period.

We will guarantee our quoted fees until the scheduled implementation.

We reserve the right to make appropriate changes to these price points if any event materially affects our net income derived under this Agreement. Such events include:

(i) The termination or material modification of any material manufacturer Rebate contract
(ii) Any significant changes in the composition of our pharmacy network or in our pharmacy network contract compensation rates

(iii) A change in government laws or regulations

(iv) A change in the Plan that is initiated by The State

(v) AWP is discontinued or modified in whole or in part

(vi) A greater than 15% change in enrollment or a material change, as defined by Aetna, in the drug utilization, plan design, geographic mix or demographic mix of the covered population from what we assumed at the time of underwriting.

We will provide the State with at least sixty- (60) days written notice of such changes together with a sufficiently detailed explanation supporting these price point changes. If sixty- (60) days written notice is not practicable under the circumstances, we shall provide written notice as soon as practicable.

We reserve the right to modify our products, services and fees, and to recoup any costs, taxes, fees or assessments, in response to legislation, regulation or requests of government authorities. Any taxes or fees (assessments) applied to self-funded benefit Plans related to The Patient Protection and Affordable Care Act (PPACA) will be solely the obligation of the Plan sponsor. The pharmacy pricing contained herein does not include any such Plan sponsor liability.

Section V Project Description and Scope of Work

2. Contractor will ensure fees quoted are not contingent upon any of the following:

   a. Minimum enrollment or utilization requirements.
   b. Participation in any supplemental programs.
   c. Direct communication with patient population.

Aetna reserves the right to make appropriate changes to these price points if any event materially affects our net income derived under this Agreement. Such events include:

- The termination or material modification of any material manufacturer Rebate contract
- Any significant changes in the composition of our pharmacy network or in our pharmacy network contract compensation rates
- A change in government laws or regulations
- A change in the Plan that the State initiates
- AWP is discontinued or modified in whole or in part
- A greater than 15% change in enrollment or a material change, as defined by Aetna, in the drug utilization, plan design, geographic mix or demographic mix of the covered population from what we assumed at the time of underwriting.

3. Postage is included in ID card generation, duplicate cards, all mail order prescriptions, and any mailings.

Confirmed.

Section V Project Description and Scope of Work

4. Quoted fees include postage paid mail order envelopes for member prescription submission.

Not Confirmed. We do not provide postage paid mail order envelopes for member prescription submission. Members can request that their physician send an electronic prescription to our mail order facility. E-Prescribing is available at no cost to the member.

5. Multi-language communication phone line support be included in the base administrative fee.

Confirmed.

6. Disabled (e.g., hearing-impaired) member calls will be facilitated through your member services area.

Confirmed. Our member service call centers have programs in place to assist members who are visually or hearing impaired, members who request translation services and senior members.

Visually impaired

Our visually impaired members can use toll-free, touch-tone or voice-activated telephone access to prescription services 24 hours a day, 7 days a week through our automated phone system. At any time, members can elect to speak to a live customer service representative (CSR) for additional service.

We have also collaborated with En-Vision America to provide members with ScripTalk talking prescription labels and ScripView large font labels. These options are available for members through home delivery.

Section V Project Description and Scope of Work

Hearing impaired

Members can utilize the national 711 relay services. The relay service acts as an intermediary for telecommunications between hearing individuals and individuals who are deaf, hard-of-hearing, deaf-blind, and/or have speech disabilities. Specially trained Communications Specialists complete the call and stay on-line with our CSRs to relay messages to members either electronically over a TTY/TDD or verbally to hearing parties. The **aetna.com** website provides secure, convenient and reliable access to pharmacy benefits 24 hours a day, 7 days a week.

Elderly plan members

We serve a large elderly population and focus our services to enhance the quality of care for these members. We include formalized training for our CSRs to develop special skills needed to serve these members.

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7. There will not be any additional charges if the plan of benefits is restructured or new classes of eligible members are added.

Aetna reserves the right to make appropriate changes to these price points if any event materially affects our net income derived under this Agreement. Such events include:

- A change in the Plan that the State initiates
- A greater than 15% change in enrollment or a material change, as defined by Aetna, in the drug utilization, plan design, geographic mix or demographic mix of the covered population from what we assumed at the time of underwriting.

Section V Project Description and Scope of Work

BB. AWP REIMBURSEMENT

1. Drugs with an "Insufficient Supply" will be included in the guarantees.

Confirmed. We do not have a minimum days' supply tied to our guarantees.

2. Member Cost Share at the point-of-sale (for retail and mail) is based on the lowest of the plan copay/coinsurance, usual and customary charges, negotiated discounted ingredient cost plus dispensing fee or retail cash price.

Confirmed.

3. The State's current plan designs qualify for the proposed rebate guarantees.

Confirmed.

CC. PERFORMANCE GUARANTEES

Please see Attachment D for the Performance Guarantees.

Confirmed. Please refer to Attachment D submitted with our RFP response.

DD. CLINICAL MANAGEMENT PROGRAMS AND CAPABILITIES

The State requires that the Contractor administer the following programs. Any additional fees associated with these programs must be provided in your response to the Cost Proposal of this RFP.

1. Contractor must offer the following clinical programs:

   a. **Timely Refill Discounts** – Discount provided for members who refill a prescription within 30 days of date it is expected to run out

   b. **Drug Utilization Review** – Monitor for drug interactions, therapeutic duplications and dosing concerns

   c. **Narcotic Utilization Review** – Monitor for number of prescriptions / physicians

   d. **Step Therapy** – Program for members to try a low-cost prescription first before a higher cost is covered

   e. **Brand Charge Program** – Members pay the cost difference if a brand is filled when a generic alternative is available

   f. **Prior Authorization** – Monitors and reviews prescribing physician, diagnosis before prescription is covered

   g. **Supply Limits** – Largest quantity of medication covered based on FDA guidelines

Confirmed.

EE. TRANSPARENCY TOOLS

Contactor tool(s) must enable members to;

1. Compare providers based on their quality, efficacy and outcomes. The tool(s) must also display provider credentials.

   Confirmed.

2. Easily view cost differences among different providers.

   Confirmed.

3. Easily view cost differences among different treatment paths.

   Confirmed.

4. Compare benefit structures for different health plans.

   Confirmed.

FF. IMPLEMENTATION AND COMMUNICATIONS

Implementation must be completed prior to the State's Annual Open Enrollment period in May 2020. The implementation plan(s) shall also define responsibilities assigned to the Contractor and responsibilities assigned to the State.

1. Contractor must provide a dedicated implementation manager whose sole account is the State, who in coordination with the dedicated account executive and account management team, will effectively manage the implementation of this program. The dedicated implementation manager must continue to support the State a minimum of 60 days after the Go Live date of July 1, 2020, should the State desire. Such support includes, but is not limited to: weekly calls with the State and the designated Account Management team; maintenance of issue tracking logs; and issue resolution. This support must be provided as part of the base administrative fees with no additional cost to the State.

   Confirmed.

2. The State requires the Contractor be available and participate in the State's Open Enrollment communications campaign.

   Confirmed.

3. Contractor shall provide member's access to written or electronic EOB statements at no cost to the State.

   Confirmed.

Section V Project Description and Scope of Work

4. When customized printing is required, Contractor must present a proof to the State for approval in a timely manner.

Confirmed.

5. Contractor shall incur all costs for printing and distribution of all communications, including but not limited to:

   a. Identification Cards (ID) printed
   b. Booklets electronic copy provided
   c. Certificates electronic copy provided
   d. Summary Plan Descriptions (SPDs) electronic copy provided

Confirmed.

6. Contractor shall incur all costs for additional open enrollment materials, including but not limited to:

   a. Additional custom printing
   b. Web hosting

Confirmed. The implementation allowance we've included in our proposed offering can be used toward these expenses.

7. No external communications material that mentions the State's benefit plans may be circulated without written approval from the State.

Confirmed.

Section V Project Description and Scope of Work

8. The State reserves the right to review, edit, or customize any communication from the Contractor to its membership.

Confirmed.

9. Contractor must produce ID cards and/or temporary proof of benefit letters in "real time". 100% of Members ID cards are mailed within ten (10) business days of open enrollment eligibility posting. Replacement ID cards and/or newly eligible member ID cards must be mailed within three (3) business days of notification.

Confirmed.

10. Identification cards will be subject to final approval by the State.

Confirmed.

11. Contractor must provide a dedicated 24-hour toll-free customer service phone line available during Open Enrollment as well as throughout the year.

Our customer service representatives are available from 8:00a.m. to 6:00p.m. CT.

Our pharmacy customer service representatives are available 24 hours a day, 7 days a week.

Our Informed Health line is available 24 hours a day, 7 days per week.

Section V Project Description and Scope of Work

12. Contractor must agree to waive any charges to the State or the State's vendors such as a set-up fee, a programming fee or a monthly fee, for establishing a connection with a third party vendor for real-time, bidirectional data integration, including non-standard data integration formats.

Confirmed.

GG. WELLNESS PROGRAM

Contractor must provide wellness programming to employees and spouses and provide seamless integration for employees and a system to track and report the progress of individuals through the systems and websites at no additional cost to the State.

Confirmed.

Request for Proposal for Contractual Services Form

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REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Request for Proposal for Contractual Services form, the bidder guarantees compliance with the procedures stated in this Request for Proposal, and agrees to the terms and conditions unless otherwise indicated in writing and certifies that bidder maintains a drug free workplace.

Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat § 73-603 DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Contractors. This information is for statistical purposes only and will not be considered for contract award purposes.

X NEBRASKA CONTRACTOR AFFIDAVIT: Bidder hereby attests that bidder is a Nebraska Contractor. "Nebraska Contractor" shall mean any bidder who has maintained a bona fide place of business and at least one employee within this state for at least the six (6) months immediately preceding the posting date of this RFP.

_____I hereby certify that I am a Resident disabled veteran or business located in a designated enterprise zone in accordance with Neb. Rev. Stat. § 73-107 and wish to have preference, if applicable, considered in the award of this contract.

_____ I hereby certify that I am a blind person licensed by the Commission for the Blind & Visually Impaired in accordance with Neb. Rev. Stat. §71-8611 and wish to have preference considered in the award of this contract.

FORM MUST BE SIGNED USING AN INDELIBLE METHOD (NOT ELECTRONICALLY)

FIRM:	**AETNA LIFE INSURANCE COMPANY**
COMPLETE ADDRESS:	**151 FARMINGTON AVENUE, HARTFORD CT 06156**
TELEPHONE NUMBER:	**(800) 872-3862**
FAX NUMBER:	**(860) 273-3382**
DATE:	**08/05/2019**
SIGNATURE:	
TYPED NAME & TITLE OF SIGNER:	**TAMI POLSONETTI, SENIOR DIRECTOR SALES SUPPORT**

Confidential Information Disclosure

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Confidential Information Disclosure

Pursuant to Nebraska Revised Statue § 84-712.05(3), We have identified / Marked Record Deemed "Proprietary or Commercial", which if released would give advantage to business competitors and serve no public purpose.

84-712.05.
Records which may be withheld from the public; enumerated.
The following records, unless publicly disclosed in an open court, open administrative proceeding, or open meeting or disclosed by a public entity pursuant to its duties, may be withheld from the public by the lawful custodian of the records:

(1) Personal information in records regarding a student, prospective student, or former student of any educational institution or exempt school that has effectuated an election not to meet state approval or accreditation requirements pursuant to section 79-1601 when such records are maintained by and in the possession of a public entity, other than routine directory information specified and made public consistent with 20 U.S.C. 1232g, as such section existed on February 1, 2013, and regulations adopted thereunder;

(2) Medical records, other than records of births and deaths and except as provided in subdivision (5) of this section, in any form concerning any person; records of elections filed under section 44-2821; and patient safety work product under the Patient Safety Improvement Act;

(3) Trade secrets, academic and scientific research work which is in progress and unpublished, and other proprietary or commercial information which if released would give advantage to business competitors and serve no public purpose;

Confidential Information Disclosure

Aetna is claiming this information as Confidential:

Document	Page and/or Section	Reasoning
6102 Z1, Attachment A Bidder Questionnaire	Network/Provider Arrangements, Question 1.101	Our aggregate trend reflects the total savings of our products and programs, including but not limited to Discount Relativities, Medical Management Savings, and Trend. These are considered critical components to our financial offer, as it relates to a customer's total cost, and would give competitive information around the value of our products and programs.
6102 Z1, Attachment A Bidder Questionnaire	Wellness Programs, Question 1.220	The information contained in the guarantee would give competitive information around the value of our clinical programs, what we project for medical management savings, and what we willing to guarantee for return on investment. This is a critical component to our overall financial offer as it relates to a customer's total cost.
References	Samples and Brochures, Entire Documents	The names, addresses and phone numbers of Aetna active references are confidential. These references have agreed to be available for specific RFP questions concerning Aetna, but they do not want to be listed publicly to be inundated with unsolicited sales calls.

6102 Z1, Attachment A Bidder Questionnaire

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Attachment A
Bidder Questionnaire
RFP 6102 Z1

Bidder Name: Aetna Life Insurance Company

Bidder should complete all questions in Attachment A.

1.1	**BIDDER IDENTIFICATION AND INFORMATION** Provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, year in which the bidder first organized to do business, whether the name and form of organization has changed since first organized and Federal Employer Identification Number.

Response:

The ultimate parent of all Aetna affiliated companies is CVS Health Corporation, a publicly traded, Delaware corporation. CVS Health Corporation's corporate headquarters are located Woonsocket, RI.

One CVS Drive – Woonsocket, RI 02895

Business operations for Aetna Life Insurance Company are based in Hartford, CT.

151 Farmington, Ave. – Hartford, CT 06156

Aetna Inc. is an indirect subsidiary of CVS Health Corporation, the publicly traded parent company of the Aetna group of companies.

Prior to December 13, 2000, Aetna Inc. was a subsidiary of a Connecticut corporation named Aetna Inc. (former Aetna). On December 13, 2000, former Aetna spun off the current Aetna parent company and its health subsidiaries to its shareholders. The remaining entity, including former Aetna's financial services and international businesses, merged with a subsidiary of ING Group N.V. and Aetna U.S. Healthcare Inc. changed its name to Aetna Inc. On November 28, 2018, we announced that CVS Health Corporation completed its acquisition of Aetna. Our for-profit tax status has remained the same.

The National Association of Insurance Commissioners (NAIC) Code for Aetna Life Insurance Company (ALIC) is 60054. However, premium falls into three different NAIC codes:

- 524113 - Direct Life Insurance Carriers
- 524114 - Direct Health and Medical Insurance Carriers
- 524292 - Third Party Administration of Insurance and Pension Funds

The majority of the premiums fall into the 524114 category.

FINANCIAL STATEMENTS AND INFORMATION

Provide financial statements applicable to the firm. Provide a copy of the bidder's most recent annual report. If publicly held, provide a copy of the corporation's most recent two (2) years of audited financial reports and statements and the name, address and telephone number of the fiscally responsible representative of the bidder's financial or banking organization.

If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation or a description of the organization, including size, longevity, client base, areas of specialization and expertise and any other pertinent information must be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm must provide a banking reference.

1.2 The bidder must disclose any and all judgments, pending or expected litigation or other real or potential financial reversals, which might materially affect the viability or stability of the organization or state that no such condition is known to exist.

The State may elect to use a third party to conduct credit checks as part of the corporate overview evaluation.

Indicate the most recent Financial Rating, Financial Rating Modifiers and the Financial Rating Effective Date that have been received by the following organizations. Indicate all changes that have occurred in the last twelve (12) months for each of these ratings.

a. A.M.Best
b. Standard and Poors
c. Moody's
d. Fitch

Response:

Please refer to *Aetna Financial Statements.zip*, located in the Samples and Brochures section of our proposal response.

Our Chief Financial Officer is Scott Walker. His contact information is noted below:

151 Farmington Avenue

Hartford, Connecticut 06156

860-273-7006

WalkerS3@aetna.com

Aetna Life Insurance Company (ALIC) and our subsidiaries/affiliates are routinely involved in non-material litigation regarding the administration of health and dental plans. Most of this litigation involves a single claim for benefits or payment for provider services.

ALIC is a wholly owned subsidiary of Aetna Inc. (Aetna). On November 28, 2018, Aetna Inc. and each of its subsidiaries, including ALIC, became subsidiaries of CVS Health Corporation (CVS). We report all material litigation in the Aetna and CVS public filings.

The credit ratings for ALIC are evidence of our financial soundness and claims paying ability.

	Rating	Reporting Date*	Next Scheduled Rating **
A.M. Best	A	8/22/18	Current rating affirmed 8/18**
Moody's	A2	11/28/18	Current rating affirmed 11/18**
Standard & Poor's	A-	11/27/18	Current rating affirmed 11/18**

Fitch***	A	11/28/18	Current rating affirmed 11/18**
Weiss Ratings Inc.	N/A	N/A	N/A
Comdex	N/A	N/A	N/A

The financial strength ratings for Aetna Life Insurance Company (ALIC) are:

* Reporting date reflects the effective date of the most current rating.

** These rating agencies do not have scheduled rating dates. Rating changes, confirmations or affirmations result from industry/peer reviews or company specific events affecting their financial profile.

***In 2000, Duff & Phelps Credit Rating Co. was acquired by the Fitch Group, which later eliminated the use of the Duff & Phelps name.

Outlook

Updated as of November 28, 2018
A.M. Best affirmed our long-term debt and financial strength ratings with a stable outlook. S&P has placed our senior long-term debt and financial strength ratings on stable outlook. Moody's affirmed our long-term debt and financial strength ratings with a negative outlook. Fitch Ratings placed our debt and financial strength ratings on stable outlook.

Rating Changes

	A.M. Best	Standard & Poor's	Moody's	Fitch
11/28/18	A	A-(2)	A2	A(3)
2/15/17	A	AA- (1)	A2	AA-

(1) Effective February 14, 2017 S&P raised its financial strength ratings on Aetna Inc.'s core operating subsidiaries to 'AA-' from 'A+'. The rating agency removed Aetna's ratings from CreditWatch Developing where they were initially placed on July 21, 2016. The outlook is stable.

(2) On November 27, 2018 S&P downgraded the financial strength ratings and long-term senior debt ratings following the approval of the acquisition of Aetna by CVS Health Corporation.

(3) On November 28, 2018 Fitch downgraded the financial strength ratings and long-term senior debt ratings following the approval of the acquisition of Aetna by CVS Health Corporation.

1.3	**CHANGE OF OWNERSHIP** If any change in ownership or control of the company is anticipated during the twelve (12) months following the proposal due date, describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded Contractor will require notification to the State. Describe any parent/subsidiary relationship.

Response:

Aetna Inc. is an indirect subsidiary of CVS Health Corporation, the publicly traded parent company of the Aetna group of companies. Our primary goal is to profitably grow and strengthen our core health and related benefits businesses. The company may, from time to time, make acquisitions and/or organizational changes as necessary to further enhance this goal.

1.4	**OFFICE LOCATION** The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska must be identified.

Response:

We will manage The State's account from our Omaha, NE office.

11819 Miami Street
Omaha, NE 68164

1.5	**RELATIONSHIPS WITH THE STATE** The bidder describe any dealings with the State over the previous twelve (12) months. If the organization, its predecessor or any party named in the bidder's proposal response has contracted with the State, identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

Response:

The State of Nebraska has had group life insurance coverage with Aetna Life Insurance Company since 7/1/13 under our control number 473449. They have been converted to The Hartford as of 7/1/19.

1.6	**BIDDER'S EMPLOYEE RELATIONS TO STATE** If any party named in the bidder's proposal response is or was an employee of the State within the past twelve (12) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State and separation date. If no such relationship exists or has existed, so declare. If any employee of any agency of the State of Nebraska is employed by the bidder or is a subcontractor to the bidder, as of the due date for proposal submission, identify all such persons by name, position held with the bidder and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the bidder may be disqualified from further consideration in this proposal. If no such relationship exists, so declare.

Response:

Pursuant to a search of our records, no employee has disclosed an affiliation of any sort with the State of Nebraska.

1.7	**CONTRACT PERFORMANCE** If the bidder or any proposed subcontractor has had a contract terminated for default during the past three (3) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default. Bidder must provide information on administrative and/or litigation within the past three (3) years, include current/pending cases, expected litigation, judgments, awards and settlements (both in and out of court) or other real or potential financial reversals, including any bankruptcy proceedings whether voluntary or involuntary, which might materially affect the viability or stability of the bidder. It is mandatory that the bidder submit full details of all termination for default experienced during the past three (3) years, including the other party's name, address and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's proposal accordingly. If no such termination for default has been experienced by the bidder in the past three (3) years, so declare. If at any time during the past three (3) years, the bidder has had a contract terminated for convenience, non-performance, non-allocation of funds or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting party.

Response:

Aetna has not had a contract terminated for default in the past three (3) years. As a national health carrier, the evolution of our business cycle and that of our customers involve terminations of contracts. These instances are initiated by both Aetna and customer. While infrequent, contract terminations are not an unnatural aspect of our business cycle.

1.8	**SUMMARY OF BIDDER'S CORPORATE EXPERIENCE** Provide a summary matrix listing the bidder's previous projects similar to this Request for Proposal in size, scope and complexity. The State will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the proposal. The bidder must address the following: 1. Provide three narrative descriptions to highlight the similarities between previous experience and this Request for Proposal. These descriptions must include: a. The time period of the projects; b. The scheduled and actual completion dates; c. The Contractor's responsibilities; d. The number of contracts and the number of covered members for each project; e. for reference purposes, three customer names (including the names of a contact person, current telephone numbers, facsimile numbers and e-mail addresses); and f. Each project description shall identify whether the work was performed as the prime Contractor or as a subcontractor. If a bidder performed as the prime Contractor, the description must provide the originally scheduled completion dates and budget, as well as the actual (or currently planned) completion dates and actual (or currently planned) budget. 2. Contractor and subcontractor(s) experience must be listed separately. Narrative descriptions submitted for subcontractors must be specifically identified as subcontractor projects. 3. If the work was performed as a subcontractor, the narrative description shall identify the same information as requested for the Contractors above. In addition, identify what share of contract

costs, project responsibilities and time period were performed as a subcontractor.

a. Is this an exclusive relationship?
b. Effective date of Subcontract?

4. Indicate years of service providing and administering the coverage(s) related to this RFP. Briefly describe abilities to administer such plans including:

a. Health Savings Accounts

5. For the entire book of business, provide the total year-end national group membership (number of contracts) that receives medical administration services and indicate how many of these are in Nebraska. Provide statistics for Public Sector clients

	National Group Membership (Number of Contracts)	Nebraska Group Membership Number of Contracts)	Number of Public Sector Groups	Number of Public Sector Groups with 15,000+ lives
2016				
2017				
2018				
2019				

6. What percentage of the 2018 total group membership renewed for the 2019 plan year?

Response:

1. We have provided the narrative project descriptions in the Samples and Brochures section of our proposal response.
2. Not applicable.
3. Not applicable.
4. Aetna is a leading diversified health care benefits company with over 160 years of experience in providing quality, reliable services to businesses, individuals and the government. Founded in 1853 in Hartford, CT, we entered the group health insurance business in 1936. Our first group hospitalization contract was issued in 1937. We introduced our first major medical product in 1951, our first dental plan in 1957 and our first stand-alone vision product in 2009.

   A subsidiary of CVS Health Corporation ("CVS Health") acquired Aetna Inc. and its subsidiaries effective November 28, 2018 and CVS Health became the ultimate parent company of Aetna and its subsidiaries.

5. For the entire book of business, provide the total year-end national group membership (number of contracts) that receives medical administration services and indicate how many of these are in Nebraska. Provide statistics for Public Sector clients

	National Group Membership (Number of Contracts)	Nebraska Group Membership Number of Contracts)	Number of Public Sector Groups	Number of Public Sector Groups with 15,000+ lives
2016	777,319 clients 23,109,965 members	16,535 clients 275,248 members	270 clients 2,103,261 members	25 clients

2017	805,752 clients 22,237,348 members	14,968 clients 163,555 members	571 clients 2,816,155 members	34 clients
2018	49,522 clients 22,101,062 members	1,352 clients 122,455 members	420 clients 2,762,697 members	24 clients
2019 (1st Quarter)	42,844 clients 22,833,881 members	1,287 clients 125,990 members	336 clients 2,736,368 members	36 clients

6. We consider our retention rates to be material, non-public information; therefore, we don't release this information outside of the company. We can provide you estimated average tenure of our customers.

The estimated average tenure for our customers across all products is six to eight years.

1.9

SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH

The bidder must present a detailed description of its proposed approach to the management of the project.

The bidder must identify the specific professionals who will work on the State's project if the company is awarded the contract resulting from this Request for Proposal. The names and titles of the team proposed for assignment to the State project shall be identified in full, with a description of the team leadership, interface and support functions and reporting relationships. The primary work assigned to each person should also be identified. The team shall include, but not be limited, to the following roles:

- Implementation Manager
- Account Executive
- Clinical Pharmacist
- Operations Director
- Network Manager
- Member Services Manager

Designated alternate Account Executive would be expected to be familiar with all aspects of the State's business as it relates to the State's Health Plan. The designated alternate Account Executive is not subject to the location requirements, but must be available via a conference call.

Provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the Request for Proposal in addition to assessing the experience of specific individuals.

Resumes must not be longer than three (3) pages. Resumes shall include, at a minimum, academic background and degrees, professional certifications, understanding of the process and at least three (3) references (name, address and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

Response:

Please refer to *Account Team Resumes.zip*, located in the Samples and Brochures section of our proposal response.

Our goal is to be your trusted advisor. That's why we support you with a strong account team that consists of an executive sponsor, account executive and account manager.

Your account management team works in close consultation with you to:

- Understand your needs and act as a true strategic partner
- Solve challenges to plan administration
- Demonstrate the value of the programs and services purchased
- Make sure that the pricing of existing and new services is compatible with your goals and objectives
- Provide the right data and information to help you better understand and manage your benefits plan

Roles and responsibilities

You'll be supported by a core account management team that consists of:

- Tim Redmond, Account Executive – Tim works with you to create your benefit program strategy and gather the right resources within our company to support it. Tim has overall responsibility for our partnership with you.
- Penny Pollard, Plan Sponsor Liaison – Penny will act as a single point-of-contact to your HR staff for claim and benefit related issues. Penny will maintain an on-going relationship with your HR staff to meet your changing needs. Penny will be responsible for reporting and analysis of your service experience.
- Hunter Williams, Account Manager – Hunter is your day-to-day contact. He is responsible for building and maintaining a strong relationship with you. That means communicating with you on a regular basis, overseeing operational services for you, connecting all areas of Aetna to ensure commitments are kept and managing day-to-day services to make sure we provide you with quality service.

Goals

The account team's goal is to exceed your expectations. We do this by providing:

- Accountability
- Consistent support
- A single point of contact to serve as the entry point for your questions and concerns

Single point of contact

Tim Redmond, your account executive, is your single point of contact. Tim coordinates inquiries and projects specific to network, administration, reporting and underwriting.

Both Tim Redmond and Hunter Williams are your liaisons between the State and Aetna. They serve as a conduit for information to those areas within Aetna that support the administration of your employee benefits program. While your account team may not have direct authority to make all commitments on behalf of Aetna, they work with the appropriate areas on your behalf to secure commitments when appropriate.

Your extended service team

While your account team is your primary advocate within our organization, you'll also be supported by an extended service team. This includes your designated eligibility consultant and billing consultant. It also includes your Plan Sponsor

Liaison, Penny Pollard, who is your direct line into claims and member services. In addition, we are providing the following contacts for the State:

- Clinical Pharmacist – Kim Haywood
- Operations Director – Jessica Casselman
- Network Manager – Greg Killinger
- Member Services Managers – Shelley Geiger and Rita Pfeifer

1.10	**SUBCONTRACTORS** If the bidder intends to subcontract any part of its performance hereunder, the bidder must provide: a. name, address and telephone number of the subcontractor(s); b. specific tasks for each subcontractor(s); c. advise if exclusive relationship for each subcontractor; d. Indicate effective date and expiration date of each Subcontract agreement; and e. Describe the management of suppliers/subcontractors to ensure delivery is effectively provided to the State of Nebraska and its employees.

Response:

We maintain stringent requirements and standards for all subcontractors. We define a subcontractor as an entity that we have engaged to provide goods or perform services for us. The following table identifies our Tier 1 subcontractors, which are a subset of our suppliers/vendors. Tier 1 subcontractors provide member constituent services directly related to the administration of a customer contract and for whom a portion of the services provided may include direct member contact or significant access to member identifiable data.

Please refer to *Subcontractor Listing.docx*, located in the Samples and Brochures section of our proposal response.

Proposals must include a current comparison to other state and large employers based on the claims data provided and current prescription programs in place at the State. Use the normative data and provide feedback comparing the State of Nebraska with other comparable state and municipality employers based on the claims data provided. This comparison should include, but not be limited to, suggestions for modifications to existing programs, the addition of new programs and/or recommendations for changes in the State's policies on how to improve the State's performance and specific methods to reduce costs.

1.11	Describe how the medical plan design and level of coverage presently offered to the State's covered member population will be duplicated for the Regular Plan.

Response:

Please refer to the Benefit Deviations document included in the Plan Design Section of the proposal response.

1.12	Describe how the medical plan design and level of coverage presently offered to the State's covered member population will be duplicated for the Consumer Focused Health Plan.

Response:

Please refer to the Benefit Deviations document included in the Plan Design Section of the proposal response.

1.13	Describe how the medical plan design and level of coverage presently offered to the State's covered member population will be duplicated for the WellNebraska Plan.

Response:

Please refer to the Benefit Deviations document included in the Plan Design Section of the proposal response.

1.14	Describe experiences in working with Direct Primary Care (DPC) models, as described in State of Nebraska's Direct Primary Pilot Program Act.

Response:

We have limited experience working with Direct Primary Care (DPC) vendors. We are not proposing an Aetna Direct Primary Care product or network at this time. However, we do have arrangements with some of our provider partners across the country where we work with similar types of programs. We also have experience building custom networks and plans to meet specific need so our clients. We don't anticipate issues administering the plan with Strata as the DPC.

1.15	Describe the DPC model and how it addresses primary care, prevention and coordination of services that are provided to State employees who choose the DPC model. If any services are provided by an affiliation or contract, describe how the standards and outcomes will be consistently met.

Response:

We are not proposing a separate or stand-alone Direct Primary Care product or network with this proposal. We will collaborate with the DPC vendor selected by the State to achieve its DPC pilot program objectives. We would expect to receive a file from the DPC vendor with claim and utilization data that will be loaded into our care engine system. This will allow us to utilize our proprietary tools to monitor member health conditions and identify utilization patterns where we have opportunities to alert providers to positively impact member health.

1.16	Describe the DPC organizational chart, infrastructure, quality control measures and outcomes.

Response:

We will partner with the state's selected DPC vendor to make the program work efficiently.

1.17	Describe the plan for working with other DPC organizations to address the needs of State employees.

Response:

We would expect to receive utilization and encounter data from the DPC vendor(s) that will allow us to monitor and help manage the overall health condition of the State employees utilizing DPC providers.

1.18	Define the relationship of the DPC model to traditional insurance options. Describe how services between entities will be coordinated.

Response:

The DPC vendor will be treated similar to other third-party vendors we work with. We currently work with on-site and near-site clinics and wellness vendors to share information. Our relationship with the State's DPC program will follow established information sharing protocol in an effort to best manage members overall health conditions.

1.19	Describe the processes to exchange data with the DPC provider? Describe how confidentiality will be assured and how patient data will be secured and protected.

Response:

We will collaborate with the selected DPC vendor to establish secure file transfer protocol (SFTP) sites for exchange of data, as applicable. We will enter into a third-party confidentiality agreement with the selected vendor to identify security roles and responsibilities of the parties.

1.20	Describe integration data from the DPC provider to gain a holistic picture of each member's health profile? Include a plan for documentation of patient visits, telehealth and securing medical records as well as how complete comprehensive healthcare records will be obtained.

Response:

We would expect to receive a file from the DPC vendor with claim and utilization data that will be loaded into our care engine system. This will allow us to utilize our proprietary tools to monitor member health conditions and identify utilization patterns where we have opportunities to alert providers to positively impact member health.

1.21	Describe how to administer the wrap plan for the DPC model.

Response:

We plan to work with the State and the States' consultant to develop protocol for guidelines and processes as needed. There may be a number of ways to administer the program that could include, setting up a custom network for this DPC membership that will allow or disallow services from traditional insurance coverage, based on guidance from the plan sponsor.

1.22	Describe the mechanisms in place to work with the DPC provider to ensure the member is referred to the medical plan for benefits, if treatment outside the DPC model is needed. Describe the process for specialist referral to ensure the maximum use of the primary care model.

:esponse:

We are offering an open access point-of-service model network with this proposal. Members can self-refer to specialists within the network. We would expect the DPC provider to assist the member in their evaluation of network specialist provider options. Members will have access to provider search capabilities through desktop, telephonic and mobile application technology to assure maximum access to network providers.

HIPAA	
1.23	Describe the capabilities in offering the State an annual HIPAA training seminar to comply with the annual education and training requirements as defined by HIPAA at no cost to the State.

Response:

We do not provide HIPAA training to our customers. As a covered entity, we are obligated under HIPAA to only provide training to its workforce.

GENERAL PLAN INFORMATION AND REQUIREMENTS	
1.24	Provide a copy of a Suggested Employer Contract with a statement that the sample include all exclusions and limitations that will apply to a policy issued to the State.

Response:

Please refer to *Sample Administrative Services Agreement.docx,* located in the Samples and Brochures section of our proposal response. The sample contract includes all exclusions and limitations that will apply to the State.

1.25	Describe any staff relocations, computer system changes/upgrades, program changes or telephone system changes in process at this time or proposed within the next 12-24 months.

Response:

We do not anticipate any staff relocations within the next 12-24 months.

System changes/ upgrades

We process claims on Automatic Claim Adjudication System (ACAS), based on the Dun and Bradstreet system ClaimFacts®, which we customized to support our book of business. ACAS is a rule-based system that allows for improved online availability, increased automatic adjudication and scalability to handle projected claim volume increases. ACAS is an online, real-time system. It supports both automated and manual claims processing and contains components for electronic claim intake, workflow management and imaging systems. It also interfaces with our plan, member, provider, quality management and utilization management databases.

Maintenance

We complete routine maintenance based on business needs. Maintenance is an ongoing process included in activities related to certain user table updates, to address jobs that abend or fail to run or other jobs that we monitor on a daily basis, as well as requests from our business areas that we can handle under a day-to-day service request.

However, when the maintenance requires a more extensive change, we complete it according to the enterprise release calendar. Most of the maintenance we perform during releases is in support of more extensive changes requested by our business areas to address production problems, small enhancements or regulatory requirements. We prioritize service requests by our business areas to determine which are to be included in upcoming releases. We use the same release calendar for this as for major enhancements to support new programs and products.

Enhancements

We make major enhancements to our system on a quarterly basis via our enterprise release calendar (February, May, August and November). We schedule system releases over the weekends to avoid meaningful downtime for our processing centers, members and providers. In addition to the four quarterly releases, we have additional opportunities for requested system changes (March, June, September and December) to address system changes of a less complex nature.

In 2019 our enhancement and updates included:

- Enhancements for new product offerings
- Additional medical rules and policies for claim processing
- Added support for expanded lines of business
- Automatic adjudication
- Changes needed to comply with legislative requirements as well as state and federal regulations

Over the next three years, we will continue with enhancements as described for 2019 with a focus on regulatory and compliance items, business process excellence support, expanded medical policy support and customer commitments.

We have over time and as a result of acquiring systems through acquisitions, consolidated various applications. We continue to seek opportunities to improve the reliability, availability, scalability and performance of our overall systems platform.

elephone system changes

We use an online tracking and documentation system called Aetna Strategic Desktop (ASD) for member and provider contacts including telephone calls, written correspondence and Internet email. We track events in the system from the moment a member contacts us. The system tracks all tasks or activities performed to resolve the service request from beginning to end.

Our customer service staff began using ASD in 2007. The application has been significantly enhanced on a consistent basis every quarter since its inception.

We have fully integrated with our Member Book of Record, which allows customer service representatives to submit updates such as PCP changes, address changes and coordination of benefits real time, without having to leave the ASD application.

We continue to look for navigation and documentation improvements.

In 2018, infrastructure upgrades were completed to ensure the application is compatible with the Windows 10 operating system.

We continue to perform incremental maintenance to sustain the stability of our platform. We will also deliver a series of small enhancements geared towards providing the customer service representative with just in time information to support customer contacts.

1.26	Provide a sample of your annual scorecard.

Response:

Recognizing that customer satisfaction begins with our own organizational accountability, we contract with Acturus to conduct ur nationwide Client Satisfaction Survey (previously called the Account Executive Survey). They are an independent market esearch firm located in Farmington, CT. They conduct the survey annually to measure how well we are meeting customer expectations. It includes a sample of Public & Labor customers. We do not share sample surveys.

The survey focuses on several areas:

- Overall satisfaction with our product offerings
- Access and responsiveness of our account management staff
- Likelihood of customer renewing their contract with us
- Customer satisfaction with product value and our customer service

We use survey results to help us:

- Develop strategies
- Deploy resources
- Plan professional development activities

Through these results, we continue to provide the State with the best products and service possible. We do not release detailed results; however, we do share overall results.

Our 2018 Client Satisfaction Survey results, based on responses from 381 Public & Labor customers, indicated an overall satisfaction rate of 82 percent.

1.27	Describe how members reach a live representative or an interactive voice response (IVR) unit when calling Member Services.

Response:

Members can request to speak to a live customer service representative (CSR) at any time during the call by speaking one of the more than 150 synonyms for CSR that the system is programmed to recognize. The CSR option is available on the first feature menu. Callers will have the option to have their call forwarded to a CSR during normal business hours only.

When a member requests to speak to a CSR, their member information is already validated and available to the CSR receiving the call.

1.28	Describe the system by which the Customer Service unit tracks and documents calls. Describe the process to review the findings of the call tracking and documentation process with the State.

Response:

We use an online tracking and documentation system called Aetna Strategic Desktop (ASD) for member and provider contacts including telephone calls, written correspondence and Internet email. This system allows us to monitor and follow those inquiries until they are resolved. We document all calls with the exception of transfers or general information questions.

We maintain a historical record of contacts online for 18 months and then archive them in accordance with applicable legal requirements, typically for 7 years.

ASD tracks:
- Date and time of inquiry (when inquiry is opened and closed)
- Method of contact
- Source of contact (e.g., member, provider, other)
- Name of contact
- Representative servicing the inquiry
- Reason(s) for the contact
- Status of inquiry
- Action taken

Our customer service staff has online access to eligibility data, benefit descriptions, provider files, detailed claim history and other online resources that allow them to resolve many inquiries during the initial contact with the member.

If we are unable to resolve an issue during the initial contact, we will document the outstanding inquiry and direct it to the appropriate area for resolution. Our systems provide the reporting capabilities needed to manage the progress of outstanding inquiries to resolution.

ASD provides the following key values to us and our customer service staff:

- Member 360-View – This view eliminates the need for the CSR to open multiple screens to see additional products a member has been or is currently enrolled in.

- Provider 360-View – ASD provides a customized view of the provider and includes provider specific workflows and reporting capabilities.

- CTI Integration – When a caller (member or provider) opts out of Aetna Voice Advantage® for additional service, the CSR will receive a screen pop that can provide important information about the caller and who they are calling for.

- Enhanced Reporting – ASD reports will encompass operational, customer and constituent views and will be accessible through a customized Business Objects interface. The report viewer will be able to filter through numerous options on the pre-formatted reports. There are member and provider specific reports as well as reports that support the ASD business case and CTI technology.

- Supporting Multiple Business Areas – ASD supports both traditional- and HMO-based products with a single front-end interface. ASD is designed as a flexible and all-encompassing front end to many back-end systems. ASD currently supports all of our business segments, Provider Services Organization, Aetna Behavioral Health and the Patient Management organization.

- Auto documentation – A key feature of ASD is a quick way for the CSR to document the event by either clicking a checkbox or simply following a specific workflow that will document the task simply by capturing where the CSR went in ASD. This will greatly reduce the need to type manual notes in support of call documentation thus, reducing overall call time and improve reporting capabilities.

1.29	Describe how members can electronically access claims information and the Member Services group. Describe the internet, i.e. web chat or email services offered.

Response:

Members can access claims information through our secure member website and mobile app. They can also reach member services by email through the website and app.

Our member website is one-stop health resource that brings together the all of the benefits information, tools and resources we offer to make managing health care convenient for every member. It supports members at every point along their health journey —from finding care and reducing their costs to learning wellness tips or managing chronic conditions.

Through a seamless user experience, our members have the ability to:

- Find care – Members can search for providers and shop for health care by comparing convenience, cost and quality.

- Manage benefits – We connect members to the information they need, whether they want to view and manage eligibility information and claims, pay for services or talk to a customer service representative or nurse.

- Access tools for health and wellness – Members can manage their health and wellness on their own terms through resources such as health surveys and online coaching and by taking steps toward recommended health actions.

Our member website is personalized and proactive. Using proprietary algorithms, it guides each member to the right information, resources and tools based on their needs and preferences.

We never stop looking for innovative and meaningful ways to give our members access to engaging, convenient and cost-effective health and wellness resources. Our member website adapts to our members' unique lifestyles and makes it easier for them to achieve their best health.

1.30	Describe the escalation process for Member Services satisfaction and complaints.

Response:

We empower customer service representatives (CSRs) with an exceptional level of real-time support, training, system access and online information they need to resolve member issues with the first call.

Customer Service representatives have real time access to subject matter experts for complex issues and to act on a member's behalf. For example, they have immediate access to support for appeals, case management and precertification. We also give them the guidance and power to make claims exceptions in certain situations.* At times, CSRs may also need to transfer a call to other areas best suited to help the member.

If the member would rather speak to a manager, the CSR gathers all relevant information and transfers the caller to a team leader or another member of management. If the caller is unable to hold, the CSR offers to take the pertinent information and have a member of management return the call. Their goal is to return the call within one business day.

Our systems have reporting capabilities that let CSRs track the progress of outstanding inquiries to closure.

*Self-funded Public and Labor customers can opt out of this.

1.31	Provide detailed information on how often provider directories are updated. Both hard copy and on-line provider directories must be made available by the Contractor to the State of Nebraska.

Response:

For the most up-to-date information, members can access our provider search online at **aetna.com**. We update our provider search information six times per week.

When using our provider search tool, members can filter and print their provider search results.

Users can narrow their search by medical specialty, physicians' hospital affiliations and/or languages spoken, as well as other criteria, such as name. Our provider search enables users to search by zip code, city and state. In addition, maps and driving directions to the location of the selected physician can be downloaded or printed.

1.32	Contractor will not render or administer services (including wellness) offshore and all work performed will be in the contiguous United States. Describe where the Customer Service unit will be located.

Response:

Agreed. We will perform all services for The State within the United States.

Our customer service center is located in Bismarck, ND.

1.33	Describe the process for handling calls "after hours" of operation? Is there a voicemail system or capability for caller to leave messages after normal business hours?

Response:

For inquiries outside of normal business hours, members have the option of using Aetna Voice Advantage, our self-service telephone system, our member website or mobile app.

Callers who exit or opt out of our telephone system after the service center has closed, hear the following message:

"If your call is regarding an emergency, please contact your primary care physician or seek care immediately. Our business hours are Monday to Friday, 8 a.m. to 6 p.m., CT."

Pharmacy after-hours calls

In addition to normal business hours, members can receive pharmacy benefit support 24 hours a day, 7 days a week, through the following channels:

- Teams of representatives available to help answer questions at any time
- Personal online access 24/7 on **aetna.com**
- Interactive voice response (IVR) service 24/7, using phone keypad or speech recognition

CSRs are empowered to function as member advocates by engaging members and educating them on how to maximize their prescription benefit. We provide the CSR teams and supervisors with customer-specific training so they will fully understand the State's pharmacy benefits.

1.34	Describe ability to meet a 24-hour nurse line program. Staff must be available 24-hours a day, 365 days a year.

Response:

Our Informed Health® Line provides members with telephone, email and chat access to experienced registered nurses to help them make informed health care decisions.

According to recent survey results, 94 percent of members said the Informed Health Line nurse helped them make a better health care decision.[1]

Program goals

- The goals and objectives of Informed Health Line are to:
- Encourage members with health information to improve utilization of health care services
- Improve patient/physician relationships by encouraging members to give a clear medical history and ask relevant questions
- Promote healthy lifestyle habits
- Provide members with health information to help improve chronic condition management
- Increase member satisfaction with employer and benefit plans

Availability

Nurses are available through a toll-free telephone number 24 hours a day, 7 days a week. We provide TDD service for speech impaired, deaf and hard of hearing members. We also offer foreign language translation for our non-English speaking members.

Members may email a nurse by clicking on the "Talk to a Nurse" link within our member website. Nurses respond to inquiries within 24 hours. They can also chat with a nurse through our member website 7 days a week from 7:00 a.m. through 7:00 p.m., ET.

Additional resource

- Healthwise® Knowledgebase – Members may access Healthwise Knowledgebase, a user-friendly decision-support tool that provides clinical information on:
  - 6,000 health topics
  - 600 medical tests and procedures
  - 500 support groups
  - 3,000 medications

This tool encourages informed health decision-making and educates members on their treatment options.

- Healthwise Video Library – After speaking to callers, nurses may email them a link from the Healthwise video library. Research shows that well-designed videos deliver instructions more effectively. Nurses choose from over 400 consumer-friendly videos based on the topic discussed or the member's needs. The videos combine plain language, an empathic tone and an expressive visual style that engages viewers with easy-to-understand health topics on health conditions, treatments, medicines and self-care. They are typically two to three minutes in length and members can view them online or through their smartphones.

[1]Informed Health® Line Member Satisfaction Survey. October 2016.

1.35	What is the average wait time to speak with a registered nurse?

Response:

The average speed of answer for our Informed Health Line is 18.8 seconds.

1.36	Is the nurse line accredited by any external organizations?

Response:

Our health plans are accredited by NCQA under the accreditation for health plan standards. Our Informed Health® Line program is accredited by the NCQA in conjunction with our health plan.

1.37	Describe if the nurse line connects members to a contact history allowing a current inquiry to be addressed with the context of previous calls?

Response:

Nurses document all calls in our system, where they can easily see a member's call history in one place. Nurses view all of this information prior to subsequent phone calls, providing members with focused education, excellent service and seamless support.

Nurses view State-specific information in our medical management system. The system displays information on additional benefit programs and services that your company offers members.

1.38	Describe the process for the nurse line to directly enroll callers into plan provided clinical programs such as case or condition management?

Response:

Informed Health Line (IHL) is managed on the same medical management system as other Aetna medical management programs. This provides our clinicians with valuable member information.

The IHL nurses refer members to other available Aetna programs as appropriate. This includes our care management and coaching programs. With permission from the member, the nurse warm transfers the caller and provides the member's name and telephone number to the other program nurse or coach.

Informed Health Line nurses also use Aetna MyPulse℠. This lets us connect with members and provide care management in ways they prefer. With access to members' digital program data, nurses and coaches gain valuable insight on members' interests and motivations. Then, they can use this data to enhance their support of members and have more meaningful conversations. They can also send messages and tasks to members through a common platform (Personal Health Record). This helps to keep them engaged in digital care.

Our IHL nurses also educate members about other State-specific programs as appropriate. When needed, they encourage members to contact member services at the toll-free number listed on their ID cards or via chat.

1.39	Does the nurse line conduct quality surveys with users to determine member satisfaction with the service? Describe the process used for these surveys.

Response:

Yes. We survey members annually for continuous quality improvement efforts. DSS Research, an independent vendor in Fort Worth, TX, collects survey data through telephone interviews. The survey measures satisfaction, loyalty measures and programs elements for our book of business.

In 2018, we had the following results:

Overall, how satisfied are you that the assistance provided through Aetna Informed Health® Line has helped you to make better informed health decisions?	99%
The Informed Health nurse I spoke with provided me with information that I otherwise would not have known.	86%
The Informed Health nurse I called was able to answer my questions or was able to refer me to an appropriate resource for an answer.	94%
The Informed Health Line program is an important part of my health benefit plan.	99%
Likelihood to recommend the program.	82%

1.40	Describe the drug cost look-up tool available to members via website that provides both the plan copay and full drug cost.

Response:

Members won't be surprised at the pharmacy counter when they use our cost estimator tool, **Price-A-Drug**. Available on both our member website and mobile app, members simply type the drug name into the tool and quickly estimate:

- What can I expect to pay for this drug?
- What does my employer pay?
- How much could I save with a generic?
- How much could I save at mail?

Example of the member experience – After leaving her doctor's office, a member named Susan types her newly prescribed drug into the cost estimator tool using the Aetna Mobile app. She immediately sees a table that shows her:

	Brand*	Generic*
90-day supply at home delivery	**$100.00 for 3 months** *$33.33 per month* *You pay 10% of the cost.* *Your Plan pays $917.08 / 3 months*	**$82.61 for 3 months** *$27.54 per month* *You pay 25% of the cost.* *Your Plan pays $247.82 / 3 months*
30-day supply at retail	**$65.00 for 1 month** *You pay 18% of the cost.* *Your Plan pays $301.29 / 1 month*	**$50.00 for 1 month** *You pay 19% of the cost.* *Your Plan pays $208.90 / 1 month*

** The figures in this table are illustrative only. We base the actual estimated drug price on the member's specific plan design, the reimbursement rate in the state where the drug is dispensed, the prescribed quantity and dosage.*

In addition to this cost information, Susan has easy access to detailed drug information. All she needs to do is click on the drug name to answer questions like:

- What is this medicine?
- How should I use this medicine?
- What if I miss a dose?
- What might interact with this medicine?
- What side effects might I notice from taking this medicine?
- Where should I keep my medicine?

We want to make sure your employees like Susan know what to expect at the pharmacy and understand all the ways they can save money. We find this tool is particularly helpful for members in coinsurance and high-deductible plans in which out-of-pocket expenses can vary. The tool can provide a cost estimate even if the member is uncertain of the drug strength.

1.41	If a new member is receiving treatment from a non-participating provider, describe how the medical plan covers transitional conditions, such as pregnancy, chemotherapy, etc.

Response:

Transition of care permits a member to continue an active course of covered treatment at the highest benefit level during a transitional period when there is a change in the member's plan (enrollment or re-enrollment), and the treating provider is:

- Not a contracted provider in the member's plan (either an inactive provider or a non-participating provider)
- A participating practitioner not included within the member's when a plan sponsor-specific network is a component of the member's plan
- A participating practitioner not included within a tiered or specialty network when a tiered or specialty network is a component of the member's plan
- A participating specialty practitioner who has individually, or as part of a multispecialty practitioner group opted out from a specialty network when the specialty network is a component of the member's plan (an example is PCPs and specialists within the same provider group)
- A home health care (HHC) agency or an individual practitioner such as a specialist, physical therapist or speech therapist

Members or their providers must submit the requests for transitional benefits within 90 days of the provider/member status change. When approved, the effective date is the enrollment/renewal date of the member's plan or the date of the provider's termination or network status change (as applicable). Except in extraordinary circumstances or in the case of approved maternity requests, transition of care does not extend beyond 90 days unless required by applicable law or regulation.

Transition of care does not apply to nonparticipating DME vendors, pharmacy vendors or facilities unless required by applicable law or regulation. The only exception is that transition of care does apply to facilities when the contract terminates (for reasons other than quality issues) and a treating participating practitioner only has privileges at the facility that is now nonparticipating.

Transition of care also applies to participating facilities and practitioners that are not included within the highest benefit level of a tiered or specialty network.

	DATA ANALYTICS TOOL
1.42	Provide information on how the data analytics tool provides and calculates data from a client's view and from the account manager's view. 1. Provide proof of these variables; a. Health Plan type/Option b. Member Status (Active, Early Retiree, Retiree) c. Relationship (Employee, Spouse, Dependent) d. Network Indicator e. Place of Service (Inpatient, Outpatient, Emergency Room, Physician's office, etc.) f. Major Diagnostic Category g. Diagnosis Related Group h. Member ID i. Provider ID j. Date of Service k. Date of Payment 2. Provide proof of these calculations; a. Admissions b. Readmissions (7,15,30 days) c. Urgent Care Visits d. Other Facilities e. Avoidable Admissions f. Inpatient Days g. Emergency Room Visits h. Office Visits i. Preventive Screens j. Total number of claims k. Net Payment l. Healthcare Reimbursement Amount m. Copayment Amount n. Coinsurance Amount o. Deductible Amount

Response:

Analyze-Rethink-Transform (ART), our business intelligence tool, is an advanced data analytics and reporting solution that delivers a flexible, fully integrated application that facilitates analysis and provides reporting across multiple products and services. We collect organize, standardize and combine the data. Then we apply best-in-class methodologies which include

valuable insights regarding costs, utilization, quality and overall plan performance.

ART leverages our data analysis and predictive modeling capabilities on one platform and provides point-in-time reporting and ever-evolving business intelligence for you and your consultant. This powerful technology helps you make more informed decisions with analytic solutions to:

- Provide value-added analytics: ART integrates diverse data inputs from multiple product lines including:
  - Medical claims, including behavioral health
  - Pharmacy claims, both routine and specialty
  - Enrollment and member demographic data
  - Provider data
  - Data on products, benefit plans
  - Aetna book of business benchmarks

We continue to enhance the system and have a roadmap to integrate additional data inputs such as:

- Care management program data
- Dental and vision claims
- Disability claims
- External industry benchmarks
- Clinical inputs, such as biometrics, onsite clinics and lab results
- Wellness programs
- Health risk assessments
- Track activities using wearable devices
- Evaluate trends, risk, care quality and employee health

Manage costs: Visualize cost drivers and trends, pharmacy utilization, network leakage and more.

- Keep up with industry trends
- Monitor costs and utilization across various product types
- Manage local outcomes to achieve company goals and objectives

Standard reporting

ART includes access to a wide variety of standard drill-down and analytic pathways and data visualizations to answer typical and highest-value customer requirements and expectations for plan information.

Strategic support

Analytic support for your Aetna account team and you – this assures you get the maximum benefit from your information and promotes efficiency when we explore data on your behalf.

Ad hoc reporting capabilities

The ad hoc reporting interface is a user-friendly drag and drop environment which includes all of the data, dimensions and measures in a customer's underlying database.

Demo

Your Aetna Account manager can provide a demo at that showcases the features of ART. We have also provided a video link that illustrates the system's basic functionality and key advantages. https://vimeo.com/251372667. Please note, the video is illustrative and not a view of the actual system.

1.43	Describe how State staff will be provided access to the data warehouse. Describe the training that will be provided to the State staff to allow them to navigate and utilize the data warehouse.

Response:

Not applicable we do not provide access to the data warehouse, rather we provide universal claims files.

CLAIMS PROCESSING

1.44	The State requires the minimum hours for claims administration operation to be Monday through Friday, 8:00 a.m. to 6:00 p.m. Central Time. Describe if any additional hours are available beyond the core hours.

Response:

Our hours of operation are Monday through Friday, 8:00 a.m. to 6:00 p.m. Central Time.

Additional hours are available for an additional cost.

1.45	Describe performance standards with respect to: a. Adherence to implementation/annual enrollment timeline b. Readiness of claims and customer service systems c. Readiness of eligibility system d. Completion of plan documents

Response:

The performance standard for these areas is to be ready for administration of your plan in a timeframe that allows adequate time for open enrollment activities. Certain things need to be in place on the end of the plan sponsor and the carrier in order to achieve this. We've provided our response for how we can comply to the requested performance standards within the enclosed Performance Guarantee document provided with the RFP.

1.46 Provide actual (achieved) performance measurements for an account size comparable to the State of Nebraska for 2017 and 2018 as well as the 2017 and 2018 performance standards targets for the claims office that will handle the State account.

Performance Measure	2017 Performance Targets	2017 Performance Actuals	2018 Performance Targets	2018 Performance Actuals	PG Measurement Utilized
Member Satisfaction Survey (% satisfied)	80%	90%	80%	91%	87%
Claim Administration					
Claim Accuracy (percentage)	95%	98.73%	95%	98.70%	95%
Financial Accuracy (percentage)	99%	98.48%	99%	98.76%	99%
Claims Turnaround Time (days)	90% in 11.89 calendar days 95% in 23.10 calendar days	90% in 14 calendar days 95% in 30 calendar days	90% in 14 calendar days 95% in 30 calendar days	90% in 8.31 calendar days 95% in 16.80 calendar days	90% in 14 calendar days 99% in 45 calendars days

	Overpayment recoveries (number of days to send check for overpayment)	Not tracked	Not tracked	Not tracked	Not tracked	
	Customer Service					
	Telephone call response time (seconds)	30 seconds	36.5 Final (25.6 seconds - 4th Quarter)	30 seconds	21.2 seconds	30 seconds
	First call resolution rate (percentage)	90%	93.80%	90%	95.30%	90%
	Closure time for open inquiries (number of days)	Not tracked	Not tracked	Not tracked	Not tracked	90% of all written inquiries within 14 business days
	Timeliness of responding to web inquiries (number of days)	Not tracked	Not tracked	Not tracked	Not tracked	
	Timeliness of resolution for grievances, complaints and appeals	Not tracked	Not tracked	Not tracked	Not tracked	Provide member appeals reports within 45 days after close of quarter.

Response:

1.47	What percentage of claims were received electronically in 2018 for: a. Hospital/Facility services b. Physician services c. Laboratory, Radiology, etc. d. Overall total

Response:

In 2018, the following claims were received electronically:

a. Hospitals – 95.96%
b. Physicians – 95.81%
c. All other providers – 89.45%
d. Total Claim EDI Submissions – 252 million

1.48	Provide auto-adjudication rate for clean claims received electronically in 2018 for: a. Hospital/Facility services b. Physician services c. Laboratory, Radiology, etc. d. Overall total

Response:

In 2018, approximately 77.0 percent of all Public and Labor claims received were automatically adjudicated.

We do not track auto-adjudication by claim type.

1.49	Describe the internal audit procedures including if audits are performed on a pre- or post-disbursement basis, what percentage of all claims are audited by an internal audit group, how claims are selected for internal audit and what triggers are utilized.

Response:

We audit claims on both a pre and post disbursement basis.

We don't audit claims using a fixed percentage. In keeping with the industry best practices, we use stratified audits. A sampling of claims is randomly selected from within each stratum. On a quarterly basis, we typically audit over 300 claims per stratified audit.

Components of our claim processing measurement include an extensive monitoring program that includes the following:

- Stratified Quality Audits – Using an industry accepted, statistically valid stratified audit methodology, populations of processed claims are segregated into dollar categories (strata) based upon the amount paid. A sampling of claims is randomly selected from within each stratum. Results are extrapolated over the respective populations based upon the weight of each stratum relative to the given populations. Sampling levels are such that an industry acceptable typical precision level of +2 percent is achieved.

- Monthly Processor Rework – Claim rework is tracked, assigned to the responsible claim processor and trended for improvement initiatives. Monthly claim rework is an integral component of an individual claim processor's performance results. In essence, 100 percent of the processor claims are considered in the use of rework as the processor level quality metric. Discretionary, targeted claim audits may be performed as warranted by a claim processor's rework results.

- Prepayment Review – We audit all claims equal to or greater than a specified dollar threshold paid on a pre-disbursement basis.

- Trainee Audit – Initially, the business unit provides mentors/auditors to audit 100 percent of claims processed by trainees. As each trainee's results reach an acceptable level in a category, the percentage of claims reviewed decreases.

- Itemized Bill Review - For certain large inpatient facility claims from network facilities, we offer Itemized Bill Review (IBR), an additional feature of our National Advantage Program (NAP). We have partnered with a vendor to review these claims for billing errors prior to claim adjudication. IBR reviews inpatient facility bills with submitted expenses of $20,000 or more incurred at a network facility (excluding per diem arrangements). We pay the claim based on our policies, Coverage Policy Bulletins (CPB) and in accordance with the facility's contractual arrangements.

- Auditor Re-audit – Auditors are subject to a re-audit of their work based on a random sample. This audit validates the accuracy of the auditors and compliance with the audit program. Overall results are reported for Pay Incidence, Pay Dollar and Total Claim Accuracy.

- Bank-Cleared Claim Draft Audit – Our corporate office oversees our automated check auditing system that monitors each bank-cleared check.

- Corporate Audit – Any of our service centers may be subject to an audit by our Corporate Audit department on an unscheduled, unannounced basis to evaluate the effectiveness of controls over processes and procedures.

- Medical Bill Audit - We have a comprehensive medical bill audit program in conjunction with external suppliers that includes hospital bill audits; DRG audits for DRG code validation; and targeted contract compliance audits for inpatient and outpatient facility claims.

We provide an electronic claim file of paid facility claims greater than $10,000 which the suppliers perform both an automated and manual review of the electronic file to identify claims paid using the "percentage of billed charges" methodology.

Once identified those claims paid with the "percentage of billed charges" methodology are run through their screening process to filter out claims with a low potential for error. After the automated filtering, a registered nurse auditor performs a focused manual screening of remaining claims. If appropriate, a vendor nurse auditor performs a final screening and prioritizes claims for audit. Hospital bill audits occur both off and on-site at the facility.

Claims paid by a methodology other than "percentage of billed charges" and claims where we negotiated a discount through our National Advantage Program are not candidates for audit.

For DRG audits, the DRG assignment and reimbursement are confirmed and any proposed DRG revision and an explanation of the basis of the revision are sent to the provider for acceptance.

Contract compliance audits are performed on targeted claims based on contract compliance criteria, home infusion, durable medical equipment (DME) and renal dialysis coding.

The medical bill audit program is a standard component of the self-funded agreement with contingency fees charged and the refund credited to the State through their wire-lines.

Quality results are based on the processing unit level and we do not notify the customer of any irregularities discovered. However, we conduct root cause and trend analysis to identify opportunities to continuously improve our service. We assess training needs and conduct training sessions as needed.

1.50	Provide in detail the procedure for processing claims based on benefit exceptions of denied claims as determined by the State.

Response:

There are significant legal, regulatory, ERISA, discrimination, funding and tax concerns associated with claim exceptions (or special claim payments). We recommend that the State discuss these issues with your own legal counsel. An authorized representative of the State may make a written request for a special claim payment. The State must fund special claim payments in advance of making the payment. You are responsible for tax reporting.

Timing

We process Special Claim Payment (SCP) requests in the order we receive them. Once we receive payment, we finalize the SCP and submit for approval from treasury. Approval from treasury takes 2-3 business days. A confirmation email will be sent once the SCP has been completed and the checks have been mailed.

1.51	The State requires claims history be maintained on-line for a minimum of ten (10) years. Provide detail on how this will be met and/or exceeded.

Response:

Our claims system maintains claims history online indefinitely, this includes detailed claim history for each family member on submitted expenses and processed claims (paid, pended and denied).

We move claims greater than five years old that meet specific criteria into an archive database. These claims are available for recall (in most cases, immediately) and will display all claim details.

We also keep three years of financial data on the claims system that are used during adjudication. Financial data beyond the

three years are available for historical view only. This includes the family/member's accumulator information such as plan limits, deductibles and amounts accumulated towards those limits.

1.52	Provide detail on how to determine usual, customary and reasonable charges for out-of-network medical, surgical and anesthesia.

Response:

We use the FAIR Health Benchmarks database for R&C and Recognized Charge based determinations. The standard value for R&C is the 80th percentile of the database. Recognized charge plan alternate percentiles (50th, 60th, 70th, 75th, 85th, 90th, 95th) may be available.

Facility Services

Facility Charge Review (FCR) reasonable charge is based on cost information submitted by hospitals to the Center for Medicare and Medicaid services (CMS). We allow 200 percent of the facility's costs. If no costs are filed by a specific facility, the state average cost-to-charge ratio based on service location is used. In this situation, we allow 130 percent of the facility's costs. Where state regulations require other methods of covering out-of-network claims, we will comply.

Anesthesia

We reimburse for general or monitored anesthesia only when an anesthesiologist oral surgeon, certified registered nurse anesthetist or certain critical care provider types administers it. Anesthesia is a unique area of medicine that requires specialized training to provide safe and qualified anesthesia to patients.

We use the American Society of Anesthesiologists (ASA) Relative Value Guide and Crosswalk as the source of anesthesia base units related to general anesthesia type services.

If we receive general anesthesia charges that are billed with codes that have zero anesthesia base units, we forward them to our Clinical Claim Review Unit for individual consideration. These would be codes for secondary procedures, codes that specifically state services are performed without anesthesia and codes for services where the ASA states that anesthesia care is not normally required.

Multiple surgeries

When a surgeon performs multiple surgeries (more than one eligible procedure) on the same patient during the same operative session, we allow anesthesia base units for the major surgical procedure only based on the ASA Relative Value Units (RVUs). The anesthesia time units will reflect the other surgical procedures.

Monitored anesthesia care

Except for certain procedures, we allow payment for monitored anesthesia care as though general or regional anesthesia had been administered without medical review of the anesthesia records. We do not allow payment for anesthesia services including monitored anesthesia care for certain pain management, back injection and vein procedures unless the member is high-risk (i.e., age 18 and under, age 65 and over) and the service is rendered by a provider who did not perform the procedure.

1.53	Describe how claims are reviewed for billing irregularities by a provider (such as regular overcharging, unbundling of procedures, up coding or billing for inappropriate care for stated diagnosis, etc.).

Response:

Components of our claim processing measurement include an extensive monitoring program that includes the following:

- Stratified Quality Audits – Using an industry accepted, statistically valid stratified audit methodology, populations of processed claims are segregated into dollar categories (strata) based upon the amount paid. A sampling of claims is randomly selected from within each stratum. Results are extrapolated over the respective populations based upon the weight of each stratum relative to the given populations. Sampling levels are such that an industry acceptable typical precision level of +2 percent is achieved.

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Once identified those claims paid with the "percentage of billed charges" methodology are run through their screening process to filter out claims with a low potential for error. After the automated filtering, a registered nurse auditor performs a focused manual screening of remaining claims. If appropriate, a vendor nurse auditor performs a final screening and prioritizes claims for audit. Hospital bill audits occur both off and on-site at the facility.

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Contract compliance audits are performed on targeted claims based on contract compliance criteria, home infusion, durable medical equipment (DME) and renal dialysis coding.

The medical bill audit program is a standard component of the self-funded agreement with a contingency fees charged and the refund credited to the State through their wire-lines.

Quality results are based on the processing unit level and we do not notify the customer of any irregularities discovered. However, we conduct root cause and trend analysis to identify opportunities to continuously improve our service. We assess training needs and conduct training sessions as needed.

1.54	Provide a sample of claim and Explanation of Benefits (EOB) forms.

Response:

Please refer to *Sample EOB.pdf* and *Sample Claim Form.pdf*, located in the Samples and Brochures section of our proposal response.

1.55	What procedures are used to administer customer specific COB provisions?

Response:

Our COB approach is to determine the order of benefits for coordination prior to payment. We investigate any other primary benefits before issuing benefits.

?OB administration

Our COB administration starts with the collection and maintenance of accurate information about other coverage. We have a variety of methods for gathering the information including:

- During enrollment, many of our customers collect information about other coverage and share it with us.
- During the precertification process, our nurses ask about other coverage.
- Due to the cooperative nature of our relationship with network providers, hospitals and physicians routinely obtain other coverage information and submit it with the claim.
- In addition to the normal "other coverage" questions on our claim form, we ask if any other family members are employed and specific details.
- Registered plan members can provide us with updated COB information at any time using the Requests and Changes feature on our member website, at **aetna.com.**
- As required by law, we exchange data with CMS (Medicare) regarding member eligibility and enrollment information. We exchange data on a quarterly basis. We update our verification files based on this information.
- In addition, we participate in COB Smart. COB Smart is a registry of member coverage information. It helps plans and providers correctly identify members who have more than one plan. It helps with order of benefits determination (OBD) when members have more than one plan. All information sent to the registry is protected and secure.

COB screening

We screen all claims for COB, even those where the member's current eligibility file does not indicate other coverage.

We consider the following as potential indicators of other coverage:

- Hospital bills submitted as paid
- Large physician bills submitted as paid
- Photocopied bills
- Hospital bills or large physician bills submitted late
- Indication of other party payment on the bill
- Auto accidents (potential no-fault insurance)
- Workers' compensation

Identifying COB claims is a combination of system-automated processes and claim processor judgment. When other coverage is possible, we pend the claim online. We send an EOB to the member requesting specific details. If the member does not respond within 45 days of sending the original mailer, we auto deny the claim.

Other coverage information

When we receive other coverage information, we update the online family eligibility record to indicate primary/secondary/tertiary status. The system automatically presents a COB edit during claim processing when the eligibility file indicates that other coverage is primary. The notice includes:

- Details about the other coverage
- Family members the other plan covers
- Carrier
- Type of coverage (for example, medical only or medical-dental)
- Date of the last update

If we are secondary and the primary carrier's EOB is not attached to the claim, the claim is pended for receipt of the primary carrier's EOB.

Upon receipt of the primary carrier's EOB, claims are processed as follows:

- For maintenance of benefits (MOB) or non-duplication plans, the COB allowance is our negotiated rate reduced by copays, coinsurance or other applicable plan provisions.

- For plans utilizing standard 100% allowable, the COB allowance expense varies based on the 100% allowable model chosen.

Once we determine the allowable expense, we subtract the primary carrier's payment from it and pay the balance, if any, as long as the balance does not exceed our normal benefit.

Our COB procedure is the same for both in-network and out-of-network. COB is system-calculated.

1.56	Provide a list of the location(s) of all service centers that would be servicing the State's members and the corresponding geographic areas/regions covered by the respective location.

Response:

Our customer service center is located in Bismarck, ND. This service center manages our customers in the North Central region of the United States.

1.57	Provide a description of premium or administrative fee billing procedures, including information on the timing of billing and billing-payment reconciliations.

Response:

We send the State a statement each month showing the administration charges per eligible employee. We extract information on the number of eligible employees from our enrollment system. The State can pay-as-billed or update the number of covered employees and calculate the total charges due for that month in the event of fluctuations. The administration charges are due no later than 31 days following the first calendar day of the month in which the services are provided.

We reconcile accounts monthly and any billing discrepancies will be brought to the attention of the customer as soon as they are apparent. All attempts to resolve issues will be handled by the assigned billing contact and the customer. Escalation through management will follow on any items that continue to be unresolved and in dispute.

We cannot agree to reconcile billing within 15 business days.

1.58	Indicate for any current plan, under what circumstances members are required to submit claim forms and bills: a. In-Network b. Out-of-Network c. Out-of-Area d. Out-of-Country

Response:

We do not require claim forms for in-network services. Network providers submit claims on behalf of the member. When the member uses network providers, the claim submission process is paperless from the member's point of view.

For out-of-network or out-of-area services, the member may need to submit claims using our standard claim form if the provider is unable or unwilling to submit the bill to us on the member's behalf.

Because there is no geographic area for claim rates outside the United States, we base payment on any charges incurred outside the United States on covered charges. We translate the claim and obtain the exchange rate based on the date of service. For inpatient hospital stays, we use the discharge date to convert currency for the entire stay.

After we process the claim, our claims system directs the prepared EOB form along with the member's payment to the appropriate address.

For members that live abroad, we store foreign addresses and mailing instructions in the notice fields of the claims system. We return EOBs for these members to a centralized claim office for mailing.

We pay claims with U.S. currency.

1.59	Provide a brief overview of programming and address how the behavioral health management interventions are integrated with the medical management interventions.

Response:

This is a core competency at the heart of all we do. Our process completely integrates medical care, behavioral health care, health plan partners (Rx, disability, EAP) and any other applicable benefits.

Members with a medical condition who call and are engaged with a medical nurse case manager are screened for other impacting issues. These issues include behavioral health concerns, stress, social determinants, etc. When a member is found to be struggling with behavioral health, stress and/or social concerns, the nurse can request a consult with a behavioral health resource. Through consultation, the nurse is provided the right clinical and resource options to support the identified needs.

To help our care management nurses support these members, we have a behavioral health specialist on each medical team. The behavioral health specialist provides support/guidance to the nurse in coordinating the member's care. Those members we identify with needs that are more complex we refer to appropriate resources included in the member's benefit plan. This ensures the member is receiving holistic care regardless of how the member contacts Aetna.

This behind-the-scenes collaboration is seamless for the member, as we prefer a single clinician model whenever possible.

When we identify members with needs that are more complex, the medical nurse case manager refers them to our Behavioral Health case management team. This can be done via warm transfer and our shared clinical system. From that point, the medical nurse case manager helps the member manage the medical concerns, while the behavioral health case manager supports the member with behavioral health concerns. In addition, both case managers collaborate and coordinate on multiple levels- ad-hoc consultations, attending joint medical rounds and reviewing care notes in our shared clinical system.

Providing behavioral health services optimally requires careful consideration of each member's overall life needs. This approach results in effective care and optimal use of resources. We realize that members have a variety of issues that influence problems they face each day. To enable the best treatment outcome, we must address all these issues as part of the treatment process. Our care managers work closely with providers and community programs to offer a holistic and fully integrated approach to treatment. Behavioral Health Utilization and Case Management teams (within the overall Aetna Behavioral Health team) work closely with each other, as well, to deliver the most comprehensive set of services possible.

1.60	Describe the behavioral health program, including the subcontractor and background concerning the organization's relationship.

Response:

Aetna Behavioral Health, LLC maintains full responsibility for managing our behavioral health services portfolio and we offer a full range of services to our members. We do not use a subcontractor

By contracting directly with providers and facilities, we are fully committed to offering an expansive and holistic provider network to our clients and their employees. Within the provider network, the Aetna name is synonymous with quality and excellence in customer service.

Our behavioral health program

Managed behavioral health mirrors managed medical care. Aetna Behavioral Health has a dedicated department with staff who has specific behavioral health skills, qualifications, credentials and experience. We follow our own care management processes, evidence-based clinical practices and protocols for behavioral health care management. For example, we use our internally developed Level of Care Assessment Tool to assess the member's level of functioning and the appropriate level of care.

Just as with medical care management, we provide the following for managed behavioral health:

Pre-certification of:

- Treatment for inpatient care (inpatient MH/CD, inpatient detox, residential treatment MH/CD)
- Partial hospitalization
- Non-routine outpatient care:
  - Applied Behavior Analysis
  - Transcranial Magnetic Stimulation

Concurrent review:
Optimum treatment and care planning through inpatient pre-certification, concurrent review and discharge planning

24/7 Triage and Referral:
- Clinicians available at all hours to handle clinically urgent and complex needs for our members to ensure access to appropriate behavioral health services and care

Condition management program:

- Engages our members and their families struggling with acute, costly and chronic behavioral health conditions
- Early identification through sophisticated triggers
- Improved engagement through intensive outreach strategies
- Health advocacy for members to coordinate and work through co-existing medical and behavioral health conditions
- A unified approach to help members get the right treatment, services and resources
- Opportunities to measure and analyze efficacy and value

1.61	Describe how plan participants access the behavioral health service.

Response:

Members call the 24-hour, toll-free member number on their ID card to access care. In an emergency, we encourage members to seek care immediately.

Members may self-refer to behavioral health practitioners of their choice. We determine benefit eligibility by benefit plan coverage.

Inpatient, partial hospital and intensive outpatient behavioral health services require prior authorization, unless otherwise indicated in the plan design. For non-emergent inpatient care, the member or the facility must contact us using the toll-free number printed on the ID card. The customer service representative will help facilitate the preauthorization process.

1.62	What credentials are required for specialty case managers that are used to manage Mental Health/Substance Abuse (MH/SA) cases?

Response:

Aetna Behavioral Health has a dedicated department with staff who has specific behavioral health skills, qualifications, credentials, licensure and experience.

All behavioral health clinicians must be a:

- Licensed Master's-level clinical professional with both a minimum of three years post-licensure and post-Master's level direct clinical behavioral health or chemical dependency experience or
- Registered Nurse with at least three years post- licensure direct clinical behavioral health or chemical dependency experience

Our clinicians must also demonstrate the ability to:

- Effectively communicate with and engage members
- Accurately and appropriately triage members for behavioral health services

Manage emergency and crisis situations

- Communicate and collaborate effectively with diverse providers
- Effectively manage integration of physical and behavioral health services
- Handle complex situations
- Effectively address member discharge and follow-up needs

1.63	Does the same case manager handle the member's care through all levels of care? For example, inpatient, intermediate and outpatient?

Response:

No. Behavioral health clinicians use a team approach to provide case management services. We designate one clinician as the primary point of contact and collaboration. Other members of the case management team are available to address the member's needs if the primary clinician is not available. This is especially important during times of crisis and emergency, when the primary clinician may be working with the member and family to achieve stabilization. Another team member works on identifying possible treatment and intervention resources. Weekly rounds, case reviews and other forms of communication keep the case management team abreast of special cases.

We base assignment on availability, as well as the clinician's skills, such as language and cultural competency. These skills can affect communication with and engagement of the member. We also consider the clinician's specialty in handling specific diagnosis or ages (e.g., adolescents, elderly). All our clinicians can address the needs of all target populations and age groups. They undergo the same level of intense initial and ongoing training. Clinicians with specific expertise in an age group, diagnosis or service can serve as consultants to others on individual cases. Clinical managers review clinician assignments routinely and changes are made to enhance team functioning and capabilities.

If a member returns for behavioral health services after discharge from treatment, we attempt to have the same clinician work with them to ensure continuity of care.

1.64	How long is a patient monitored after discharge?

Response:

The periods following discharge from an intensive treatment program are times of significant change and challenge for members. The length of time a patient is monitored is individualized and based on each member's needs, but the average is 3 to 4 months.

1.65	How frequently are outpatient cases evaluated for case management?

Response:

Routine outpatient care does not require precertification. Therefore, members do not enter our system to be reviewed. Members are free to see the provider of choice at any time.

We recommend precertification only for Applied Behavior Analysis and Transcranial Magnetic Stimulation. Precertification is performed by one care manager per members call, unless other care managers or medical directors are called in due to case complexity.

1.66	Are out-of-network cases considered for case management?

Response:

Yes, both in-network and out-of-network cases receive the same case management services.

1.67	Describe methods that are available and used within the organization to ensure appropriateness of treatment (utilization and duration).

Response:

A licensed behavioral health clinician handles all assessment and referral for inpatient and intermediate levels of care. Upon referral, the clinician evaluates the member's needs, requested services and authorizes an appropriate level and duration of care based upon the benefit design and contract language. We provide authorization for requested inpatient acute care, residential treatment, partial hospitalization and intensive and non-routine outpatient services as necessary to accommodate the clinical urgency of the situation. The clinician takes the following into consideration during the assessment:

- Level of urgency for treatment services (life threatening emergency, non-life-threatening emergency, urgent or routine care) as defined pursuant to federal and state mandates
- Level of care needed to promote the optimal behavioral health
- Coverage of medically necessary behavioral health treatments
- Provider characteristics suited to meet the individual needs or preferences of each member

To support the evaluation process, we use the following guidelines:

- Our internally developed Level of Care Assessment Tool (LOCAT)
- American Society of Addiction Medicine Criteria: Treatment for Addictive, Substance-Related and Co-Occurring Conditions
- Applied Behavior Analysis Medical Necessity Guide
- Aetna's Clinical Policy Bulletins
- State guidelines when required

If the member requires inpatient services, we precertify for this level of care and provide a date for a concurrent review of the member's status. At that time, based on updated clinical information obtained, we will determine the need for further care in an inpatient setting or at an alternative level of care.

We refer the case to the physician advisor for review if the clinician determines that the patient does not meet the criteria for the level of care requested. Master's-level clinicians and board-certified psychiatrists conduct all clinical reviews.

We approve treatment that is medically necessary and within the limits of the member's benefit plan. We monitor care regularly based on the member's condition. The treatment plan goes through review every three to six days.

We establish reasonable timeframes for update reviews with the utilization department or the treating provider. We base timeframes on the individual clinical needs of the member. We do not directly engage with the member for pre-admission and continued hospital stay certification.

1.68	Do MH/SA case managers routinely co-manage cases with medical and/or disease management case managers?

Response:

Yes. Our behavioral health clinical case managers work together to coordinate and co-manage the holistic needs of our members. We use the same clinical system for medical and behavioral health, making referrals and co-management seamless. Both participate in mutual clinical activities, such as medical and behavioral health grand rounds, team meetings and clinical consultations.

<u>The goals of our behavioral health/medical Integration model</u>

A clinical model that demonstrates real integration of care across all programs and populations:

- Identifies and addresses routine behavioral health issues by leveraging behavioral health and medical management expertise
- Improves the effectiveness of medical interventions and outcomes by addressing behavioral health drivers of medical outcomes through one clinician

Components of the behavioral health/medical Integration model

- Behavioral health specialists serve as trainers/mentors and support for medical teams regarding mental and behavioral health issues. Nurses, with the support of the behavioral health specialist, manage most routine behavioral health issues.
- Behavioral health care managers are available to work with members we identify with moderate to severe behavioral health issues or those that are not responding well to the efforts by the medical management clinician.
- Our systems are integrated to support the model and provide a holistic view of the member's health.
- Training includes motivational interviewing techniques which can help to uncover member resistance to positive behavior change.

Results of the integration model

- Member total health addressed
- 44 % increase in depression screenings
- 50 % increase in identifying members with both a behavioral health and medical condition

1.69	Explain how reporting on State-specific outcomes data will be provided. Describe the type of reporting available.

Response:

Your account team is available to provide analytic assistance for the performance of the State's plan of benefits using a report package that targets key areas, which have the greatest impact on cost, utilization, member engagement and health. This package contains a wealth of useful information and illustrates prior and current views. It includes Aetna and industry benchmarks, to easily identify trends.

The report package is arranged in chapters that align with actionable topic areas and include the following:

- Executive Summary – Shows a high-level summary of your current offerings and the top things you need to know and recommendations based on an analysis of the results
- Key Measures Summary – Quickly shows trend, trend cost drivers, membership demographics, program savings and productivity
- Member and employee characteristics – Provides a summary of age, gender and location to help explain utilization and trend results
- Financial and Utilization – Illustrates distribution of medical spend
- Network Management – Gives a summary of network use to help drive strategies for quality and cost optimization
- Diagnostic Categories – Shows costs and high cost claimants to help identify trends and clinical areas for further focus

- Population Health – Summarizes illness burden, predictive scoring, disease prevalence, compliance with preventive and screening services and targets specific areas for health improvement
- Health Promotion & Risk Reduction – Includes lifestyle coaching, risk assessment and metabolic syndrome information
- AITC Experience and Results – Gives a detailed snapshot of members with clinically urgent and chronic conditions, including costs, participation, membership volume and outcomes
- Case/Disease Management Experience – Summary of members in case and disease management, engagement and cost savings
- Maternity Experience – Summary of deliveries, outcomes, intervention engagement and infertility services
- Clinical Program Impact – Snapshot of current intervention and improvement program activities.
- Behavioral Health – Summary of Behavioral Health utilization and costs
- High Cost Claimants Key Statistics – Summarization of utilization, costs, demographics and clinical details driving this metric
- Value Based Network Management – Snapshot of trends in eligibility, PMPM costs and savings
- Emergency Room Detail – Snapshot of ER utilization, clinical detail and demographics
- Medical Pharmacy Detail – Snapshot of injections and infusions utilization
- Oncology Detail – Key financials for cancer care utilization.
- Musculoskeletal Key Statistics and Clinical Details – Key financials for orthopedic utilization and summary of clinical utilization
- Inpatient Facility Key Statistics and Conditions Details – Snapshots of inpatient facility utilization and costs and clinical distribution

Analytic consulting

Our Plan Sponsor Insights group also provides analytic consulting. Consultants support your account team to interpret your plan data. Together they provide insights to guide solutions for optimizing plan performance. Analytic consulting services include ad hoc reporting.

1.70	Is a virtual network part of the programming? Describe the virtual network.

Response:

We offer behavioral health tele-video services to customers as part of their in-network outpatient benefit. Aetna Behavioral Health enables members who need behavioral health services—but can't get to their provider's office—the ability to have a session with a behavioral health provider using their computers, laptops, smartphones or any mobile device.

Tele-video provides online face-to-face access with clinical specialists such as: social workers, counselors, psychologists, marriage and family therapists and psychiatrists.

There is no impact on the number of face-to-face sessions offered within a member's plan. Members can receive behavioral health services face-to-face with a provider, in their office or through tele-video. No precertification is required. We reimburse tele-video services at the same rate as in-person face to face services. Claims will be applied towards the plan benefit under in-network outpatient counseling and will auto adjudicate.

Depending on where the member lives, Inpathy, MDLive or Arcadian Telepsychiatry will provide tele-video services.

Technical needs - In order to receive tele-video services, a member must have all of the following:

- High-speed internet
- Web cam
- Email – to receive a HIPAA compliant tele-video link

Benefits of offering a tele-video option to our members include:

- In urban areas, tele-video helps members who may have difficulty making their appointments due to traffic, parking and long work hours.

- In rural areas, tele-video helps members who have a very limited number of providers in their area or no providers within a reasonable distance.

- Given the growing demands on families, tele-video can help members who may have childcare constraints and can't travel outside the home for a private session.

AbleTo

Undiagnosed and untreated, behavioral health issues can make it difficult for people to follow their doctors' advice. Like taking medicine, eating healthier, getting some exercise. This can make their health conditions even worse - and lead to higher-cost hospital care down the road.

The AbleTo program makes it easy for your members to get the behavioral health help they need — before it can complicate the health conditions they are already dealing with and before it can drive up overall medical costs.

Our AbleTo offering identifies members with specific conditions or life events that could benefit from behavioral health support. Members are then invited to join one of the AbleTo programs. Each program includes eight weeks of personal professional support through web-based video conferencing or by telephone.

AbleTo provides support for the following health care conditions and life changes:

- Cardiac events
- Diabetes
- Breast cancer recovery
- Prostate cancer recovery
- Pain management
- Depression and anxiety
- Postpartum depression
- Stress related to the care of another adult
- Loss of a loved one
- Anxiety and panic
- GI health
- Respiratory
- Caregiver for adults
- Caregiver support for children
- Caregiver support for autism

Members meet with behavioral professionals through web-based video conferencing or by telephone. This removes the time and hassle of having to drive to appointments. Even more convenient, they schedule their appointments based on their schedule. The AbleTo professionals are available to meet during the daytime, evening and even on the weekend.

Members work with two AbleTo specialists for the first seven weeks:

- Once a week with a therapist, who uses evidence-based approaches to address emotional challenges, like depression, stress and anxiety, that can come with their diagnosis
- Once a week with a behavior coach, to identify health goals and develop an action plan for members to follow and help keep them on track

That's two sessions a week and a final meeting with the therapist - 15 sessions in total. All for one copay a week. The participant meets with the therapist for a final consultation in the eighth week.

The therapist helps the member address the emotional challenges – like depression, anxiety and stress – that can come with a medical diagnosis. The behavior coach works with the participant to identify personal health goals and develop an activity plan to help keep on track.

1.71	Describe which specialty providers are included in the network, i.e. Medication assisted treatment, ABA, eating disorder, etc.

Response:

Our behavioral health network, consisting of 188,000 providers nationwide, is robust and continually growing. The following mental health and substance abuse providers are within the behavioral health network:

- Psychiatrists
- Psychologists
- Social workers
- Psychiatric nurses
- Therapists - includes licensed professional counselors and marriage/family therapists
- Autism-specific providers
- Substance Abuse Counselors

Notes; (1) Medication assisted treatment is a form of therapy, not a type of provider, so is not tracked as such. (2) Similarly, the above providers may specialize in eating disorders, but this is not tracked as a specific provider type.

Aetna Behavioral Health is available 7/24/365 to help members locate a needed provider. Specialty information is available through our on-line provider directory, as well.

1.72	Describe the pay-for-performance strategy for the Behavioral Health providers.

Response:

Our Pay-for-Performance program consists of a payment model that provides incentives for provider performance. Our current network consists of freestanding behavioral health facilities. We also have outpatient behavioral health multi-specialty group practices on pay-for-performance arrangements.

When scoring these programs on an annual basis, we use claims data to measure readmission and ambulatory follow-up rates and audits of the program's policies and procedures. We also conduct chart audits to ensure providers are documenting appropriately on a given set of quality and efficiency measures relating to the patient and the patient's care. We reimburse these facilities and provider groups through rate adjustments and/or additional payments based on their yearly performance review.

Some key pay-for-performance metrics include:

Outpatient Groups

- Timely access
- Psychiatric availability
- Use of evidence-based tools
- Collaboration with medical providers
- Follow up with members who leave treatment
- Consumer satisfaction survey and follow up on identified issues
- No Quality of Care issues identified that resulted in the need for a Corrective Action Plan
- Use of participating labs only

Facilities

- Use of evidence-based tools
- Use of medication assisted treatment for members receiving substance abuse treatment
- Complete discharge planning process
- Collaboration with medical/behavioral health providers
- Family/significant other involvement
- Consumer satisfaction survey and follow up with identified issues
- No quality of care issues that resulted in the need for a corrective action plan
- No evidence of unnecessary use of non-participating labs
- Use of MATx for substance use disorders for recovery

1.73	Describe the strategies that are used to drive in-network and/or high-quality care.

Response:

To help drive in-network use, we offer the following:

- Behavioral health tele-med options (Teladoc, telemedicine providers, AbleTo) to help members stay in-network when access/availability are issues

- Behavioral health care management and utilization management (with a focus on precertification) all steering to in-network options

Most importantly, we work with customers to promote member education, plan design and benefit changes to differentiate or remove out-of-network benefit.

In addition, we do the following on a reactive and proactive basis:

Reactive: If the member elects to use their out-of-network (OON) benefit for higher levels of care, we:

- Require the OON provider to contact us for precertification and ongoing treatment authorization. If the OON provider fails to do this and they request authorization for treatment post care, we require retrospective reviews of treatment records.
- During our utilization management process, we actively promote in-network (INN) treatment options for all subsequent care post discharge.
- Members admitted to higher level of care are also referred to our BH care management (CM) team. For members we engage, we always work with the member to identify INN treatment providers wherever possible.

Proactive:

- When members call in to member services lines, we provide INN options,
- When members call into our EAP to and have issues requiring higher levels of care, they provide INN options,
- Medical team nurses to refer to BH CM when they identify one of their physically ill triggered members struggling with a substance misuse issue that will require facility-based levels of care. Our BH CM team will then work with the member on the best treatment options,
- Active promotion of our Substance Abuse Institutes of Quality network
- Consider benefit design options such as reduced or no cost share for going to one of our IOQs and consider a travel benefit.
- During our engagement with members and caregivers within our BH CM and Member Care Coordination programs, we educate on the benefits of INN options and when needed and steer them to INN options when needed.
- When admitted to an OON facility, ask to speak to the member to inform them of OON cost share.

1.74	Describe how the organization is helping customers deal with the opioid epidemic.

Response:

Actions that help our customers and their employees struggling with opiate misuse include:

- Member Care Coordination – This model wraps around the member and caregivers by working with the facility to provide holistic discharge planning and support pre- and post -discharge.

- Integrated Service Delivery model –This model helps caregivers find in-network options for their loved ones needing treatment for opiate misuse and provides support for the caregivers. It also helps members and caregivers get in-network help sooner along the progression of the opiate misuse condition.

- Utilization Management Transformation – A streamlined utilization management approach removes the precertification administrative burden so that treatment so we can authorize in-network care quickly. The concurrent review team focuses on discharge planning.

- Behavioral Health Condition Management program – Members with opiate misuse disorders will trigger and/or be referred for Behavioral Health Condition Management support. These include members going to the emergency room for opiate issues, being admitted to detox/in-patient/RTC, referred from a JV/ACO, utilization management, medical teams, disability and EAPs.

- Behavioral Health Medical Integration – We train nurses to identify behavioral health comorbidities, including opiate misuse issues, especially involving pain management. Through behavioral health consultation, we determine what is needed.

- Institutes of Quality (IOQ) – Substance abuse IOQ all provide evidenced based treatment for opiate conditions.

Additionally, our Guardian Angel program reaches members during the critical time following an overdose. As soon as we learn that a member has had an opioid-related overdose, a specially trained registered nurse or licensed clinical social worker reaches out to educate them on treatment options in their area. Our Guardian Angel clinicians can also provide access to nearby social support services. Above all, our clinicians serve as a lifeline for members and their families when they need us most.

Outreach and support

Once we contact a member, our clinicians educate them about available resources including:

- Medication-assisted treatment (MAT)
- Narcan
- Substance Abuse and Mental Health Services Administration (**samhsa.gov**)

- Pain alternatives other than opioids

We strongly encourage the member to contact their primary care provider (PCP) to discuss these options. Because many members using opioids have other chronic conditions, connecting with their PCP also allows members to address all their needs. If the member is ready to start MAT, we also encourage them to ask if their PCP is a certified Suboxone provider. If their PCP is not a Suboxone provider, we can locate one nearby and assist in scheduling an appointment.

Our clinicians also discuss how certain medications, such as benzodiazepines, muscle relaxers and other contraindicated medications, can cause adverse reactions or a possible overdose while using opioids.

We refer pregnant members using opioids to our Aetna Maternity Program for additional support.

For more information on our Guardian Angel program, please refer to the following article: **news.aetna.com/2018/06/guardian-angel-opioids-program-reaching-members-at-critical-time/.**

1.75	Describe if eligibility is processed in real time with the claims system.

Response:

We upload data to our eligibility systems in both real time and through nightly batch runs. We upload in real time any eligibility sent online or electronically. We manually load eligibility sent on paper.

Updated information appears in our eligibility and claims system immediately.

1.76	Describe member's capabilities to request additional or replacement ID cards.

Response:

Members can request an ID card by calling member services. They can also view and print an ID card from the member website or mobile app.

1.77	Describe member's capabilities to print ID cards directly from site.

Response:

Members can print their card by going to our member website at **aetna.com.** They can print a card for themselves and their dependents.

1.78	Describe member's capabilities to access historical health data.

Response:

Our Personal Health Record (PHR) allows members to access historical health data.

Internal integration

Aetna claims data automatically feeds our PHR and prepopulates the appropriate fields. This includes data from provider visits, tests and screenings, lab results and pharmacy claims.

Third-party claims data

In addition, we can integrate data from a third-party vendor into our data warehouse and the PHR. Data must include LOINC (Logical Observation Identifiers Names and Codes).

Because of our strategic relationship with Quest Diagnostics, lab results from these vendors automatically populate data in the Tests and Procedures tab in a subscriber's PHR. Our data warehouse receives the onsite screening results within three to four weeks of the event. We update the PHR the night the data is received.

Pharmacy claims data

We integrate external pharmacy claim data into our Personal Health Record (PHR).

Pharmacy data integration

Each member's PHR includes integrated pharmacy data. It is fed into the "Medications" section of the PHR. Here, it can be viewed alongside current and past over-the-counter medications. Members can also add notes about a medication's effectiveness or side effects, making it a very useful resource to reference over time.

Claim history

The PHR can be prepopulated with claim history from your prior carrier(s).

1.79	Describe member's access to provider directories.

Response:

Through our mobile and web platform, we provide members with personalized easy access to plan and provider information. We are constantly refining and working to improve the search experience for members by investing in data quality, machine learning and service optimizations to improve speed and accuracy of expected search results. Members are able to search by:

- Provider name
- Provider specialty
- Provider type
- Facility name
- Facility specialty
- Facility type
- Procedure
- Health service
- Labs

Members may enter in a specific zip code or enable locations settings in the Aetna Health mobile app to initiate a search.

Displaying search results

Our provider search returns results in a default order of "Best Match" based on an algorithm that weighs quality, network tiers (if applicable) and distance. Provider results and details may include the following information dependent on the provider information and how the user starts a search:

- Doctor name
- Specialty
- Network status along with out-of-network messaging
- Accepting new patients
- Address and other locations
- Distance from searched address/zip code
- Phone number
- Languages Spoken
- Board certifications
- Quality designations
- Education
- Hospital affiliations
- Patient reviews
- Out-of-pocket cost estimates (if procedure, specific lab or health service search or from specific provider detail page)

Facility results will include the following details:

- Facility name
- Type of facility – Acute Short Term Hospital, Radiology Center, Laboratory
- Address and other locations
- Distance from searched address/zip code
- Phone number
- Network status
- Aetna Quality Measures – Institute of Quality, Institute of Excellence

In addition, Teladoc and premium labs are promoted as other lower cost option with certain search results.

Filtering a search

When using our Aetna Health app, members may refine provider results by gender and languages spoken, the two most highly filtered categories by users. When performing a search from their computer, members can refine results by using the following filters:

- Languages
- Gender
- Hospital Affiliations
- Office Detail
- Plan Information
- Certifications, Specialized Training and Programs
- Group Affiliations
- Type of Doctor or Facility

Additionally, members can customize their search results by:

- Provider name
- Cost
- Rating/reviews
- Distance
- Gender
- Languages

Pharmacy Directories

Members can search by location or pharmacy name in English or Spanish. When they find the pharmacy, members can view:

- Address
- Telephone number
- Hours of operation
- A map with driving directions

Mobile experience

The provider search function on our Aetna Health app has been streamlined to make it easier to find providers quickly. We give our app users the following quick task options:

- Primary care physicians
- Emergency room
- Urgent care centers
- Lab facilities
- Participating pharmacy

1.80	Describe member's access to provider selection where users enter search criteria.

Response:

After the user has searched by specialty, provider name or a procedure for the location of interest, they will see a list of providers near their zip code. The search results include:

- Doctor name
- Specialty
- Address
- Phone number
- Distance
- Out-of-pocket cost estimates (for procedure searches only)

Users can then filter results based on provider gender, language or acceptance of new patients.

1.81	Describe member's access to review claim status.

Response:

Members who register for our member website can view the status of a medical, dental or pharmacy or flexible spending account (FSA) claim for themselves or a covered dependent, 24/7. They can check to see if a claim is completed, in process or if more information is needed.

In addition, members may download personal claims safely and securely for use in planning for health care expenses, tax reporting and record keeping.

1.82	Describe member's access to plan design.

Response:

Members can access their plan design on the member website and the mobile app.

1.83	Describe member's ability to email member services.

Response:

Knowing that members want to contact member services quickly and securely, we make it easy for them to send us email from our member website. Members can register and log in to our member website 24 hours a day, 7 days a week. Every page on the site has a "Contact Us" link, making it simple to send a secure message to member services whenever they have a question or concern. Members can also access their secure message center from every page on the site where they can submit new questions as well as view responses.

KANA Response is our enterprise level application used to respond to member "Contact Us" web forms and emails. KANA is ar email routing and reporting system, which routes and tracks our member's submissions and their outgoing responses.

Customer Service Professionals using KANA, compose responses from a library of standard templates that help ensure consistency and clarity when responding to our member's questions. They have the ability to customize a response specific to a member's question or concern if no standard response is available. Our goal is to respond to email inquiries within one business day.

Because member emails may contain personal health information, we make member privacy a top priority. To assure security, our responses are sent to the members secure message center located within our member website. Members must log in to view the customer service responses.

For those not using the website, we encrypt every email members sent from "Contact Us." We also encrypt every email response. Our responses provide easy instructions for opening encrypted messages.

Our goal is to respond to 90 percent of all inquiries received through the "Contact Us" link within 24 hours.

1.84	Describe member's capabilities to customizable health content tools.

Response:

In general, our wellness content and tools cannot be customized. However, we welcome the State's input and requests for additional resources. For example, if you have a particular need for a digital coaching program for your population, we consider this in our development review.

1.85	Describe tools available to members for evaluation of cost and/or quality of healthcare providers.

Response:

Our cost estimator helps users shop for health care services just like they shop for other items by comparing price, quality and convenience.

When searching for a procedure within our digital platform, members see the out-of-pocket costs associated with each provider displayed. The member can view a detailed summary of their out-of-pocket costs and how they were calculated based on the health plan and provider network, the procedure and the member's real-time deductible and co-insurance information. The tool typically bases cost estimates on two years of aggregated claim history for a particular procedure or diagnosis at the provider level.

Knowing these costs in advance can help members budget for and manage health care expenses. It also makes it simpler for members to discuss their financial responsibility with providers.

Our cost estimator empowers members to anticipate their health care costs, compare costs and quality between providers and decide where to receive care. We are committed to maintaining and enhancing our position as a leader in transparency. We feel that the level of detail and accuracy provided by our cost estimator goes beyond other estimators and helps people better plan for and budget for their health care services.

How it works

Claim system technology

We leverage an analytical data approach to price transparency. We provide estimates more than 300 for service bundles, which epresent the most likely combination of services that may be performed together in a doctor's office or in a facility setting. We derive these bundles from our own historical claims experience and include all related costs from admission to discharge. We typically base cost estimates on two years of aggregated claim history for a particular procedure or diagnosis at the provider level. Our cost estimator updates the pricing and quality indicators in real-time.

In-network

Our cost estimator can calculate in-network costs for certain non-emergency, highly utilized services performed by doctors and other health care professionals directly contracted with Aetna. These in-network services include:

- Physician office visits
- Surgical procedures
- Diagnostic tests and procedures
- Emergency room services
- Urgent care services

This information can be extremely beneficial when members look at certain non-emergency, outpatient services such as an MRI, as it can help them to understand where they might find the most cost-effective care.

Out-of-network

Estimated costs are not available for all procedures and services. Estimates are only available for providers with sufficient claims history.

Rating and reviews

We offer a provider rating and patient review feature which appears in our cost estimator's search results. This includes more than 1.5 million reviews/ratings for over 250,000 providers from over 20 sources. These ratings and reviews allow members to get an idea of other patients' experiences with a provider. Ratings are based on a 5 star system which provides a consistent comparison metric members can consider when selecting providers. When a member views provider details, up to three review snippets can be read. To read more or to submit their own rating and review, members simply click on a link to our vendor DocSpot.com.

We expect that future enhancements will improve our cost estimator with additional plans, services, facilities and health care professionals.

1.86	Describe member's online access to member appeals.

Response:

Members can submit an appeal through our member website, **www.aetna.com.**

1.87	Describe member's access to applications for mobile devices.

Response:

Consumers want access to their health care to be convenient, wherever and whenever they need it. That's why we've invested in on our mobile capabilities. But, just being mobile isn't enough. Consumers also want tools to be simple and easy to use.

Today, we provide our members with many powerful mobile tools to help them manage their health and wellness. Our tools help our members to accomplish four key types of tasks:

- Shopping for care
- Paying for care
- Improving their health
- Accessing and using their benefits

Shopping for Care

We provide members with the tools they need to shop for care on the go, including:

- Aetna Health – Aetna Health makes it easy for members to shop for health care like they do for anything else. Our app enables members to search a doctor, facility, procedure or medication while comparing options based on what means the most to them – whether that's quality, cost, distance or type of facility. Plus, members can even schedule an appointment online or call the provider's office directly.

- Teladoc app – Teladoc is an affordable alternative to ER and urgent care that allows members to resolve many of their common medical issues 24/7/365 through the convenience of phone and video consultations. The ability to access care on the go is important to our members, so we offer mobile access to Teladoc.

- The Plan Selection and Cost Estimator Tool is available as an option for the State. This tool needs to be selected and implemented by your account manager.

Paying for Care

Members can pay for care using:

- PayFlex – PayFlex offers both a mobile web and app experience to help members manage their health funds, including accessing and using Health Savings Accounts and Flexible Savings Accounts
- Pay a claim features – Members can pay providers using their preferred payment method (i.e., credit card, checking or savings account) on the mobile web version member website or the Aetna Health mobile app. After logging in, members can view, manage and pay for health care expenses in a few easy clicks. They can also track the status of submitted payments.

Improving Health

The mobile web version of our member website is designed to provide members with a convenient and secure, way to access health improvement and support tools from anywhere at any time – while allowing them a continuous, multi-touch experience. Members have access to a variety of tools including:

- Comprehensive health assessment
- Online coaching programs
- Personal health record
- Health trackers

We also provide full mobile capabilities for the following condition-specific health improvement programs:

- For behavioral health, immediate access to help managing stress, recording mood and emotions and one-click access to live help from a counselor (Resources for Living app)
- For post-acute and post-diagnosis treatment adherence, completely mobile televideo Cognitive Behavioral Support after life-threatening illness, new diagnosis of chronic disease or post-partum depression (AbleTo - platform available via mobile web)

Access and Using Benefits

Our Aetna Health mobile app gives members the tools they need to manage their benefits right in the palm of their hands. Using our app, members can:

- See plan phase and accumulator status, limits and balances
- Check benefits overview
- View claim activity and details
- Access a digital ID card
- Find care and schedule appointments
- Make and track claim payments to medical and dental providers
- See HSA, HRA or FSA fund balances

1.88	Describe the ability to customize web site for the State.

Response:

We can add the State's logo to our member website.

We also have the ability to add the following items to our website:

- Links to relevant documents or external websites

- Health assessment messages
- Other reminders
- Welcome message language and add a PDF to this site that may include detailed information on your wellness and incentive strategy.

We are happy to discuss additional details with you upon request.

1.89	Describe the ability to hyperlink to the State's site.

Response:

The State can link to our member website from their intranet for easy member access.

1.90	Describe employer/actuarial consultant inquiry capabilities.

Response:

At the State's request, we can authorize brokers or consultants as designated users of Analyze·Rethink·Transform (ART), our web business intelligence tool.

Brokers or consultants may also have access to monthly claim reporting through secure email. We format the file in Microsoft Access and compress it using WinZip. The file contains recorded claim data and the checks that cleared the banking system. This financial file is an audit trail for the claim activity for the month.

The State must sign hold harmless documents for us to release the information.

There is no charge for a consultant or broker to have access to these reports.

1.91	Describe security/privacy issues.

Response:

Unfortunately, despite our best efforts, privacy breaches do occur from time to time. We provide specifics to impacted customers. We also report such information to applicable government websites.

Covered entities must report protected health information (PHI) breaches to the Department of Health and Human Services (HHS). The HHS posts a list of these breaches of unsecured PHI affecting 500 or more individuals at https://ocrportal.hhs.gov/ocr/breach/breach_report.jsf).

1.92	Describe future plans/timeframes for enhancements.

Response:

Our digital capabilities include the following core foundational components:

- Provider search
- Integrated cost transparency, benefits and financial information
- Claims
- Claims payment capabilities
- Wellness, including next best actions personalized to each member

We will be expanding additional functionality throughout 2019, including:

- Expanding our library of Next Best Actions
- Secure messaging and chat
- Reward integration
- Integrated user experience for members with pharmacy and dental coverage with Aetna in addition to medical
- Medication and dental price transparency
- Mail-order refill capabilities
- Additional services for specialty pharmacy medications

Using Agile SAFE 4.6 methodology, we continuously enhance our website and Aetna Health mobile app. We manage priorities according to our high-level product strategy while also focusing on immediate development needs. We are able to deploy incremental changes quickly and adjust our product delivery to ensure optimal quality upon deployment.

Long term vision

Our vision is "a world where every member is empowered to achieve a healthy lifestyle on their own terms." As a company, we are bringing together all of our products and services and presenting them seamlessly to each member so each experience is personalized. The intersection of data, analytics and consumer technology has upended virtually all consumer experiences and reset consumer expectations. We recognize the health care industry is not immune to this transformation and we intend to lead this new standard of customer experience.

Our goal is to join our members on their personal health journey and support their unique goals. Our member interactions are becoming experiential instead of transactional in nature.

1.93	Provide an accessibility report using Optum, GeoAccess, GeoNetwork or comparable software. Note geo-mapping method used. Urban/Suburban must be 1 within 20 miles and Rural must be 1 within 35 miles for the following provider types: e. Facilities: i. Hospitals ii. Ambulatory Surgical Center iii. Urgent Care facilities iv. Imaging Centers v. Inpatient Behavioral Health Faculties f. Primary Care: i. General/Family Practitioner ii. Internal Medicine iii. Family Medicine iv. General Medicine OB/GYN v. Pediatrician g. Specialists: i. Endocrinologist ii. Urologist iii. Cardiologist iv. Dermatologist v. Allergist

	vi. Psychologist/Psychiatrist vii. General Surgeon viii. Hematologist/Oncologist ix. Chiropractor

Response:

Please refer to the GeoAccess reports included in the Network Information section of the proposal response.

1.94	Indicate whether the network proposed for the State is leased or owned or a combination. If a combination, indicate what percent is leased and what percent is owned. If any portion of the network is leased, provide the name of network lessee. As the result of this arrangement, the State will require no impact on preauthorization, quality assurance and hold harmless arrangements. Indicate how this requirement will be met. Also, indicate how negotiated discounts for leased networks are on-line and fully integrated with the claims system.

Response:

We are proposing our Choice POS II network and Aetna Whole Health Catholic Health Initiatives (AWH CHI) network for the State of Nebraska.

Our AWH CHI Accountable Care Network is a collaboration between Aetna and CHI Health. Our AWH CHI Accountable Care Network is a collaboration between Aetna and CHI Health. This product model ACO through the CHI network is a significant differentiator and would be a great option for the State's members. The AWH CHI ACO provides access to 72 percent of the State's employees, based on the census that was provided. AWH CHI is lower in price than the broad network that we are also offering and provides an average savings that ranges from 13-16 percent.

We have designed the plan to offer improved quality, outcomes, efficiency and member experience. Our locally based accountable care model centers on the relationship between the primary care doctor and the patient. Through that, we strive to reach members where, when and how they live.

Our Aetna Whole Health CHI plan offers member-focused, doctor-driven health care. CHI sends welcome letters to members, introducing the Aetna Whole Health plan's unique coordinated care services and providing a dedicated phone number to reach CHI Health's care coordination team.

The CHI Health Accountable Care Network will provide members with highly coordinated care through their clinically integrated network. The overall network includes:

- More than 800 primary care doctors
- More than 4,500 specialists
- 28 acute care hospitals
- 7 quick care locations
- 21 urgent care centers

Members are strongly encouraged to select a primary care doctor who will help to guide them when making important health care decisions and direct them to the care they need at the right time in the right setting.

Aetna Whole Health delivers a new health care model to consumers, providing members access to efficient and highly coordinated care.

We directly contract with 90 percent of our provider network. In certain instances, generally for smaller towns and rural areas, we do lease networks. If we do not have a directly contracted network in an area, we may use rental network vendors that administer provider networks on our behalf. These networks are based on our contract standards and principles.

We do not change vendors unless there are concerns with network adequacy and/or discounts. In the event of such a change, we would seek to identify an alternative vendor that would minimize membership disruption while maintaining or improving network discounts.

For self-funded Choice POS II, we also offer a Rural PPO network to supplement existing directly contracted and rental networks in areas that have previously been considered out of area. We contract with PHCS to offer network access on a self-funded basis through the PHCS Network.

We will be using the following leased networks for the State of Nebraska:

- Wyoming-First ChoicePOSII
- CO Cofinity OAMC/POSII
- MN PrefOne MC
- CenWI HealthEOS OAMC/CPII
- FoxRvHealthEOS OAMC/POSII
- Montana-HIN-Choice POS II
- SDakotaFirstChoiceMPOSII
- BowlingGreenCenterCareMC

We maintain data on all contracted providers and all nonparticipating providers who have filed a claim with the health plan, in ur Enterprise Provider Database (EPDB). The EPDB, our single source of provider data, also holds provider credentialing data and is accessed by our claims systems. The rental vendors perform credentialing and recredentialing activities for the rental networks.

We update rental network records in the EPDB as new information is received. For most rental networks, we receive provider rates from the rental network vendor and we automatically load these rates into our systems for pricing claims. We also continuously update the contracts stored in our systems to incorporate new negotiations, which can occur anytime during the year.

For certain rental networks, our Rural PPO network and our National Advantage™ Program (NAP), we automatically send claims to an external pricing entity that has access to real-time information from these networks. This process allows us to price the claims against the most up-to-date vendor databases, which may result in greater savings for members who are responsible for paying a portion of the claim and for the customer who funds the claim.

Repricing Process

The external repricer forwards the claim to the rental or Rural PPO network vendor, which prices the claim and returns the rate to us. If the vendor does not have a contract with the provider and the plan does not include NAP, then the external repricer returns the claim to us and we apply our internal rating systems.

If the rental or Rural PPO network vendor does not have a contract with the provider and the plan does include NAP, the external repricer forwards the claim to the appropriate NAP vendor, which prices the claim and returns the rate to us. If a NAP contract does not exist with the provider and the claim is below our global claim services thresholds, the external repricer will send the claim to a vendor for fee negotiation.

If a discount cannot be achieved, we will follow our usual claim process for nonparticipating providers.

1.95	Indicate which accreditation was selected, provide the date of accreditation and give analysis on why said accreditation was selected.

Response:

We hold NCQA Health Plan Preferred Provider Organization (PPO) Accreditation for commercial PPO plans in 50 states and Washington, DC. We are accredited until December 31, 2019.

1.96	Describe in detail any restrictions or exclusive requirements for any provider Network.

Response:

Our networks do not have any restrictions or exclusive requirements.

1.97	Indicate if separate provider contracts for PPO and POS networks are maintained and describe in detail the reasoning and methodology behind such provider contracts.

Response:

Separate contracts are not maintained.

We do maintain separate contracts with our ACOs. So a provider can be contracted with our Choice POS II network and also have a contract with the ACO.

1.98	Indicate how Centers of Excellence are utilized for high intensity procedures: a. List of Centers of Excellence by procedure b. Method of referral to Centers of Excellence c. Credentialing process for Center Excellence

Response:

Please refer to *Centers of Excellence Facilities.zip*, located in the Samples and Brochures section of proposal response.

Aetna Institutes™ facilities are publicly recognized, high quality, high value health care facilities. Our goals are to:

- Recognize facilities with distinguished performance for health services that are critical to members.
- Engage consumers by providing them with information to help make informed choices about facilities with distinguished performance.
- Provide members access to high quality, cost-effective care.

Our program also offers travel and lodging reimbursement for patients and a companion who must travel over 100 miles to our facilities. However, travel and lodging excludes our infertility network.

Major components of Aetna Institutes

Institutes of Excellence™ (IOE)

This is our name for health care facilities that offer highly specialized clinical services to members with complex or rare conditions. Our nurse case managers nationally coordinate a member's clinical care for these cases. IOEs include:

- Transplant care
  - Heart

- Lung
- Heart/Lung
- Simultaneous pancreas kidney (SPK)
- Pancreas
- Kidney
- Liver
- Intestine
- Bone marrow/stem cell
- CAR-T cell therapy*

- Pediatric congenital heart surgery
- Infertility

* Beginning in 2019, we added Chimeric Antigen Receptor T-cell therapy (CAR-T) to our IOE list. CAR T-cell therapy is cancer treatment that uses a patient's immune system cells, called T cells, after these cells are modified to better recognize and kill the patient's cancer. The T cells are engineered in a laboratory and then expanded to large numbers and infused back into the patient. This service is available to self-funded customers using CAR-T IOE facilities. National Contracting - Institutes Programs™ transplant program negotiates mutually acceptable rates with our IOE BMT/Stem Cell facilities providing these services.

Institutes of Quality® (IOQ)

This is our name for health care facilities that offer clinical services to members for prevalent health conditions. IOQs include:

- Bariatric surgery
  - Gastric bypass
  - Adjustable gastric band
  - Sleeve method

- Cardiac care
  - Cardiac medical interventions
  - Cardiac rhythm disorders
  - Cardiac surgery

- Orthopedic surgery
  - Total knee replacement
  - Total hip replacement
  - Spine

We identify IOE and IOQ facilities in our provider search, a key feature of the Aetna member website.

The member's PCP or treating specialist doctor starts the member participation process in the National Medical Excellence Program®. The member's doctor must call our unit and pre-authorize the initial transplant evaluation and any subsequent transplant-related service. This allows our transplant case managers, who are registered nurses, to gather all case-specific information. It also begins early interaction to coordinate the member's care with a participating facility that is appropriate for the member's needs.

Once we accept a member into the program, we:

- Assign a nurse transplant manager to provide support
- Coordinate care
- Act as a member advocate during the member's time of medical crisis

A full-time medical director oversees all reviews performed by the transplant case manager and personally reviews all questionable cases and potential denials. The transplant case manager develops a plan of care; then works with the member, the family, the attending doctor, the specialist and the facility to coordinate access through doctors who have admitting privileges. This process maximizes the benefits available through their medical plan.

Our transplant case managers direct members to the closest Institutes of Excellence™ (IOE) facility contracted for their specific transplant type. However, members may use any IOE facility contracted for their transplant type to receive in-network benefit levels.

Members also have the option to select a noncontracted or out-of-network facility for their transplant type. However, if they choose to use a facility not in our network, the care is subject to the plan's transplant coverage for out-of-network providers. In addition, there is no allowance for transportation or lodging for out-of-network facilities.

IOE

Each transplant facility that seeks Institutes of Excellence™ (IOE) designation must be in our network and must complete a response to our request for information. We also determine if an access need exists for their services. If a need exists:

- The facility must be certified by The Joint Commission and Medicare.
- The organ transplant programs must be a member in good standing with UNOS (United Network for Organ Sharing).
- All bone marrow transplant programs must be FACT (Foundation for the Accreditation of Cellular Therapy) accredited and NMDP (National Marrow Donor Program) certified.
- The facility for CAR-T must be an IOE facility for autologous hematopoietic stem cell transplants and must be certified to administer CAR-T cell therapy by an FDA approved manufacturer for the drug.

The programs must meet specific program and operational requirements. For example, they must:

- Disclose and explain a history of closure or suspensions
- Have a UNOS approved primary surgeon and physicians
- Include a comprehensive primary improvement program

For each organ, there are specific volume and outcome requirements. For example, we evaluate one-month and one-year patient and graft survivals. After meeting these requirements, the facility must enter into a comprehensive contractual agreement specific to transplant services. This includes meeting our cost efficiency guidelines (cost threshold) and our global financial arrangements covering pre and post-transplant care facilities, doctors and all other related inpatient and outpatient costs. All doctors providing transplant services must be in our network.

Our evaluations include both the professional and facility competencies together.

IOQ

Criteria vary by type of institute and procedure in the Aetna Institutes™ program.

All Institutes of Quality facilities are also required to meet cost efficiency guidelines (cost threshold).

Our evaluations include both the professional and facility competencies together.

1.99	Indicate ongoing provider quality monitoring activities, such as physician profiling.

Response:

We implement quality improvement through a cross-functional team approach, as evidenced by multidisciplinary committees, such as the National Quality Oversight Committee, which oversees and addresses quality improvement activities and the National Quality Advisory Committee, which sets direction for clinical quality improvement initiatives. We use quality reports to monitor, communicate and compare key indicators.

We use continuous quality improvement (CQI) techniques and tools on an ongoing basis to improve the quality and safety of clinical care and service delivered to members. These techniques and tools help us to support and monitor the consistent implementation of processes that affect our Quality Management (QM) program goals, as well as support our accreditation strategies.

We use quality reports to monitor, communicate and compare key indicators, such as for the following purposes:

- Monitoring medical, behavioral health, case and disease management programs
- Evaluating the accessibility and availability of network providers
- Evaluating member experience and physician satisfaction

Developing, implementing and monitoring patient safety initiatives

In addition, our annual QM program evaluation provides a comprehensive summary of completed and ongoing quality improvement activities performed under the scope of our QM program and identifies opportunities for improvement.

We consider our quality reports and QM program evaluation report to be proprietary.

1.100	Provide detailed information on how Contractor hold-harmless provisions and network agreements are enforced with providers/pharmacists.

Response:

We contractually require network providers to agree to accept our payment for covered services on behalf of the member (i.e., accept assignment of benefits). We do not allow network providers to waive this requirement, which would result in the provider billing the member and us reimbursing the member. The provider must accept our payment plus any applicable member financial responsibility (e.g., copayment, coinsurance and/or deductible) as payment in full.

We also contractually require network providers to submit clean claims and to agree to permit us to rebundle and make other adjustments for inappropriate billing or coding practices when applicable. Providers contractually agree to hold members harmless and never balance bill for covered services.

Pharmacy Network

Participating retail pharmacies must at all times hold policies for general and professional liability insurance, including malpractice, at a minimum, in the amount of $1,000,000 per occurrence and $3,000,000 in aggregate, unless otherwise agreed to or such amount required by law.

We periodically have follow up activities conducted with participating retail pharmacies to obtain updated information and to confirm the current information on file is correct. Through this process, the pharmacies can update the stated liability carrier and policy terms.

1.101	Provide the average trend rates for public sector customers with similar demographics and plan designs for the last five (5) years for PPO plans and POS plans.

Response:

[redacted]

1.102	Describe the average in-network participation by provider and by claims paid for 2017 and 2018 for clients located in Nebraska.

Response:

For Choice POS II in Nebraska, 97.2% of allowed claims were in-network in 2017 and 98.1% of allowed claims were in-network in 2018.

1.103	Describe the capability to develop and administer a network specifically for the State based upon State-defined criteria.

Response:

We have the ability to create custom network arrangements for various customer network needs. We support custom networks for all types of providers, including physicians, ancillary providers and hospitals. We can exclude specific participating providers from the custom network.

We can set up a separate benefit level for the providers in the custom network. To administer these arrangements, we create a unique system identifier that includes all of the providers that the State designates as part of their network.

We can administer specific contracted rates for providers, if required, within the custom network. We load the provider data into our systems, as well as any specific provider reimbursement/contracted rates, to facilitate auto-adjudication of claims.

Depending on the size and complexity of the network, additional fees may apply. Our team works with the State to understand your goals and assist in building the custom fee schedule according to your specifications.

We'll provide resources to support the State's custom network. This includes a designated network manager who assists in the implementation and serves as a liaison for ongoing maintenance and all questions related to the network.

[redacted]

1.104	Provide the ratio of physicians to members maintained in the State of Nebraska's provider network.

Response:

The ratio of physicians to members is **1:5.96.**

1.105	Provide the ratio of participating specialists to physicians in the State of Nebraska's provider network (i.e., all providers not including family/general practitioners, OB/GYN, Pediatricians and Mid-Level Clinicians such as nurse practitioners and physicians assistants).

Response:

Using the formula above of excluding family/general practitioners, OB/GYN, Pediatricians and Mid-Level Clinicians such as nurse practitioners and physician's assistants we have a total of 9,463 physicians in the network. We have 8,905 specialists.

The ratio is 1:1.06.

1.106	In the service areas where there are plan members, indicate if there are any medical services or specialties that are not available in the physician networks. Indicate what services are not available and what provisions are made for patients requiring these services.

Response:

We are not aware of any specialized treatment conditions that we cannot is not part of our network of physicians and hospitals in the Nebraska service area. Our network coverage is more than adequate. If there are any gaps, it is typically due to lack of available providers to join the network.

Based on population size, we focus on service areas and types of services provided at each hospital and their affiliated physicians, so that appropriate levels of care are available to members. A fully developed, mature network may include all hospitals in a defined geographic area that meet and agree to contractual criteria.

If the service is not available within the network, the member can obtain the service out-of-network at the in-network benefit level.

1.107	Describe how the State would be informed of the termination of a provider.

Response:

The State's account team will communicate any significant network changes to you in a timely manner.

Our standard policy is to notify you at least 30 days prior to any significant network changes, such as hospital or large physician group terminations.

We use a network update process to notify our internal account representatives of these changes. These communications provide the account teams with the important details and a customizable customer email, which the account teams can use to alert the State to the network change.

We would be happy to provide a sample communication upon request.

1.108	Describe the contract period for physicians.

Response:

The initial terms of our provider contracts vary based on negotiations, but are generally for a period of one year or more. Many of our contracts, particularly with hospitals, are long-term agreements, typically for three to five years. After the initial term, the contracts usually automatically renew for additional terms of one year each until either party initiates discussions to renegotiate the terms and the renegotiations are completed.

1.109	Describe how often physicians are credentialed.

Response:

Physicians are credentialed every three years.

1.110	Describe physician credentialing process, specifically if the selection and credentialing process allows the declining of an individual physician or provider group or organization. What is the average time to credential and add an individual physician? What is the average time to credential and add a medical group?

Response:

For physician selection, we use standardized physician participation criteria. To participate in one of our network, we require all physicians to submit an application and successfully complete the credentialing process.

Our credentialing process for practitioners is consistent with NCQA, URAC and CMS credentialing requirements and is supported by our NCQA-certified and URAC-accredited Credentials Verification Organization. Our credentialing policies and processes are compliant with state, federal and accrediting entity requirements and employ standard methodologies for all provider types.

After our initial screening of a provider's confidential information form, which is submitted with the application, we may require the submission of additional information from the provider.

We consider the following items in the credentialing process:

- Licensure and/or certification verified through state licensing boards in geographical areas where network providers will care for our members
- Board certifications (when applicable)
- Loss of/limitation of hospital admitting privileges (when applicable)
- Current professional liability coverage
- Conviction for Fraud/Felony
- Drug Enforcement Agency (DEA) and state controlled-drug substance registration, when applicable, through verification by the U.S. Department of Commerce National Technical Information Service (when applicable)
- Disciplinary history or adverse actions related to licensure and DEA registration, which we query through state licensing boards and the National Practitioner Databank
- Malpractice insurance claim history to examine any possible trends and to look for evidence that might suggest any probable substandard professional performance in the future
- Mental and physical health to determine if the provider's history might suggest any probable substandard professional performance in the future
- Participation in government programs such as Medicare, Medicaid
- Professional education and training through verification by the American Medical Association (AMA) Masterfile, American Osteopathic Association (AOA) and specialty board or specific residency/training program (highest level of education, depending on provider type)
- Work history

We obtain documents and verify them through a variety of primary sources, such as:

- American Board of Medical Specialties
- AMA Masterfile
- American Osteopathic Association
- Hospitals
- Medical schools and training programs
- National Practitioner Data Bank
- National Technical Information Services
- Office of Inspector General (OIG) reports
- Professional liability insurance carrier, as appropriate
- State licensing boards

The regional Credentialing and Performance Committee (CPC) reviews the credentialing file. This peer review process includes the determination of professional competence and conduct and whether the provider will be approved for participation in Aetna networks. Between credentialing/recredentialing cycles, the CPC may review a provider if adverse actions have been reported.

Between formal recredentialing cycles, we routinely monitor state board sanctions, loss of license and Office of Personnel Management/Office of Inspector General Reports to capture any adverse activity that could potentially result in a non-renewal. We review these reports as frequently as they are made available and have processes in place to communicate the information to the appropriate department for action.

Upon receipt of a credentialing application, we make commercially reasonable efforts to complete primary source verification within 45 days of receiving the physician's completed application unless state regulations require a shorter timeframe.

We believe that credentialing is a key component in maintaining member access to quality health care. More information on our provider credentialing process is available on our website at **aetna.com.**

1.111	Describe if physicians in the network may limit the number of patients/cases that are accepted. Indicate how the limit is determined and what the limit is.

Response:

We do not require participating group physicians to accept or decline new patients based upon the practice status of any of the other physicians in the group. A participating physician's practice closed or open status is determined at the individual level and not at the group level.

If a participating physician wishes to close their practice to new patients, we contractually require the physician to submit written notice to us with good cause at least 90 days prior to the close date.

Participating providers are required to provide our members with the same level of care, service and access as they typically provide to patients who are not members.

1.112	Indicate what percentages of physicians in the provider network for the State's health plan are at full capacity.

Response:

As of July 2019, 4.93 percent of PCPs and 3.98 percent of specialists are closed to new patients.

1.113	If a network gap or deficiency is identified by the Contractor or the State, how will the need for additional providers be addressed?

Response:

One of our competitive advantages is our uncompromising focus on providing access to care in as many geographic locations as possible. We base our strategy on providing our members with a comprehensive provider network through directly contracted and, depending on the health care plan, indirectly contracted providers. We are generally able to offer network access in most areas of the country. Additionally, we review individual network accessibility to see that members have appropriate access to a full complement of providers. Our inclusive network strategy allows us to offer our members, regardless of product, the most comprehensive network available.

Our accessibility standards utilize accessibility reporting indicators for urban, suburban and rural ZIP Codes. Where we identify gaps, we will work with the State to formulate a potential solution for member coverage.

1.114	Describe what criteria is used to select hospitals and other health care facilities to participate in the network.

Response:

For physician selection, we use standardized physician participation criteria. To participate in one of our network, we require all physicians to submit an application and successfully complete the credentialing process.

We require hospitals to be in good standing with state and federal regulatory bodies and to have been reviewed and approved by The Joint Commission (TJC), the American Osteopathic Association (AOA), Det Norske Veritas Healthcare, Inc. (DNVHC) or an accrediting entity deemed appropriate by Aetna policy. These accrediting bodies perform detailed reviews of hospitals including on-site visits and require demonstration of quality improvement activities. If a hospital is not accredited, we require an on-site quality assessment; however, if we find that the Centers for Medicare and Medicaid Services (CMS)/state survey includes review of substantially the same scope of our review for hospitals, the CMS/state survey may be substituted for an on-site quality assessment.

We contractually require hospitals to maintain comprehensive general and professional liability insurance or self-insurance in adequate amounts and to provide documentary evidence of such coverage upon request. Hospitals must notify us of any material change of licensure or accreditation status or any changes to their general or professional liability coverage. We also contractually obligate hospitals to participate in our quality management and patient management activities.

Between formal recredentialing cycles, we routinely monitor the Office of Personnel Management/Office of Inspector General reports to capture any adverse activity that could potentially result in a non-renewal. We review these reports as frequently as they are made available and have processes in place to communicate the information to the appropriate department for action.

We confirm every three years that the hospital continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body.

1.115	Indicate which of the hospitals participating in any network are accredited by JCAHO and which are not.

Response:

We do not require hospitals to provide this information to us. Therefore, we are unaware of the total number of hospitals that hold JCAHO accreditation. We have provided a report in the Samples and Brochures section of our proposal response that indicate which Nebraska hospitals have reported JCAHO accreditation and which hospitals have not reported this information (indicated as No/unknown).

1.116	Indicate what liability coverage limits the participating hospitals are required to carry.

Response:

We contractually require hospitals to maintain comprehensive general and professional liability insurance or self-insurance in adequate amounts and to provide documentary evidence of such coverage upon request. Hospitals must notify us of any material change of licensure or accreditation status or any changes to their general or professional liability coverage. We also contractually obligate hospitals to participate in our quality management and patient management activities.

The limits differ by state. In Nebraska, hospitals are required to carry $1M/$3M in general and professional liability insurance.

1.117	Indicate if any hospitals or other medical facilities have been terminated or dropped from the network. Identify the hospital/medical facility and for what reason(s).

Response:

We have not had any hospital or medical facilities term or drop from our network over the past two years.

1.118	Indicate what percentage of hospitals/facilities in Nebraska are in the provider network.

Response:

One hundred percent of the key hospitals in Nebraska are included in our network. This includes all of the Short-Term Acute Care Hospitals and Critical Access Hospitals.

1.119	Indicate what provisions are made for enrolled patients when hospitals/facilities leave the provider network.

Response:

Our member notification process notifies members of all HMO and PPO-based medical plans when their PCP, specialist, hospital, facility, ancillary or other health care provider leaves our network, either voluntarily or involuntarily.

When we know a provider is leaving our network, an automated system typically generates member notices 30 days prior to the provider's termination date or in accordance with applicable regulations. If the provider is a PCP, we send letters to all members assigned to the PCP. We also send letters to members who have not selected a PCP, but have had at least 1 visit with the PCP during the previous 12 months.

If the provider is a specialist, hospital, facility, ancillary or other medical health care provider (as defined by state mandates), we send letters to all members who have had at least 2 visits within the past 12 months, in accordance with NCQA standards. The process may vary based on state specific criteria. We also send retraction notices if a provider is reinstated, which is automatically generated the night the termination is removed from the system.

Where allowed by applicable state law, our standard provider contracts allow both parties to terminate without cause, typically with a 120-day notice for physicians, a 90-day notice for physician groups of less than 5 and a 120 to 180-day notice for hospitals. Both parties also may terminate for default or breach, typically with a 60-day notice. All participating providers are required to continue care until treatment is completed or we are able to make appropriate arrangements to have another provider render the service.

Member letters

The member notification letters identify the provider and when the provider will no longer be part of the plan's network. The letters vary based on provider type:

- PCP/specialist: The letter for PCPs and specialists contains information regarding:
    - Possible higher out of pocket expenses for continuing to get care after the termination date.
    - The address to the online provider search to find a list of providers in the network.
    - Selecting a new PCP if the physician is the member's PCP and their plan requires PCP selection.
    - Contacting their PCP for a referral to a new network specialist if the physician terminating is a specialist.
    - Transition of care coverage, requirements and where to get a Transition Coverage Request form if the member is under current treatment.
- Hospital: The hospital letter contains information regarding:
    - Possible higher out of pocket expenses for continuing to get care after the termination date.
    - The address to our provider search to find a list of network hospitals and physicians in the area.
    - Transition of care coverage, requirements and where to get a Transition Coverage Request form if the member is under current treatment.
    - What to do in case of an emergency.

Changing providers

To change PCPs or request assistance locating a provider, members can call the toll-free member services number listed on their ID cards or visit our member website. When applicable, PCP changes are typically effective immediately and a new member ID card is mailed shortly thereafter.

Members can identify participating providers by accessing our provider search, which is updated six days per week. They can also request a paper version of our provider search by calling member services. We update the paper version annually.

1.120	In the event that any of the Contractor's medical facilities are unable to provide service due to complete or partial destruction, labor disputes, epidemic or other causes, the Contractor shall make a good faith effort to arrange to have the services (to which a member is entitled) provided by other facilities and providers of services. Explain how to comply with this provision.

Response:

Confirmed. If a member is unable to receive services due to one of the situations noted above, we will assist the member in finding another provider. If another in-network provider is not available to perform the service, the member may be able to obtain service out of network at the same level of benefits.

1.121	In addition to the hospitals in the provider network, list all other types of facilities and ancillary providers available through the hospital provider network and indicate how each is paid.

Response:

While the representation of provider types may vary by network, the following services are typically available:

- Alcoholic/drug inpatient care
- Chiropractic services
- Dental services
- Emergency room coverage
- Home health services
- Inpatient hospitalization
- Inpatient mental health hospitalization
- Long term nursing care
- Mental health outpatient visits
- Outpatient lab services
- Outpatient X-ray services
- Pharmacy services
- Physician outpatient office visits
- Podiatry services
- Prescription eye exams and glasses
- Psychiatric inpatient care
- Routine injections/immunizations
- Skilled nursing facility

We use a variety of reimbursement arrangements to compensate ancillary providers. We typically compensate participating ancillary providers on a contracted fee-for-service basis.

Network ancillary services include:

- Durable medical equipment
- Home health care
- Hospice
- Lab
- Radiology
- Physical therapy
- Medical transport (including air ambulance)
- Podiatry (in most of our networks)
- Chiropractic services (in most of our networks)

When ancillary services such as lab work or X-rays are provided in an inpatient setting, these fees will be included in the per diem or case rate payment to a hospital.

Arrangements may vary by provider type, region and individual provider contracts.

1.122	Indicate if there are any forms of treatment that cannot be provided by hospital provider network; indicate which ones. Describe what arrangements are made for the provision of these necessary services.

Response:

We are not aware of any specialized treatment conditions that cannot be managed by our network of physicians and hospitals in the Nebraska service area. If we are not able to provide a service, it would only be because the service is not available in the area.

1.123	Indicate if there are designated facilities for specific specialty care for services such as transplants, etc. and describe such arrangements in detail.

Response:

Aetna Institutes™ facilities are publicly recognized, high quality, high value health care facilities. Our goals are to:

- Recognize facilities with distinguished performance for health services that are critical to members.
- Engage consumers by providing them with information to help make informed choices about facilities with distinguished performance.
- Provide members access to high quality, cost-effective care.

Our program also offers travel and lodging reimbursement for patients and a companion who must travel over 100 miles to our facilities. However travel and lodging excludes our infertility network.

Major components of Aetna Institutes

Institutes of Excellence™ (IOE)

This is our name for health care facilities that offer highly specialized clinical services to members with complex or rare conditions. Our nurse case managers nationally coordinate a member's clinical care for these cases. IOEs include:

- Transplant care
  - Heart
  - Lung
  - Heart/Lung
  - Simultaneous pancreas kidney (SPK)
  - Pancreas
  - Kidney
  - Liver
  - Intestine
  - Bone marrow/stem cell
  - CAR-T cell therapy*
- Pediatric congenital heart surgery

- Infertility

* Beginning in 2019, we added Chimeric Antigen Receptor T-cell therapy (CAR-T) to our IOE list. CAR T-cell therapy is cancer treatment that uses a patient's immune system cells, called T cells, after these cells are modified to better recognize and kill the patient's cancer. The T cells are engineered in a laboratory and then expanded to large numbers and infused back into the patient. This service is available to self-funded customers using CAR-T IOE facilities. National Contracting - Institutes Programs™ transplant program negotiates mutually acceptable rates with our IOE BMT/Stem Cell facilities providing these services.

Institutes of Quality® (IOQ)

This is our name for health care facilities that offer clinical services to members for prevalent health conditions. IOQs include:

- Bariatric surgery
  - Gastric bypass
  - Adjustable gastric band
  - Sleeve method
- Cardiac care
  - Cardiac medical interventions
  - Cardiac rhythm disorders
  - Cardiac surgery
- Orthopedic surgery
  - Total knee replacement
  - Total hip replacement
  - Spine

We identify IOE and IOQ facilities in our provider search, a key feature of the Aetna member website.

IOE

The payment methods vary for our Institutes of Excellence™ network transplant services. We usually negotiate a global case rate for the facility and doctor charges. This rate includes:

Evaluation
Transplant surgery
Follow-up care for a defined time

Occasionally, we may use a fee schedule to contract and pay doctors separately from the hospital agreement for transplant-related services.

Case rates for major procedures by region or hospital are confidential.

IOQ

We reimburse bariatric surgery, cardiac care and orthopedic surgery (total joint replacement and spine) according to our negotiated contracts. Reimbursement methods vary by hospital system. There is no separate contracting for our Institutes of Quality® facilities.

1.124	Provide a quality assurance program in terms of any qualitative and quantitative measures used in the program. a. Describe how these programs are communicated to providers within the network(s). b. Describe how these programs are communicated to health plan members.

Response:

The scope and content of the Quality Management (QM) Program are designed to continuously monitor, evaluate and improve the quality and safety of clinical care and service provided to members. Specifically, the QM Program includes, but is not limited to, the following:

- Review and evaluation of preventive and behavioral health services; ambulatory, inpatient, primary and specialty care; high volume and high-risk services; and continuity and coordination of care
- Development of written policies and procedures reflecting current standards of clinical practice
- Development, implementation and monitoring of patient safety initiatives and preventive and clinical practice guidelines
- Monitoring of medical, behavioral health, case and disease management programs
- Achievement and maintenance of regulatory and accreditation compliance
- Evaluation of accessibility and availability of network providers
- Evaluation of network adequacy
- Establishing standards for and auditing medical record and behavioral health record documentation
- Monitoring for over and underutilization of services (Medicare)
- Performing credentialing and recredentialing activities
- Oversight of delegated activities
- Evaluation of member and practitioner satisfaction
- Supporting initiatives to address racial and ethnic disparities in health care

- Collaborate in the development of provider performance programs: standardization and sound methodology; transparency; collaboration; and taking action on quality and cost or quality only, but never cost data alone except in unique situations where there are not standardized measures of quality and/or there is insufficient data.

Quality improvement activities that support the goals and objectives of the QM program are coordinated on an annual basis.

We use continuous quality improvement (CQI) techniques and tools to improve the quality and safety of clinical care and service delivered to members. We implement quality improvement through a cross-functional team approach, as evidenced by multidisciplinary committees such as the National Quality Oversight committee. We use quality reports to monitor, communicate and compare key indicators.

We prioritize the selection of measures based on an evaluation of our performance compared to benchmark data. We evaluate whether measures are integrated into accreditation or at risk for being integrated into the accreditation data set or are critical to meeting regulatory or customer expectations.

We evaluate proposed strategies for the project to accomplish the following:

- Address barriers
- Favorably impact the use of services and management of acute and chronic conditions
- Meet NCQA, HEDIS® (registered trademark of NCQA) or other business goals
- Ensure relevance to the population
- Ensure cost-effectiveness
- Measureable impact

Quality improvement initiatives focus on encouraging members to obtain needed care and providing them with tools and resources to help them accomplish their goals. We also provide support to physician practices to help them improve the quality of care provided.

In addition to quality improvement initiatives, we conduct clinical studies and use statistical analysis to test the effectiveness of improvement strategies. Examples of recent studies:

Cervical cancer screening birthday card reminder

This analysis observed the time period beginning at the time of the mailing and ending 90 days later. At the end of the 90-day period, claims were reviewed for evidence of gap closures for women who were due for a cervical cancer screening as defined the HEDIS 2016 CCS measure. Members who received the mailing (the intervention group) were compared to members who were not sent the material (the control group).

The percent of outreached HMO members (intervention group) who closed the gap in care for cervical cancer screening was lower than the rate for members in the control group. For the PPO members, the intervention group was higher compared to the control group but not statistically different.

A comparison to the method of delivery (email vs mailed) was also studied. There was no statistically significant difference in gap-closure based on the method of delivery. This most likely can be explained by the much smaller email population compared to the mail.

Since there was not enough evidence in this analysis to conclude that there is any difference in gap-closure rates between the intervention group and the control group for the Cervical Cancer Screening Campaign, we decided to discontinue the birthday card and seek market research. Market research performed showed members not wanting to associate cancer screening messaging with a happy birthday message. A new communication was designed and is being implemented for 2018.

Women's Health (breast and cervical cancer screening)

This analysis observed the time period beginning at the mailing of the program materials to the member and ending 90 days later. At the end of the 90-day period, claims were reviewed for evidence of gap closures where the member had been initially identified as having a gap in either breast cancer or cervical cancer screenings. Members who received the mailing (the intervention group) were compared to members who were not sent the material (the control group).

There was a better gap closure rate for breast cancer screening among members receiving an outreach from this campaign compared to members in the Control group. Regardless of whether members were sent the BCS reminder or BCS/CCS combo reminder, members in the Intervention group were more likely to get breast cancer screening than members in the Control group.

Members who have a gap in care for cervical cancer screenings do not seem to show the same likelihood to respond to the reminders. There was not a significant difference between the members who receive our mailings and the members who do not receive them in completing cervical cancer screenings.

Since the cervical cancer screening messaging did not show effectiveness, market research was performed to develop a new communication. A new design was implemented for 2018.

1.125	Provide descriptions for each UM/CM program, including the process to include individuals in the UM/CM program once paid claims exceeds $50,000. List and describe the case management services provided to members: Address complex, chronic and short-term conditions.

Response:

We want your employees and their families to enjoy their best level of health. Our utilization management program ensures members get needed care from network providers, avoid unnecessary treatment and use benefit dollars wisely. Our nurses work together to get members the care they need.

Program components include coverage and eligibility reviews for precertification and utilization management (concurrent review, discharge planning, retrospective review).

Coverage and eligibility reviews

Our care teams manage reviews of coverage. These reviews help:

- Determine whether care is needed and/or covered under the plan
- Identify cost-effective network providers
- Allow for program referrals to our programs that may further help the member

Reviews include:

Precertification

Precertification is the process of collecting information before inpatient admissions and select ambulatory procedures and services. The process permits advance eligibility verification, determination of coverage and communication with the physician and/or member. It also allows us to coordinate the member's transition from the inpatient setting to the next level of care (discharge planning) or to register members for specialized programs like disease management, case management or our maternity management program.

helps confirm members are covered for certain tests and procedures before they have a test done or are admitted into a hospital. By focusing on high-cost, overused and underused procedures, precertification reduces unneeded care and manages costs.

Concurrent review and discharge planning

Our clinical staff reviews inpatient admissions (except normal maternity care) while the member is in the hospital. We use proven guidelines to help make sure care given is covered and necessary. Following members closely helps lower the average length of hospital stays and helps them get quality care. Not all inpatient admissions require this clinical review. For example, routine admissions with a short length of stay normally don't need concurrent review.

Our clinical staff determines the frequency of review on a case-by-case basis. They base it on the member's clinical progress and our internally developed Focused Interaction Tool (FIT).

Discharge planning

A need for care doesn't stop when the member gets out of the hospital. Our proactive discharge planning begins during the hospital stay. We work with doctors, members and their families to develop a transition plan from one level of care to the next.

After a hospital stay, a member may need to go to a skilled nursing facility or set up home health care visits. Our staff helps arrange these to make sure members are getting the most efficient and effective care.

Retrospective review

This process includes a review after a member completes a medical service or hospital stay. We want to make sure we made the correct coverage determination based on the member's benefit plan and the appropriate level of care that is consistent with the member's needs at the time of the member's service.

Examples when we use retrospective review:

- Member met precertification/notification requirements at the time the service was provided, but the dates of service don't match the submitted claim.
- We became the primary payer instead of the secondary payer at the time of inpatient claims adjudication.

Technology

Industry leading technology is at the heart of our care management programs. This technology identifies opportunities for improved care by applying clinical rules to the medical information derived from members' medical and pharmacy claims, lab data and health risk assessments.

This technology powers our clinical desktop, Aetna Total Clinical View℠ (ATV). It:

- Provides a 360 degree view of each member to give medical management staff the information they need to better understand a member's current (and past, if applicable) health situation.
- Increases consistency and efficiency for business users through improved automation
- Provides integration of clinical information across programs which eases cross-product care team communication

- Provides capability to add new programs more rapidly
- Promotes a clinical decision-making based on branching logic
- Case management referrals reduce readmission rates and ER visits

During utilization review, we look for members who can benefit from a nurse case manager to help prevent more significant health events. We refer these cases to case managers.

Case management is one way we partner with members on their journeys toward better health. We find members at the right time, engage them to take action and help them manage their health. We deliver value by helping people achieve their best health.

Our program helps:

- Improve coordination among providers
- Effectively use plan benefits
- Increase knowledge
- Assess for behavioral health concerns

Identification

Our integrated systems, processes and people work together to find members earlier. We identify members using:

- Predictive modeling
- Frequency of ER visits
- Claims data
- Utilization management reviews
- Referrals from doctors, members or other Aetna programs

By identifying members sooner, we can engage them in our programs to get the right care at the right time.

Engagement

Once we identify a member, our nurses work to get them the care they need. We use a team approach, proven medical guidelines and industry-leading technology.

Our case management program has two components:

Proactive case management

We look for opportunities to improve care and work with members to close gaps in care. Our nurses reach out to members, so they know the best way to receive care under their plan. A single nurse case manager handles the member's case and partners with them on their unique health journey.

Complex case management

Our nurses coordinate care and benefits to help members through difficult care situations. We create individual case management plans and monitor each member's progress. Our goal is to identify and close gaps in care that lead to better clinical outcomes and lower costs.

Our proactive and complex care management programs help members:

- Address health concerns
- Improve self-management
- Get the right services in the right setting
- Maintain or enhance quality of life
- Use their benefits wisely
- Understand their health status
- Set realistic health goals

We engage members in their health journey to improve the member experience and help them reach their health ambitions.

Handling of Costly Treatments

We work with you to improve your bottom line on costly treatments as well as your employees' health and well-being. Our industry leading strategies for care management solutions actively shape the future of health benefits.

Our program offerings for costly treatments

Regional case management program

Our regional case management manages targeted complex needs for example catastrophic cases such as members with trauma. As part of our case management, we also created specialty programs and services to meet our members' unique needs. For example, the Aetna Compassionate Care℠ program offers case management services to members and their families who are managing complex and emotional issues involved in advanced illnesses. Our experienced case management nurses specialize in all aspects of complex care. They work with the patient, doctor, facility and family throughout the process. We also identify members proactively using our predictive algorithm. Our case managers also work with members with rare diseases, for example help with arranging benefits for transportation and lodging for the patient and companion when the facility is over 100 miles away.

National Medical Excellence Program®

Our National Medical Excellence Program provides case management services for members receiving a transplant. Our nurses steer members to our Institutes of Excellence™ (IOE) transplant network. The network handles transplants and transplant-related services including evaluation and follow-up care. We select hospitals to participate in the IOE network that:

- Exhibit successful clinical outcomes
- Meet quality of care standards
- Agree to acceptable contractual terms

We contract with these facilities on a transplant-specific basis.

Aetna Maternity Program

If offered in the benefit plan, our Aetna Maternity Program provides specialized case management for women with high-risk pregnancies.

Women's Health programs

We also have Women's Health programs that provide services for breast and ovarian cancer screening and infertility.

Our Breast Cancer Support Center on **aetna.com** is a comprehensive site that provides members with plan-specific coverage information about diagnostic tests, cancer treatments and other relevant benefits. It has multimedia resources in plain language, including videos, checklists and support from the American Cancer Society. We've also divided it into four categories Awareness, Diagnosis, Treatment, After Treatment and Living with Cancer that gives members trusted sources of information throughout each step of their journey.

The BRCA Genetic Testing Program, our national breast and ovarian cancer genetic testing program, promotes early risk identification and intervention by covering screening for an inherited mutation in breast cancer genes 1 and 2 (BRCA1 and BRCA2).

Infertility staff look at state mandates when they review treatment plans for eligibility. They encourage the use of eSET (elective single embryo transfer) protocol when appropriate. They also encourage use of participating providers and direct members to our IOE infertility networks if in their area.

Program goal

The goal of our case management programs is to drive better health outcomes, increase satisfaction and ultimately lower overall costs. We focus on identifying and working with members and others on their health care team to influence health outcomes. We help members take an active role in their health and health care so they can achieve their optimal level of health.

1.126	Describe the process for population risk analysis and population stratification. Identify the guidelines that are used to support UM/CM decisions. a. Who is responsible for follow up after discharge? b. Does this protocol apply to all discharges or is it limited to those with identified medical needs at discharge? c. How is follow up after discharge tracked? d. What processes are in place to assist individuals in obtaining qualified medical services at a low cost? e. Does a single/same case manager follow the case throughout its course in case Management? f. Does the case manager serve as the primary reviewer if the patient is readmitted to an acute care setting?

Response:

a. Members identified for case management receive a post-discharge call or attempted call within 3 to 12 business days of their hospital discharge from a case manager.

b. If a member is identified for case management, we make the call. We do not perform post discharge calls for maternity, newborns, behavioral health, coordination of benefits (COB) or Medicare.

If a member transitions from an inpatient setting to a skilled nursing or acute rehabilitation facility, the post discharge call occurs once the member is discharged from these facilities, if identified for case management.

c. Follow-up is tracked in Aetna Total Clinical View℠ (ATV) our care management system. This single system takes in and combines care management data from direct entry and multiple sources and makes it easily accessible to our staff. ATV tracks a member's full history of care management events including:

- Inpatient/outpatient services
- Pharmacy information
- Lab/diagnostic information
- Behavioral health and EAP services
- Member participation in Women's Health
- Member participation in disease management
- Member participation in case management

ATV also:

- Provides integration of clinical information across all programs
- Increases consistency and efficiency for business users because it:
  - Automatically identifies members for most program triggers
  - Automatically creates program enrollments due to automated triggers
  - Automatically populates user activities in the case plan based on the automated enrollment and member assessment responses. This eliminates many manual and process workarounds
- Makes the customer experience more seamless through consistent delivery of required care management activities

Our system also documents member specific case plans, which includes goals, deficits (opportunity/needs), activities (intervention/action) and progress of goals. However, these goals are not reportable.

d. Our clinical policies and reviews work together to help drive effective and efficient use of the health care system. By finding members through these reviews, we can direct them to the care they need. For example:

In 2018, there were 1,688 transplants of all types for our members. Of these, 1,535 or 90.9 percent were at a designated Institutes of Excellence™ (IOE) facility.

Steering members to network doctors and facilities for care helps ensure quality care is given and costs are held down.

e. Yes. Participants work with one case manager. Once we assign a member to a case manager, that case manager remains on the case throughout the current episode of care managing all comorbidities.

f. If the member requires case management again, we attempt to re-assign the same case manager who managed the prior episode of care.

1.127	Describe the UM/CM program in detail, including information on the following: a. Management of complex cases. b. Identification of complex cases. c. Ability for nurses to access member notes from other internal programs, including nurse line, condition management, wellness coaches. d. Management of special needs cases (traumatic brain injury, co-morbid conditions, neonatal cases, etc.). e. Ratio of case managers per 1,000 members. f. Methodology for determining savings related to the case management program.

Response:

a. The goal of the Aetna Compassionate Care℠ program is to provide support to medically fragile members and members with advanced illness in a culturally sensitive manner that supports and respects their decisions and choices.

The program:

- Provides support for members and their family. It helps them understand their illness and gives them the tools and resources to make informed decisions. And it helps with supportive therapy such as pain relief and caregiver support.
- Uses RN case managers and medical social workers that are dedicated to providing expertise through every stage of the member's decisions, in concert with their treating doctors.
- Provides a dedicated website with online tools and information about advance directives and livings wills, as well as tips on how to begin discussions about personal wishes for advanced illness.
- Uses an algorithm to identify members dealing with advance stages of illness to allow earlier case management. Earlier outreach leads to better relationship building to provide more long-term support for members.

Our nurses establish and build a rapport with members as far in advance of a final decline in health. As health issues become more intense, nurses use behavioral health awareness and motivational interviewing techniques to provide support.

Nurses use emails and telephone contact to stay in touch with members. Intensive training helps them be aware of the member's evolving needs and provide their support according to the member's unique situation. The nursing staff uses their training and clinical judgment to determine how often to stay in contact with members.

Our case managers have long provided advanced illness care coordination as part of their responsibilities. They also receive additional training on issues specific to the challenges raised by these clinical situations. And there is no additional charge for these services.

We generate referrals to our case management program from:

- Specific diagnosis groups or procedures related to specific services
- Certain inpatient admissions
- Specialty teams such as our NICU, SNF/Rehabilitation or National Medical Excellence Program®
- Administrative data sources such as Predicted Utilization by Statistical Evaluation for Action-able Impactable Members (PULSE℠ AIM)

- Staff from our precertification, concurrent review/discharge planning, disability services, disease management and behavioral health units

- Sales and marketing

- External referral sources include but are not limited to:
  - Hospital discharge planners
  - Physicians
  - Members
  - Family members/caregivers
  - Customers

Our member services unit can also accept external case management referrals:

- By telephone
- In writing

We make behavioral health referrals to our behavioral health program or to the member's delegated behavioral health contractor as appropriate.

The following represent a sampling of conditions that may result in identification for our program:

- Multiple Admissions - All members identified with 2 or more admissions within a rolling 90 days

- Members with advanced illness needs

- Inpatient acute hospital admissions with the following conditions:

  - Selective heart diseases or disorders
  - Diabetes mellitus
  - Neuromuscular disease
  - Traumatic injuries
  - Infectious disease
  - High-risk maternity
  - Premature babies
  - Selective blood disorders

We also consider the following triggers:

- High-dollar claims
- Members identified through our predictive modeling tool (PULSE)
- Members identified through the Re-Admission Risk Tool

We refresh PULSE predictive modeling data monthly to give us up-to-date information for identification of case management opportunities. In addition to a member's predictive modeling risk score and historical medical and pharmacy data, actionability flags may indicate certain characteristics or outcomes such as:

- A member's noncompliance to medication
- High total use of out-of-network providers or facilities
- High emergency room activity

- High dollar claims equal to or greater than $75,000 within 12 months

Case managers receive and review referrals based on a PULSE score of 13 or higher and 2 or more flags.

We periodically review our case management criteria for program performance and clinical validity. We may make changes based upon the results of the review.

We accept members into the program who have care coordination needs or gaps in care and are likely to benefit from case management. We define a gap in care as any deviation from the doctor's treatment plan or accepted standards of medical practice.

c. We have a single system platform for all our care management services. Our platform, Aetna Total Clinical View℠ (ATV) is comprised of two main parts:

- A view only consolidation of data important for clinicians from multiple sources ("Clinical 360° View")

- An Interaction Toolset which provides tools for clinicians to do their day-to-day job

We designed the system on three strategic principles -- Member centricity, business flexibility and automation. ATV provides a comprehensive member picture to allow medical management staff to better understand all aspects of member involvement. It organizes all information by member instead of by program.

This single system takes in and combines care management data from direct entry and multiple sources and makes it easily accessible to our staff. ATV tracks a member's full history of care management events including:

- Inpatient/outpatient services
- Pharmacy information
- Lab/diagnostic information
- Behavioral health and EAP services
- Member participation in Women's Health
- Member participation in disease management
- Member participation in case management

ATV also:

Provides integration of clinical information across all programs

Increases consistency and efficiency for business users because it:

- Automatically identifies members for most program triggers
- Automatically creates program enrollments due to automated triggers
- Automatically populates user activities in the case plan based on the automated enrollment and member assessment responses. This eliminates many manual and process workarounds

Makes the customer experience more seamless through consistent delivery of required care management activities

Our system also documents member specific case plans, which includes goals, deficits (opportunity/needs), activities (intervention/action) and progress of goals. However, these goals are not reportable.

d. Our case managers that are assigned to high-risk members work to link the patient, hospital, doctor and family members throughout the process. If appropriate, we'll explain our Aetna Compassionate Care℠ program that offers services to members and their families who are managing complex and emotional issues involved in advanced illnesses. We'll also work together with other specialty programs and services for highly complex and costly events. Examples include neonatal intensive care, rare diseases, skilled nursing facility/acute rehabilitation services and our National Medical Excellence Program for transplants.

   We use proven guidelines to help make sure members receive care that is necessary and covered by their plan. We're with members every step of the way, monitoring the quality of care and contacting their doctor if needed. Our nurses also have access to social workers that can research local and national resources to meet members' needs.

e. Staffing ratios for our standard case management model are:

   - 1 Case manager to 90,000 members (self-funded)
   - 1 UM care management associate (CMA) to 160,000 members
   - 1 Medical director to 145,000 members

   Staffing ratios may vary due to regional variations.

f. Our ROI for case management in 2017 was 1.5:1.

   We measure ROI annually for our book of business.

   Valuation methodology

   There are three primary drivers of savings within the case management program. They are:

   - Steerage to participating providers
   - Reduction in acute admissions
   - Reduction in emergency room visits

   We conduct an annual analysis that compares a case-managed group to a non-case managed group for the above metrics. Control group members are those individuals who qualified and were identified for case management, but were unable to be reached. Managed group members are those where the case was worked by nurse and had the potential for savings.

   The analysis uses the case management identification date and compares managed members to a control of non-managed members. Using the case management identification date, we collect claim and pharmacy data for the twelve-month period following the case management identification date. We then compare the two group's outcomes and utilization. We calculate savings by taking the average cost of an ER visit or inpatient admission multiplied by any variance in utilization rates between the managed and control group. We also calculate a variance for steerage. We generate separate savings per case for complex and proactive case management.

   We review savings annually at a commercial book-of-business level.

   Our case management ROI studies use accepted methodologies including adjusting for differences in risk between our intervention groups. We review our methods and results with external epidemiology and statistical experts.

1.128	Describe predictive modeling and how predictive modeling capabilities identify at-risk members and potential interventions the State should consider. Include the ability to benchmark the wellness program and its financial impact.

Response:

For standard case management, Aetna Medical Cost Analytics assigns a Predicted Utilization by Statistical Evaluation (PULSE℠) severity score to all our members. The Forecasted Severity Index (FSI) score represents an individual's relative predicted health expenditure for the coming year. Medical Cost Analytics extracts this information and score from our predictive modeling tool and feeds it monthly through a highly-secured network link to the Member Health tab and the Opportunities tab in our Aetna Total Clinical View℠ (ATV) system. The entire care management staff can then view this score.

The scoring process is proprietary. We use cluster analysis and regression models that includes medical/lab claims, pharmaceutical, behavior health, health risk assessment surveys and eligibility/demographic data as independent variables acting as predictors of future health services usage. We cross validate the model with multiple data sets to provide a relationship between these variables and future usage. The score is based on the predicted, allowed dollars for the next year and uses the previous year experience for these independent variables.

If the State selects Aetna In Touch Care, our unique, internally developed algorithms scan your entire population to find members with potential health risks. We use claims, pharmacy, lab and self-reported data to identify members so nurses can contact members at a point in their care and treatment when it really matters.

The predictive modeling and tools identify members based on:

- Clinical urgency – It capitalizes on the critical clinical window of opportunity for member intervention and support. In fact, this predictive technology identifies members at risk for future avoidable admissions in the next 6 and 12 months.
- Financial impact – It assesses member need and the likelihood that the member will incur high cost expenses in the near future
- Clinical impact – It provides the ability to prevent further member decline or improve or sustain clinical outcomes

Our algorithms identify members and assign individual risk scores. Based on the scores, we stratify members as high, moderate or low. Then we match them to the right level of program support and perform outreach and intervention for their risk level.

We refresh scoring data monthly, based on updated claim and self-reported data.

We further identify participants for Aetna In Touch Care Solutions program through daily opportunity triggers. Examples of daily triggers include but are not limited to:

- Acute inpatient admissions – Members identified through the precertification process receive pre-admission phone calls to discuss their upcoming hospitalization
- Discharges – Members discharged from a hospital (excluding maternity and behavioral health) receive a post discharge call
- Advanced illness – Members identified for home or inpatient hospice care related to an advanced illness
- All members with at least $75,000 claim threshold annually
- Multiple provider or ER utilization
- Oncology admissions with primary and secondary cancer diagnoses
- Other proprietary trigger activities

We periodically review our triggers for program performance and clinical validity.

Our health assessment report includes benchmark data. The Health Risk Profile section of our report compares the State's data to Healthy People 2010 health objectives. Details include a comparison of:

- Healthy People 2010 health indicators for the percent of the national population at risk
- Healthy People 2010 target percentage and percentage of participants completing the health assessment who are at risk.

This provides a comparison of the aggregate report population to the national population.

Healthy People 2010, developed by the Centers for Disease Control and Prevention and the National Institutes of Health, is a comprehensive set of disease-prevention and health promotion objectives to be achieved by the nation over the first decade of the new century. Healthy People 2010 was developed through a broad consultation process and designed to measure progress over time. Additionally, Healthy People 2010 identifies a wide range of public-health priorities and specific, measurable objectives.

Also, we generally use our experience of disease prevalence. We base this on logic that reviews administrative data for evidence of the given disease, where the member has demonstrated evidence of the given disease on more than one occasion.

Our Health Profile Database tracks every member against approximately 100 diseases/conditions. For example, our database can report and compare disease prevalence between our markets and segments.

Additionally, we provide benchmark and normative data for cost and utilization statistics through our Analyze-Rethink-Transform (ART) reporting system, which provides comparative data to allow the State to better gauge the performance of your plans. We update standard report norms monthly and adjust them by product, region and age and gender.

Industry data is available using data for companies within a like industry, but not adjusted for product or region. We produce and provide data our internal book of business only.

In a future release of ART, we plan to incorporate external, public domain benchmark data to enrich our ability to compare data and establish strategic planning based on reasonable goals.

These are standard services available at no additional charge.

1.129	Describe the preauthorization and utilization review services in detail, including information on the following: a. Location of the office providing preauthorization and utilization review services, relationship with any subcontractors and current procedures with them to integrate data, criteria and program results. b. Nurse line and how these services integrate with medical/behavioral/wellness programs, including medication adherence education.

Response:

a. Hours of operation for our case management teams are Monday through Friday, 8 a.m. to 5 p.m. local time.

Our Bethlehem, PA location services your employees.

b. Your health doesn't stick to a 9-5 schedule, so why should we? That's why we offer all members 24/7 virtual access to trained, nurses that can help with your health care needs. Our Informed Health® Line provides members with telephone, email and chat access to experienced registered nurses to help them make informed health care decisions.

According to recent survey results, 94 percent of members said the Informed Health Line nurse helped them make a better health care decision.[1]

Program goals

The goals and objectives of Informed Health Line are to:

- Encourage members with health information to improve utilization of health care services
- Improve patient/physician relationships by encouraging members to give a clear medical history and ask relevant questions
- Promote healthy lifestyle habits
- Provide members with health information to help improve chronic condition management
- Increase member satisfaction with employer and benefit plans

Availability

Nurses are available through a toll-free telephone number 24 hours a day, 7 days a week. We provide TDD service for speech impaired, deaf and hard of hearing members. We also offer foreign language translation for our non-English speaking members.

Members may email a nurse by clicking on the "Talk to a Nurse" link within our member website. Nurses respond to inquiries within 24 hours. They can also chat with a nurse through our member website 7 days a week from 7:00 a.m. through 7:00 p.m., ET.

Additional resource

- Healthwise®Knowledgebase - Members may access Healthwise Knowledgebase, a user-friendly decision-support tool that provides clinical information on:
    - 6,000 health topics
    - 600 medical tests and procedures
    - 500 support groups
    - 3,000 medications

This tool encourages informed health decision-making and educates members on their treatment options.

- Healthwise Video Library - After speaking to callers, nurses may email them a link from the Healthwise video library. Research shows that well-designed videos deliver instructions more effectively. Nurses choose from over 400 consumer-friendly videos based on the topic discussed or the member's needs. The videos combine plain language, an empathic tone and an expressive visual style that engages viewers with easy-to-understand health topics on health conditions, treatments, medicines and self-care. They are typically two to three minutes in length and members can view them online or through their smartphones.

1 Informed Health® Line Member Satisfaction Survey. October 2016.

Informed Health Line (IHL) is managed on the same medical management system as other Aetna medical management programs. This provides our clinicians with valuable member information.

The IHL nurses refer members to other available Aetna programs as appropriate. This includes our care management and coaching programs. With permission from the member, the nurse warm transfers the caller and provides the member's name and telephone number to the other program nurse or coach.

Informed Health Line nurses also use Aetna MyPulse[SM]. This lets us connect with members and provide care management in ways they prefer. With access to members' digital program data, nurses and coaches gain valuable insight on members' interests and motivations. Then, they can use this data to enhance their support of members and have more meaningful conversations. They can also send messages and tasks to members through a common platform (Personal Health Record). This helps to keep them engaged in digital care.

Our IHL nurses also educate members about other State-specific programs as appropriate. When needed, they encourage members to contact member services at the toll-free number listed on their ID cards or via chat.

1.130	Describe the qualifications of the case management staff and the level of staff providing interventions. Address how Utilization Management, Clinical Program Management, Behavioral Management and Pharmacy integrate to assist members in maximizing benefits while containing Plan costs.

Response:

Case Managers

Our case managers are licensed registered nurses. To continue their education, we encourage our nurses to attend clinical and company-sponsored educational programs and to maintain any nursing certifications they may have. We highly recommend that our case managers obtain case management certification (CCM) within three years of employment.

Most of our staff has three to five years of experience in an acute care setting as well as managed care and/or utilization management experience.

Medical directors

Our medical directors have a current license to practice medicine (M.D. or D.O.), knowledge of the principles of case management and knowledge of quality standards requirements. They must have significant experience in managed care and utilization management as a prerequisite for employment with us.

On average, our medical directors have four years of experience providing care management services with us.

Care management associates

Our care management associates are non-clinical staff that provide administrative assistance to the clinical team. Examples of duties include mailing educational materials to members, entering data for hospital notifications and triaging calls from member services. We require them to have a high school diploma or higher education with minimum one-year customer service.

On average, our care management associates have two years of experience in providing services for us.

Engaged employees are healthier, more productive and have lower overall health care costs. Our integrated resources, products and services help us engage members where, when and how they live.

Our integrated care management model helps drive smarter health care decisions and healthier outcomes. Our people, systems and processes work together to:

- Find at-risk members sooner using innovative technology
- Engage members with personal attention and smart tools to drive better decision making and healthier outcomes
- Help members achieve better health and reduce health care costs through proactive care management

With our core medical management capabilities, you can potentially have further savings when combined with optional program enhancements, wellness and network management programs. A key factor in these savings is our ability to maximize engagement for program success.

Utilization management steers to quality, low-cost care

Our clinical policies and reviews work together to help drive effective and efficient use of the health care system. By finding members through these reviews, we can direct them to the care they need. For example:

In 2018, there were 1,688 transplants of all types for our members. Of these, 1,535 or 90.9 percent were at a designated Institutes of Excellence™ (IOE) facility.

Steering members to network doctors and facilities for care helps ensure quality care is given and costs are held down.

Precertification steerage

Our precertification program engages doctors and provides information on costs for local care services. The doctors can then refer members to quality, low-cost care options.

Case management nurse support makes a difference

Nurses in our case management program help members manage complex care. The personal high-touch support helps improve quality of care and lower costs.

We effectively engage more than 95 percent of members reached and have reduced their 30-day readmission rate by 20 percent.[1]

Overall, our case management saved our customers $0.34 to $2.55 per member per month in 2017. The weighted average was $1.16 per member per month[2].

Our special programs for high blood pressure, cancer and advanced illness help members get the care they need while managing difficult situations. Our nurses get to know the members well, so that we can give them support that fits their needs and lifestyle.

The Aetna Compassionate Care℠ program for members with advanced illness has helped double the use of hospice services. This has resulted in a reduction in inpatient admissions

Aetna Specialty Pharmacy

For members who use high-cost specialty drugs we offer our Specialty Health Care Management℠ program. Our program includes is a team of nurses who reach out to members who are newly diagnosed, new to therapy, having adherence issues or referred by another area within Aetna.

An opt-in program, we call members and ask them if they would like to participate. If they agree, we can send them a welcome letter which includes contact information and disease-specific educational materials.

We assess each member using industry validated assessment tools and benchmarks of care to identify any gaps in care or areas of concern. We evaluate how much help they need and develop a customized care plan. The nurse coordinates with the physician's office and provides additional member education and support to effectively manage care.

The specialty nurses work hand-in-hand with our case management teams to coordinate the overall call of the member. The team will determine who will be the main contact with the member, provider and caregiver, if applicable.

Technology advantage

Our technology advantage lets us intervene earlier and help prevent major health problems.

We use demographics and clinical profiles to find the best ways to motivate your employees. By segmenting your workforce and tying in utilization patterns and clinical data, we can find the right communication approach and incentive strategy to drive deeper member engagement.

The Aetna difference is that we offer innovative technologies and processes that drive engagement and total cost management. The results are improved quality of care, healthier outcomes and lower health care costs.

[1] Results from Aetna Operations Dashboard.
[2] 2017 case management valuation (self-funded), August 2018. Aetna Clinical Analytics.

1.131	Describe the degree to which the medical management programs are integrated (i.e., electronic systems integration, etc.).

Response:

We have a single system platform for all our care management services. Our platform, Aetna Total Clinical View℠ (ATV) is comprised of two main parts:

- A view only consolidation of data important for clinicians from multiple sources ("Clinical 360° View")
- An Interaction Toolset which provides tools for clinicians to do their day-to-day job

We designed the system on three strategic principles – Member centricity, business flexibility and automation. ATV provides a comprehensive member picture to allow medical management staff to better understand all aspects of member involvement. It organizes all information by member instead of by program.

This single system takes in and combines care management data from direct entry and multiple sources and makes it easily accessible to our staff. ATV tracks a member's full history of care management events including:

- Inpatient/outpatient services
- Pharmacy information
- Lab/diagnostic information
- Behavioral health and EAP services
- Member participation in Women's Health
- Member participation in disease management
- Member participation in case management

ATV also:

- Provides integration of clinical information across all programs
- Increases consistency and efficiency for business users because it:
  - Automatically identifies members for most program triggers
  - Automatically creates program enrollments due to automated triggers
  - Automatically populates user activities in the case plan based on the automated enrollment and member assessment responses. This eliminates many manual and process workarounds
- Makes the customer experience more seamless through consistent delivery of required care management activities

Our system also documents member specific case plans, which includes goals, deficits (opportunity/needs), activities (intervention/action) and progress of goals. However, these goals are not reportable.

1.132	Provide an engagement model DM program that includes, at a minimum, asthma, diabetes for adult, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease and co-morbid conditions. DM program must include a proven methodology for calculating and reporting a return on investment (ROI). Describe all DM programs currently available and if the member has the option to opt-out of DM programs.

Response:

We are proposing our Aetna In Touch Care℠ (AITC) Solutions program as a buy-up option for the State.

AITC Solutions is specific to customers who want:

- A team that understands and is focused on the specific needs and desires of your population
- An integrated utilization management and care management program to improve overall support and effectiveness
- A platform to seamlessly transition programs as your needs and objectives evolve

AITC Solutions is an innovative, industry leading care management program that helps your employees and their families easily and successfully navigate the health system. Our program is an alternative to having separate case management and disease management programs.

AITC finds the members who need help most, engages them in meaningful and personalized ways and helps them manage their health on their terms. From identification to nurse engagement, our entire process is member centric.

It includes three primary functions:

- Find – Our algorithms identify at-risk members by comparing member data against the latest medical knowledge. Our goal is to identify potential health issues before they become a major problem. Once identified, we can reach out to offer those members with an appropriate level of support.

- Engage –Our nurses connect with members using techniques, such as motivational interviewing and preference-based outreach, to engage members into taking action.

- Help – Digital and nurse support options allow members to personalize the way they receive help as they strive to reach their best health.

Finding members based on present and future needs

We find the members that need our help most through intelligent algorithms and daily opportunity triggers.

Algorithms

Our unique, internally developed algorithms scan our population and find members with potential health risks. It then scores the members and assigns them a risk level — low, moderate and high.

Rather than limiting its search to members with specific conditions or tracking by disease state, the algorithms target individuals who have the best opportunity for cost and health improvement. This is how we stay proactive with the member's present and future needs, instead of reacting to one condition.

We identify members based on the following factors:

- Financial impact – It assesses a member's need and the likelihood that they will incur health care expenses in the near future

- Clinical urgency – It capitalizes on the critical clinical window of opportunity for member intervention and support

- Clinical impact – It provides the ability to prevent further member decline or to improve and sustain optimum health

Once identified, our nurses reach out when and to whom it matters most. We then match members to the proper program resources to provide relevant and effective support.

Daily triggers and alerts

We also identify participants for the Aetna In Touch Care program through daily opportunity triggers. Examples of daily triggers include but are not limited to:

- Acute inpatient admissions – We identify admissions through the precertification process and then make pre-admission phone calls to members to discuss their upcoming hospital stay

- Discharges – Members discharged from a hospital (excluding maternity and behavioral health) receive a post discharge call within seven days

- Home or inpatient hospice – Members identified for home or inpatient hospice care related to an advanced illness

- A $75,000 (AITC Solutions) trigger amount for catastrophic care management

Additionally, our MedQuery program identifies gaps in care and produces alerts called Care Considerations℠. We deliver these alerts to the treating doctor, enrolled members and their Aetna In Touch Care nurse. We also post them to the member's personal health record under the Activities and Alerts tab as "alerts." A clinically urgent Care Consideration is created for a potentially serious issue where communication with treating doctor could have a significant impact and the situation should be addressed immediately. Aetna In Touch Care nurses reach out to members identified for the Aetna In Touch Care program who receive these clinically urgent Care Considerations.

Engaging members

AITC nurses are experienced in motivational interviewing and cultural sensitivity. These techniques help them discover the member's goals and what motivates them to make sustainable behavior change. Nurses uncover any hurdles to making positive behavior change and help them eliminate or manage these obstacles.

Members can also use our health record to help them manage their health and wellness. The "Activities & Alerts" page of our health record acts as a "to do" list. Not only does our MedQuery create health alerts and actions for the member that display on the member's health record, but the member's nurse can also suggest health actions that display in the "From Your Coach" section. With the member's permission, they can review these activities together and track the member's progress in the dynamic progress bar.

AITC is focused on personalized care, on the member's terms. We can accommodate members who prefer online or digital support, as well as those who like having a conversation with a nurse. Of course, those that elect digital support can always connect with a nurse when they have a specific question or issue.

Members can also choose how they communicate with us — whether that's by phone or email. And they can choose to bring their doctors in on the discussions.

Helping members with the right support

We connect digital care and live support to improve member health through Aetna MyPulse℠ and our Health Decision Support tool. Digital care engagement is increasingly important to our AITC clinical program models and to our members. By connecting digital care with nurse coach support, we can provide even better support to the members we serve.

The AITC program matches the member with the right type of support:

Nurse support

Our nurses reach out to members with greater health risks and potential for impactful intervention. Traditional case management and disease management programs just target specific conditions. Our AITC program addresses the member, regardless of a chronic or acute condition.

Because case management and disease management are no longer separate functions, we can provide the member with a single care management experience. Whether it's support for an upcoming hospital stay or a recent discharge from a hospital, members are supported by a nurse they are already comfortable with. Our AITC program delivers a personalized and relevant care management experience, from identification to ongoing care support.

Digital support

We send an invitation letter to those members identified as low risk encouraging them to take advantage of our online tools and programs. We also send emails through our member website, if the member has agreed to receive email communications. Members can work at their own pace and in the privacy of their own homes on whichever programs they choose. They may also call the Aetna In Touch Care telephone number with any questions.

Access to digital care data improves nurse discussions with members. By connecting the two, nurses can understand a member's effort to manage their health on their own. They can send messages and tasks to members to keep them engaged in digital care. And members have a trusted person supporting their digital activities to help keep them engaged and motivated.

We provide several digital support programs to help members manage their health on their own terms. This includes:

- Aetna administered health assessment – Members complete an online health assessment and receive a report of their health condition. The health report also suggests various programs that best fit the member's most urgent health needs.

- Online programs – Our suite of online programs address various health issues, including low back pain, diabetes, high blood pressure, smoking, stress, obesity and poor eating habits.

- Health record –It's more than a repository of health information. It provides targeted messages and alerts and personalized reminders that encourage immunizations, preventive exams and screenings, based on member need. It also updates automatically based on claims data, as well as member added information such as over-the-counter medications and member health trackers.

- Member Health Engagement Plan – A progress bar motivates members and allows them to see the results of their efforts. We can also tie incentives to member's actions.

Additionally, we provide a semi-annual newsletter through our member website to all identified members, including those engaged with a nurse and those who are engaged through digital support. This newsletter includes relevant and valuable health information and tips.

Collaboration Between Aetna Whole Health CHI and AITC

Accountable care relationships leverage the best medical management programs of both the provider system and the insurer. The shared financial accountability arrangements help to motivate both parties to invest in higher quality outcomes at a lower cost. Some programs are better implemented by the providers, such as direct patient engagement at the point of service. Some are better executed by insurers, such as predictive modeling of members who are at high risk for readmission. For each ACO partnership, we work together towards an approach that is most likely to result in a positive outcome.

Payers have traditionally led this clinical support component of care, but shared financial accountability arrangements motivate providers to take on a leadership role with these programs, when appropriate. Our experience shows that when doctors engage in health management programs, they are better able to influence their patients. This growing trend of providers leading these programs is good for the health of the individual and the population as a whole. The result can favorably impact medical cost trends, improve patient satisfaction and encourage members to actively engage in improving their health.

Welcome activities

Our Aetna Whole Health plans emphasize provider-directed initiatives that supplement Aetna's telephonic programs. At enrollment, Aetna sends the member a welcome letter that informs them of the providers that are part of their network. That letter is followed by a letter from one of our Aetna Whole Health providers, offering direct assistance in locating a primary care doctor.

Collaboration

ACO and In Touch Care (ITC) nurses collaborate to leverage each other's case management and disease management programs and capabilities. We facilitate this by:

- Educating ITC care managers on provider capabilities
- Educating provider care managers on ITC capabilities
- Establishing forums (case rounds) for discussing complex cases and agreeing on strategy and roles for optimal patient outcomes

In support of personalized and local health care delivery, ITC care managers are encouraged to refer members to provider case/disease management programs. In return, provider care managers recognize that Aetna has some specialized case/disease management programs that a provider may not. In these cases, they will utilize ITC for programs to supplement their own organizational resources. The dedicated resources of ITC allow for a greater degree of collaboration than is otherwise available. Aetna maintains responsibility for the delivery of the ITC program, regardless of which entity delivers the specific member care.

Outreach

Each member that has selected Aetna Whole Health is encouraged to choose a primary care doctor to manage all of their care within the ACO network. The member can still use any provider in the network. Daily and monthly reports are shared with each ACO for their assigned members. This allows them to make telephonic outreach to members who:

- Have frequently used the emergency room for non-emergent reasons
- Are using out-of-network providers
- Are high-cost and/or high-risk
- Meet the standards for enrollment in a provider-based case management or disease management program

As appropriate, members may be provided with the following types of assistance:

- Locating and scheduling an appointment with, an in-network doctor
- Enrolling in a case or disease management program, offered either through Aetna or the provider
- Receiving education on other resources available within the provider's delivery system

As you would expect, these collaborations are most successful because they leverage the care team (ITC Nurse & ACO Provider) to reach and engage more members to take action.

Our AITC Solutions program has an ROI of 2:1.

The AITC program is an opt-out model. We consider all members identified for the program as participating unless they opt out.

Participation in the program is voluntary. If members do not wish to participate, they may opt out by calling our toll-free Aetna In Touch Care telephone number.

We expect opt-out rates to be typically less than 1 percent. We do not track engagement at the 6-month interval.

1.133	Indicate the percentage of members identified as candidates for DM and enrolled in the programs are actively participating, with a minimum of quarterly engagements, i.e., phone calls, face-to-face and virtually.

Response:

We estimate 10 to 18% of a population will be identified for program tracks as follows:

- High – 1 to 3%
- Moderate – <1 to 1%
- Low – 9 to 14%

Of those reached:

- High risk - Of those reached, we nurse engaged 51% and we digitally engaged 92%.
- Moderate Risk - Of those reached, we nurse engaged 40% and we digitally engaged 93%.

1.134	Indicate the percentage of members identified and enrolled for DM who receive only written communication, e.g. general health newsletters, disease specific educational materials?

Response:

We estimate that 9-14% of a population will be identified as low risk and receive only written communication.

Low risk members meet our threshold for clinical impact. We send these members an introduction to virtual support letter inviting them to complete online modules. The letter includes instructions on how to access our online programs and educational material through our member website. We also send them two outreach emails each month. Low risk members can also choose to call an AITC nurse anytime with questions about health topics or for additional support.

We can also accept calls from the member, the member's doctor and you for referral into the AITC program.

We also use online resources such as the Healthwise Knowledgebase to help members become informed about their health and health care in active partnership with their doctors. Topics include health conditions, medical tests and procedures, medications and everyday health and wellness issues.

1.135	Indicate the total number of members of a similar account size to the State of Nebraska that are managed within the DM programs by diagnosis for calendar year 2018.

Response:

We have 1,625,515 members enrolled and participating in our Aetna In Touch Care Solutions program.

1.136	Describe how member compliance and participation are monitored and reported on a quantified basis.

Response:

Care managers track their cases for review and outreach through a personalized task list in our Aetna Total Clinical View℠ system (ATV). The list shows the follow-up days and next-call dates broken out over a period. The nurse can sort the task list by date. In addition, past-due tasks turn red in color, so that the nurse can instantly address them. All ATV users can view any member's plan of care and status of case.

We have no standard frequency or a set amount of calls that a case manager is required to make. Care managers determine how often they monitor and evaluate a case based on all of the following:

- Clinical judgment
- Need for support services
- Member/family compliance with the case management plan
- Medical director or care team supervisor suggestion

The nurse and member may agree to schedule a specific time and day or they may agree on call back in a specific time frame. In addition, care/case managers share their confidential email and phone number with members or caregivers. This way, they can contact their case manager directly whenever they wish.

We require care managers to evaluate and confirm member case plans at least once a month (every 30-calendar days) or as clinically appropriate. We give more frequent attention to complex cases and members with unstable medical conditions.

Supervisors monitor the work of their care managers and have access to their staff's task lists. They frequently track the volume and timeliness of each care manager's work to make sure we are meeting members' needs. They also use system productivity reports to monitor each of the care management nurses along with other weekly reports.

1.137	With the data collected on members (e.g. health risk assessment, biometrics, claims), how is it made actionable for the member?

We use the data to identify and stratify members to determine the level of outreach. The member takes action by participating in the program and meeting the goals set forth by the doctor's treatment plan and the care management plan. Additionally, members identify their health goals and work towards meeting those health goals in collaboration with their care manager and doctor.

We also remind them to call their care management nurse for any health-related questions.

1.138	Confirm availability and describe each of the following programs and/or services and how long each has been in effect, including modalities for participation in: a. Health Risk Assessment (both web-based and telephonic) b. Individual action steps c. Online biometric tracking tools d. Blood pressure, blood sugar, BMI/weight and other online trackers e. Self-management education and goal-setting f. Nutrition g. Physical activity and related online trackers h. Prenatal care i. Tobacco cessation j. Stress management k. Weight management l. Injury prevention m. Preventive service reminders, sent by mail, phone or electronically n. Gaps in care reminders, sent by mail, phone or electronically o. Type of smart innovative health programming (i.e., smart phone tracking, Fit Bit, etc.)

Response:

Confirmed. We provide all of the programs and services noted above. Our health assessment is provided online only.

Our program start dates are listed below:

- Standard Case Management - 1985
- Aetna In Touch Care Solutions - 2015
- Informed Health Line – 1994
- Healthwise Video Library (IHL) – 2013
- Discount Programs – 1997
- Preventive Reminders – 2001
- Simple Steps To A Healthier Life online wellness programs – 2003
- Simple Steps To A Healthier Life online health assessment – 2004
- Aetna Healthy Actions – Incentives management - 2004
- Onsite Screenings/Educational Services (Quest Diagnostics) – 2008
- Personal Health Record – 2008
- Aetna Get Active – 2009
- Simple Steps To A Healthier Life online disease management programs – 2010
- Health Decision Support– 2012
- Fitness Reimbursement – 2013
- Attain – 2019
- Aetna Maternity Management – 1985 (renamed 2019)

1.139	For the above programs and/or services (a. - o.), describe the performance results and anticipated ROI for each program and the total number of employees eligible for each program in 2018.

Response:

We do not calculate ROI for all of the programs noted above. However, you can witness program impact as you see change in factors such as health status, health risks and perception of productivity levels through our reporting packages.

We have noted those programs that do have a reported ROI below:

Case Management

Our ROI for case management in 2017 was 1.5:1.

Valuation methodology

There are three primary drivers of savings within the case management program. They are:

- Steerage to participating providers
- Reduction in acute admissions
- Reduction in emergency room visits

We conduct an annual analysis that compares a case-managed group to a non-case managed group for the above metrics. Control group members are those individuals who qualified and we identified for case management, but we were unable to be reach them. Managed group members are those where a nurse worked the case had the potential for savings.

The analysis uses the case management identification date and compares managed members to a control of non-managed members. Using the case management identification date, we collect claim and pharmacy data for the twelve-month period following the case management identification date. We then compare the two group's outcomes and utilization. We calculate savings by taking the average cost of an ER visit or inpatient admission multiplied by any variance in utilization rates between the managed and control group. We also calculate a variance for steerage. We generate separate savings per case for complex and proactive case management.

We review savings annually at a commercial book-of-business level.

Our case management ROI studies use accepted methodologies including adjusting for differences in risk between our intervention groups. We review our methods and results with external epidemiology and statistical experts.

Aetna In Touch Care Solutions

Our AITC Solutions program has an ROI of 2:1.

1.140	Describe the standards related to frequency and content of interactions between the member and attending physician.

Response:

Our care managers, together with the attending doctor, member or member authorized/appointed representative, develop an individualized care management plan. The plan includes member specific deficits, goals and activities. The nurse targets activities to help the member achieve health goals and to resolve issues/barriers. We send a letter to the member's primary doctor to introduce the program and elicit their support to engage the member in the program. Our nurses also call, fax or write member's doctor as needed.

Our MedQuery® program continues to look for opportunities to improve health. When we identify a member for the AITC program, MedQuery produces alerts, called Care Considerations℠, to notify members and doctors of possible health risks. This includes:

- Drug interactions
- Alternative treatment possibilities
- Missed care opportunities

MedQuery delivers these alerts to the treating doctor and the member's AITC nurse. We also post these alerts to the member's Personal Health Record in the Activities and Alerts tab. For clinically urgent Care Considerations, AITC nurses call and/or mail members.

We do not require physician consent for members to participate in our program.

1.141	Describe the qualifications of the staff that manage the DM cases.

Response:

Our clinical staff includes nurses, dieticians, social workers, behavioral health specialists and medical directors. Our non-clinical staff includes care management associates. Their credentials are:

Nurses

Our nurses must have a current unrestricted state licensure and three to five years of experience in an acute care setting, as well as managed care and/or utilization management experience. To continue their education, we encourage our nurses to attend clinical and company-sponsored educational programs and to maintain any nursing certifications they may have.

We do not require our care management nurses to be CCM (Commission for Case Manager) certified, although we strongly encourage CCM certification.

Dieticians

Our dieticians must be educated through an appropriately accredited higher education institution, duly licensed, registered or certified by national or state regulatory bodies and have three to five years' experience in the field. We also require them to have experience with face-to-face consultations with members. They have a wide range of experience working with members with varied nutritional needs.

Social workers

Our social workers should have a BSW degree and must be educated through an appropriately accredited higher education institution and duly licensed, registered or certified by national or state regulatory bodies. We encourage annual continuing education requirement in the area of clinical specialty. Their average work experience should be five years. They have varied experiences to support patients and their families with all types of diagnoses.

Behavioral health specialists

Our behavioral health specialist must be either a:

Licensed master's-level clinical professional with both a minimum of three years post-licensure and post-master's level direct clinical behavioral health or chemical dependency experience.

Registered nurse with at least three years post-licensure direct clinical behavioral health or chemical dependency experience.

Medical directors

Our medical directors must be board certified in a recognized specialty, including post-graduate direct patient care experience with an MD or DO degree. They must have an active and current state medical license without encumbrances. We require a minimum of two to three years of experience in the health care delivery system such as clinical practice and health care industry. They must also possess a demonstrated appreciation of cultural diversity and sensitivity towards target populations.

Care management associates

Our care management associates (CMAs) are non-clinical staff that provide administrative assistance to the clinical team. Examples of duties include mailing educational materials to members, entering data for hospital notifications and triaging calls from member services. We require them to have a high school diploma or higher education with minimum one-year customer service.

On average, our CMAs have two years of experience in providing services for us.

1.142	For the diagnoses that are managed in DM, indicate if there has been a resulting decrease in the admissions / ER visits for these diagnoses from the year prior to the program being implemented. Provide the percentage decrease.

Response:

Members engaged with AITC Solutions have:

- 18% fewer inpatient days
- 5% lower medical costs for those with chronic and behavioral conditions
- 2% lower overall medical costs

We're working to reduce unnecessary readmissions by:

- Reaching members early and proactively coordinating post-discharge care
- Counseling members and reconciling medications within 48 hours of discharge
- Providing 360-degree support and easy access to clinicians

With the introduction of connected devices, our care teams can have even more access to the data they need to help monitor the member's condition remotely. That means they can identify adverse trends and intervene more quickly when appropriate. And that could mean a potential savings of $12,000 per readmission prevented.

During our utilization reviews, we look for members who can benefit from a nurse case manager to help prevent more significant health events. We effectively engage more than 95 percent of those members reached. And, our 30-day readmission rate is 5.4 percent.

In 2017, care management saved our commercial self-funded customers and members $83 million in:

- Fewer visits to the emergency room
- Reduced readmissions to hospitals
- Steerage to more cost-effective care providers

With this level of attention, we can spot opportunities for a change in the level of care. We can let doctors know, for example, of coverage for home health care. This simple step can allow a safe, earlier discharge from the hospital.

In addition, we automatically identify members for our Aetna In Touch Care℠ program if they have two or more admissions within a rolling 90-day period. We update our utilization system with admission data on a daily basis, meaning that this multiple admission trigger can occur at any time.

We also identify members for our program using our Inpatient Predictor. A predictive modeling algorithm predicts the potential for inpatient admission (including readmissions) within the next 6 and 12 months. The Inpatient Predictor factors in:

- Emergency room
- Inpatient and ambulatory utilization
- Labs
- Medications
- Additional member attributes

We refresh data monthly.

1.143	If no decrease has occurred in the hospitalizations for the diagnoses managed through DM, provide an assessment as to why this occurred, including what corrective actions were taken.

Response:

Not applicable. We have seen a resulting decrease in the admissions and ER visits.

1.144	If a participant has more than one DM diagnosis, describe how the programs manage the member's care. Describe the program that manages gaps in clinical care, beginning with the identification process and concluding with outcome.

Response:

The AITC program manages comorbidities in conjunction with primary disease conditions. In fact, our program addresses all aspects of the member's health across a range of conditions.

The program provides the member with a single nurse point of contact for his or her health conditions. The nurse may also arrange for specialty referrals as needed. This may include referrals to a maternity management program or to a behavioral health program for complex behavioral health issues.

We do not have a hierarchy for determining priority. The same nurse manages the member for all conditions and the nurse would start by addressing the most urgent condition first and work with the member on other condition issues as applicable.

Our MedQuery® program, powered by the CareEngine® alerts physicians to opportunities for improved patient care by turning our member data into information that can be used to enhance clinical quality, patient safety and financial outcomes.

We constantly analyze our entire population using this technology to pinpoint specific, evidence-based opportunities to improve care for individuals.

Our MedQuery program uses approximately 1,200 evidence-based clinical alerts spanning over 200 unique conditions. It applies nearly 9,000 clinical rules and member data including:

- Medical claims (current and historical)
- Behavioral health claims
- Dental and visions claims (received as medical claims)
- Pharmacy claims
- Laboratory claims
- Demographics
- Self-reported health record and health assessment data
- Biometric screening data
- Wearable and medical device data

The program continually scans the data and identifies potential errors, omissions or commissions in care. MedQuery helps us turn clinical intelligence into actionable information with 98 percent accuracy[2] and ultimately results in 5 percent reduction in medical costs.[3] It finds members in need, engages a health care professional who can provide help and engages members to take action to improve their health.

MedQuery sorts its findings into severity levels. We alert the member's physician by faxing the Care Considerations to their office within 24 hours of it generating. If the physician would like to speak directly with a clinician, they may call the toll-free number on the bottom of the Care Consideration. We will arrange for a clinician or medical director (upon request) to call the physician.

- Level 1 – a potentially serious issue where communication with the treating physician could have a significant impact and the situation should be addressed immediately. In 2017, book-of-business results show 70.5 percent compliance with Level 1 Care Considerations.[1]
- Level 2 – a potentially serious, but non-urgent issue. 2017 results show 49 percent compliance with Care Considerations.[1]
- Level 3 – a less-serious issue

Increased compliance results in savings of $7.84 PMPM/$14.69 PEPM.[1]

Preventive Care Considerations

MedQuery® includes electronic Preventive Care Considerations (PCCs), which enhance our program through the delivery of wellness and preventive services alerts directly to members. We send the PCCs to members who need, but who have not received, necessary vaccinations, preventive exams and screenings, according to our claims records.

Member Messaging

MedQuery includes our Member Messaging program, which mails hard-copy consumer versions of Care Consideration directly to members at the same time as we send the Care Considerations to their physician. Care Considerations are not wellness related.

Integration with our nurses

Our AITC nurses may make an outreach call or discuss the care considerations/health actions with the member based on the program and situation.

[1]Aetna book-of-business results for self-funded and fully insured customers from Q4 2017 report (severity 1,2).

[2]Wei H. et al. Clinical Validity of Alerts Generated by the CareEngine Claims-Driven Decision-Support Engine. AMIA Annu Symp Proc. 2008. Nov 6: 1171.

[3]Aetna Commercial 2017 book-of-business study.

1.145	Describe the ability to administer copay waivers or customized member cost sharing based on individual member eligibility within the same plan options. For example, diabetics participating in a diabetic DM program may receive copay waivers for routine office visits.

Response:

Our Aetna Healthy Actions[SM] program includes an incentive component to help employees and their families take steps toward a healthier lifestyle.

Activities we reward

We can provide incentives and tracking for:

- Completing our health assessment
- Completing an online coaching program
- Completing routine preventive care services such as:
  - Well Adult (includes well adult visits, Prostate Specific Antigen (PSA) test, routine hearing exam and routine X-ray)
  - Well Baby/Well Child
  - Immunization
  - Flu Shot
  - Well Woman (includes Routine OB/Gyn and Routine Pap/Radiologist/Pathologist and Lab)
  - Mammogram
  - Routine Eye Exam
  - Colonoscopy
  - Sigmoidoscopy
- Participating in a telephonic coaching program
- Participating in a care management program
- Participating in our Aetna Maternity Program and completing the pregnancy risk survey
- Completing a maternity program postpartum survey
- Complete a biometric screening
- Completing the Personal Health Record Walk-Me-Through tool
- Using tracker tools and devices to track physical activity
- Completing recommended actions in the wellness portal
- Indicating tobacco use status
- Participating in a wellness challenge
- Participating in a mindfulness program

Funding options for incentives we administer

We can administer the following incentive options:

Health plan contributions and enhanced benefits

Our Aetna HealthFund customers may elect to have an incentive reward contribution credited toward an employee's Health Reimbursement Arrangement (HRA). We have the ability to automatically fund members' HRAs with incentive dollars, based on the reporting schedule the customer elects.

Reduced member out-of-pocket expenses

We offer our self-funded, PPO-based customers a health incentive credit (HIC) option that applies rewards earned by members to their medical deductible and/or coinsurance, reducing their out-of-pocket expenses. The incentive credit is:

- Applied to a member's medical deductible and/or coinsurance* as claims are processed.
- Included as a rollover feature, as long as the customer continues to offer incentive credits and non-Aetna HealthFund medical plans with deductible and/or coinsurance features.

** Incentive credits are not applied to copayments or pharmacy expenses at this time.*

Gift certificates

Members can receive gift card rewards through our vendor partnerships.

Alternative plan of benefits

We have customers interested in offering an enhanced plan of benefits for members who trigger an incentive reward for showing sustained healthy behaviors or completing/participating in specific health-related tasks. The customer can move employees to the alternate plan in the year following their meeting incentive eligibility requirements.

Funding options for incentives that our customers administer

For customers who prefer to administer their own incentives, we provide detailed reporting on participants who complete health-related activities. You have the option to receive the rewards tracking reports on a daily, twice weekly, weekly, monthly (standard) or quarterly frequency.

Some of the most popular customer-administered incentives include:

Gift certificates

These are appealing to participants because they are equivalent to cash. Different dollar amounts are available – usually $25 or more – and employees have a choice of how to redeem them.

Prize drawings

With this type of incentive, eligible participants have a chance to win one or more prizes through a random drawing if they complete specific actions by a certain date. The advantage is that customers can control program costs because they determine the prize amount and the number of prizes offered. Examples of prizes include health-related items (such as a gym bag) or gift certificates, including those to a health or sports-related retail store.

Incentive gifts

Items related to health and wellness make good incentive gifts. Customers may also want to consider using items that their employees will want to keep at their desks and use regularly, such as calendars.

Contribution credits

For our HSA/FSA, we provide comprehensive reports to our customers so that they can fund members' HSAs/FSAs in accordance with their HSA/FSA funding schedule.

The State would be responsible for funding and distributing incentive gifts to employees.

1.146	Provide a case study that highlights success in providing customized programs and solutions to a customer with similar characteristics as the State. Describe the goals, initiatives developed to achieve the goals and successes and challenges in implementing the initiatives. Include specific metrics and outcomes measured to determine success.

Response:

Please refer to *Aetna In Touch Care Solutions Case Study.doc*, located in the Samples and Brochures section of our proposal response.

1.147	Describe how current DM program history from the State's existing services can be utilized to transition DM services.

Response:

We work with you to establish a transition plan for handling ongoing care management from a previous carrier. It may include receiving a list of case management participants from the carrier. This helps us with continuity of care and minimizes inconvenience to the member. We also evaluate members who apply for transition of care coverage to determine if a member may benefit from our care management programs.

1.148	Attach sample of standard medical and utilization report(s) that would be prepared for the State. Items 1 through 11 are minimum reporting requirements for the State: 1. Daily Reporting The State requires a daily reporting of claims paid in a format acceptable to meet State requirements for Contractor reimbursement; such format shall be determined during contract finalization with the specified Contractor. The following are required data fields for daily reporting and should not include Personal Health Information (PHI): a. Policy/Group/Plan Number b. Claim Number c. Payee d. Provider Name e. Claim Expense Incurred Date f. Claim Payment Date g. Claim Process Date h. Claim Billed Amount i. Claim Allowed Amount j. Claim Paid Amount 2. Monthly reporting containing the following information: a. Paid claims b. Administrative/Network Fees (if applicable) c. Monthly enrollment counts d. Reconciliation of claim drafts to paid claims e. ASO reconciliation of monthly PEPM Administrative Fees

f. Membership (Census) report
g. Large Loss Report
h. EPR and Rx Executive Summary

3. Quarterly Reports

a. Appeals Reports
b. Workers Comp Report
c. Performance Guarantees (Service Report)
d. Health Plan Review Report
e. Medical/Rx Rebate report

4. Annual Reports

a. General claim utilization reports by major line of coverage identifying:

i. Claims submitted
ii. Claims eligible
iii. Deductible and coinsurance application
iv. Payment reductions due to network negotiated rates
v. Reasonable and Customary cutbacks and savings
vi. COB savings
vii. Ineligible expenses
viii. Net benefits paid by major line of coverage

5. Consultative Reports

a. Reports that analyze utilization of healthcare services of plan members:

i. Identifies opportunities for plan design or care management interventions

6. Claim utilization report will show separate experience for:

a. Members
b. Dependents
c. COBRA Participants
d. Retirees

7. Member contested claims separated by denial reason

8. Claim lag report

9. Network savings reports for each network offered

10. Most utilized hospitals and physicians reports

11. A year-end financial accounting for the program within 90 calendar days after fiscal year end

Response:

Please refer to *Sample Reporting Package.zip*, located in the Samples and Brochures section of the proposal response.

1. Confirmed. We can provide all the daily reporting elements listed.
2. Confirmed. We can provide all the monthly reporting elements listed.
3. Confirmed. We can provide all of the quarterly reporting elements listed except for the Workers Comp report.
4. Confirmed. We can provide all of the annual reporting elements listed.
5. Confirmed. We can provide our CAIR report. A sample is included in the Sample reporting package.zip.

6. Confirmed. During the installation process, we work with the State to set up a reporting account structure that will be most meaningful for analysis.
7. Reports to address claim denial reasons are available for the State. However, the reports do not show all claims denied or a subset of claims denied for a specific reason. The reports are available on a fee-for-service basis. We are unable to identify whether a claim is employee contested.
8. Confirmed. We provide an estimate of claims reserves in our annual accounting package based on customer-specific runoff, claim patterns and our book-of-business factors. We also provide a monthly Claim Detail report to help the State perform your own lag study.

   For an additional charge, we can provide the State with specific claim lag reports by product. The charge varies by requested report complexity.
9. Confirmed. Our Provider Network Experience reports include network savings and utilization metrics for current and prior periods. The reports show the value of our network discounts based on the use of network providers by your members and our book of business comparisons.
10. Confirmed.
11. At the end of each contract period, we provide a look-back at the year to determine an overall financial balance. The package includes detailed and summary exhibits of service fee payments, claims and reserve charges and administrative expenses. We provide the accounting 120 days after the end of the policy period. The reports are available electronically, usually in Microsoft Word format.

1.149	Describe Ad Hoc Reporting Capability both online and paper formats.

Response:

Analyze-Rethink-Transform (ART), our new business intelligence tool, includes three integrated modules for your reporting needs: analytic pathways, dashboards and ad hoc reporting. All modules access enhanced data for:

- Medical claims
- Pharmacy claims
- Behavioral health claims
- Dental claims
- Care management program operations
- Member demographics

For support beyond standard reporting, the State have access to our regionally aligned Plan Sponsor Insights (PSI) consulting group and 150 Analytical Hours and 150 Clinical Hours of support. This service includes ad hoc reporting. We quote highly complex requests on a fee-for-service basis.

Timing

ART is an on-demand reporting application. Therefore, the latest monthly results present as the user navigates through the application. For ad hoc reporting outside of ART, we prepare the reports within three to five business days. However, turnaround times may vary depending on project complexity.

1.150	Describe how reporting capabilities (other than the ones required in 1.148 above) would provide value to the State.

Response:

Analyze-Rethink-Transform (ART), our new business intelligence tool, is an advanced data analytics and reporting solution that

delivers a flexible, fully integrated application that facilitates analysis and provides reporting across multiple products and services. We collect organize, standardize and combine the data. Then we apply best-in-class methodologies which include valuable insights regarding costs, utilization, quality and overall plan performance.

ART leverages our data analysis and predictive modeling capabilities on one platform and provides point-in-time reporting and ever-evolving business intelligence for you and your consultant. This powerful technology helps you make more informed decisions with analytic solutions that:

- Provide value-added analytics: Integrate data from medical and pharmacy claims, care management, disease management and wellness programs and other sources such as onsite clinics and health risk assessments.

- Model clinical episodes of care over time
  - Measure, monitor and manage quality of care
  - Understand and respond to both retrospective and prospective risks
  - Compare performance to benchmarks

- Engage employees: Influence health care and wellness behaviors for increased engagement and improved outcomes.
  - Monitor outcomes of disease and care management
  - Track activities using wearable devices
  - Evaluate trends, risk, care quality and employee health

- Manage costs: Visualize cost drivers and trends, including health and lost productivity, pharmacy utilization, network leakage and more.
  - Keep up with industry trends
  - Monitor costs and utilization across various product types
  - Manage local outcomes to achieve company goals and objectives

Standard reporting

ART includes a wide variety of standard drill-down and analytic pathways and data visualizations to answer typical and highest-value customer requirements and expectations for plan information.

Preformatted reports

Standard templates such as reports, dashboards and analytic pathways are viewable on demand. And users can define their own "standard" (or "favorite") reports and schedule them to run automatically each month as the data are refreshed.

Strategic support

Analytic support for your Aetna account team and you – this assures you get the maximum benefit from your information and promotes efficiency when we explore data on your behalf.

Ad hoc reporting capabilities

The ad hoc reporting interface is a user-friendly drag and drop environment which includes all of the data, dimensions and measures in your underlying database.

Demo

Your Aetna account manager can provide a demo that highlights the features of ART. We have also provided a video link that illustrates the system's basic functionality and key advantages. https://vimeo.com/251372667. Please note, the video is illustrative and not a view of the actual system. You can view the tool via Microsoft Edge or Google Chrome.

1.151	Provide a brief sample of the reports listed below and the frequency of each report. a. Eligibility Report which shows accuracy of updates and changes b. Paid Claims Summary (Ingredient cost, days' supply, dispensing fees, taxes, copay totals by month) c. Detail Claim Listing (Utilization and Ingredient cost by individual claimant, listing the Drug name and dosage, submitted charge, allowable charge, paid) d. Cost Sharing Report (Amounts determined to be ineligible, amounts applied to copays and coinsurance and amounts adjusted for COB) e. Detailed Utilization Report (# of prescriptions submitted by single source brand, multi-source brand and generic drugs, including average AWP, Ingredient cost per Rx, Dispensing fee and average days' supply) f. Top Drug Report (detail of cost and utilization by top drug products) g. High Amount Claimant report h. Therapeutic Interchange Report detailing success rates and cost impacts of Contractor initiated interchanges i. Drug Utilization Review activity and Savings Report by type of edit j. Member compliance and adherence to therapy k. Formulary Savings and Rebate report l. Paid Claims Summary (see b.) showing total number of claims, eligible charges and claim payments for each category m. Prior Authorization and other clinical program reporting n. Specialty Rx reporting o. Pharmacy cost and utilization reporting

Response:

We think you should see your data the way you want it, when you need it and with all the analysis, you need. To that end, we offer you various reports and tools:

- Consultative reviews on your schedule
- On-demand reporting when you need it
- Customized reporting available any time

Let's review your data together

The best way to analyze plan data is with a pharmacist who joins you in meeting your goals. We will assign Kim Haywood, Pharm.D to serve as your clinical account executive (CAE). Kim is a highly trained pharmacist who can regularly meet with you to analyze your plan's performance, review reports and discuss initiatives for your population.

One example of our consultative support is our RxInsights Review. Kim can use this report to review your plan's financial and drug utilization metrics. The report includes:

- Your key performance metrics
- Data explaining your specialty and non-specialty cost drivers
- High-cost claimant analysis
- Therapeutic categories to watch
- Comparisons with similar customers and our book of business
- Opportunities to improve your plan's performance

We do more than just review your data. Kim and your account team can walk you through this report, using your data to identify strategies focused on improving performance. She makes recommendations based on facts, aligning solutions with your unique goals. We have provided a sample report labeled *RxInsights Sample.pdf* in the Samples and Brochures section of our proposal response.

Access your online reports on demand

You have real-time access to integrated medical and pharmacy data through our online reporting tool, Aetna Health Information Advantage™. You can use our standard monthly reports to perform analysis on key measures, such as use and membership. These topics, called modules, offer a high-level view of your current data as well as book of business and prior year comparisons.

You can drill each module down into more detailed reporting and graphs with options such as time period, products, age, gender, region, pharmacy detail and geographic-specific detail. You can save reports in Microsoft® Excel format.

We also include preformatted reports that compare your current data against previous years, using easy to understand graphs and charts. We update our reports monthly, within 30 days following the end of the reporting period.

Tell us what customized reports you need

Kim and your pharmacy account manager Karen Convoy can generate nearly unlimited customized reports using your pharmacy claims data. They frequently access an online tool that provides the following features:

- Convenience to design custom reports with hundreds of variables
- Flexible formatting and data manipulation for in-depth analysis
- Access to a sizable portfolio of preformatted clinical and financial management reports

We can design and format custom reports, beginning with hundreds of variables from industry dimensions. Your account team can provide you with these customized reports on an ad hoc basis. We can also set up any ongoing customized reports to run on an agreed-upon schedule, giving us greater flexibility in getting you your reports when you need them. We do not charge you any fees when we generate customized reports through this tool.

Please refer to the *APM Sample Reports.zip* file included with this proposal in the Samples and Brochures section for your review.

1.152	Provide an analysis report indicating which prescription drugs would not be included and which prescription drugs would be added to the State's current formulary. Refer to http://das.nebraska.gov/Benefits/Active/2019/2019July-DecPrescriptionDrugList.pdf for the State's current formulary.

Response:

Please refer to the Aetna Standard Formulary Disruption Impact Report.pdf we have completed with our analysis. We have also included a listing of our formulary exclusions and alternatives within the *Aetna Standard Formulary.zip* file included in the Samples and Brochures section of this proposal for your review.

1.153	Describe the current formulary appeal process to address member concerns regarding formulary alternatives or provider indications of medical necessity.

Response:

Medical Exception Process

Prescribing physicians must submit a request to obtain a medical coverage exception for drugs on our precertification, step therapy and formulary exclusions lists. Physicians can make this request by:

- Fax
- Telephone
- Password-protected physician website

Because we want members to receive medically necessary treatment, we ask physicians to include the member ID, medical history and any applicable laboratory data with their request.

We grant or deny these medical exceptions based on specific coverage criteria, which health care professionals can access on our website at **aetna.com**. We communicate the medical exception decision back to the physicians by telephone, fax or e-mail depending on how we receive the request). If we deny the request, we fax or mail a follow-up letter to the physician and member within two business days (or as otherwise required by state law). This letter states the reason for denial and explains the appeal procedure. Once entered into the system, the information is immediately available to participating pharmacies.

Pharmacists calling for precertification

Due to the nature of certain drugs on our precertification or formulary exclusions lists, such as antibiotics and analgesics, pharmacists may call our precertification unit to request authorization for coverage. The precertification unit is open Monday through Friday from 9 a.m. to 8 p.m. ET, with the exception of major holidays.

After hours support

When the precertification unit is closed, we ask callers to contact our Pharmacy Help Line, staffed 24 hours a day, 7 days a week. After granting the emergency supply, the customer service representative (CSR) will direct the caller to have the prescriber contact the precertification unit to request authorization during regular business hours. This one-time emergency exception is not a guarantee of future or continued coverage of the requested medication.

National Appeals Process

We provide a nationally standardized process for resolving member complaints and appeals to enhance our ability to handle complaints and appeals in a consistent and timely fashion.

Some states have requirements that are different from federal requirements. State requirements supersede plan or federal guidelines for fully insured plans only when they are more advantageous to the member (e.g., more aggressive turnaround times for response). Our law department will support the business area in the interpretation of applicable law.

\ppeals – A Level I appeal is defined as a verbal or written request by a member or a member's authorized representative,

requesting a change in an initial determination decision.

This includes but is not limited to requests related to the following:

- Certification of health services (e.g., precertification, concurrent review, emergency services)
- Claim payment
- Plan interpretation
- Benefit determinations
- Eligibility

To start the appeals process, the member or provider/representative acting on behalf of the member submits a verbal or written request asking for a change in the initial determination decision.

Timing

The member or authorized representative has 180 days after receipt of a coverage decision to file an appeal.

We will forward a written notice stating the result of the review to the member within the following timeframes:

- Expedited appeals – 36 hours
- Pre-service appeals – 15 calendar days
- Post service appeal – 30 calendar days

Appeal denial notice

If we deny an appeal, the written notice includes:

- A statement of the reviewer's understanding of the pertinent facts of the appeal (description of the health care service/claim)
- Evidence or documentation used for the basis of the decision in clear terms
- An explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the member's medical circumstances
- The specific rule, guideline, protocol or other similar criterion that was relied upon in making an adverse determination
- A statement that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the member upon request
- The specific plan provisions on which an adverse benefit determination is based
- A list of the titles and qualifications of the individuals participating in the review of the appeal (those individuals involved in the decision making process). Specific names of medical directors are available upon request.
- A statement that the member is entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records and other information relevant to the member's appeal.
- A description of the next review level, if applicable, including time frames and how to file
- The following or similar statement, when appropriate, (including consumer assistance contact information): "If you do not

agree with the final determination on review, you have the right to bring a civil action under Section 502(a) of ERISA.

- The availability of external review and how to request it, if applicable
- The following statement, when appropriate:

  "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your Plan Administrator or your local U.S. Department of Labor Office."

Level II Appeal

If the member or authorized representative is not satisfied with the outcome of the Level I appeal decision, they may submit an oral or written request, within 60 days of receipt of a Level I decision, for further appeal review. For clinical appeals, the second level review is performed by a practitioner who typically treats the condition, performs the procedure or provides the treatment under review and was neither involved in the original denial of coverage determination or Level I appeal.

If a Level II appeal is denied, the written notice includes all specific reasons for the denial, including the clinical rationale, reference to applicable plan provisions, medical, dental information reviews and any other applicable appeal procedures that may be available.

State of Nebraska

We will work with your organization during the implementation of your pharmacy benefits to define the process you would like to have in place for the final determination of appeals.

1.154	Are any generic drugs considered "non-preferred" in the proposed formulary (i.e., subject to the "non-preferred" copay)? If yes, describe in detail and provide examples.

Response:

No. As part of our formulary management strategy the majority of, but not all, generics are included on the Aetna Standard Formulary. Additionally, you may choose to exclude certain therapeutic categories from coverage through plan design, which may include other generics.

Your plan design determines medication placement within tiers, yet we do not recommend placing generic medications on a non-preferred formulary tier. We promote generics as a first line of prescribing.

1.155	Does the formulary currently exclude any prescription drugs from coverage? If yes: a. provide a list of those excluded from coverage b. indicate the notification process for any future changes to the exclusion list, including the amount of advanced notification that will be provide to the State and its members and the form the notification will take If no: a. Confirm that no such future exclusions will be required during the term of this contract?

Response:

Yes.

a. The Aetna Standard Formulary includes a list of drugs that we do not cover based on medical necessity criteria. In all cases, the excluded drugs have a less expensive formulary alternative. We also do not include experimental or investigational drugs, except as required by law. Please refer to the Aetna Standard Formulary.zip file for our list of our preferred and excluded drugs.

b. We send member formulary update notifications 30 to 45 days prior to the effective date in order to provide awareness of the upcoming change and action steps needed to address the transition, for example notifying their physician of the change.

c. We conduct an annual review of the proposed formulary to ensure that we represent the most favorable therapies and may exclude specific drugs at that time. In addition, we conduct quarterly reviews and may exclude products that have experienced egregious price inflation (such as hyperinflation) at that time. We make reasonable efforts to provide advanced communication to you for exclusions. We will work with The State should you require that those hyperinflated drugs are only removed twice per year.

1.156	Do the manufacturer agreements contain provisions that limit the amount the manufacturer can raise the AWP price of prescription drugs each year? If yes, describe.

Response:

Our price protections are in place on approximately 99 percent of our manufacturer contracts, across specialty and traditional medications. We consider the specific terms and conditions of these contracts confidential and proprietary and are not subject to disclosure.

Hyperinflation management program

We have taken a stand against egregious drug price increases that unnecessarily add costs for the States and their members. We began offering our Hyperinflation Management program in 2017 as part of our trend management program. The Aetna Standard Formulary that we have recommended for the State aligns with this program. When a drug increases significantly in price, we will determine whether the drug should remain on the formulary.

As part of our hyperinflation management strategy, we maintain a database of targeted drugs for removal that we update on a quarterly basis. We will provide the State with the option of only removing these drugs twice per year, if requested. Our process for selecting drugs that fit the profile for hyperinflation management is as follows:

- Analysis overview – quarterly review, incorporating a multi-year look-back period
- Products identified – looking at factors of pricing, prescription volume and member impact, clinical applicability and already addressed by existing program
- Final assessment – aligned with formulary selection, incorporated into current formulary review process and involves multiple internal teams

1.157	What reporting will be provided to the State to demonstrate such manufacturer price limit agreements provide meaningful benefits to the State?

Response:

RxInsights® reporting and review

In addition to supporting your analytic needs through customized, State-specific planning and reporting tools, your Clinical Account Executive, Kim Haywood, Pharm.D will meet with you regularly to review your custom RxInsights report. RxInsights is a comprehensive management report that contains key plan performance, utilization and cost metrics as well as results from our clinical programs, benchmarking data and forecasting information. Included in these reports will be information regarding the savings that resulted through our hyperinflation management program.

The RxInsights report is the basis for identifying opportunities for improved plan performance and for collaborating on solutions to help manage your pharmacy benefit. Specifically, your RxInsights Review can:

- Provide benchmarks for and monitor performance of your pharmacy benefit
- Monitor the impact of any plan design or clinical strategies that you implemented
- Identify additional strategies you can implement to improve benefit performance
- Make specific recommendations supported by data
- Identify year to date or quarterly trends associated with price, product and utilization

During the review meeting, Kim will use her understanding of your goals to collaborate with you to identify and implement solutions or initiatives that focus on key issues that are unique within your plan, control overall health care spending and improve health outcomes.

PHARMACY NETWORK ACCESS AND MANAGEMENT

1.158	What is the current number of retail pharmacies in the network?

Response:

Our Aetna National Retail Pharmacy network consists of over 67,000 retail pharmacies in all 50 states and the U.S. Territories.

1.159	List any pharmacy chains excluded from the retail pharmacy network.

Response:

All national, regional and local retail pharmacies are included in our network. In addition, we include thousands of independent pharmacies in the network.

1.160

Perform and provide a GeoAccess (driving distance) analysis based on the contracted pharmacy network. Utilize the access standards in the table below for the analysis.

Provider Type	Urban and Suburban Enrollees	Rural Enrollees
Pharmacies	2 in 20 miles	2 in 35 miles

Response:

Please refer to the *GeoAccess_Aetna Pharmacy Management.pdf* documents for our completed analysis' included in the Network folder for your review.

1.161

Provide the number of participating retail pharmacies that were terminated from the network in the past 24 months:

Termination Rates	# of Pharmacies	% of Pharmacies	Reasons for Terminations

By Organization+	144	0.21%	Involuntary Termination • Due to Audit Findings • Contract Violations
By Pharmacy++	5,429	7.97%	Voluntary Termination • Cancelled membership • Change of Ownership • Inactive Pharmacy • No Longer in Business

+when the termination is initiated by the Contractor
++when the termination is initiated by a pharmacy

Response:

Typically, each year we have less than a 2 percent net change in the size of our retail pharmacy network. The number one reason for a retail pharmacy to leave our network is that they go out of business or there is a change in ownership.

If we have identified a pharmacy that we suspect has been involved in fraud, waste or abuse, we have the pharmacy investigated. We provide all information collected during the investigation to the pharmacy review committee. If the committee determines that a pharmacy has engaged in abusive or excessive billing practices, they initiate a follow-up audit or terminate the pharmacy's network participation.

1.162	Using the pharmacy identifier on the provided PBM Claims Data File, identify and list all pharmacies that are not in your proposed retail pharmacy network.

Response:

Please refer to the *APM National Retail Network Disruption.xlsx* analysis we have completed and included with this proposal for your review.

1.163	The State has designed its pharmacy plan benefits to minimize the use of manufacturers' coupons or savings cards. Does the retail network agreements allow pharmacies to utilize manufacturer coupon and other programs to circumvent plan design incentives and disincentives? What action is taken to deter or minimize the use of manufacturer's coupons?

Response:

Currently, our mail order pharmacy does not accept manufacturer coupons. In the retail environment, each individual pharmacy provider makes the decision whether to accept manufacturer copay coupons. We typically address these transactions separately from our claim transaction.

We cannot track, monitor or audit manufacturer coupons since their usage occurs outside of adjudication.

The Provider Manual distributed to all participating retail pharmacies provides direction for handling manufacturer coupons. We consider any item or mechanism, including but not limited to paper coupons, copay cards, e-vouchers, mail-in rebates and electronic coupon codes funded by a manufacturer, repackager or supplier of pharmaceutical, chemical or compounding products and that reduces the portion of the member pay amount that an eligible member is required to pay for a covered item, to be a pharmaceutical manufacturer coupon.

Pharmaceutical manufacturer coupons may be accepted by a Provider and applied to reduce a member pay amount for a covered item only if:

1. The Provider has complied with all terms and conditions of the pharmaceutical manufacturer coupon program, including but not limited to program prohibitions on the use of a pharmaceutical manufacturer coupon in connection with covered items reimbursed by a governmental healthcare program; and

2. The covered item is not a compounded drug; and

3. Either

   a. The covered Item is approved by the US Food and Drug Administration (FDA) through a New Drug Application (NDA) or Abbreviated New Drug Application (ANDA) and is published in the Approved Drug Products with Therapeutic Equivalence Evaluations (commonly known as the *Orange Book*); or

   b. A Biologics License Application (BLA) including drugs classified as Biosimilars approved under section 351(k) of the Public Health Service Act and is published in the Lists of Licensed Biological Products (or commonly referred to as the *Purple Book*); or

   c. The covered item in an Over-the-Counter (OTC) Covered Item marketed under an official final OTC monograph; or

   d. The covered item is a grandfathered drug marketed pre-1938 or pre-1962 or is otherwise Generally Recognized as Safe and Effective (GRASE) by the FDA.

The Provider's application of a pharmaceutical manufacturer coupon to reduce a member pay amount of this section are subject to chargeback.

Considering the above requirements, which come from our Provider Manual, we take action when our audits uncover violations of the Manual. In general, coupon utilization can be challenging to monitor as noted by the Office of the Inspector General, in its report "Manufacturer Safeguards May Not Prevent Copayment Coupon Use for Part D Drugs", in part as it tends to occur post-claim adjudication. Further, CMS places the expectation that the Pharmaceutical Manufacturers take responsibility for safeguarding the issue.

Pharmaceutical manufacturer coupons

Claims submitted by Provider for which the member pay amount is modified by a pharmaceutical manufacturer coupon program shall comply with all the terms and conditions of the program, including but not limited to program prohibitions against application of the coupon to certain governmental health care programs and their plan participants.

1.164	What options are available to members regarding Prescription Drug Discount card programs for entities that do not accept the branded card used by the Contractor?

Response:

We offer the ExtraCare Health Card which members can use only at a CVS pharmacy. Through this card, members can receive a 20 percent discount on CVS/pharmacy brand health-related OTC items*. The discount applies to thousands of regularly priced CVS/pharmacy brand OTC products valued at $1 or more. We can provide reports to you so that you can to identify the amount of savings your employees and their dependents have received through this program. The ExtraCare Health Card is available to you at no additional cost.

More than savings

The ExtraCare Health Card can help:

- Decrease member prescription drug spending through OTC alternatives
- Ease disruption that may arise from premium or copay changes
- Help members become engaged in their care and make cost-effective decisions

Card delivery

We will have the ExtraCare Health Card mailed directly to member homes. Once received, the member can use the card immediately. After we mail the initial cards to your current employees, new employees will automatically receive their cards within four to six weeks of becoming eligible for pharmacy benefits.

*The ExtraCare Health Card is not valid at CVS/Target store locations (CVS retail store locations only)

1.165	What programs are available that can increase rebates to card programs.

Response:

Specialty copay card plan designs

Our copay plan design strategies, True Accumulation and Copay Optimization can help minimize the impact of specialty copay cards. This helps to ensure plan design integrity and reduce your spend. Our plan design for select specialty medications can provide overall claim level savings. This includes features such as:

True accumulation

We ensure that when members are using specialty copay cards the use is accounted for when accumulating member cost for deductible and max out of pocket. Historically, when members have used copay cards, members appear to reach any accumulator, including deductibles and/or out-of-pocket maximums more quickly with dollars paid by third party manufacturers. Our solution preserves plan design integrity by preventing third-party dollars from funding the accumulator.

Our automated functionality will help ensure we only apply a true member cost share towards any accumulator at an Aetna or CVS Specialty pharmacy. As an example, if a member's benefit design requires a $100 specialty copay and uses a manufacturer copay card of $95 the true out-of-pocket cost for the member is $5. The only amount counted towards the accumulator would be the true out-of-pocket cost of $5 the member paid. We accomplish this by adjusting the member's accumulation.

Copay optimization

We capture the value of manufacturer copay cards for select specialty medications, which provides overall claim level savings. This includes features such as:

- Updating member cost share at the drug and/or therapy level to maximize the value of the copay cards
- Reimbursement assistance for submitting and receiving copay card support
- Daily monitoring of copay cards for updates or changes.
- True Accumulator functionality to ensure that we only apply the true member paid share towards the accumulator at an Aetna or CVS Specialty pharmacy.

For example, if a member's benefit design today requires them to pay a $100 specialty copay when they receive manufacturer copay card of $750; we would recommend a plan design change to $750. Aetna and CVS Specialty will then bill the available copay assistance program for the $750. The member will then pay the amount required by the copay assistance program which, in most cases is $0-$5, but can be upwards of $75. You will receive the remaining $700 in savings on that claim, assuming in this example that the copay assistance program requires that the member pay $50. Overall savings from the program will vary based upon plan design and drug mix.

We will work with you to review and modify your Summary Plan Documents (SPD) as necessary to maximize program savings.

Advanced copay optimization

We also have our Advanced Copay Optimization solution to leverage a list of non-essential health benefit drugs to ensure maximum value of the copay cards used is benefiting you and your employee. This solution designates select drug categories

as essential or non-essential health benefits based on ACA benchmarks.

This solution requires modifications to copay structures to increase copays to maximize assistance available from manufacturer across these therapeutic classes. Since non-essential drugs do not qualify as Essential Health Benefits (EHB), we can exclude out of pocket costs from a member's Out of Pocket (OPP) accumulation. This provides the ability to continue to bill copay card program after member hits their MOOP from other pharmacy or medical claims.

As an example, a member's benefit design requires a $100 specialty copay when the member is offered a copay card of up to $750. We would recommend a plan design change to $750 and Aetna or CVS Specialty bills the copay assistance program for the $750. The member pays the amount required by the copay assistance program, which in many cases is $0, but not more than $50. In this case, the member cost is $5. You receive the additional $650 in savings on that claim. $5 accumulates towards the member's deductible accumulation, but does not apply to the OOP. Each claim occurrence calculates a member copay of $750 regardless of member's deductible or OOP balance.

On April 25, 2019, HHS published the final Notice of Benefit and Payment Parameters for the 2020 benefit year. You would need to acknowledge the amended rule in writing in order for us to implement and administer these programs.

Potential program savings

Your savings will vary based on the copay card plan design implemented, as well as your drug mix. We estimate that the following savings can be realized of net pharmacy ingredient costs:

- True Accumulation - Up to 5%
- Copay Optimization – Up to another 3%
- Advanced Copay Optimization – up to another 7%

Reporting

As part of our copay card plan design, we can provide monthly reports of members that have utilized a copay card/patient assistance program at one of our specialty pharmacies. These reports include:

- Member name
- Drug name
- Amount paid by the patient assistance program
- Amount paid by the plan
- Amount paid by the member (after assistance program)

1.166	Describe the Mail Order process.

Response:

We have provided a complete description of the mail service process below.

Order submission

Members can submit new prescriptions through mail, physician-submitted fax or e-prescribing. Members can order refills through our interactive voice response (IVR) telephone system, through our website or through the mail using the reorder form provided with each outgoing order. Members may also contact our mail pharmacy and ask that we contact their physician to have a prescription provided for processing.

Members can submit physician-authorized refills for up to one year for non-controlled substances and up to six months for most controlled substances, before having to renew their prescriptions.

Order imaging

We scan each prescription so that we retain a high-resolution image of the actual prescription. We reference the scanned documents throughout the dispensing process.

Member registration/order entry

We have the order entry process automated with menu driven screens to optimize accuracy and efficiency. Order entry technicians key information from the order forms to the pharmacy system and match it with the member's pharmacy plan benefit data.

Order review

During the order review process, a pharmacist examines new prescriptions for details such as:

- Member and physician ID
- Drug name
- Drug strength
- Instructions for use
- Quantity
- Refill status

The pharmacist compares these to the corresponding image in the system. The pharmacist examines the printed label and after confirming order accuracy, the pharmacist releases the order for eligibility and payment confirmation.

Clinical review

We have the clinical review conducted with an electronic support system responsible for DUR activities and other clinical exception processes within each order. Examples include informational or consultative physician and member calls concerning therapeutic duplication, medical diagnosis, dosage confirmation, member counseling and generic substitution.

Prescription dispensing

Once forwarded to the dispensing area, orders enter a streamlined routing system that promptly sends them to the correct location. We have the following systems used to dispense drugs:

- Automated prescription selector – We have this system used for unit-of-use packages. Orders fill through a time-paced conveyor system. Computerized scanning confirms that we had the correct drug selected and directed to the right prescription order.
- OptiFill® system – We have this system used for solid-dose drugs. The process begins when a series of electromechanical functions select, label, fill, check and cap a bottle. The system photographs the prescription content and verifies the count.
- Semi-automated dispensing – We use this approach for less frequently prescribed drugs. This approach includes pharmacy filling stations equipped with laser counting machines. These orders account for approximately 10 percent of all mail service prescriptions.

The dispensing pharmacies operate in accordance with strict standard operating procedures. An independent quality department regulates and routinely audits the pharmacies.

Pharmacist quality assurance

Computerized systems and imaging technology enhance the final pharmacist check. The automated conveyor system delivers the completed order to the pharmacist check station. We have the tote scanned and the order displays on a computer screen. The pharmacist compares the actual drug to the reference picture.

If the pharmacist is not satisfied that the order is correct, we have a dedicated pharmacist assigned to research the order. Once resolved, we have the order placed back on the line for forwarding to the shipping area.

At least two pharmacists check every new order. If an order requires prescribing physician clarification or modification, a third pharmacist may become involved.

Packing

We have orders packed using a tamper-resistant special shipping mailer or a corrugated box sealed with tamper-evident brown stitch tape depending on the number of ordered drugs. We have special packaging used for refrigerated products as well as for those requiring pressure-sensitive handling.

We have environmentally sound packaging materials continually incorporated into the shipping process:

- White prescription bottles are recyclable
- Amber prescription bottles carry a recycling code of one (or just state Amber vials are recyclable)
- Corrugated shipping containers are recycled
- Shipping envelopes are either polyethylene mailing bags or 100 percent recycled Kraft mailing bags
- Bubble liner is 85 percent recycled (35 percent is post-consumer).

Shipping and metering

When the package reaches the metering area, we have the order number bar code scanned. The member's address and the number of prescriptions ordered will appear on a computer screen only when the order is complete. The system then determines the best available method for sending the prescription, taking into consideration:

- Medicine type
- Speed of delivery
- Destination
- Package weight

The shipping label includes the member's address, the return address and method of shipment (U.S. Mail, Priority Mail, UPS, FedEx or if an adult signature is required). To prevent tampering, we have the shipping label placed over the package seal. To maintain further security and confidentiality, the shipping label indicates only the return address. Neither the word "prescription" nor the word "drug" appear anywhere on the outside of the shipping container.

1.167	Provide the locations of all Mail Order facilities nationwide.

Response:

We provide home delivery services through three regional order creation centers (ROCCs), five prescription-processing facilities and two dispensing pharmacies.

ROCCs
- Mount Prospect, IL
- Pittsburgh, PA
- San Antonio, TX

Prescription processing centers
- Phoenix, AZ
- Mount Prospect, IL
- Pittsburgh, PA
- Wilkes-Barre, PA
- San Antonio, TX

Dispensing pharmacies
- Mount Prospect, IL
- Wilkes-Barre, PA

1.168	Describe the standard floor limit for accepting prescription orders from members without the correct payment?

Response:

When we receive home delivery claims, the claim system verifies member eligibility, plan coverage, financial information and member claim history. This link promotes safe drug dispensing according to established pharmaceutical guidelines. We ask members to submit a completed order form, with the original prescription and the appropriate copayment amount. We collect copayments when members place their order. Payment options include check, money order, FSA, HSA, debit and credit cards (Visa, MasterCard, American Express and Discover). Members can also provide a check by phone, at no charge. We adjudicate copayments directly into the pharmacy claim system, at the point of care.

If we do not receive payment with the order, we can ship orders up to a $300 limit before we call members to obtain a form of payment before shipping the order. If we receive a home delivery prescription with an overpayment, we credit it to the member's next order. We typically do not send checks back to members after processing unless the member requests a refund. If requested, we have a check issued for the overpaid amount.

1.169	Provide location information on specialty pharmacy if different from Mail Order Facility.

Response:

Aetna Specialty Pharmacy® has a centralized pharmacy and member service center located in Orlando, FL. From this facility, we provide high-touch, therapy-specific support services to members living with complex conditions.

Our dedicated team of pharmacists, nurses and pharmacy CSRs can address all therapy support needs through our toll-free number. Regular business hours are Monday through Friday, 8 a.m. to 8 p.m. ET. Our clinical representatives remain available for member education and support 24 hours a day, 7 days a week.

1.170	Describe the relationship with the specialty pharmacy, including if it is part of a specialty pharmacy network.

Response:

We own and operate Aetna Specialty Pharmacy, our preferred specialty provider.

1.171	Provide the definition and qualification criteria of a specialty drug.

Response:

Specialty drugs means:

- Certain pharmaceuticals, biotech or biological drugs (including "biosimilars" or "follow-on biologics")
- That are Covered Drugs and that are used by the Aetna or CVS Health specialty pharmacy
- Are used in the management of chronic, rare or genetic disease

  Include, but are not limited to injectable, infused or oral medications, or products that otherwise require special handling
- Includes, without limitation those listed in your Specialty Fee Schedule in the Financials Section of this proposal, which we may amend from time to time.

1.172	Describe how the State is notified of the pricing terms for new specialty drugs including how far in advance such notice is provided.

Response:

Your pharmacy account team will keep you informed of drugs that are newly available through Aetna Specialty Pharmacy along with pricing upon request and during your quarterly plan meetings.

We determine the pricing for new-to-market specialty drugs by considering various factors, such as acquisition cost, expected dosages, package sizes and utilization.

While actual prices vary by drug, we generally price new-to-market specialty drugs within 1 percent (100 basis points) of the default discount rate for drugs on your specialty drug price list, which is AWP -15% and Limited Distribution Drugs are AWP -10%.

1.173	Describe any separate plan design that can be implemented for specialty drugs that would include generic, preferred brand and non-preferred brand tiers.

Response:

We offer benefit plan designs that incorporate a fourth or fifth copay tier for specialty drugs on the pharmacy benefit. Members pay copayments ranging from 10 percent to 50 percent with a 10 percent spread between tiers as follows:

Fourth Tier – Copayment covers all preferred and non-preferred brand specialty drugs.

Fourth/Fifth Tier – Copays for preferred brand specialty drugs can be included on the Fourth Tier and non-preferred brand

specialty drugs can be included on the Fifth Tier of the plan design.

Additional specialty drug copayment options include flat dollar ranging from $10 to $100 and minimum/maximums per prescription ranging from $10 to $200. Please note that not all tier copayment plan designs are available on every formulary. We can incorporate copays or coinsurance for specialty drugs.

1.174	Describe the courier services utilized for specialty product delivery and how courier service vehicles maintain temperature control.

Response:

We maintain agreements with national carriers and local couriers for circumstances in which members have an immediate medical need for product. Temperature sensitive products are packaged according to our standard protocols that maintain the appropriate temperature throughout the shipping process to assure integrity of the medications, regardless of the method of transportation. All shipping packages are unmarked (e.g., as to contents or other confidential information) and include only a shipping label with the member's name and address and instructions for handling (e.g., "Refrigerate immediately upon arrival").

In addition, we always call the member in advance regarding the expected shipment to determine a convenient delivery date and time. We use UPS and FedEx to provide reliable and consistent, high-quality services. We use a direct computer link with these couriers so that we can immediately determine package status. This prevents or minimizes product loss resulting from prolonged exposure to temperatures outside of the required parameters.

1.175	Describe any limits on certain specialty drugs to less than 30 days' supply for a patient's initial prescription. Indicate which drugs and the days' supply limit.

Response:

We have in place a Specialty Starter Fill program to administer partial fills for a defined list of specialty medications. Our program targets toxic therapies that demonstrate high discontinuation rates for new-to-therapy members who are more likely to discontinue therapy and helps to prevent wastage by dispensing a short-term days' supply. We will dispense a partial fill for the first six fills. If the member demonstrates tolerability, they will receive a full month's supply for the targeted therapy. We review therapies for side effect profile, tolerability, dosing, stability, packaging and storability before we add them to the list.

We are able to support partial fill dispensing for the following therapies:

- Hematological Disorders
- Hepatitis B
- Oncology
- Parkinson's Disease – Psychosis

Please refer our Starter Fill Drug List.docx document included in the Samples and Brochure folder for your review.

1.176	Describe any quantity limit rules for specialty drugs and include a list of the quantity limits by drug.

Response:

Specialty Guideline Management (SFM)

We established our specialty quantity limits program, part of our core suite of utilization management solutions, as a supplement to our Specialty Guideline Management offering. Implementing quantity limits on select specialty drugs ensures appropriate dosing based on FDA labeling to better manage utilization and manage cost.

If the coverage limit is exceeded, the claim is rejected at the pharmacy and the member is responsible for the cost of the additional quantity over the limit of the prescription. Selected drugs on our quantity limit list have a post-quantity limit prior authorization available. The prior authorization criteria are applied after the quantity limit has been met, allowing for additional quantities of the drug to be covered under appropriate circumstances. These criteria – defined as post-quantity limit prior authorization criteria – are designed to address actual or potential overuse or inappropriate use, which could be of clinical and/or economic concern. Post-quantity limit prior authorization criteria are determined and approved on a client-specific basis.

Standard prior authorization fees for this service would apply.

Please refer to the *Specialty Quantity Limits Drug List.docx* document within the *Aetna Standard Formulary.zip* file for our quantity limits and precertification lists.

1.177	Provide the customer and member service operation hours of the specialty pharmacy program.

Response:

Aetna Specialty Pharmacy® has a centralized pharmacy and customer service center located in Orlando, FL. From this facility, we provide high-touch, therapy-specific support services to members living with complex conditions.

Our dedicated team of pharmacists, nurses and pharmacy CSRs can address all therapy support needs through our toll-free number. Regular business hours are Monday through Friday, 8 a.m. to 8 p.m. ET. Our clinical representatives remain available for member education and support 24 hours a day, 7 days a week.

1.178	Provide a concise description of member service pharmacist support for specialty drugs, including how many pharmacists provide member support, the hours of availability and any specialized expertise.

Response:

Our specialty pharmacy has 20 pharmacists, 22 nurses and 265 non-clinical staff. The pharmacist at Aetna Specialty Pharmacy® will screen prescriptions for potential drug therapy problems including:

- Appropriateness of therapy
- Potential drug interactions
- Drug allergies
- Contraindications
- Medication dosage/duration of treatment

We offer clinical support with a nurse and/or pharmacist to all members, 24 hours a day, 7 days a week. Clinicians will follow up with members on an as-needed basis with prescriber intervention, as appropriate. Clinician support may include:

- Side effect management
- Adherence counseling
- Potential drug interactions
- Disease state information
- Medication review (dosing, administration and storage/stability)

Members taking Otezla, Ampyra, Tecfidera and Hepatitis C medications, that are new to therapy, are contacted by a pharmacist to review medication dosing, concurrent medications and discuss risks and benefits of therapy with prescriber intervention if we identify any risks of treatment.

The Aetna Specialty Pharmacy Clinical Hub provides counseling services to a select group of high-touch members on high-cost therapies. We assign members with IVIG, hemophilia and enzyme replacement a specific clinical nurse to establish a care management relationship and provide personalized services. Our nurses coordinate Home Health Care and work closely with the precertification team and National Medical Excellence nurses to ensure therapy is appropriate and timely. PAH and oral oncology members are contacted monthly and provided counseling services before each fill. Nurses offer teaching and injection training for patients who need assistance with self-administration of medications.

1.179	Provide a concise description of the member support services provided to members who utilize oncology specialty drugs.

Response:

Supporting members through Aetna Specialty Pharmacy®

Members can fill many different types of oncology drugs through Aetna Specialty Pharmacy. When we receive an order for an oncology drug, our pharmacy services representatives contact members, confirm delivery and provide the opportunity for the member to speak with a nurse to discuss their condition and determine their unique needs.

Cancer educational materials

The educational materials that we can provide to members with cancer include, but are not limited to, the following topics:

- Tips for setting short- and long-term goals
- Tips for remembering to take your medicine
- How cancer treatment impacts your nutritional needs
- Increasing exercise – From lying in bed to walking to playing sports

Some medications like Revlimid require extensive counseling prior to shipping the prescription. The nurse will speak with the member on each fill to ensure all safety precautions are taking place in the home and the member understands how to manage through the side effects.

Specialty Health Care Management℠

We also engage members with cancer through our Specialty Health Care Management program. This nurse team reaches out to members if they have recently been diagnosed with cancer, are new to a particular therapy, having trouble continuously taking their drugs or referred by another area within Aetna. Once identified, a nurse calls the member and performs an assessment. Topics covered in the assessment include, but are not limited to, the following:

- Type of cancer
- Stage of cancer
- Medications
- Side effects
- Nutrition
- Red blood cell and white blood cell count monitoring

After we identify and assess a member who needs support, the nurse creates a customized care plan. While every care plan we create is unique to that member, all plans identify long-term goals and actions. Examples of what may be included in a care plan for a member with cancer include:

Problem	Activity
Member has a high knowledge deficit of cancer condition	• Evaluate the member's knowledge level regarding condition • Determine member's compliance with treatment • Counsel member to gaps in knowledge • Offer educational materials • Determine how frequently member needs follow up calls

Member is new to oncology therapy	• Assess member's knowledge of oncology therapy (for example Afinitor/Xeloda) • Educate the member regarding the particular drug's side effects

The Specialty Health Care Management nurse team will also actively refer members to other Aetna resources when necessary. For example, because nausea and vomiting are common side effects, we may refer the member to another Aetna program with dietician support, such as disease management or In Touch Care. We also use connections with Compassionate Care end of life planning, when necessary.

Supporting physicians in the fight against cancer

Aetna Oncology Solutions℠ is a coordinated, multi-dimensional approach to managing cancer care. We work with the medical community to help set standards for quality cancer care with:

- Greater adherence to accepted guidelines
- Fewer unanticipated side effects
- Less financial strains

We support network and contract negotiations for oncology drug reimbursement with the physician buy and bill model. They develop utilization management algorithms for prescribing appropriateness. They also evaluate new oncology therapies while in the pipeline and as new drugs launch.

We also collaborate with oncology vendors such as P4 Healthcare, Innovent and Eviti. This helps oncologists make treatment decisions based on medical evidence, research and treatment practices by promoting use of clinical pathways. We mainly have pathways compared by efficacy, toxicity and cost.

Pathways address the following:

- A combination of drugs used and the sequencing of how they are given
- Appropriateness of when to begin and discontinue treatment
- If a new line of therapy is needed when a chemotherapy regimen did not meet clinical outcomes or the cancer progresses

By using evidence-based pathways, we have seen a reduced cost for chemotherapy drugs, fewer chemotherapy-related ER visits and fewer chemotherapy-related inpatient hospital admissions and inpatient days.

1.180	Provide a brief recommendation of how the Specialty Pharmacy will collaborate with the State's selected medical carriers to optimize patient care and utilization of specialty drugs.

Response:

What makes our specialty drug solution unique is that we are building it on seamless integration with our Aetna pharmacy and medical services. What this means for you is that we not only make decisions based on lowering spend, but also on what is best for the member's overall health. We have provided some of the benefits of our specialty drug solution below.

- Drug choice – Comprehensive clinical evidence and policies for therapy
- Method of care – Affordable options for delivery of care
- Support – A knowledgeable support system that covers all patient needs

Drug choice

We manage drug selection across both the medical and the pharmacy platform:

- Diagnosis Validation – Our Diagnosis Validation edit applies to specialty drugs administered under the medical benefit. The edit uses actual claim data to ensure that the J code on the claim is appropriate to treat the diagnosis that is on the claim.
- Dosing edit – Through this edit, the system reduces the paid amount to the maximum units allowed using industry accepted dosing guidelines
- Limits on oral J code drugs – Quantity limits on oral drugs given by oncologists from their office practices and billed to Aetna medical under J codes to assure that self-administered drugs are applied to the pharmacy benefit.
- J code drug dose frequency edits – Frequency checks on certain medical drug claims that we receive too soon after a prior claim for the same drug for the same member based on product labeling and FDA dosing guidelines for frequency.
- Specialty Guideline Management (SGM) – We ensure appropriate utilization for specialty medications based on the application of currently accepted evidence-based medicine guidelines and consensus statements for the appropriate use of medication in a specific disease state. This program, which is available for more than 50 therapy classes, determines whether a member meets criteria to initiate therapy as well as evaluates each member to determine whether they are meeting expected outcomes for continuing treatment. SGM combines precertification, step therapy and day one utilization management control. It includes prospective review that takes place prior to the start of therapy, as well as concurrent review of therapy appropriateness while members remain on therapy.

Method of care

Some of the ways we ensure cost effective drug delivery include:

- Where physicians buy drugs – We encourage physicians to order drugs through Aetna Specialty Pharmacy when administering specialty drugs to our members. We do this because it allows us to coordinate care and can save you and your employee higher drug costs. We work with physicians to fulfill member-specific prescription orders, but we do not support fulfillment of physician bulk orders.
- Services that we provides – Our specialty pharmacies are designed to meet the needs of members and health care professionals through an integrated medical and pharmacy platform. We offer plan designs that shift use under the pharmacy benefit, fills prescriptions and ships them to members.

Site of Care Optimization – This is one of the most unique and effective programs in the industry. Through this program, we identify certain members receiving care at high cost delivery sites and recommend alternate delivery options for the drug. When we receive a precertification request, we look up the recommended health care professional in our internally developed RxFinder tool to check and compare costs with other health care professionals in the area and may recommend alternate lower-cost sites to the prescribing physician.

Nurses also retroactively analyze claims to identify drugs currently being administered at expensive locations. A nurse then calls the member and recommends the most cost effective site of care for the member (for example home infusion). It's important to note that we offer this program at no additional cost and it is voluntary for both the member and the customer. If members agree to the new site of care, we then continue to monitor them closely to ensure a successful transition.

- Mandatory specialty network – Through our mandatory specialty network, we can help you manage your specialty pharmacy costs while improving member health. This program steers members toward Aetna and CVS Specialty Pharmacy and indicates whether the drug should be covered under the medical or pharmacy benefit. By shifting drug spend from the physician's office to the PBM, we save money for you and your employees. We automatically include this for all formularies, where permitted by law.

Support

Support options must consider all needs and should be connected:

- Specialty CareTeam – This nurse team reaches out to members with certain conditions who are newly diagnosed, new to therapy, having adherence issues or referred by another area within Aetna. We call members and ask them if they would like to participate. If they opt in, we send them contact information and disease-specific educational materials. We assess each member using industry validated assessment tools and benchmarks of care to identify any gaps in care or areas of concern. We evaluate how much help they need and develop a customized care plan. The nurse coordinates with the physician's office and provides additional member education and support to effectively manage care.

- Case and disease management – Because we can provide pharmacy, medical and behavioral health benefits through a single carrier, we are in a unique position to support member needs. When our Specialty CareTeam is the first point of member contact, it can serve as a referral source to others within Aetna, such as medical disease management or case management. These two areas would then determine how we could pull our resources together to best serve the member while avoiding duplicative services.

- Aetna Behavioral Health – We also work closely with our internal behavioral health services area to identify and refer members who may benefit from additional support. Upon therapy initiation, a Specialty Health Care Management nurse reaches out to the member to perform a depression/anxiety screening. The nurse asks targeted questions to uncover behavioral health concerns. When we collect the results of this screening, we engage our behavioral health team to reach out to those members who screen positive.

- Aetna National Medical Excellence Program® – This is a case management program offered under Aetna's medical benefit that provides consistency in the coordination of care for transplant, hemophilia therapies and other rare conditions. Specialized case management nurses work with the patient, doctor, hospital and family members to help coordinate all phases of the procedure.

  Our Aetna Specialty Pharmacy nurses also proactively manage hemophilia and transplant therapies. We avoid duplication of services between these two programs by giving both nursing teams access to Aetna Clinical View (ATV). With this shared technological platform, our nursing teams partner together to add additional support while avoiding duplication of services.

- Aetna Oncology Solutions[SM] – This coordinated, multi-dimensional approach to managing cancer care works with the medical community to help set standards for quality cancer care. We support network and contract negotiations for oncology drug reimbursement with the physician buy and bill model. They develop utilization management algorithms for prescribing appropriateness. They also evaluate new oncology therapies while in the pipeline and as new drugs launch.

We also collaborate with oncology vendors such as P4 Healthcare, Innovent and Eviti. This helps oncologists make treatment decisions based on medical evidence, research and treatment practices by promoting use of clinical pathways. We mainly have pathways compared by efficacy, toxicity and cost.

1.181	Describe any specialty drug categories that are recommended to clients which limit coverage to the pharmacy benefit only.

Response:

Our policy for specialty drugs is that regardless of the type of specialty drug which can include self-injectables, injectable, IV or oral medications (including tablets, capsules, powders and creams) are dispensed through a pharmacy (retail, Aetna mail order or an Aetna or CVS specialty pharmacy) the drug is paid under the pharmacy benefit. Any specialty drug administered and provided by a healthcare provider is processed and covered under the medical benefit.

With that said, costs for infusion drugs can vary widely. Where a member receives care makes a difference. The cost of a hospital outpatient infusion is often twice the cost of an infusion of the same drug received at a physician's office or home infusion.

Our Site of Care Optimization program identifies members who are subject to the mandatory policy which would direct them to a more cost-effective solution for specialty drug infusions and injections. We differentiate ourselves by looking at the members entire situation to determine the most clinically appropriate location for their therapy. This means that a member would still receive therapy in a hospital setting when medically necessary. If we find that a hospital isn't necessary, we redirect members to a more cost-effective solution. Another key differentiator compared to other PBMs is that we offer this program at no additional cost to you or your employees.

As an integrated provider of both medical and pharmacy benefits, we offer a Site of Care program that truly is looking at the lowest net cost site of care that is in the best interest of the employer and employees. It includes both mandatory and voluntary programs. We maintain a list of drugs where movement to a lower cost site of care is mandatory and a separate list where the lower cost site of care is voluntary. We identify patients on mandatory drugs through our precertification process and we identify the voluntary patient by retrospective claim review. Once the new site of care is determined, we coordinate everything on the member's behalf to guide them through the process as easily as possible. We then continue to monitor them closely to ensure a successful transition.

Those Site of Care programs managed by a medical carrier have greater control and success because we already manage the precertification process. When we receive a precertification request, we grant a 45-day, short-term authorization for the member to continue receiving therapy in a hospital setting and we then assign a dedicated infusion consultant to that member. Instead of just sending members letters in the mail, we assign an infusion consultant who will act as that member's single point of contact. Nobody else in the industry is offering anything close to this level of patient support. This dedicated consultant uses the 45-day window to handle end-to-end service in transitioning the patient to the new site of service, including:

- Educating the patient on copay assistance opportunities and assisting in enrolling the patient in the program
- Working with the physician to get new authorization in place, referral and prescription sent to new vendor
- Following up with new vendor to assure infusion is scheduled and the patient has been notified
- Additional follow up with the patient after infusion to assure everything went as expected

- Ongoing support available as needed by the patient or physician

Another unique differentiator for our program is that both Aetna and CVS Specialty Pharmacy are set up as medical infusion providers. This means that even if a high-cost hospital is the only available site of care for a member, we can still work with that hospital to ship in medication from our pharmacy which lowers the cost of care significantly. In this case, we ship the drug to the hospital, bill the medical benefit and save money for both you and your employees. Once again, this capability is unique to Aetna's Site of Care best-in-class program in the industry today.

Program results

2019 – Our site of care policy has saved a total of $214M in cost avoidance through May of this year.

2018 - $99M expected* savings (cost avoidance) for 1,188 patients. Estimated savings of $83K per infusion patient per year.

2017 – $48M actual savings (cost avoidance) for 869 patients. Savings of $55K per infusion patient per year.

*We estimate expected savings for a year from the date of the first infusion at the new site of care. Calculations based on net savings.

1.182	Describe what procedures or management tools the organization has in-place to manage the use of manufacturer coupons for high cost drugs.

Response:

Our True Accumulation strategy can help minimize the impact of specialty copay cards, helping to ensure plan design integrity and reduce your spend. Our plan design for select specialty medications can provide overall claim level savings that may be shared by you and your employees. This includes features such as:

True accumulation

We ensure that when members are using specialty copay cards the use is accounted for when accumulating member cost for deductible and max out of pocket. Historically, when members have used copay cards, members appear to reach any accumulator (i.e., deductibles and/or out-of-pocket) maximums more quickly with dollars paid by third party manufacturers. Our solution preserves plan design integrity by preventing third-party dollars from funding the accumulator.

Our automated and systematic functionality will help ensure only true member cost share is applied towards any accumulator at Aetna Specialty Pharmacy® or CVS Specialty Pharmacy.

As an example, if a member's benefit design requires a $100 specialty copay and uses a manufacturer copay card of $95 whereas the true out-of-pocket cost for the member is $5, the only amount counted towards any accumulator would be the true out-of-pocket cost of $5 the member paid (this is accomplished by adjusting the member's accumulation).

Reporting

As part of our copay card plan design, we can provide monthly reports of members that have utilized a copay card/patient assistance program at one of our specialty pharmacies. These reports include:

- Member name
- Drug name
- Amount paid by the patient assistance program
- Amount paid by the plan
- Amount paid by the member (after assistance program)

1.183	Describe any specialty drug copay assistance programs (e.g. variable copay design, concierge service) available to reduce the State's Plan costs and describe any member impact and Plan requirements to implement.

Response:

We will work with you to find a plan benefit with the right level of member cost sharing. If it is too high, members may not take their drugs as prescribed. Non-compliance often leads to an increased number of physician visits, ER visits and hospital stays. By setting an affordable cost share, we help members comply with therapy and remain stable and consistent with their treatment plans. The combined cost of non-compliance is more costly to customers than the cost of ensuring members can afford to regularly take their medication.

We can supply specialty drugs and other services to members with various benefit plan designs. We have many customers with various needs that we must offer coverage to meet their members' medical needs. In the current health care industry, consumer driven health plans (CDHPs) will affect the benefit level and out-of-pocket expense experienced by members.

Members may be eligible to participate in payment plans if they struggle paying for their specialty drugs. We provide information on manufacturer programs as well as funded social service organizations that offer copay assistance. We also keep members and prescribing physicians informed of assistance support throughout treatment.

We facilitate on a needs-based and non-needs based financial support assistance to members who are taking high-cost specialty drugs.

Funded copay assistance

- Funded copay assistance is available directly to the member by means of foundations and charitable organizations.
- Funds are available in the form of a grant usually with a set dollar amount within a certain period and is loaded as a secondary payer.
- The member must meet "needs based" financial criteria for eligibility.
- We apply grant amounts to established member responsibility.
- Members benefit from a reduction in out of pocket cost.
- We apply funds to annual deductibles and coinsurances up to out-of-pocket maximums.

Manufacturer copay assistance

- Manufacturer copay assistance is available directly to the member by means of discount cards, debit/credit cards and online coupons.
- The only criteria for eligibility is having a valid prescription.
- Aetna Specialty Pharmacy® facilitates this assistance for the member and is able to load and verify these benefits as secondary payers.
- We process orders with primary and copay payor to determine member responsibility.
- Members benefit from an immediate reduction in out of pocket cost.
- We can also apply funds to annual deductibles.
- Government plans such as Medicare Part D and Medicaid are not eligible for copay assistance programs.

Specialty copay card plan designs

Our copay plan design strategies, True Accumulation and Copay Optimization can help minimize the impact of specialty copay cards. This helps to ensure plan design integrity and reduce your spend. Our plan design for select specialty medications can provide overall claim level savings. This includes features such as:

True accumulation

We ensure that when members are using specialty copay cards the use is accounted for when accumulating member cost for deductible and max out of pocket. Historically, when members have used copay cards, members appear to reach any accumulator, including deductibles and/or out-of-pocket maximums more quickly with dollars paid by third party manufacturers. Our solution preserves plan design integrity by preventing third-party dollars from funding the accumulator.

Our automated functionality will help ensure we only apply a true member cost share towards any accumulator at an Aetna or CVS Specialty pharmacy. As an example, if a member's benefit design requires a $100 specialty copay and uses a manufacturer copay card of $95 the true out-of-pocket cost for the member is $5. The only amount counted towards the accumulator would be the true out-of-pocket cost of $5 the member paid. We accomplish this by adjusting the member's accumulation.

Copay optimization

We capture the value of manufacturer copay cards for select specialty medications, which provides overall claim level savings. This includes features such as:

- Updating member cost share at the drug and/or therapy level to maximize the value of the copay cards
- Reimbursement assistance for submitting and receiving copay card support
- Daily monitoring of copay cards for updates or changes.
- True Accumulator functionality to ensure that we only apply the true member paid share towards the accumulator at an Aetna or CVS Specialty pharmacy.

For example, if a member's benefit design today requires them to pay a $100 specialty copay when they receive manufacturer copay card of $750; we would recommend a plan design change to $750. Aetna and CVS Specialty will then bill the available

copay assistance program for the $750. The member will then pay the amount required by the copay assistance program which, in most cases is $0-$5, but can be upwards of $75. You will receive the remaining $700 in savings on that claim, assuming in this example that the copay assistance program requires that the member pay $50. Overall savings from the program will vary based upon plan design and drug mix.

We will work with you to review and modify your Summary Plan Documents (SPD) as necessary to maximize program savings.

Advanced copay optimization

We also have our Advanced Copay Optimization solution to leverage a list of non-essential health benefit drugs to ensure maximum value of the copay cards used is benefiting you and your employee. This solution designates select drug categories as essential or non-essential health benefits based on ACA benchmarks.

This solution requires modifications to copay structures to increase copays to maximize assistance available from manufacturer across these therapeutic classes. Since non-essential drugs do not qualify as Essential Health Benefits (EHB), we can exclude out of pocket costs from a member's Out of Pocket (OPP) accumulation. This provides the ability to continue to bill copay card program after member hits their MOOP from other pharmacy or medical claims.

As an example, a member's benefit design requires a $100 specialty copay when the member is offered a copay card of up to $750. We would recommend a plan design change to $750 and Aetna or CVS Specialty bills the copay assistance program for the $750. The member pays the amount required by the copay assistance program, which in many cases is $0, but not more than $50. In this case, the member cost is $5. You receive the additional $650 in savings on that claim. $5 accumulates towards the member's deductible accumulation, but does not apply to the OOP. Each claim occurrence calculates a member copay of $750 regardless of member's deductible or OOP balance.

On April 25, 2019, HHS published the final Notice of Benefit and Payment Parameters for the 2020 benefit year. You would need to acknowledge the amended rule in writing in order for us to implement and administer these programs.

Potential program savings

Your savings will vary based on the copay card plan design implemented, as well as your drug mix. We estimate that the following savings can be realized of net pharmacy ingredient costs:

- True Accumulation - Up to 5%
- Copay Optimization – Up to another 3%
- Advanced Copay Optimization – up to another 7%

Reporting

As part of our copay card plan design, we can provide monthly reports of members that have utilized a copay card/patient assistance program at one of our specialty pharmacies. These reports include:

- Member name
- Drug name
- Amount paid by the patient assistance program
- Amount paid by the plan
- Amount paid by the member (after assistance program)

1.184	How will the State be kept informed of changes to clinical management rules?

Response:

Kim Haywood, Pharm.D, your Clinical Account Executive will keep you informed as necessary of any changes to our clinical management rules. In addition, Kim will provide you with your RxInsights review.

The RxInsights review offers a customized and comprehensive look at your prescription plan's financial and service-related metrics. The report includes trends associated with price, product, utilization and comparisons with clients of similar demographic makeup and/or market segment. The report also monitors the impact of any plan design or clinical strategies you implement, identifies additional strategies and forecasting that could improve the performance of the benefit and makes specific recommendations based on your data.

Kim will use the RxInsights annual review to make plan design recommendations aligned with your goals. Team members can also suggest programs or initiatives designed to reduce your health care spending and improve member health outcomes.

1.185	Provide a sample client management report that details clinical rule activity and savings a. Provide a sample of client clinical management performance report. b. Describe PA, step therapy and quantity level limit program capabilities. c. Attach a list of drug categories for which such programs can be applied. d. Briefly describe drug utilization review (DUR) process and indicate which point-of-sale edits can be overwritten and which are "hard" rejects. Include a list of point-of-sale edits. e. Provide the detailed utilization management program list, including specific drugs names in each program. f. Provide a sample DUR report that is produced and made available to clients.

Response:

a. Please refer to our Sample Clinical Management DUR Report.pdf document within the *APM Sample Reports.zip* file which included in the Samples and Brochures folder of this proposal.

b. Please refer to our Prospective DUR Clinical Programs.docx document included in the Samples and Brochures folder of this proposal.

c. Please refer to the Aetna Standard Formulary Utilization Edits.xlsx document within the Aetna Standard Formulary.zip file, which is included in the Samples and Brochures folder of this proposal.

d. Please refer to our DUR Clinical Programs.docx document included in the Samples and Brochures folder of this proposal.

e. Please refer to the Aetna Standard Formulary.zip file for listing of drugs that require step therapy and precertification included with this proposal.

f. Please refer to our Sample Clinical Management DUR Report.pdf document within the *APM Sample Reports.zip* file which included in the Samples and Brochures folder of this proposal.

1.186	What was the overall average DUR savings as a percentage of plan cost in 2018 in reference to Public Sector cases similar in size to the State of Nebraska?

Response:

Our 2018 Aetna Standard Formulary average DUR savings was up to 2% savings as a percentage of plan cost including rebate impact. Please note individual results will vary based on plan design, formulary status, demographic characteristics and other factors. Customer-specific modeling available upon request.

1.187	Summarize the DUR edits that detect fraud and/or abuse.

Response:

Through our Misuse, Waste and Abuse (MWA) programs, we want to ensure that the right drugs are prescribed to the right member, at the right time. The following programs focus on ensuring member safety.

Drug utilization review

Before a pharmacy dispenses a drug for our members, our system reviews the claim to make sure it meets our clinical and administrative criteria. When a claim does not meet the criteria, a hard-coded edit stops the claim and prompts the pharmacist to call us before dispensing the drug. The system can also indicate that the prescribing physician needs to call us. We have listed some of the edit programs that specifically relate to MWA cases.

- Safety Edits – These edits are quantity limits and precertification edits that apply to drugs that have a high potential for abuse. These edits ensure appropriate use and limit the quantity to a specific number of units for a defined time. Safety edits help members take drugs safely and within clinical guidelines.

- Max Pay Edit – This edit prevents the pharmacy from dispensing excessive quantities of a drug, by stopping the claim when the cost of the single drug is $750 or more. We maintain an electronic exception list for drugs that we know cost more than the $750 amount. We typically find that this edit is the result of a mistake when the pharmacy entered the claim. Once the pharmacy submits the claim correctly, they then dispense the drug.

- High Dose Edit – These edits prevents claims for brand drugs like Vicodin®, Lorcet®, Norco® or generic equivalents containing hydrocodone and all products containing acetaminophen, from processing when the dose is higher than the maximum recommended amount. The pharmacist can indicate electronically whether the medication should continue to be processed, based on information obtained by the member and physician, as well as their clinical judgment. The goal of our High Dose edit program is to improve patient safety and reduce waste in drug spending.

- Buprenorphine DUR Edit – This edit identifies concurrent use of opioids and a buprenorphine product indicated for the treatment of opioid dependency. Use of these products with opiates may lead to serious adverse events. When triggered, this edit sends a reject message to the dispensing pharmacist. After reviewing the patient's medication history, pharmacists may either fill the prescription based on their professional judgment or contact the prescribing physician.

- Opioid informational edits – We send messages to dispensing pharmacists when we see multiple physicians, multiple pharmacies and excessive opioid use across multiple therapies. These edits do not stop the claim from paying, but do notify the pharmacist about potential concerns regarding the member's behavior. We automatically exclude members in hospice care or with a claim for a cancer drug in the last 180 days.

Opioid physician communication initiative

We send letters to network physicians who are in the top 1 percent for prescribing opioids based on our claim data. The letter notifies them that they are outliers and educates them on CDC best practices for prescribing opioids. We base our methodology on refill-to-fill ratios, as this metric has a strong correlation to patient overdoses in our claims data.

Opioid Safety Program

Our Opioid Safety Program identifies members at risk for opioid abuse. This patient safety program identifies members who fill opioids from four or more prescribers in a 90-day period. Once identified, we send alert letters to both the member and the prescribing physician. The physician's letter includes a medication profile. When needed, we also call the prescribing health care professional. We also include Aetna Behavioral Health contact information in both letters as a way for members to receive help, if desired.

Clinical interventions include locking members into a particular health care professional or pharmacy. When warranted, we may also deny medication and engage the patient for chronic pain management and behavioral health support. We offer this program at no additional cost.

High Dose Opioid Program

We offer this opioid overdose intervention program for members who are at high risk for overdose. We identify members for this program when we see they are filling high dose opioids averaging morphine equivalent dose of 120 or more. Criteria includes concurrent use of benzodiazepine and sedative hypnotics, comorbid depression and other mental health disorders.

An Aetna pharmacist contacts the prescribing health care professional to discuss how to best coordinate care, non-opioid pain alternatives and reduce/discontinue the member's use of opioids. We also contact the member to engage them in chronic pain management and behavioral health support.

2022 Strategy

By 2022, Aetna is committed to the following goals:

- Increase percentage of members with chronic pain treated by an evidence-based multimodal approach by 50 percent
- Reduce percentage of inappropriate opioid prescribing for our members by 50 percent
- Increase percentage of members with opioid use disorder treated by medication-assisted therapy and other evidence-based treatments by 50 percent

1.188	Describe the "look-back" period utilized for the refill-too-soon edit and indicate whether it includes only the previous claim or cumulative historical claims.

Response:

We have refill-too-soon edits programmed in our system. Refill-too-soon parameters are that we deny refill claims until 80 percent of the day supply is used. This is consistent across participating retail, home delivery and specialty pharmacies.

We also apply the cumulative refill-too-soon edit to all claims, with the exception of eye drops. With this edit, we are evaluating the total supply accumulated over a specific time. What this means in practice, is that the edit stops future claims from paying once members reach a 197 cumulative day supply over 180 days. The goal of the edit is to make sure members are taking their drugs and not stockpiling them. We base this accumulating total on the day supply submitted by participating pharmacies for each individual claim.

We cover the next refill for our cumulative refill-too-soon edit once members use 90 percent of the drug previously filled at retail or mail.

1.189	In addition to point-of-sale edits, describe any other tools or programs that are available to detect, prevent and resolve fraud and/or abuse. Also provide a complete description and samples of any documents used.

Response:

In addition to our point of sale edits, we perform multiple types of audits and reviews to ensure that claims pay correctly. These include:

Concurrent daily review and compound review processes

We perform a daily review of high dollar claims and claims submitted with unusual quantities or dosages. The daily review supplements the system edit processes and focuses on the reasonableness of quantity and dosage form.

Keying errors are usually due to incorrectly entered quantity, days' supply, dosage and NDCs. We contact pharmacies when we suspect that they made an error. We ask they reverse the claim and resubmit the appropriate data. We are more likely to select pharmacies for onsite audits if they have repetitive or substantial billing errors.

We have a high dollar review performed for all compound drug claims. This review ensures that retail pharmacies are submitting compound claims at the contracted rates and meet your plan design requirements.

We identify any concerns we have regarding a member's activities through the daily review of high dollar claims or on-site audits. We then refer them to our clinical services team for referral to you. We do not allow the audit group to notify members of fraud. If there is a fraud issue, we will create an audit summary for you that will provide information regarding the fraud and discuss the next steps that need we need to take.

In 2018, our 75 dedicated audit staff contacted approximately 65.5 percent of our network pharmacies through one of our audit programs. Our field auditors performed 4,823 onsite audits, covering more than 6.7 percent of our network pharmacies. Our investigational audits accounted for more than 8 percent of the field audits. Through our desktop audit process, we contacted more than 19.7 percent of our network through the more than 26,000 phone calls we made to pharmacies. In 2018, we recovered over $15.3 million in pharmacy audits.

Retrospective audit

We are committed to identifying and eliminating fraud, waste and abuse. Our retrospective audit analysis supports this through onsite and investigational audits.

Onsite audit process

In addition to the techniques discussed above, we conduct over 4,900 onsite pharmacy audits each year. The onsite auditing process uses a proprietary program that performs a systematic review of the claim history and automatically flags claims meeting specific criteria. Auditors have access to the entire claim record, as transmitted by the pharmacy and adjudicated by the system, allowing the auditor to deviate from the original audit plan as the situation dictates.

The audit function is also educational. Auditors answer questions about the company, inform pharmacists about our programs and policies and relay pharmacists' concerns back. We have educational material provided to all pharmacies to assist in improved program performance and to prevent future point of care and submission issues.

Investigational audits

Investigational audits are much more complex audits. We may select a retail pharmacy for an investigational audit if:

- Analysis indicates irregularities
- Receipt of a customer referral
- A tip is received from a regulatory agency, member, physician or customer
- The case is referred from other audit processes

We then determine the next steps in the investigation, which may include:

- Reviewing purchase invoices
  Contacting the prescriber-of-record for validation
- Contacting the patient to verify they received the medication

The Aetna Special Investigations Unit (SIU)

We collaborate with the Aetna Special Investigations Unit (SIU) who retroactively recovers incorrectly paid claims. he Aetna Special Investigations Unit (SIU) detects, investigates, recovers, prevents and reports fraud for our health businesses, including pharmacy. This unit conducts data mining activities using completed claim information available from our Enterprise Data Warehouse. SIU also pursues suspected fraud referred by areas within or outside of our organization.

SIU coordinates and works with CVS Health Retail and Part D Services in regards to pharmacy audit investigations as well as assistance with requirements of certain member investigations. CVS Health conducts investigative pharmacy audits and shares the results with us.

As part of an ongoing investigation, we may send prescription verification questionnaires to members who had prescription claims processed through the pharmacy to verify that the members actually received the billed prescriptions. SIU shares suspect results with CVS and based on their evaluation, the pharmacy may be subjected to an audit if warranted.

Once we have identified, or become aware of improper payments or misuse, we take appropriate action. We pursue overpayment recovery when appropriate and we initiate referrals to the proper authorities including federal and state law enforcement.

Audit reports are for internal purposes only.

1.190	Indicate whether or not a DEA or other provider identifier is required to fill a prescription for controlled substances and also describe how such prescriptions are monitored and managed to identify and deter fraud or abuse.

Response:

Yes, For controlled substance prescribing, a health care professional must have an active DEA identifier in good standing and have the authority to prescribe a controlled substance in a given DEA drug class schedule (2, 2N, 3, 3N, 4, 5).

Additionally, we mandate that a pharmacy NPI number must be submitted in order to process each claim, including all Medicare claims. Claims submitted without this information are rejected.

We target suspicious behavior that may indicate prescription medication fraud, waste or abuse (FWA) is occurring. Unmanaged FWA contributes to higher overall health care costs. Every $1 of pharmacy fraud, abuse and misuse translates into $40 of additional medical spend[1] or up to 10% of overall healthcare expenditures[2]. We can implement strategies to help you curb this activity.

Prescription medication misuse can take many forms:

- **Member Level**
  - Opioid addiction (abuse of medication often prescribed for acute or chronic pain)
  - Doctor shopping (obtaining prescriptions for controlled substances from several doctors)
  - Drug diversion (obtaining controlled substances in order to sell the prescriptions for personal gain)

- **Prescriber Level**
  - Unintentional prescribing (not prescribing according to evidence-based guidelines or prescribing too much medication because the prescriber is unaware of all of the medication a member is taking)

- Illegal or irresponsible prescribing (writing prescriptions more for financial gain than to truly help a patient)

- **Pharmacy Level**
  - Incorrect billing of suspect claims
  - Inaccurate prescription dispensing (processing refills too soon, not checking that a valid prescription is on file, not questioning or screening suspect member or prescriber activity)

We have a range of solutions that identify and address FWA at all levels to meet your goals which helps identify potential fraud, waste and abuse by addressing and effectively managing misuse using the approaches below:

- **Member Level**:
  - Analysis of all pharmacy claims to identify and address potential issues
  - Targeted communications with a structured utilization management approach
  - Prevention and reporting
- **Prescriber Level**:
  - Education to influence and promote evidence-based prescribing
  - Monitoring and intervention for suspicious prescribing activities
  - Collaboration to address suspect member behavior
- **Pharmacy Level**:
  - Network oversight and audit activities to help prevent, identify and resolve improper or unusual claims
  - Audit recovery reimbursement

Core safety and monitoring programs

Standard audit services

We designed our comprehensive core audit process to:

- Identify discrepancies
- Prevent and detect fraud, waste and abuse
- Provide a deterrence message to pharmacies

All of these audits help us fulfill our commitment to reducing total health care costs to you and your employees.

When we identify fraud, waste or abuse involving a network pharmacy, we work closely with the impacted customers to communicate the issues and provide the necessary support to correct any future problems. In addition, we can provide quarterly audit reporting, as requested. The typical reporting includes audits performed, audits in process, audits closed and the resulting recovery/savings identified.

Our pharmacy audit process involves both **on-site** and **off-site** procedures:

- Our on-site procedures were designed to verify the accuracy of claims submitted through observation of original records including, among other things, prescription hard copies and patient signature logs. On-site auditors provide education to the

pharmacy staff on Aetna initiatives and proper billing methods. The on-site process also includes a review of the pharmacy for appropriate adherence to other contractual requirements, i.e., review pharmacy computer DUR/Medication allergy screening, drug stock review, partial and return-to-stock procedures and compliance.

- Off-site procedures include Investigational and Desk audits. Investigational audits are based on utilization and cost data obtained from reports designed to identify erroneous billings. An investigational audit is a scrutiny of pharmacy records that may include its purchases, documentation of records and confirmation of prescriptions from prescribers. All participating pharmacies are subject to our Desk Audit process, which audits for erroneous billings including four off-site teams – Daily Review, Compound Review and member submitted paper claims review. Each team has processes to confirm that the pharmacy or member properly submits claims.

1.191	Does the prior authorization rule for drugs used to treat Hepatitis-C (Harvoni or Viekira Pack) take into account severity of illness? If yes, provide a copy of the complete criteria for approval.

Response:

No. Our Hepatitis-C criteria does not restrict coverage based on severity of disease.

1.192	Describe medication compliance and adherence therapy programs.

Response:

For mail order, we maintain a Refill Reminder Service to increase medication compliance. We auto-generate reminders to members of their next refill once they have used 66 percent of their medication.

Members can manage their supply of maintenance drugs through our easy to use automated refill and renewal tools. Aetna Rx AutoFill is an automatic prescription refill and renewal program for members using home delivery. Members can enroll either online or by calling Member Services.

Members can choose how to receive their reminder:

- An e-mail sent to their e-mail address
- A voice mail sent to their cell phone
- A text message sent to their cell phone
- A letter mailed to their home

Before having a refill dispensed, we notify members to ensure they are continuing with the drug therapy and indeed need a refill. If the member does not take action, we have the prescription automatically filled and shipped to the member. The program's goal is to improve adherence, close gaps in care and reduce health care costs. If there are no refills left on their maintenance medication, we reach out to their physician to obtain a new prescription. If members are not taking advantage of the Aetna Rx AutoFill program, they will receive letters encouraging them to enroll in the program from time to time.

Specialty Pharmacy Therapy Compliance

Depending on the specialty drug prescribed or disease type, we clinically drive each member's prescription through our state-of-the art clinical informatics platform, COMPASS. This platform automatically triggers appropriate nurse follow-up in a decision-tree/branching logic fashion. COMPASS generates alerts in the clinician's workflow indicating when a specific member follow-up or refill is due.

Active Refill to ensure continuity of therapy

Our active refill service encourages member compliance. Through this service, we contact members seven days before their next refill renewal date. This allows members a chance to discuss their treatment progress and be assured their next refill is on 's way.

During this call, we ask members questions to ensure they are taking the correct dose and to discover whether they are experiencing any unmanageable side effects that might interfere with therapy compliance.

Risk stratifying and engaging members

If our assessment indicates the member needs further clinical support, our nurses risk stratify the member and provide follow up assessments as needed.

Every time a nurse or pharmacist speaks to a member, they update that member's electronic medical record (EMR) with the conversation, date and topic. We also list each teaching session in this EMR.

Critical Package Recovery Program

We also maintain member compliance through the Critical Package Recovery Program. This program uses online tracking to monitor over all shipped packages to ensure safe, fast delivery to the member's home, physician's office or to any other location the member chooses. Members receive all specialty drug shipments, including standard supplies for self-injectable drugs, free of charge.

Payment options

When necessary, we will work with the member to research viable financial assistance programs and payment options for any out-of-pocket expenses so the member can continue their specialty drug therapy.

Adherence Therapy Programs

We offer adherence programs to reduce overall costs, improve medication adherence and close gaps in care. We are committed to you and your employees on the issue of adherence. We work diligently to improve the member experience, helping them achieve optimal health and ultimate savings to you and their plan.

We have described the programs we currently offer. Unless otherwise noted, our adherence programs are available at no additional cost.

Pharmacy Advisor Counseling

We alert pharmacists at local CVS/pharmacies to counsel members regarding diabetes and cardiovascular conditions. We provide the pharmacist with the information they need regarding the member right away. The pharmacists receive training to address diabetes, as well as high blood pressure, high cholesterol, coronary artery disease and congestive heart failure. They can see any applicable gaps in care or refill-related issues and address them with the member.

Members using our home delivery program also receive telephonic counseling for diabetes. We have one of our pharmacists call the member when we receive their prescription and the advisory notification.

Adherence to Drug Therapy

As part of our Pharmacy Advisor counseling program, we engage members through education and reminder communications. This solution monitors different drug classes used to treat various high-cost disease states. We identify members using one of these drugs, when they fill a prescription. We then engage the member in the following ways:

- Adherence Education Letter – Approximately 10 days after the first fill
- Refill Reminder Message – Approximately 15 days before the next refill
- Missed Refill Communication – Approximately 10 days after a missed refill

Gaps in Care

This program uses pharmacy claims data to identify gaps in diabetes care that can negatively affect the member's health. We reach out to both the member and the treating physician to fill the gap. Once we identify a gap, both the member and the treating physician receive a letter. The letter explains the gap in care and the steps the physician and member can take to close the gap.

Specialty Pharmacy Adherence Support

Our specialty care management nurses receive monthly reports for members taking specialty drugs. They review these reports to identify members not filling their prescriptions. A nurse calls a member who is not complying with their treatment and encourages them to continue taking their prescribed medication while providing any needed support. The nurse tracks the conversation with the member and when appropriate, contacts the prescribing physician to discuss the member's compliance.

Chronic Medication List Report

Our Chronic Medication List Report is an online report that we update monthly to allow the physician to see how we scored them on a variety of factors including drug-to-drug interactions. The physician can see which specific members had drug-to-drug interactions. They can then choose to either discontinue one of the interacting medications or change it to a different drug. This ensures that members do not continue taking drugs that negatively impact their health.

Aetna Healthy Actions – Rx Savings℠

We offer Aetna Healthy Actions Rx Savings to encourage members living with chronic conditions to continue taking their drugs. Compliance may lead to improved health outcomes and a healthier lifestyle.

The conditions/drug classes include diabetes, asthma, heart failure, high cholesterol and high blood pressure. Members receive reduced copays for generic and preferred brand drugs when taking drugs within the specific therapeutic classes. We offer this program for an additional fee to self-funded customers.

Summary

Our Gaps in Care and Pharmacy Advisor counseling programs are available to all customers as part of our core enhanced pharmacy benefits management plan. Self-funded customers can opt-in to any of these programs, at no additional cost. When you opt into the Pharmacy Advisor Counseling program, we include our Adherence to Drug Therapy and Aetna Rx AutoFill at no additional cost. We recommend that you take advantage of these programs that we have designed to assist in member compliance and lowering future medical costs.

1.193	Describe how outcomes for specialty drug management programs (ROI, Clinical Results, etc.) are reported.

Response:

We track interventions and outcomes each time members interact with Aetna Specialty Pharmacy®. We can track:

- Any side effects or therapy-related issues that they express
- Any clinical intervention that the clinician suggests
- Interventions and outcomes by disease state

We can report intervention and outcome calculations by group. This calculation includes the following information, which we quantify and use for outcomes data, productivity reports and validation:

- Problem identification
- Action taken
- Problem resolution
- Monetary effect of resolution (if applicable)
- Future cost savings for you as result of interventions, as appropriate

1.194	Describe policies for lost medication, vacation supplies and overseas supplies for prescription early refills.

Response:

To ensure that members comply with therapy, we have policies in place to provide replacement medication for members when they need them.

Lost, stolen or damaged medication

Our standard is to exclude replacement supplies. Under a self-funded arrangement, you may choose to request that we cover replacement supplies. For lost, stolen or damaged medication, we would then work with members to override the refill-too-soon edits which will allow the retail pharmacy to dispense the replacement drug.

Vacation

For members who will be on vacation and away from their local retail pharmacy when they are due for a refill, we provide one refill, in addition to their normal refill. Members traveling outside the country may be eligible to receive additional early refills up to six month based on the length of time outside the country. Members should request the vacation override at least five days (seven days for specialty drugs) before their departure date. The State will be able to determine the number of fills the member can have dispensed. Prescriptions can be written for up to a one year supply of the medication.

Overseas or Claims Filled Outside the United States

At your request, we can process paper foreign claims according to existing standard processes. When members need to use a pharmacy outside the United States, they pay the full drug cost at the pharmacy and submit a foreign claim form to us for reimbursement. If a foreign claim form is unavailable, the member may use a standard paper claim form, clearly indicating that it is a foreign claim.

We require the following information to process foreign claims accurately:

- The country where the member filled the prescription
- A receipt for payment
- The amount paid in the currency of the country (reimbursement will be in U.S. dollars)
- Legible drug names and dollar amounts

- Copays are applied to foreign/international claims based on the benefit you select

We have drug names researched to ensure that they match a U.S. equivalent. We also have dollar amounts converted to the exchange rate in the country of origin, based on the exchange rate for the fill date. If information is not legible, we return the claim to the member for assistance. We apply copays to foreign/international claims based on the benefit you choose.

Emergency refill

In a disaster, we relax our policies to assist members in the disaster areas. We override any precertification or step therapy programs. In addition, we override any refill too soon edits. If members can use retail pharmacies, we have the pharmacy fill their prescriptions. If a retail pharmacy is unavailable, we have drugs shipped from home delivery to any requested location.

Processing override requests

To process an override request, pharmacists need to call our Pharmacy Help Line and request a claim system override. We may require a new prescription from the prescribing physician. Certain drugs subject to misuse or abuse may require further review to obtain authorization.

Members are responsible for paying the applicable copays at their standard retail rate. Any refills requested above the maximum 90-day supply will need approval from a pharmacy associate.

1.195	Describe policy for synchronization of prescriptions (refer to Legislative Bill 442). (5) For purposes of this section, synchronizing the patient's medications means the coordination of medications for a patient who has been prescribed two or more medications for one or more chronic conditions so that the patient's medications are refilled on the same schedule for a given time period.

Response:

We can coordinate refill and renewal schedules for members taking multiple maintenance medications so that they may pick up all medication refills in a single pharmacy visit according to state-specific requirements related to synchronization. We developed logic called Script Sync Prorated Cost Share within the adjudication platform that is used to set up medication synchronization and copay proration for each of our lines of business. This logic can be customized and allows for medication type selection to include and exclude different drug classes as required by legislation. The copay proration logic takes the days' supply and divides that by the copay amount and then multiplies the total by the days' supply submitted to ensure the member is being charged appropriately. Similar logic is in place to ensure the health plan is being billed appropriately based on the per unit ingredient cost of the medication; the dispensing fee is paid in full, according to the contracted rate.

Below is the process for the pharmacies:

- If synchronization is in the best interest of the member, the pharmacist should discuss medication synchronization with the member and obtain their approval.
- Pharmacist should select the next required medication refill due. This is the "Anchor Medication".
- When synchronizing medications to the "Anchor Medication", pharmacist can enter an override code for the other maintenance drugs to allow for a partial fill of those medications.
- On each partial fill, Pharmacy should enter a specific code to override any refill too soon rejects.
- Pharmacy should bill for a partial fill of the synchronized medications(s) and dispense enough days' supply to align with the Anchor Medication.
- If member copay is applicable, the copays on the early refills will be prorated for the days of medication dispensed.
- Pharmacy will receive its' normal dispensing fee.

1.196	Provide a detailed description of how drugs that are preferred versus non-preferred are determined.

Response:

We design our formularies to meet member, health care professional and customer expectations for quality, cost-effective pharmacy benefits. Our formularies include FDA-approved brand and generic drugs, including specialty drugs. Our Pharmacy and Therapeutics (P&T) committee makes all formulary decisions. They conduct an extensive clinical therapeutic class review to determine each drug's safety and effectiveness.

Typically, when a brand has an appropriate generic alternative available, we designate the generic as the preferred drug and the brands will move to the preferred brand or non-preferred tier. If there are no generics available for a specific drug class, but there are multiple brands available, then we review the drugs clinical efficacy and cost factors in order to determine which brand drugs we designate as our preferred drugs.

Please note we may also consider drugs not on the formulary to be non-preferred or we may contractually exclude them.

We exclude drugs on the Formulary Exclusions list unless the member's physician first obtains a medical exception. Coverage is typically subject to precertification, step therapy, quantity limits or other plan terms and conditions, but can vary by plan.

Only members in a three-tier copay benefit plan are subject to increased cost sharing for non-preferred brand and generic drugs. Members in a three-tier plan pay a lower copay for preferred generics, a middle copay for covered preferred brands and the highest copay for drugs not listed on the formulary.

Our formularies are subject to change. The most current version is available online at **aetna.com**.

1.197	Describe how individual physician prescribing patterns are monitored. Describe what actions are taken with physicians who have a high degree of non-compliance.

Response:

We use national, regional and market data for program analysis. Our Aetna Informatics team measures physician performance and quality of care. We collect pharmacy, medical and laboratory data to evaluate and help improve physician performance. We then use this information to develop appropriate management programs. With Aetna Informatics and our experienced team of pharmacists, we have the resources and systems to perform the following:

- Evaluate the performance of participating physicians to help promote quality and affordable drug prescribing and pharmaceutical services
- Integrate pharmacy and medical data to support disease management programs and help promote improved treatment outcomes
- Develop formulary programs encouraging physicians to consider prescribing therapeutically appropriate, cost-effective medications
- Provide access to drug utilization review information to help pharmacists at participating pharmacies promote safe, appropriate drug use

Because we are a truly integrated carrier, we can leverage our existing relationships with health care professionals. We are continuously collaborating with the medical community to promote member health and safety. A few examples of what a truly integrated PBM brings to the table include:

Encouraging safer opioid prescribing

Prescriptions for opioids like hydrocodone and oxycodone have increased 340% over the last two decades*. We are supporting the Center of Disease Control's (CDC) efforts to reduce over-prescribing of opioids by working directly with our medical community. Based on our claim data, we are now sending letters to network physicians who are in the top 1 percent for prescribing opioids. Through this letter, we notify them that they are outliers and educate them on CDC best practices for prescribing opioids.

Fighting antibiotic resistance

Another global health problem we're addressing is antibiotic resistance. This threatens the efficacy of last-resort treatments for deadly infections. According to the CDC, at least two million Americans become infected with antibiotic resistant bacteria each year.

We leverage our data capabilities to identify high-risk antibiotic super-prescribers and collaborate with the CDC. Together we are working towards reducing unnecessary antibiotic prescribing. When we identify these super-prescribers, we send a letter to them. We also continue to encourage safe prescribing habits, sending thank you letters to clinicians who follow appropriate prescription treatment guidelines. The United Nations General Assembly recently recognized Aetna for these efforts as the only national payer to commit to a series of efforts that promote antibiotic stewardship.

In 2018, we further enhanced this program by collaborating with multiple State Health Departments in regions with high rates of antibiotic overprescribing. To date, Aetna has notified over 2,500 high prescribers, resulting in a 16 percent decrease in inappropriate prescriptions among those identified in 2016. In 2019, we plan to expand our work with the CDC to include additional states.

Helping physicians find gaps in care

Pharmacy Advisor Counseling®

Through our Pharmacy Advisor Counseling® program, we identify opportunities for improved diabetes care through a daily review of pharmacy claims that we run against clinically based rules. When we identify a gap in care that can negatively affect the member's health, we send an alert to the prescribing physician to address gap. The physician receives an evidence-based recommendation to address the gap in care.

MedQuery ®

Through this program, we identify opportunities to enhance care by empowering physicians with information that they can use to improve outcomes and avoid adverse events. We analyze and share pharmacy, medical, lab and demographic data with physicians to provide them with a broader clinical view of members. We review data every week and compare it against treatment recommendations to identify potential errors, gaps, omissions or co-missions in care. Available for an additional fee.

Suggesting ways to improve therapy

We provide the Selected Members' Clinical Information Lists to prescribing physicians as part of our quality management initiatives. Through these lists, we give physicians actionable information for reviewing members' treatment and adherence.

We profile members with asthma, diabetes and cardiac disease. We provide a list of the physicians' patients to them when the member may benefit from an adjustment in their therapy or a review for medication adherence.

- Example 1 – The list points out that a physician's patient with diabetes may not be compliant with prescribed lipid-lowering

medications.

- Example 2 – The list informs a physician that their patient with atrial fibrillation shows no evidence of using the drug Coumadin, which may help reduce the risk of stroke.

These reports also identify members with potential drug interactions or evidence of six or more prescriptions dispensed simultaneously. Physicians can access the lists on our secure health care professional website or through NaviNet®.

***cdc.gov/vitalsigns/opioid-prescribing/**

1.198	Briefly describe methods currently in place to influence prescribing behavior. Include the process for State to opt-in/out of these programs.

Response:

Please refer to our response for number 1.197.

The State can choose to not Opt-In to the Pharmacy Advisor Counseling® and MedQuery programs. The other programs and processes described above are included as part of our core pharmacy benefit services and in place to encourage member safety and compliance. We welcome the opportunity to further discuss these programs with you in order to meet your needs.

1.199	Provide a copy of any physician score card or other reporting that is provided to clients.

Response:

We don't use provider performance scorecards. However, we do communicate treatment opportunities to improve care. Our evidence-based MedQuery® program identifies the opportunities and faxes them to doctors.

The system automatically generates these communications called Care Considerations[SM]. We base Care Considerations on a member's:

- Medical and pharmacy claims
- Laboratory data
- Self-reported information

We add new data to the member profile on a weekly or biweekly basis, as it becomes available. This allows us to address current, relevant care issues. We also send Care Considerations to members who we identify for the disease management program.

Each Care Consideration we send to doctors includes:

Reference(s) to the relevant clinical evidence of the recommendation

A survey asking the doctor to provide feedback on the appropriateness of the recommendation

Doctors can also call our toll-free number and discuss our findings and the patient's care plan with a nurse or medical director.

1.200	Describe the process for the State to have managed injectable programs administered.

Response:

We manage injectable programs through Aetna Specialty Pharmacy®. Specialty pharmacy services are included at no additional cost to you as part of our core pharmacy benefit. We have a centralized pharmacy and customer service center located in Orlando, FL. From this facility, we provide high-touch, therapy-specific support services to members living with complex conditions.

Our dedicated team of pharmacists, nurses and pharmacy CSRs can address all therapy support needs through our toll-free number. Regular business hours are Monday through Friday, 8 a.m. to 8 p.m. ET. Our clinical representatives remain available for member education and support 24 hours a day, 7 days a week.

Transition of Prescriptions

We will work with your current vendor to obtain the necessary information when transitioning members to Aetna Specialty Pharmacy. We transition all members to ensure a smooth transition and avoid disrupting therapy. Our transitioning process involves:

- Data transition files – We receive three separate industry standard open refill files (test, production and lag) which includes prescriptions with open refills. The file excludes the following prescription types:
  - Expired
  - Cancelled
  - Controlled substances
  - Compounds

Additionally, current vendor may provide, upon our request, a Specialty User Report (SUR). This report provides information on all specialty members with or without refills. We use this information when initiating member outreach to coordinate with the member and their physician to ensure seamless care.

- Multiple conference calls – We share multiple conference calls with the current vendor. We agree on a transition date for each file, normally six weeks before the implementation date (test), implementation date (production) and one to two weeks post implementation date (lag).

- Discuss high-touch members – Upon receipt of the test file, we review, identify high-touch members and initiate appropriate action for each prescription that requires special handling.

- Contact prescribing physicians – Our pharmacists may contact prescribing physicians to obtain a new member prescription for swift transition or to learn more about the members current prescription.

- Contact members – We send each new member a welcome packet which includes a notification letter and current specialty drug list. We include the service start date, instructions for the first shipment, a description of our services, FAQs and tips for success. We begin calling members one week after they receive their welcome packet. Our nurses call each high-touch member directly.

- Verify prescription receipt – We perform a review to confirm receipt of all transitioning member prescriptions.

TRANSPARENCY TOOLS	
1.201	Describe the capabilities regarding member access to: a. Physician and hospital quality and/or outcomes data b. Physician and hospital ranking or premium designation c. Physician and hospital pricing data by procedure by provider

Response:

Our goal is to provide our members with objective information to help them make more effective decisions on where to seek necessary care. We developed an algorithm to showcase high quality providers and facilities in provider search where applicable.

We use the following designations in our tool to indicate high quality providers:

- Institutes of Excellence™
- Institutes of Quality®
- Aexcel®

When a member performs a facility search, if that facility is an IOE or IOQ facility, the IOE/IOQ designation shows with the search result. In addition, users can select to search for these types of facilities from the guided search tiles on the main page.

Our provider search also identifies Aexcel®-designated specialists, determined through a review of clinical performance and cost efficiency measures. In addition, it identifies physicians who are recognized by Bridges to Excellence and the NCQA's Physician Recognition Programs. The Physician Recognition Programs include:

- The Diabetes Physician Recognition Program
- The Heart/Stroke Physician Recognition Program
- Physician Practice Connections
- Physician Practice Connections - Patient Centered Medical Home™ Recognition

We recently included new designations for network surgeons experienced in gender confirmation surgery, also known as gender reassignment surgery. The two designations are:

- Gender Reassignment Surgery top or chest
- Gender Reassignment Surgery bottom

Cost estimator

Our cost estimator helps users shop for health care services just like they shop for other items by comparing price, quality and convenience.

When searching for a procedure within our digital platform, members see the out-of-pocket costs associated with each provider displayed. The member can view a detailed summary of their out-of-pocket costs and how they were calculated based on the health plan and provider network, the procedure and the member's real-time deductible and co-insurance information. The tool typically bases cost estimates on two years of aggregated claim history for a particular procedure or diagnosis at the provider level.

Knowing these costs in advance can help members budget for and manage health care expenses. It also makes it simpler for members to discuss their financial responsibility with providers.

Our cost estimator empowers members to anticipate their health care costs, compare costs and quality between providers and decide where to receive care. We are committed to maintaining and enhancing our position as a leader in transparency. We feel that the level of detail and accuracy provided by our cost estimator goes beyond other estimators and helps people better plan for and budget for their health care services.

low it works

Claim system technology

We leverage an analytical data approach to price transparency. We provide estimates more than 300 for service bundles, which represent the most likely combination of services that may be performed together in a doctor's office or in a facility setting. We derive these bundles from our own historical claims experience and include all related costs from admission to discharge. Cost estimates are typically based on two years of aggregated claim history for a particular procedure or diagnosis at the provider level. Our cost estimator updates the pricing and quality indicators in real-time.

In-network

Our cost estimator can calculate in-network costs for certain non-emergency, highly utilized services performed by doctors and other health care professionals directly contracted with Aetna. These in-network services include:

- Physician office visits
- Surgical procedures
- Diagnostic tests and procedures
- Emergency room services
- Urgent care services

This information can be extremely beneficial when members look at certain non-emergency, outpatient services such as an MRI, as it can help them to understand where they might find the most cost-effective care.

Out-of-network

Estimated costs are not available for all procedures and services. Estimates are only available for providers with sufficient claims history.

1.202	Describe capabilities toward educating members on price transparency and quality, include any decision matrices to help guide members in making a decision.

Response:

Our cost estimator helps users shop for health care services just as they shop for other items by comparing price, quality and convenience.

When searching for a procedure within our digital platform, members see the out-of-pocket costs associated with each provider displayed. The member can view a detailed summary of their out-of-pocket costs and how they were calculated based on the health plan and provider network, the procedure and the member's real-time deductible and co-insurance information. The tool typically bases cost estimates on two years of aggregated claim history for a particular procedure or diagnosis at the provider level.

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Estimated costs are not available for all procedures and services. Estimates are only available for providers with sufficient claims history.

Rating and reviews

We offer a provider rating and patient review feature which appears in our cost estimator's search results. This includes more than 1.5 million reviews/ratings for over 250,000 providers from over 20 sources. These ratings and reviews allow members to get an idea of other patients' experiences with a provider. Ratings are based on a 5 star system which provides a consistent comparison metric members can consider when selecting providers. When a member views provider details, up to three review snippets can be read. To read more or to submit their own rating and review, members simply click on a link to our vendor DocSpot.com.

We expect that future enhancements will improve our cost estimator with additional plans, services, facilities and health care professionals.

Pharmacy Drug Pricing Tools

Members won't be surprised at the pharmacy counter when they use our cost estimator tool. Available on both our member website and mobile app, members simply type the drug name into the tool and quickly estimate:

- What might I pay for this drug?
- What does my employer pay?
- How much could I save with the generic?
- How much could I save at mail?

Example of the member experience – After leaving her doctor's office, a member named Susan types her newly prescribed drug into the cost estimator tool using the Aetna Mobile app. She immediately sees a table that shows her:

	Brand*	Generic*
90-day supply at home delivery	**$100.00 for 3 months** *$33.33 per month* *You pay 10% of the cost.* *Your Plan pays $917.08 / 3 months*	**$82.61 for 3 months** *$27.54 per month* *You pay 25% of the cost.* *Your Plan pays $247.82 / 3 months*
30-day supply at retail	**$65.00 for 1 month** *You pay 18% of the cost.* *Your Plan pays $301.29 / 1 month*	**$50.00 for 1 month** *You pay 19% of the cost.* *Your Plan pays $208.90 / 1 month*

** The figures in this table are illustrative only. We base the actual estimated drug price on the member's specific plan design, the reimbursement rate in the state where the drug is dispensed, the prescribed quantity and dosage.*

In addition to this cost information, Susan has easy access to detailed drug information. All she needs to do is click on the drug name to answer questions like:

- What is this medicine?
- How should I use this medicine?
- What if I miss a dose?
- What may interact with this medicine?
- What side effects may I notice from taking this medicine?
- Where should I keep my medicine?

We want to make sure your employees like Susan know what to expect at the pharmacy and understand all the ways they can save money. We find this tool is particularly helpful for members in coinsurance and high-deductible plans in which out-of-pocket expenses can vary. The tool can provide a cost estimate even if the member is uncertain of the drug strength.

1.203	Can members be messaged on more cost effective treatment options? For example, if a member has a non-emergent emergency room visit that does not result in a hospital admission, will a message be sent to the member suggesting alternatives?

Response:

Our goal is to ensure that every interaction is meaningful and helps encourage the member take action on their health. We will deliver messages designed to trigger action based on data analytics.

We outreach to members when we have relevant information to share or are engaging in a personal way. By leveraging member information and health data to prioritize and contextualize personalization, we can increase utilization and promote specific and relevant actions. Based on a member's preferences, our communication channels include:

- Push notifications
- In-app messaging
- Email
- Text

Next Best Actions

Next Best Actions are a core piece of our member engagement strategy. They are based upon a combination of:

- Data analytics
- Predictive and behavioral modeling
- Demographics
- Claims history
- Generative research
- Geo-location attributes specific to the member

Our data analytics personalizes the delivery time of specific messages, delivering them at the time each individual is most likely to read and act upon the message. Some examples of messages a member may receive include:

- Flu immunization – Members who have not received a flu shot will receive a proactive notification at the beginning of flu season encouraging the member to receive a flu shot at a more appropriate location (for example, onsite clinic, CVS pharmacy or doctor's office)

- Primary Care – Members with no recent claim for a Primary Care provider will receive a notification encouraging them to schedule an appointment with their current PCP or find a new one. They will be able to see options and then click to call or schedule an appointment through the tool.

- Medication adherence – Members with a condition requiring ongoing medications will receive proactive notifications reminding them when it's time to refill the medication. They will also receive educational notifications on the availability of alternative options such as mail order and generic substitutions.

While we are continually evolving our library of Next Best Actions, additional alerts include lab steerage, preventative exams, telemedicine usage and urgent care utilization.

We measure the effectiveness of outreach based on outcomes. If needed, we determine alternative messaging or communications channels. We also use analytics to ensure that we deliver the most meaningful message first (for example, clinical and health related).

1.204	Is member messaging available electronically, telephonically and/or through the mail? What types of messages are sent to members?

Response:

MedQuery offers our Member Messaging program, which mails hard-copy consumer versions of Care Consideration (Health Alert) directly to members at the same time as the Care Considerations sent to their physician. Care Considerations are not wellness related. Members can request to be opted out of the member messaging.

Examples of Care Considerations (severity level two) that are generated by MedQuery:

- Diabetes – Consider Adding a Statin
- Chronic Hepatitis B - Consider Screening for Hepatocellular Carcinoma
- Asthma – Consider Step 2 Therapy
- Primary Prevention of Heart Disease – Consider Adding a Statin
- Diabetes - Consider HbA1C Monitoring

- Heart Failure – Consider Adding an ACE Inhibitor or ARB
- Females 65 yrs or Older - Consider Osteoporosis Screening
- High Dose Opioids - Consider Risk Mitigation Strategies
- LDL Greater Than or Equal to 190 - Consider Adding a Statin
- Pediatric Type 2 diabetes - Consider Screening for Kidney Disease
- Chronic Opioid Therapy - Avoid Benzodiazepine Use

Member Messaging is included at no additional cost is the State selects the Aetna In Touch Care Solutions program.

1.205	What steps have been taken toward improving Health Information Technology (HIT)? Describe the progress, state of development and future commitment in terms of education, communication, awareness and integration with utilization management.

Response:

We comply with the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act), which is part of the American Recovery and Reinvestment Act of 2009 (ARRA).

We have made the necessary changes to our policies, procedures, protocols and systems to comply with ARRA requirements.

Aetna Health

Our digital capabilities include the following core foundational components:

- Provider search
- Integrated cost transparency, benefits and financial information
- Claims
- Claims payment capabilities
- Wellness, including next best actions personalized to each member

We will be expanding additional functionality throughout 2019, including:

- Expanding our library of Next Best Actions
- Secure messaging and chat
- Reward integration
- Integrated user experience for members with pharmacy and dental coverage with Aetna in addition to medical
- Medication and dental price transparency
- Mail-order refill capabilities
- Additional services for specialty pharmacy medications

Using Agile SAFE 4.6 methodology, we continuously enhance our website and Aetna Health mobile app. We manage priorities according to our high-level product strategy while also focusing on immediate development needs. We are able to deploy incremental changes quickly and adjust our product delivery to ensure optimal quality upon deployment.

Long term vision

Our vision is "a world where every member is empowered to achieve a healthy lifestyle on their own terms." As a company, we are bringing together all of our products and services and presenting them seamlessly to each member so each experience is personalized. The intersection of data, analytics and consumer technology has upended virtually all consumer experiences and reset consumer expectations. We recognize the health care industry is not immune to this transformation and we intend to lead this new standard of customer experience.

Our goal is to join our members on their personal health journey and support their unique goals. Our member interactions are becoming experiential instead of transactional in nature.

1.206	Provide an implementation plan detailing the implementation timeline with a July 1, 2020 effective date. At a minimum, the Implementation Project Plan must provide specific details on the following: a. Identification and timing of significant responsibilities and tasks b. Names, titles and implementation experience of key implementation staff and time dedicated to the State during implementation c. Identification and timing of the State's responsibilities d. Transition requirements with the incumbent Contractors e. Staff assigned to attend and present (if required) at Open Enrollment f. Data and timing requirements from current Contractors to ensure transition of care and prior-authorization data is appropriately transferred

Response:

Please refer to the Implementation Solutions document included in the Exhibits section of the proposal response.

1.207	Provide detailed information on communication to the members. Provide sample communication materials such as certificate of coverage booklets, up-to-date provider network directories, request letters for clinical programs and sample EOBs.

Response:

Member communication materials we offer to the State include, but are not limited to, product brochures and overview brochures. We also offer several communication guides on topics like wellness, transparency and consumer-directed health plans to help you successfully engage your employees in their health benefits and health care decision making.

Pre-enrollment materials

Pre-enrollment communication materials may include:

- Discount program flyers
- Special program flyers
- Wellness program brochures
- Flyers and html emails promoting our online tools and resources
- Provider search

In addition, we provide communication materials on other plans and programs available to the member, such as pharmacy and dental flyers, where appropriate.

Post-enrollment materials

Post-enrollment materials may include:

- ID cards
- Plan documents
- Wellness educational information and reminders
- Html emails and electronic newsletters on educational, quality and patient safety topics

Please refer to *Sample Communication Materials.zip*, located in the Samples and Brochures section of our proposal response.

1.208	Provide detailed information on how long it will take to print and distribute benefits literature and indicate how long it will take to print and mail identification (ID) cards after receipt of correct eligibility data. During the year, ID cards must be distributed by the Contractor within three (3) business days of being notified of the new or changed enrollment by the State.

Response:

To provide ID cards on or before the plan effective date, we need the following:

- If you use electronic submission, we need the clean eligibility file at least 15 business days before the plan effective date
- If you use paper enrollment forms, we need the clean enrollment forms 30 business days before the effective date

During the year, new members will receive their ID card within 7 to 10 business days from when we receive request.

We provide a digital image for replacement ID cards to our members. Members can view the digital ID card in approximately 48 ours after the enrollment has been updated.

1.209	Provide detailed information on its procedures and time frame to prepare for annual Open Enrollment. The State will offer an annual Open Enrollment period during which time covered members may switch plan coverage. The Contractor shall provide staff to assist State Human Resource Personnel and Administrative Services – State Employee Benefits with annual Open Enrollment meetings in various locations throughout the State. The Contractor shall have certificate books ready for distribution prior to the State's annual Open Enrollment; State will provide plan designs electronically to Contractor sixty (60) days prior to annual Open Enrollment. Describe timelines and deadlines for Open Enrollment (system updates due to plan changes or file formats, new divisions, manual workarounds, dates for last pre-OE updates, OE file updates, etc.).

Response:

We provide the following services to help employees during the enrollment process and thereafter:

- Enrollment Services - Upon your request, we provide representation at on-site meetings to help members understand the benefit plan.
- Toll-free Member Services - We provide toll-free lines staffed by customer service representatives (CSRs) who have online access to immediately answer the member's questions. Our CSRs provide the following information and promote the following services:
  - Network Information

    To help members understand how to use the network
    How to access their physicians
    How any preferred and non-preferred benefit levels operate

- Benefit Plan Information

  To explain benefits
  To explain plan requirements
  To explain covered and non-covered services

- Provider Information

  To provide background and availability of network providers
  Updated provider search information

- Utilization Management Information

  Describe our utilization management (UM) programs
  Describe referrals to a UM nurse consultant

- Internet Services - Members can log onto our website at **aetna.com** and access the following:
  - Our provider search is available to assist in the selection of providers
  - Member Services Online to contact member services with issues or questions.

We give members tools and resources that make their health care journey simpler and easier to navigate.

To support member questions prior to the plan effective date or at open enrollment, we need to have the plan of benefits so customer service representatives may respond to prospective member questions. The customer service team can be operational to answer member questions 30 to 60 days prior to the plan effective date.

1.210	Describe what a one-time implementation credit could be used for as approved by the State. (I.e. implementation support, pre-implementation audits, readiness assessments, communication plans, etc.).

Response:

The plan sponsor should only use the implementation/communication allowance to offset expenses it actually incurs as a result of moving their business to us or promoting new products with us. It can be applied to reimburse the plan sponsor for identifiable charges for the reasonable value of services performed. Some examples of the transition-related expenses it could be applied against are:

- Issuing our Summary Plan Descriptions (creating, printing, mailing)
- Maintaining our subscriber/member records due to the transition of business
- Maintaining our subscriber/member records due to the transition of business
- Our Member communications (creating, printing, mailing)
- Our system front-end charges

1.211	Describe the level of support that will be provided in assisting members in learning about benefit options.

Response:

Members can contact member services to discuss available benefit options.

The account team representatives will be available to assist members during open enrollment meetings.

Additionally, ALEX®, our virtual benefits advisor tool, offers members a simple, engaging and informative enrollment decision support experience. ALEX simplifies the process of choosing a benefits plan as it personalizes recommendations for each individual employee.

Personalized user experience

ALEX, the friendly virtual host, provides employees information about how their plans work and helps them make the best possible benefits choices for them and their families. ALEX also points out opportunities to save money on taxes along the way. ALEX begins the session by learning about the employee so that he can tailor his approach and content to the needs of the individual. ALEX uses plain language to ask questions about topics such as:

- Family status
- Dependents
- Health care needs
- Lifestyle
- Financial status
- Risk tolerance

ALEX does all this while avoiding the insurance jargon often associated with choosing a benefits plan.

The online and mobile-friendly experience includes audio, on-screen text and animations to ensure an engaging, personalized interaction.

Convenient access and consistent messaging

ALEX meets employees where they are and when they need it. The URL is an external experience that employees can access at work or home. ALEX provides consistent messaging and decision support no matter where employees are located.

The technology's portability also eases some of the administrative burdens and expenses typically associated with open enrollment campaigns. It eliminates and/or replaces logistical challenges of coordinating benefit trainings, especially during Open Enrollment season. Recent studies have shown timesavings, increased employee participation in CDHP plans, reduced human resources call volume and significantly lower print costs for ALEX customers. Once Open Enrollment activities are complete, ALEX can be used for onboarding and life change events throughout the year.

Broad spectrum of product and program support

ALEX is a carrier neutral solution that supports a customer's total benefits program. This includes both Aetna and non-Aetna benefits. ALEX can provide decision support and education guidance for any combination of the following.

Full ALEX includes:

- Medical
- Dental
- Vision
- Tax savings (FSA and HSA guidance, dependent care benefit, commuter benefit)
- Life insurance (Accidental Death and Dependent Insurance)
- Disability
- Critical illness
- Accident
- Pharmacy Savings
- EAP
- Robust Analytics

Additional Buy-up tools:

- 401(k)-403(b) (Retirement)
- Making the Most of Your Plan Single Tips
- Benefits Sneak Peek (2 options – for Open Enrollment and New Hires)
- Medicare Enhancement Module
- Leave of Absence

Proven results and valuable reporting

ALEX has earned high marks from both members and customers. Feedback has consistently shown employees value the education and decision support it provides.

In addition to traffic and utilization reporting, we provide the customer with direct employee feedback collected through the tool as ALEX includes a short survey to capture feedback on the user's experience. Recent open enrollment results showed:

- Over 90 percent of surveyed users found ALEX to be a helpful resource in picking their benefits
- Over 90 percent of surveyed users confirmed ALEX gave them a better understanding of how their benefits work

While this feedback validates the positive impact of the technology, it also highlights the most common benefit questions that employees may still have so that the customer can adjust and refine their communications strategy.

Additionally, customers feel that the experience accurately supports their benefits strategy and have reported a high level of satisfaction. Find out more at **meetalex.com/resource**.

To view a demo and see ALEX in action, visit, **myalex.com/placeholder-industries/2019.**

1.212	Provide a description, capabilities, benefits and execution process of all Wellness Programs that could be made available to the State. Describe experiences administering various wellness program structures. I.e., requirement-based/point-based/etc.

Response:

Our proposal includes the Aetna Healthy Commitments® Enhanced Wellness Package. The Enhanced Package includes all of the Core offerings, along with onsite biometric screenings, our Get Active℠ fitness challenges and incentives for completing the health assessment and one online health coaching program.

Personalized wellness solutions

Our Enhanced package includes a suite of programs to help your employees manage their well-being on their terms and according to their preferences for engaging in health improvement activities.

Simple Steps To A Healthier Life

This personalized, online health and wellness program includes a suite of online health coaching programs in addition to a health assessment. Simple Steps helps you improve the health and productivity of your employees. The program encourages participants to identify and reduce health risks and improve and maintain healthy lifestyles. This results in better health outcomes, which can lower costs for you and your employees. Simple Steps focuses on prevention and health risk reduction to help you address health issues critical to the success of your business.

Aetna Personal Health Record (PHR)

The Personal Health Record is a secure, online tool that helps members keep track of doctor contact information, prescription drugs, immunizations and medical tests. Each time a claim is filed, the tool automatically updates. Members can also add additional information about their health that is not reflected by claims data, such as family health history or the use of over-the-counter medications.

But our PHR is more than a data repository. Our patented CareEngine technology continuously evaluates data to identify any conflicts or gaps in care, as well as other opportunities to improve the member's health. The CareEngine then generates health alerts and reminders specific to that member that which appear in the member's PHR.

Informed Health Line

Our toll-free nurse line, which is staffed around the clock with registered nurses, helps members make more informed decisions about their health. Our nurses teach them how to communicate more effectively with their doctors and save money by learning how to get the right care at the right time.

We also offer Informed Health Line Service Plus as a buy-up option, which offers additional communications and reports.

Aetna Get Active!℠

Aetna Get Active is an online wellness program that offers interactive, seasonal fitness challenges to keep people moving and motivated throughout the year. This worksite health program drives engagement and helps create lasting behavior change by incorporating team fitness challenges with social networking and competition. Virgin Pulse, an industry leader in the wellness arena, powers our Aetna-branded program.

Decision and health education support tools

We offer and promote reliable decision support and health information tools because we believe it is critical for our members to understand their health needs and actively participate in their treatment.

Health Decision Support

Our Health Decision Support gives members the information they need through our member website to make better decisions about their health. It helps them understand a variety of conditions and treatments and explains procedures, tests and surgery options. After learning more about their options, members are better able to select the course of action right for them and discuss those options with their doctor. The programs encourage thought, discussion and preparation. They don't diagnose a patient's condition or favor one treatment over another.

Healthwise® Knowledgebase

Available in both English and Spanish, our user-friendly online tool features information on 6,000 health topics, 600 medical tests and procedures, 500 support groups and 3,000 medications.

Member website and mobile technology

Our secure member website is an online resource for personalized benefits and health information. Available 24/7, our website gives members easy access to not only information such as claims, benefits and a provider directory, but also a health assessment, online health coaching programs, their PHR and a vast amount of health and wellness information.

Our members have access to mobile applications (or "apps") and a mobile website. Our consumer research found that the most appealing health-related mobile apps help users save money and easily access health information. Consumers particularly favor resources that offer personalization and convenience – with an emphasis on items like online provider directories, pricing tools and personal health records. Based on this research, we offer mobile access to a variety of features including our online provider directory, the Aetna PHR, Price-a-Drug, claims search and electronic ID cards.

Worksite Biometric Screening Services

As part of our Enhanced Wellness Package, we offer the convenience of onsite biometric screenings through our healthcare partner, Quest Diagnostics. We provide a simplified biometric experience for your employees, right at your workplace that includes convenient scheduling, easy access to results and offsite alternatives for those who can't make the event. Onsite screenings include:

- Core screening panel - Fasting lipid and glucose panel which includes total cholesterol, HDL, calculated LDL, calculated cholesterol/HDL ratio, triglycerides and glucose, height, weight, blood pressure and body mass index (BMI)
- Core screening panel- Non-fasting panel which includes Direct LDL, HDL, total cholesterol and HgbA1c, Height, weight, blood pressure and body mass index (BMI)

Discounts

Our Aetna Discount Program offers members choice and flexibility. They get a variety of discounts on products and services that keep them healthy, fit and help them save money. The Aetna Discount Program, available to all Aetna medical plan members, includes the following discounts:

<u>At home products</u>

Through Omron Healthcare, members get discounts on blood pressure monitors, pedometers and activity trackers, electrotherapy TENS (transcutaneous electrical nerve stimulation) units and many other Omron products.

Fitness

Our fitness discounts help members save on gym memberships, health coaching, fitness gear and nutrition products that support a healthy lifestyle.

Hearing

Members save on hearing exams, hearing aids, batteries, repairs and other hearing aid services from Hearing Care Solutions and Amplifon®.

Hearing Care Solutions

Hearing Care Solutions offers:

60-day trial period with money-back guarantee to ensure your satisfaction

Annual complete hearing evaluation at no charge

Hearing aids available from multiple major manufacturers in all sizes, styles and colors

A 3-year supply of batteries (up to 240 cells per hearing aid purchased)

1-year service follow-up at no charge with the original provider

Free routine services (cleanings, checks and battery door replacements) for the life of the hearing aid.

Hearing Care Solutions has over 2,000 providers at more than 1,300 locations.

To schedule an appointment, members call Hearing Care Solutions who schedules appointments for them. Before their appointment, members also receive a welcome packet that includes information on hearing loss, hearing aids and what to expect at their appointment.

Amplifon

Amplifon offers:

60-day trial period with money-back guarantee to ensure your satisfaction

Continuous care – one-year free follow-up, two years of free batteries and three-year warranty

A discounted rate for hearing exams

Savings on many hearing aid styles

Discounts on hearing aid repairs

Amplifon has more than 1,600 participating locations. To receive discounted rates, members call Amplifon to receive a validation packet and make an appointment with a selected provider.

Oral Health Care

We partner with ZDental to offer Aetna Branded oral health care products to members and their eligible family members at a discount.

Z Dental products include:

Z Sonic Toothbrush and Replacement Brush Heads

Oral Health care kits to fit all needs

Adult Travel Kit
Teen Kit
Kids Oral Health Kit
Baby Oral Health Kit
Travel/Hygiene Kit

Natural products and services

In response to the growing interest in specialty health care products and services, we offer discounts delivered through the ChooseHealthy® program[1].

With the ChooseHealthy program, members receive a discount off the normal fee for acupuncture, chiropractic, massage therapy and nutrition services.

[1] The ChooseHealthy program is provided by ChooseHealthy, Inc., a subsidiary of American Specialty Health Incorporated (ASH). ChooseHealthy is a federally registered trademark of ASH and used with permission herein.

Vision

Aetna vision discounts help members save on many eye care services and products, including eye exams, eyeglasses, contact lenses, nonprescription sunglasses, contact lens solutions and other eye care accessories.

We contract with EyeMed Vision Care to offer a network of participating vision discount providers. Members choose from a large network of optical centers nationwide including Sears Optical®, JCPenney® Optical, Lenscrafters®, Target Optical® and participating Pearle Vision® locations, as well as independent optometrists and ophthalmologists. Members get these discounts even if they have other vision benefit coverage. If they do have coverage, they should check their plan requirements first.

Weight management

Members can meet their weight loss goals, get healthier and save money with discounts on weight loss meal plans, home meal delivery options and coupons for local grocery stores, helpful online tools and coaching support.

HIGI Machine Allowance

In addition to our wellness programs noted above, we are providing a $100,000 allowance for HIGI machines.

higi is a consumer health engagement company making it easier for consumers to measure, track and act on their health data through a free nationwide network of over 10,000 FDA-cleared self-screening smart health stations located in pharmacy retailers and other community points of trust, such as corporate office locations. Enhanced by over 80 different third-party integrations (i.e. apps, devices, monitors, EHRs and more), higi's smart health stations connect across the existing healthcare ecosystem, bridging station activity with digital tools to interact with consumers on the go and extend engagement, making it easier for consumers to remain active in their health. Healthcare stakeholders use higi as a new access point to better reach, connect with and activate targeted populations into appropriate condition management programs; collect biometric and other health determinant data to stratify and prioritize; motivate consumers to take specific actions at a point of care or within the expanding care ecosystem activated by higi connectivity. To date, more than 56 million people have used a higi station to conduct over 322 million biometric tests. For more information, visit us at www.higi.com.

The higi platform qualifies and refers employees to employer-sponsored benefits through self-service biometric screening and configurable risk assessment survey tools. Payers and employers leverage the higi network and platform to digitally inform populations about available benefits, screen and identify the highest risk individuals for triage into appropriate condition management programs and targeted health services. Ongoing participation is encouraged and monitored to understand population health risks and the efficacy and utilization of programs and offerings.

1.213	Describe overall wellness solution for State of Nebraska and how it is integrated for a seamless member experience.

Response:

We have described the wellness package we are offering to the State in the response above.

Our wellness and care management programs address members' needs along the continuum of health. These programs are complementary in an overall health care strategy by providing:

- Early identification — Our health assessment identifies members with health risks and existing conditions and serves as a conduit to wellness and care management programs. Our clinicians also refer members to available programs under their benefit plan. For example, Aetna In Touch Care nurses can refer a member to our health coaching program and a health coach can refer a member to our or Aetna In Touch Care program.

- Engagement - We connect our digital tools with our care management system. It unites online and telephonic support, creating a multichannel support system that keeps members engaged.

- Clinical staff can easily access member data and insights from digital care tools to see what members are doing and understand their priorities and motivations. This results in better, more personal engagement and stronger overall care support that empowers members, improves quality and, ultimately, lowers health expenses.

- Self-reported data — When members enter information into the Personal Health Record (PHR) and into our health assessment, the data feeds into the CareEngine. This allows us to generate patient safety alerts through our MedQuery program. This is particularly important for members with existing conditions.

- Prevention and behavior modification — We design wellness programs to promote wellness, prevent the development of chronic conditions and increase awareness of health risks. Examples of wellness programs include worksite health screenings, online and telephonic coaching programs. The State may also introduce incentive programs to encourage healthy behaviors and the use of wellness programs by employees.

  Educational resources – Our wellness programs provide information that empowers members and allows them to take control of their health. Wellness resources through our member website such as Healthwise Knowledgebase, Personal Health Record and the Informed Health Line, provide valuable information to help members manage their chronic conditions.

- Data analytics – Our wellness and Aetna In Touch Care reports allow the State to view the prevalence of or potential for, chronic conditions within their employee population and also identify opportunities for improvement. This information allows you to further develop an overall health strategy that has the greatest impact on their employees' health risks and conditions.

1.214	Describe the availability of and the process to ensure members have: a. Lifestyle coaching. b. 24-hour nurse line. c. Other Wellness services, including medication adherence education.

Response:

a. We provide a best-in-class digital coaching experience that leverages our deep clinical expertise. Through Your Health Goals and Your Health Education, we provide members with the support they need to make and sustain meaningful lifestyle changes.

Your Health Goals

Your Health Goals focuses on supporting lifestyle changes, sustained engagement and improved outcomes with a proven

behavior change model. Consistent with our telephonic coaching programs, we rely on an evidence-based approach incorporating motivational interviewing, cognitive behavioral therapy and behavioral economics techniques. The approach is simple. The member selects a goal, links their values, confidence and barriers to that goal and then makes a weekly vow.

For seven days, they are presented with fun and engaging activities to help them develop the skills to overcome their barriers, enhance their confidence and develop new and healthier habits. The activities include great tips, tricks and tracking supported by helpful and easy-to-use tools like recipes, articles, videos, challenges and more. The available goals focus on healthy eating, improved physical activity and weight management. Members earn "hearts" for each activity completed that accumulate toward achieving their desired goal.

Your Health Education

These online coaching modules are dynamic and interactive, as the program incorporates logic based on the participant's responses and clinical profile and presents them with tailored and relevant information. The learning modules are typically two to five minutes long so they are easily consumable in a single session. The platform is designed for long-term sustained engagement and participants will be unable to unlock levels and redeem "hearts" in a single session. The program continually recommends additional topics to participants so they remain engaged.

The digital coaching content includes 35 categories spanning both wellness and condition management with hundreds of topics such as:

- Diabetes
- Hypertension
- Chronic pain
- Weight loss
- Exercise
- Depression
- Smoking cessation
- Stress management
- Cholesterol
- Back pain management
- Osteoarthritis
- Fitness
- COPD
- Maternity
- Women's health
- CAD
- Cancer care
- Financial wellness
- Heart health
- Medication management
- Pediatrics

We base Informed Health Line process guidelines on the following:

A comprehensive review and analysis of current medical literature, including:

- Online medical databases (such as Medline)
- Medical textbooks
- Outcomes research findings
- Technical assessments and updates

An in-depth medical review by family physicians, medical specialists and physicians involved in outcome research.

A non-directive counseling model – We encourage individuals to make their own decisions, rather than direct them to specific types of medical care. The guidelines outline how we handle specific calls and define the parameters of our care counseling approach.

Years of experience – Over time, we've refined our approach and proven its effectiveness with measurable results in member satisfaction and cost savings.

Nurses use these guidelines in conjunction with our online health information resources to encourage members with the information they need to live healthier lives.

CVS Minute Clinic

Aetna and MinuteClinic, the walk-in medical clinic inside select CVS/Pharmacy locations, have come together to give members easy access to wellness coaching and chronic condition support. It's a fast and easy way for members to focus on their health, right in their neighborhood and at a time that works best for them.

Wellness focus areas

CVS MinuteClinics clinicians provide face-to-face lifestyle and preventive coaching support to members for three focus areas:

- Biometric counseling (for members who get a screening at CVS MinuteClinic)
- Weight management coaching –including healthy diet and nutrition
- Smoking cessation

Chronic Condition Monitoring

We later added chronic condition monitoring to this program. With this, we take another step forward to engage members in managing their chronic health conditions. With chronic condition monitoring, members can get a better understanding of members chronic health conditions and and learn how to manage them. This personal support and education can improve overall health management and lead to better outcomes.

Our chronic condition monitoring services focus on these conditions:

- Diabetes monitoring
- High cholesterol monitoring
- High blood pressure evaluation

With chronic condition monitoring, we provide support through:

- Condition-specific testing
- Education
- Counseling and support services

The clinicians, who are nurse practitioners and physician assistants, deliver these services in the MinuteClinic physical locations to Aetna medical members age 18 and older.

Preventive coaching sessions are available at no or limited additional cost.
Chronic condition monitoring sessions are not considered preventive under member benefit plans and may be an added cost to members. We encourage members to check their benefit plan for any out-of-pocket cost.

How to get started

To get started, members visit www.minuteclinic.com to find a location by state or zip code. No appointment is necessary. They simply walk into a CVS MinuteClinic location and sign in at the clinic kiosk. Then, they show their medical ID card and choose a health goal to focus on. The sessions are 15-20 minutes. After the first session, the clinician and member discuss a timeframe for future sessions, if applicable. They may also receive resources from the MinuteClinic provider.

Aetna Healthy Actions℠ (AHA) can track and incent on preventive coaching sessions members complete at CVS MinuteClinics. You can elect how many preventive coaching sessions members need to complete to earn the reward.

b. Our Informed Health® Line provides members with telephone, email and chat access to experienced registered nurses to help them make informed health care decisions.

According to recent survey results, 94 percent of members said the Informed Health Line nurse helped them make a better health care decision.[1]

Program goals

The goals and objectives of Informed Health Line are to:

- Encourage members with health information to improve utilization of health care services
- Improve patient/physician relationships by encouraging members to give a clear medical history and ask relevant questions
- Promote healthy lifestyle habits
- Provide members with health information to help improve chronic condition management
- Increase member satisfaction with employer and benefit plans

Availability

Nurses are available through a toll-free telephone number 24 hours a day, 7 days a week. We provide TDD service for speech impaired, deaf and hard of hearing members. We also offer foreign language translation for our non-English speaking members.

Members may email a nurse by clicking on the "Talk to a Nurse" link within our member website. Nurses respond to inquiries within 24 hours. They can also chat with a nurse through our member website 7 days a week from 7:00 a.m. through 7:00 p.m., ET.

Additional resource

- Healthwise®Knowledgebase - Members may access Healthwise Knowledgebase, a user-friendly decision-support tool that provides clinical information on:
  - 6,000 health topics
  - 600 medical tests and procedures
  - 500 support groups
  - 3,000 medications

This tool encourages informed health decision-making and educates members on their treatment options.

- **Healthwise Video Library -** After speaking to callers, nurses may email them a link from the Healthwise video library.

Research shows that well-designed videos deliver instructions more effectively. Nurses choose from over 400 consumer-friendly videos based on the topic discussed or the member's needs. The videos combine plain language, an empathic tone and an expressive visual style that engages viewers with easy-to-understand health topics on health conditions, treatments, medicines and self-care. They are typically two to three minutes in length and members can view them online or through their smartphones.

2 Informed Health® Line Member Satisfaction Survey. October 2016.

c. We offer an onsite biometric screening program through our partnership with Quest Diagnostics.

Participant experience

We offer a simplified biometric screening experience for your employees, which includes:

- Convenient scheduling – Employees can make an appointment for a screening event through online scheduling system or by telephone.
- Offsite alternative – Employees can visit a Patient Service Centers (PSCs), purchase Home Kits or offer physician forms.
- Easy access to results –Quest provides fingerstick results at the event. They mail venipuncture results directly to the participant's home address and also make them available to the participant online.
- Access to our Metabolic Health Advisor, ALEX®,(for the venipuncture fasting and venipuncture/fingerstick Metabolic Syndrome Screenings) a virtual conversation that motivates participants to participate in screenings, explains results and risks and motivates the member to make lifestyle changes and participate in other Aetna programs such as coaching and disease management.

Core screening panels for venipuncture screens

We offer the following core screening tests:

- Fasting venipuncture panel
  - Total cholesterol - HDL, calculated LDL, calculated cholesterol/HDL ratio, triglycerides and glucose
  - Blood pressure, measured height/ weight, calculated BMI and waist circumference
- Non-fasting venipuncture panel
  - Direct LDL, HDL, total cholesterol and HgbA1c, calculated cholesterol/HDL ratio
  - Blood pressure, measured height/ weight, calculated BMI and waist circumference
- Fasting venipuncture metabolic syndrome screening
  - Total cholesterol, HDL, calculated LDL, calculated cholesterol/HDL ratio, triglycerides and glucose
  - Blood pressure, measured height/weight, calculated BMI and waist circumference

1.215	Describe the process for population risk analysis, population stratification, including predictive modeling with respect to Member outreach.

Response:

We validate and stratify members' conditions using our clinical predictive model. Members receive a clinical risk score, which is the sum of the risk of each condition. And we factor in any risk scores for open Care Considerations. We also evaluate co-morbidities, at-risk conditions, lifestyle risks and the Aetna Health Index.

Aetna Health Index measures opportunities for health improvement based on condition, age, impactability and clinical risk score. We assign a program intensity value of low, moderate or high. This intensity value tells us the degree to which our population management program can impact members' health status and clinical outcomes and which members are most likely to benefit from program interventions.

1.216	Describe the predictive modeling capabilities and the ability to benchmark the wellness program and its financial impact.

Response:

For standard case management, Aetna Medical Cost Analytics assigns a Predicted Utilization by Statistical Evaluation (PULSE SM) severity score to all our members. The Forecasted Severity Index (FSI) score represents an individual's relative predicted health expenditure for the coming year. Medical Cost Analytics extracts this information and score from our predictive modeling tool and feeds it monthly through a highly-secured network link to the Member Health tab and the Opportunities tab in our Aetna Total Clinical View SM (ATV) system. The entire care management staff can then view this score.

The scoring process is proprietary. We use cluster analysis and regression models that includes medical/lab claims, pharmaceutical, behavior health, health risk assessment surveys and eligibility/demographic data as independent variables acting as predictors of future health services usage. We cross validate the model with multiple data sets to provide a relationship between these variables and future usage. The score is based on the predicted, allowed dollars for the next year and uses the previous year experience for these independent variables.

If the State selects Aetna In Touch Care, our unique, internally developed algorithms scan your entire population to find members with potential health risks. We use claims, pharmacy, lab and self-reported data to identify members so nurses can contact members at a point in their care and treatment when it really matters.

The predictive modeling and tools identify members based on:

- Clinical urgency – It capitalizes on the critical clinical window of opportunity for member intervention and support. In fact, this predictive technology identifies members at risk for future avoidable admissions in the next 6 and 12 months.
- Financial impact – It assesses member need and the likelihood that the member will incur high cost expenses in the near future
- Clinical impact – It provides the ability to prevent further member decline or improve or sustain clinical outcomes

Our algorithms identify members and assign individual risk scores. Based on the scores, we stratify members as high, moderate or low. Then we match them to the right level of program support and perform outreach and intervention for their risk level.

We refresh scoring data monthly, based on updated claim and self-reported data.

We further identify participants for Aetna In Touch Care Solutions program through daily opportunity triggers. Examples of daily triggers include but are not limited to:

- Acute inpatient admissions – Members identified through the precertification process receive pre-admission phone calls to discuss their upcoming hospitalization
- Discharges – Members discharged from a hospital (excluding maternity and behavioral health) receive a post discharge call
- Advanced illness – Members identified for home or inpatient hospice care related to an advanced illness
- All members with at least $75,000 claim threshold annually
- Multiple provider or ER utilization
- Oncology admissions with primary and secondary cancer diagnoses
- Other proprietary trigger activities

We periodically review our triggers for program performance and clinical validity.

Our health assessment report includes benchmark data. The Health Risk Profile section of our report compares the State's data to Healthy People 2010 health objectives. Details include a comparison of:

- Healthy People 2010 health indicators for the percent of the national population at risk
- Healthy People 2010 target percentage and percentage of participants completing the health assessment who are at risk.

This provides a comparison of the aggregate report population to the national population.

Healthy People 2010, developed by the Centers for Disease Control and Prevention and the National Institutes of Health, is a comprehensive set of disease-prevention and health promotion objectives to be achieved by the nation over the first decade of the new century. Healthy People 2010 was developed through a broad consultation process and designed to measure progress over time. Additionally, Healthy People 2010 identifies a wide range of public-health priorities and specific, measurable objectives.

Also, we generally use our experience of disease prevalence. We base this on logic that reviews administrative data for evidence of the given disease, where the member has demonstrated evidence of the given disease on more than one occasion.

Our Health Profile Database tracks every member against approximately 100 diseases/conditions. For example, our database can report and compare disease prevalence between our markets and segments.

Additionally, we provide benchmark and normative data for cost and utilization statistics through our Analyze-Rethink-Transform (ART) reporting system, which provides comparative data to allow the State to better gauge the performance of your plans. We update standard report norms monthly and adjust them by product, region and age and gender.

Industry data is available using data for companies within a like industry, but not adjusted for product or region. We produce and provide data our internal book of business only.

In a future release of ART, we plan to incorporate external, public domain benchmark data to enrich our ability to compare data and establish strategic planning based on reasonable goals.

These are standard services available at no additional charge.

1.217	Describe the process to share recommendations for improvement based on risk factors.

Response:

We are offering a designated Wellness Consultant as part of our proposal to the State. The wellness consultant serves as a strategic consultant to the account team and customer for health promotion programs and communications guiding the creation of a multi-year strategy. The overarching goal is to improve engagement in health programs that address the entire health continuum, from chronic illness, to acute events, to maintain good health.

The wellness consultant's responsibilities include:

- Assisting with the definition of practical and actionable wellness goals, gather and define baseline data, define measures of success over time
- Participation with wellness committee and wellness champions to drive goals and advance the wellness culture
- Implementation support for onsite services focused on preventive care, weight management and smoking cessation
- Leveraging existing programs, relationships and resources to utilize wellness dollars wisely
- Promotion of Aetna's digital coaching and discount programs
- Positioning, assessment and evaluation of health promotion programs such as biometric screenings and health assessments
- Introduction of new programs such as telephonic coaching or workplace health challenges
- Recommendations for the creation of meaningful incentive strategies that drive participation in new and existing programs

The wellness consultant also has access to the data-reporting warehouse and can add strategic value through identification of key cost and utilization drivers, including medical and behavioral conditions in the population.

1.218	Describe monitoring activities to identify gaps in care and opportunities for improvement.

Response:

Our MedQuery® program, powered by the CareEngine® alerts physicians to opportunities for improved patient care by turning our member data into information that can be used to enhance clinical quality, patient safety and financial outcomes. In 2018, we found 379 opportunities for health improvement per 1,000 providers.[1]

Our program's technology helps it all run smoothly. What makes our technology different is that it is built to focus on people, not conditions. We constantly analyze our entire population using this technology to pinpoint specific, evidence-based opportunities to improve care for individuals.

Our MedQuery program uses close to 1,200 evidence-based clinical alerts spanning over 200 unique conditions. It applies nearly 9,000 clinical rules and member data including:

- Biometric screening data
- Wearable and medical device data
- Medical claims (current and historical)

- Behavioral health claims
  Dental and visions claims (received as medical claims)
- Pharmacy claims
- Laboratory claims
- Demographics
- Self-reported health record and health assessment data

The program continually scans the data and identifies potential errors, omissions or commissions in care. MedQuery helps us turn clinical intelligence into actionable information with 98 percent accuracy[2] and ultimately results in 5 percent reduction in medical costs.[3] It finds members in need, engages a health care professional who can provide help and engages members to take action to improve their health. MedQuery sorts its findings into severity levels.

We alert the member's physician by faxing the Care Considerations to their office within 24 hours of it generating. If the physician would like to speak directly with a clinician, they may call the toll-free number on the bottom of the Care Consideration. We will arrange for a clinician or medical director (upon request) to call the physician.

- Level 1 – a potentially serious issue where communication with the treating physician could have a significant impact and the situation should be addressed immediately. In 2018, book-of-business results show 70.3 percent compliance with Level 1 Care Considerations.[1]

- Level 2 – a potentially serious, but non-urgent issue. 2018 results show 49.3 percent compliance with Care Considerations.[1]

- Level 3 – a less-serious issue.

'ncreased compliance results in savings of $8.40 PMPM/$15.62 PEPM.[1]

Preventive Care Considerations

MedQuery® includes electronic Preventive Care Considerations (PCCs), which enhance our program through the delivery of wellness and preventive services alerts directly to members. The PCCs are sent to members who need, but who have not received, necessary vaccinations, preventive exams and screenings, according to our claims records.

[1]Aetna book-of-business results for self-funded and fully insured customers from Q4 2018 report (severity 1,2).
[2]Wei H. et al. Clinical Validity of Alerts Generated by the CareEngine Claims-Driven Decision-Support Engine. AMIA Annu Symp Proc. 2008. Nov 6: 1171.
[3]Aetna Commercial 2017 book-of-business study.

1.219	Describe affirmative steps that are employed to promote compliance among members.

Response:

Beginning with our first outreach, we engage members through innovative and thoughtful interactions. Our Aetna In Touch Care[SM] nurses use motivational interviewing techniques and tools to guide the member through roadblocks and past distractions that would otherwise block successful behavior change.

Motivational interviewing focuses on the member's internal desire to change rather than just education. We designed our program to engage members in a manner that is meaningful to them. While some people respond better to online programs, others prefer the comfort of a knowledgeable nurse. We're able to accommodate our members by offering both kinds of support based on their needs and preferences— whether it's working with a nurse by telephone, communicating via email, engaging 'hrough online programs or a combination of these methods.

Upon member engagement, our nurses work with members to keep them engaged by:

- Addressing their health concerns and managing costs
- Getting the services they need in the setting that's right for them
- Using integrated digital care programs
- Providing information to help maintain or enhance their quality of life
- Helping them use benefits wisely to promote quality, cost-effective health care

We also train our nurses in cultural sensitivity and integrated behavioral health/medical care management. This means an increased focus on individual members, their needs and helping them find out what will drive them to make lasting behavior change.

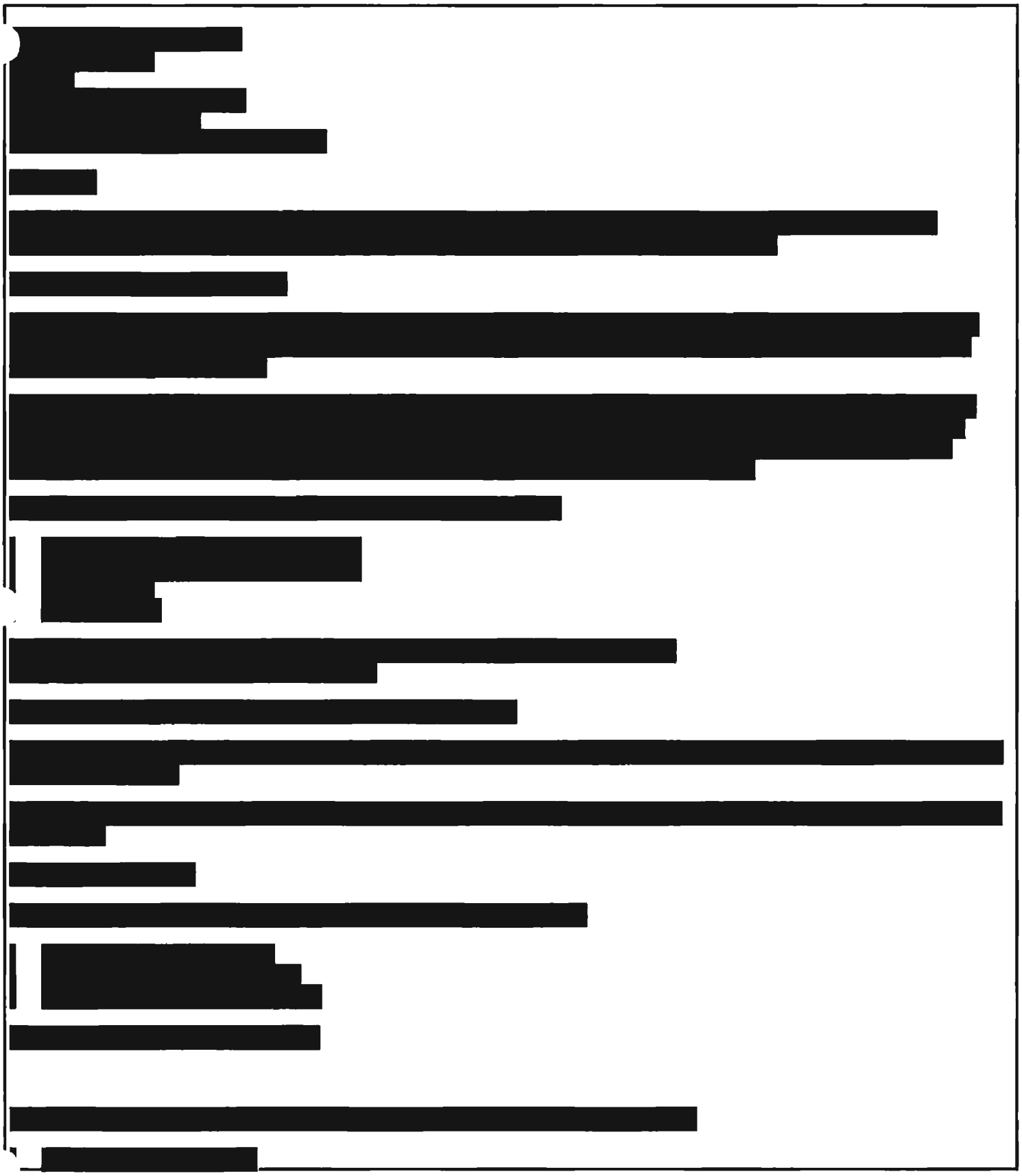
We also incent members to participate in our programs. We never stop looking for innovative and meaningful ways to give members access to engaging, convenient and cost-effective health and wellness resources. Developed in collaboration with Apple, Attain by Aetna℠ is the next step in our journey to transforming the consumer health care experience. It's a unique health experience that enables us to connect with members using the mobile devices they already use. Powered by sensors in the Apple Watch® and each member's unique health history, the Attain app:

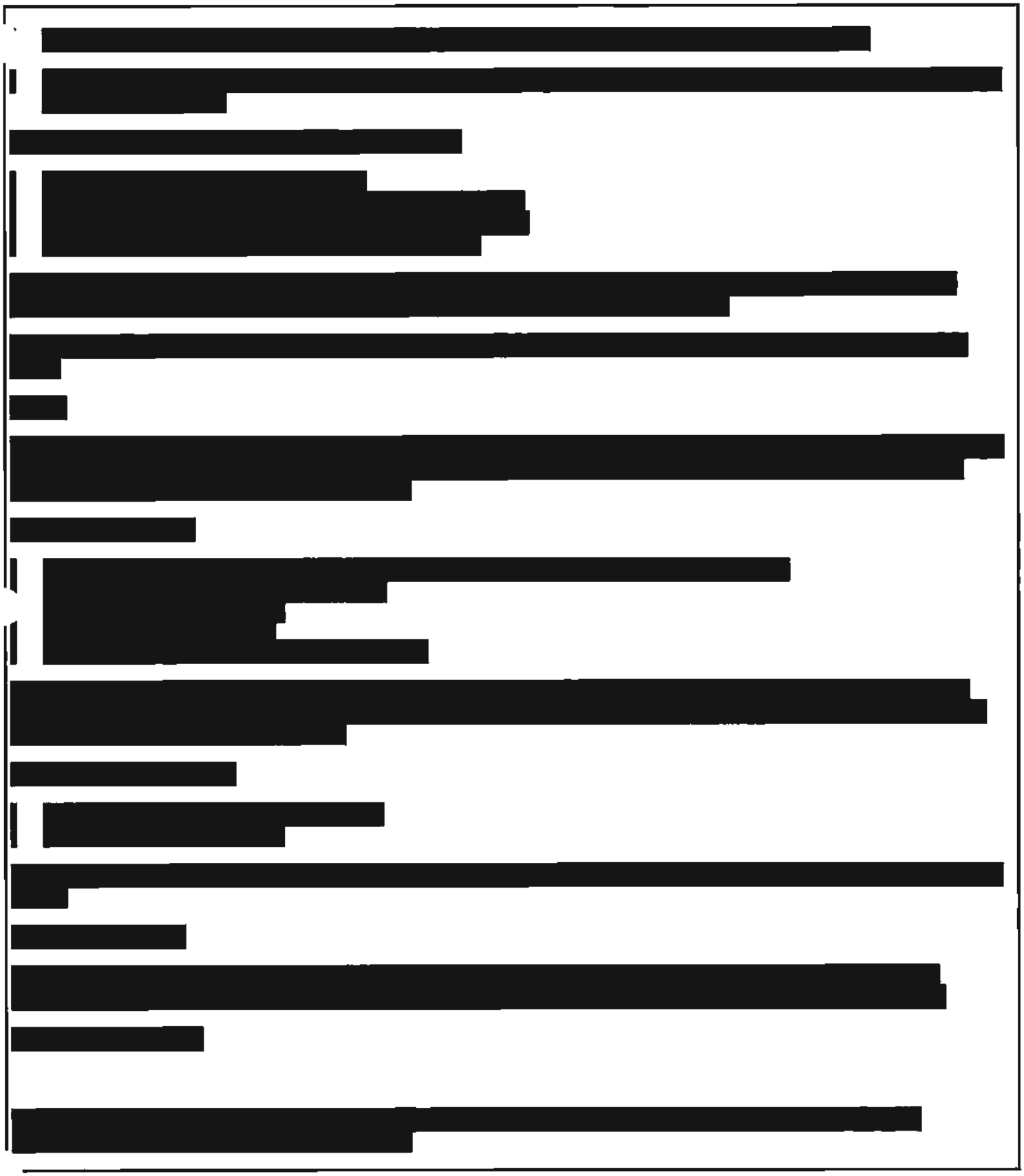
- Helps members set and achieve personalized activity goals
- Encourages actions that improve overall health
- Provides personalized health notifications at key moments
- Rewards members for taking actions to improve their well-being

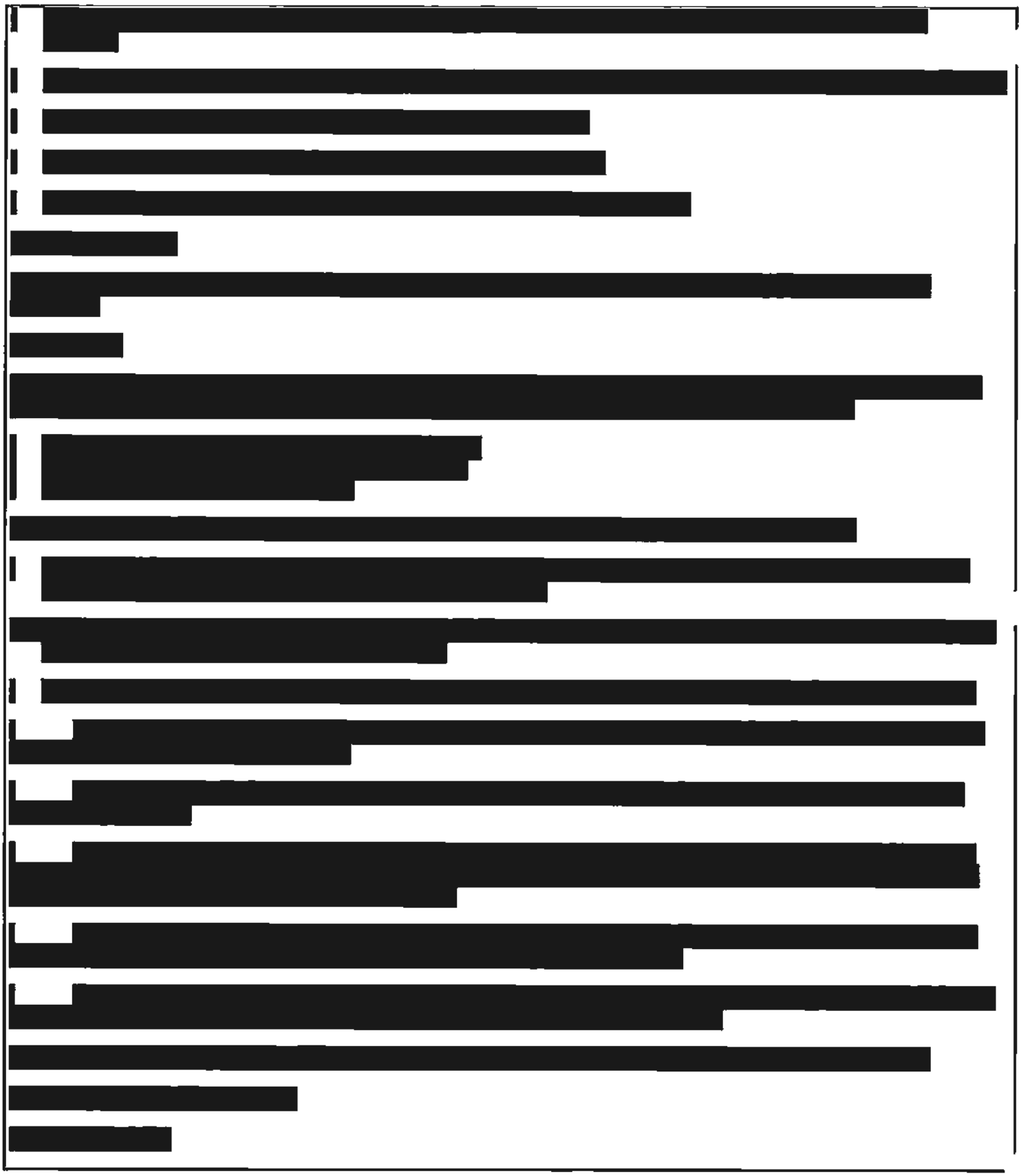
Participants obtain an Apple Watch through the program or use their own. Activity from the Apple Watch – along with Aetna health history — powers the program. Attain provides personalized goals, based on age, weight and sex. Participants can earn reward points by reaching activity goals, completing healthy actions or joining health challenges. Participants then can redeem these points to reduce the cost of an Apple Watch or get electronic gift cards from popular retailers.

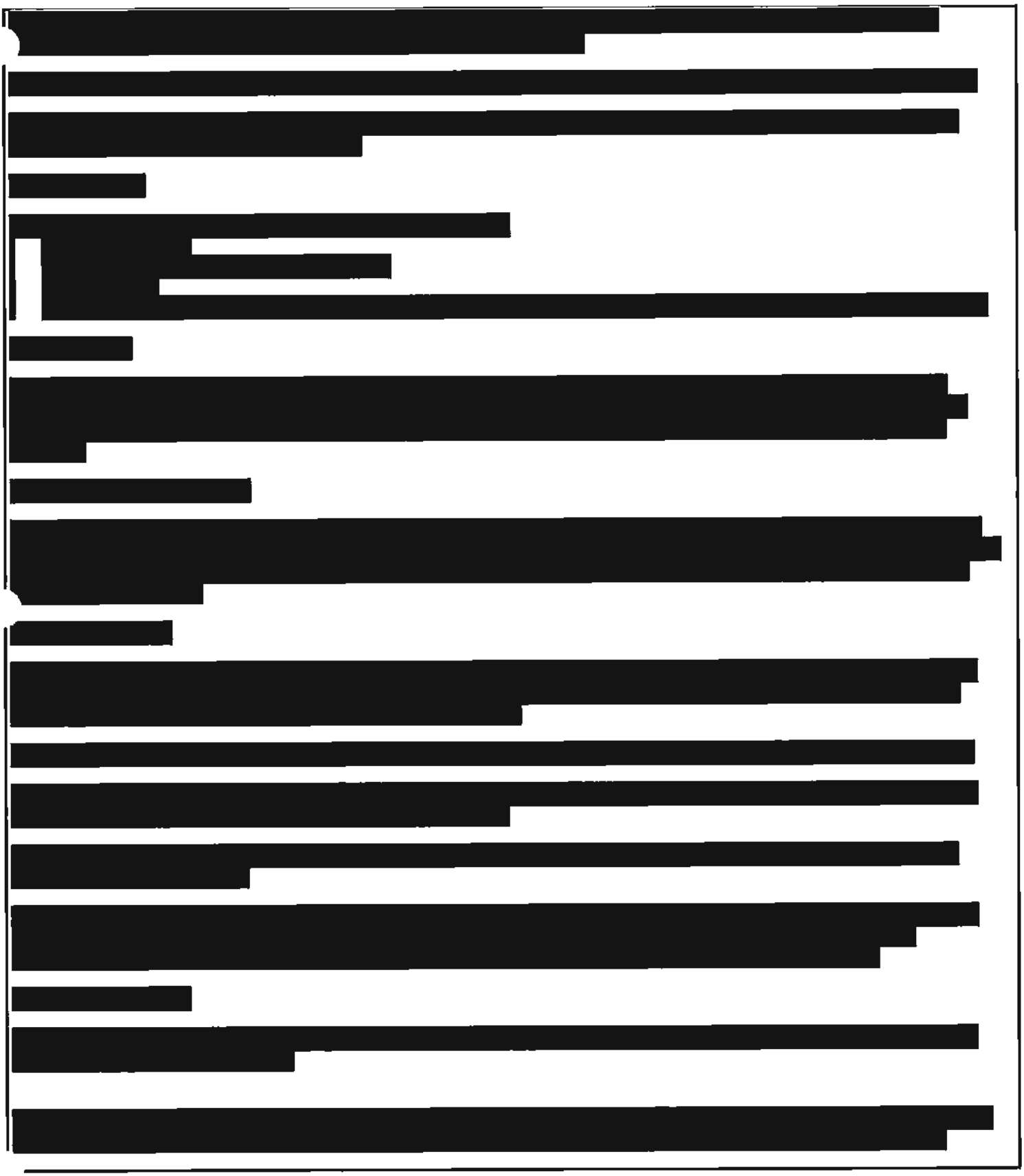
1.220	Provide the following outcomes results, for each of the last two (2) years, for each Wellness service: a. Overall and program specific engagement rates (defined as the percentage of Members who are contacted, consent to participate in the program, complete an assessment and schedule a follow-up) and realized ROI for each program offered including: i. 24 hour nurse line ii. Lifestyle coaching iii. Other Wellness services b. Member participation and ROI for incentive programs. c. Provider satisfaction survey results. d. Member satisfaction survey results. e. Clinical measures for each Wellness services provided. f. Gaps in care closures. g. Monitor changes in Member-reported physical and mental health status through a tool.

Response: [redacted]









[redacted]

1.221	Describe the ability to provide designated health coaches, lifestyle coaches, exercise physiologists, nutritionists, behavioral health specialists, maternity specialists or other clinical staff to carry out Wellness activities such as health risk assessment, telephonic coaching interventions including lifestyle coaching, a 24-hour nurse line and education about treatment options and health education to empower Members to manage their health.

Response:

As part care management programs, members have access to our clinical staff which includes nurses, dieticians, social workers, behavioral health specialists, maternity management specialists and medical directors. They can refer members to wellness programs and resources as needed.

In addition, our Informed Health® Line staff includes a team of 46 registered nurses and 3 nurse supervisors. The IHL nurses can also refer members to other available Aetna programs as appropriate. This includes our care management and coaching programs.

Our Informed Health® Line provides members with 24-hour telephone and email access to experienced registered nurses to help them make informed health care decisions. They can also connect with a nurse via online chat through our member website 7:00 a.m. through 7:00 p.m., ET.

After speaking to members, our Informed Health Line nurses can send links to health education videos from the Healthwise Video Library.

Produced by the Healthwise, the videos are designed to help members make decisions and take action on their health. Research shows that well-designed videos are more effective in delivering instructions. The video library includes over 400, 2 to 3 minute videos about health conditions, treatments, medicines and self- care.

The videos help to:

- Provide members with more education and support on the health topic they discussed or based on their needs
- Share information in simple way, with plain language and a sympathetic tone
- Engage members with easy to understand health topics and an expressive visual style

Members can view videos online or through their smartphones. They can access the video as long as they want or call back the Informed Health Line nurse for additional videos. There is no limit to the number of videos they may receive.

Access to the Healthwise video library is available at no extra cost and is included in all Informed Health Line program options.

1.222	Describe outreach strategies including those for reaching Members with incomplete contact information. If outreach strategies vary by risk level or program, describe each of the different strategies and when each is used.

Response:

If the State selects standard case management, during plan enrollment, we document telephone numbers through the eligibility system that integrates into ATV, our Aetna Total Clinical View℠ system. If we don't have a current telephone number, our nurses have access to our external phone directory.

If not successful and our staff has information on the member's doctor, we may contact the doctor to obtain a valid member phone number.

We don't call cell phones unless the member gave us earlier consent.

Once we identify a member as meeting potential case management criteria, the case manager makes two call attempts to each the member. To improve our chances of reaching the member or family, we make calls on different days and times.

Outreach letters and email

If we don't have a phone number for a member, we send a case management introductory letter or a "Trying to Reach You" email. They alert members that we were attempting to contact them regarding the program.

Contacting providers

When we're unable to contact members despite outreach attempts, the case manager may alternatively engage the treating doctor to impact the member's health status.

Our case management program is voluntary and members or their doctors can decline enrollment at any time. If we're unable to reach the member, the case manager closes the case and documents the information in ATV.

If the state selects AITC Solutions, our nurses reach out to members using member preference information from the Aetna Strategic Desktop and information from the eligibility file. If we have incomplete contact information, the nurse reviews our care management systems for past events and a possible alternate telephone number.

If the nurse is still unable to reach a member, the nurse may:

Use external resources

- Contact the member's provider
- Send an outreach letter to the member
- Send emails to the member
- Send a message to the member's Personal Health Record (PHR)

External resources

Our nurses use **www.whitepages.com** and **www.switchboard.com** to find member telephone numbers if this information is not initially available.

Contacting a member's provider

Nurses may contact a member's provider for a valid telephone number if they are unsuccessful in reaching the member.

Outreach letters and email

If the number is still inaccurate, the nurse sends a letter to the address we have on file through our eligibility files. The nurse also updates the member preference information in our documentation system.

Our unable-to-reach letter contains a toll-free telephone number for call back.

We also send two emails per month to moderate and low risk members, provided they have registered through our member website to receive emails and have not yet engaged directly with a nurse.

1.223	Describe the health risk assessment completion rate.

Response:

Our overall book of business health assessment completion rate is 10.8 percent.

We distinguish health assessment completion/wellness participation rates into the following two categories:

- The completion rate is on average 18 percent for customers offering an incentive or reward program for completing the health assessment. However, this does not take into account the amount or type of communications or level of management support.

- The completion rate is on average less than 3 percent for customers that promote the health assessment very little or only once and do not offer incentives.

1.224	Describe how data collection will be administered and evaluation for the health risk assessment.

Response:

Our health assessment is available online only.

Our member website includes our personalized, online, health and wellness resources to help improve the health and productivity of your employees. We provide a simplified experience to be sure that your employees get engaged and stay engaged.

Here's how it works:

- Step 1: Assess your health – Participants take our online health assessment
- Step 2: Take action – Participants review their resulting member report and engage with applicable health and wellness resources
- Step 3: Learn more – Participants can continue to research their conditions or risks using our online resources

Note: Participants may access online health wellness programs without completing a health assessment.

Participant features

Our program helps participants turn knowledge about their health into action for making positive health changes with:

- An online health assessment
- Tailored health reports
- Online health coaching programs
- Engaging emails, game mechanics and incentives

1.225	Describe availability and describe each of the following programs and/or services: a. Health Risk Assessment (both web-based and telephonic) with Individual action steps b. Online biometric tracking tools c. Blood pressure, blood sugar, BMI/weight and other online trackers d. Self-management education and goal-setting e. Nutrition f. Physical activity and related online trackers g. Prenatal care h. Tobacco cessation i. Stress management j. Weight management k. Injury prevention l. Preventive service reminders, sent by mail, phone or electronically m. Gaps in care reminders, sent by mail, phone or electronically n. Type of smart innovative health programming, i.e., smart phone tracking, Fit Bit, etc.

Response:

Health Assessment

Our member website features a health assessment to help members understand and take action on their health. We only offer the Health Assessment online.

Health assessment features

Our health assessment features a complete view of health through a variety of topic areas, personalized support and actionable feedback and integrates with other wellness programs.

Topic areas addressed

Our health assessment measures a variety of life- and health-related factors including:

- Exercise, tobacco use and diet
- Biometrics
- Weight
- Stress, sleep and dental health
- Chronic conditions
- Prevalence of health conditions
- Readiness to change
- Health and productivity
- Barriers and support
- Other risk-related issues such as no PCP or overdue screenings

Access and results

Upon completion of the Simple Steps To A Healthier Life health assessment, the participant receives:

- A Health Risk Score – Computed using a scientific algorithm, the score predicts the relative level of health risk a participant may have, compared to other people of the same age and gender.

- Tailored Health Reports – The tailored health reports address specific individual health risk factors for developing certain conditions. Within the reports, risk for diseases is broken into modifiable and non-modifiable components and ranked as low, moderate, high or very high. This helps the participant focus on how to improve their chances for remaining healthy and productive.

- Health Summary Report – Through the health summary report, participants are able to save and compare their results over time.

Outreach

After completing the health assessment, participants may click on a link to access their action plan, which is specifically designed to address common health/wellness concerns, such as:

- Weight loss
- Nutrition
- Stress management
- Smoking cessation

Those who elect to close out after reviewing their health assessment results may receive a personalized email that invites them to access their action plan and participate in the online health coaching programs.

Online Tools and Trackers

We believe it is our role to promote wellness and preventive services that help get our members to and keep them at healthy. Our member website provides access to a variety health education resources designed to engage members in managing their health care. Our available tools and resources include:

- Healthwise® Knowledgebase – The Healthwise Knowledgebase offers clinical information on various health topics including medical tests and procedures, support groups and medications.

- Health assessment and health actions – Our health assessment reviews a member's individual risk level and provides actionable steps that can help them make positive changes in their overall health.

- Health Decision Support - Health Decision Support is a library of online learning programs that give members the

information they need to make better decisions about their health. It helps them understand a variety of conditions and treatments and explains procedures, tests and surgery options. After learning more about their options, members are better able to select the course of action right for them and discuss those options with their doctor

- Incentive tracking – We offer incentive administration for members who complete a variety of health-related activities.
- Online coaching – Our online coaching provides member education and support for chronic conditions and lifestyle management.
- Personal health record – Our personal health record helps members maintain accurate records of their most important health data.
- Social Communities – Our social communities allow members to interact with other individuals facing similar health challenges and goals. Members can ask questions on various topics such as diabetes, depression, cancer, high blood pressure and cholesterol.
- Health trackers – We offer members the option to track a variety of health metrics including activity, calories and more through self-reporting or device integration.
- Device integration - We offer integration with a variety of app and device manufacturers, enabling members to synchronize data from activity monitors, pedometers, blood pressure cuffs and weight scales.

We never stop looking for innovative and meaningful ways to give your employees access to engaging, convenient and cost-effective health and wellness resources.

Self-directed Education and Behavior Change

Aetna Get Active[SM] helps employees of all health and fitness levels get and stay motivated to improve their fitness and well-being.

The Get Active program focuses on individuals at all risk levels, including high, moderate and low. Through peer-to-peer support and engagement, individuals can focus on increased activity to drive behavior change and make health improvements. Through focused competitions, personalized challenges and social interaction, individuals are able to work together and achieve superior outcomes, including reduction in BMI/weight, increase in physical activity (exercise) and improved nutrition.

Get Active is a great way for you to help employees of all health and fitness levels get and stay motivated to improve their fitness and well-being. The program empowers individuals to take action, while giving them permission to be healthy. It features an online fitness and nutrition tracker, team-based challenges, social networking, emails, newsletters, activity tracking, full reporting capabilities and the option to purchase a welcome kit that includes a pedometer.

The program starts with a company-wide, multi-week exercise, walking and weight loss competition that promotes friendly competition, group support and camaraderie in the workplace and continues with other seasonal and/or physical activity challenges. The site also allows for personal challenges (such as exercise, sports, nutrition, smoking cessation, relaxation), the ability to find activity partners, form health-related interest groups (e.g. healthy cooking club, lunch-time walking group) and share fitness plans with colleagues.

Online Coaching

Our online health coaching programs offer a greater opportunity to provide holistic support to members for chronic conditions and wellness. This suite includes several focus areas including:

- Be Tobacco Free
- Blood Pressure in Check
- Diabetes Life
- Eat Healthier
- Get Active
- Healthy Back
- Heart Healthy Cholesterol
- Living Well with Asthma
- Sleep Well
- Stress Less
- Weigh Less
- Health In a Hurry

With this personalized technology, each member has a unique user experience that supports engagement and long-term lifestyle behavior change.

Preventive Reminders

MedQuery® includes Preventive Care Considerations (PCCs), which enhance our program through the delivery of wellness and preventive services alerts directly to members. The PCCs are sent to members who need, but who have not received, necessary vaccinations, preventive exams and screenings, according to our claims records. They are not sent to member's physician. Members can request to be opted out of the receiving preventive care considerations.

MedQuery generates these preventive/wellness alerts only when there is a lack of compliance with a clinical risk, condition or demographic-related (e.g., age, gender) recommendation for preventive care. Our MedQuery program analyzes claims weekly.

We estimate that each member in your group will receive at least one PCC per year. The frequency and specificity of these alerts will help NNN Company foster a culture of wellness and will assist you with your companywide prevention and wellness goals. In addition, PCCs help you meet your HEDIS® (registered trademark of NCQA) requirements.

Examples of PCCs include:

- Routine vaccinations for influenza (only if member has not received it)
- Vaccinations for high-risk patients, such as childhood immunizations and routine hepatitis B vaccine
- Cancer screenings
- Routine annual health screenings (e.g., eye exams, cholesterol screens) when indicated but not received
- Condition-specific screenings, such as a member having diabetes mellitus who needs to consider the pneumococcal vaccine

Electronic PCCs are on our member website and sent to the member's health record. We also provide an email notification of the PCC if the member provides their email address. Paper PCCs are available as a buy-up for self-funded, split-funded and fully insured retrospectively rated customers. Please note flu shot reminders will not be sent as paper PCCs due to volume.

Smart Phone Tracking

We never stop looking for innovative and meaningful ways to give members access to engaging, convenient and cost-effective health and wellness resources. Developed in collaboration with Apple, Attain by AetnaSM is the next step in our journey to

transforming the consumer health care experience. It's a unique health experience that enables us to connect with members using the mobile devices they already use. Powered by real-time sensors in the Apple Watch® and each member's unique health history, the Attain app:

- Helps members set and achieve personalized activity goals
- Encourages actions that improve overall health
- Provides personalized health notifications at key moments
- Rewards members for taking actions to improve their well-being

Helping members achieve activity goals

Health ambitions are not one size fits all. Neither are Attain's customized activity goals. Attain provides participants with personalized daily and weekly activity goals, based on their age, sex and weight. Attain's definition of activity is not just restricted to steps taken. It also includes other activities that can be measured by the Apple Watch, such as swimming and yoga.

Encouraging actions that improve overall health

Attain offers weekly challenges where participants earn points for taking actions that improve their overall health and well-being. Examples of these challenges include:

- Getting more sleep
- Increasing mindfulness
- Improving nutrition

Providing personalized notifications at key health moments

Attain recommends personalized healthy actions based on the member's health history, as well as their Apple Watch sensor data. Created in collaboration with a team of doctors, the recommendations are based on clinical guidelines. At Attain's launch, our notifications include reminders to:

- Meet activity goals
- Get the flu shot or other vaccinations
- Refill prescriptions
- Visit their PCP
- Research lower-cost options for scheduled lab or imaging tests

Using analytics, machine learning and additional functionality from Apple's iOS platform, we'll continue to collaborate with Apple on new features for Attain. This includes expanding our library of personalized recommendation designed to decrease barriers to healthcare.

Earning Rewards

We give members options to use Attain in the way that works for them. Members can choose to use Attain to purchase an Apple Watch over 24 months, or they can connect their current Apple Watch. As they complete their activity goals and take action on the recommended healthy actions, participants earn reward points using the Attain app. Members can choose use their points to reduce the cost of their monthly payment for their Apple Watch or redeem them for electronic gift cards to many popular national retailers.

Attain helps members achieve healthier lives through a personalized experience driven by their health history and backed by the power of the Apple Watch. Combining the convenience and unmatched user experience of Apple products and our health care expertise gives us the opportunity to create simple, intuitive and personalized technology solutions like Attain that can help our members achieve their health goals.

1.226	Describe wellness-coaching success.

Response:

We do not have current ROI data for the digital coaching program. We place a major focus on providing personalized health and condition-specific resources through our digital coaching programs. Our programs are evidence-based, customizable and incorporate the industry's latest technologies, communication strategies and digital capabilities to achieve member engagement.

Our online coaching modules are dynamic and interactive, as the program incorporates logic based on the member's responses and clinical profile and presents tailored and relevant information to the user. We've already seen high levels of engagement, including:

- 2.3 million digital topics completed
- An average of 25 minutes spent in each digital coaching session

Success is defined as coaching having a positive impact on modifiable risk factors. This includes pharmacy costs and savings attributed to reduced and avoided risk factors.

1.227	Describe the concept of success relate to improvement in employee population health risks.

Response:

Our holistic approach to care management and wellness is unique in the industry. It focuses on the whole member, including:

- Health status
- Self-reported family history and over-the-counter medications
- Benefit plan design
- Claims and care history

Our programs are effective because we:

- Identify members who have care coordination needs and/or gaps in care
- Act early to prevent members with chronic conditions from getting worse

We use advanced technology to identify members who have gaps in care. For example, we apply a set of steps and computations that analyze claims and pharmacy information. These tell us which members:

- Have medical problems
- Are at risk for medical problems
- Need more medical help
- May soon incur higher medical costs

Based on this information, we offer our members timely, cost-effective and high-quality programs and services.

Our programs reduce how often members are in the hospital and coordinates care to help members lead healthier lives. By tracking our members' health information and by reaching out to them, we improve their quality of life, support their ongoing care, manage costs and resources and promote higher quality outcomes.

1.228	Describe how risk stratification is conducted for wellness programs.

Response:

We identify participants and assign their risk level based on the following:

- Health assessment results – This includes the Simple Steps To A Healthier Life® health assessment score, BMI or indication that the individual uses tobacco
- Claims data – We monitor claims for use of Chantix or Zyban (smoking cessation aids)
- Self-referral – Individuals can refer themselves by telephone or through our member website
- Biometrics – This includes BMI, triglyceride levels, HDL level, blood pressure and blood glucose

Stratification and risk levels

Based on a participant's health assessment results and other data, we assign them to one of the following risk levels:

High opportunity

We identify members as high opportunity if their:

- Health assessment score is greater than 65
- Health assessment indicates a BMI equal to or greater than, 30
- Health assessment indicates tobacco use
  Claim data shows use of either Chantix or Zyban (smoking cessation aids)
- Biometric data indicates three or more of the following:
  - BMI equal to or greater than, 30 or large waist circumference (40 inches for men, 35 inches for women)
  - A raised triglyceride level (150 or higher)
  - A reduced HDL level (lower than 40 in men, lower than 50 in women)
  - Raised blood pressure (130/85 or higher)
  - Raised blood glucose (100 or higher) or previously diagnosed type 2 diabetes

Moderate opportunity

We identify members as moderate opportunity if their:

- Health assessment score is 56 to 65
- Health assessment indicates a BMI of 25 to 29.9
- Their health assessment score is less than 65 and their work limitations questionnaire score is greater than 11
- Biometric data indicates two of the following:

- BMI equal to or greater than, 30 or large waist circumference (40 inches for men, 35 inches for women)

A raised triglyceride level (150 or higher)

- A reduced HDL level (lower than 40 in men, lower than 50 in women)
- Raised blood pressure (130/85 or higher)
- Raised blood glucose (100 or higher) or previously diagnosed type 2 diabetes

Low opportunity

We identify members as low opportunity if their:

- Health assessment score is less than 56
- Health assessment indicates a BMI of less than 25

1.229	Provide the ROI calculation methodology for the overall Wellness program.

Response:

Return on Investment for the overall wellness program is not available. The State can witness program impact as you see change in factors such as health status, health risks and perception of productivity levels through our reporting packages.

While a formal ROI rate is not available, we know that biometric screenings deliver significant benefits to you and your employees.

Proven results

Our partner, Quest Diagnostics, has seen strong results when people participate in screenings. Members are less costly and they are less likely to be hospitalized or use the emergency room. We've observed the following successes[1]

- 30 percent less spending overall per employee, per year
- 50 percent less likely to have an inpatient hospital stay
- 33 percent fewer emergency room visits

A study by Quest Diagnostics indicates that biometric and metabolic screenings offer the following benefits[2]:

- Early identification of health conditions – Biometric wellness screenings can identify health conditions before they show themselves as serious medical conditions or catastrophic claims.
  - More than 70 percent of all medical decisions involve clinical laboratory test results. Population level biometric screenings help close the gap in missing laboratory and claims data.
- Identification of unknown health risks – Screenings help identify conditions that were otherwise unknown to participants:
  - 22 percent of those participants who had never reported a diagnosis of diabetes were found to be in a pre-diabetic or diabetic state through fasting glucose levels

- 23 percent of participants who had not previously been diagnosed with high cholesterol have elevated or high LDL (bad) cholesterol levels

- Significant improvement in health risks – The study found that improvements to health risks occurs among returning participants who were identified in a high risk status based on clinical results. Outcome-based wellness programs have even higher rates of health improvement associated with them.

- 42 percent of those participants who had a high glucose level in year one achieved an in range glucose level in year two. A 50 percent improvement was achieved for outcomes-based wellness programs.

- 36 percent of those participants who had a high-risk LDL (bad) cholesterol level in year one had a low risk LDL level in year two. A 40 percent improvement was achieved for outcomes-based wellness programs.

[1] Screening participant outcomes compared to non-participants. Quest Diagnostics employee wellness analysis 2016.

[2] Quest Diagnostics Database, 2010

We also do not have return on investment (ROI) figures for our member website and consumer tools including the health assessment. The success of any of our online tools is contingent on many factors such as, offering incentives and developing a strong communications strategy. These factors can help drive program participation and engagement and ultimately determine the success of our tools. Since the level of support varies from customer to customer, we are unable to quantify or predict a certain savings level or a specific ROI.

1.230	Define and measure wellness outcomes related to the programming structure.

Response:

Healthy behavior change is at the core of any successful health and wellness strategy. Because we know this change usually takes place in small steps, we understand the benefits of a progressive approach. We work with you to define your health and wellness goals and then propose a creative, multi-year solution to drive and sustain healthy lifestyle changes. This results in:

- Healthier employees and their families
- Higher employee productivity
- Lower medical costs over time

Five steps to a successful health and wellness strategy

We partner with you to build this evolutionary strategy through a proven, five-step approach:

1. **Gather and analyze-** First, we assess the health and productivity levels of your employees. We study your workplace culture and your business and benefit goals. Then we review claim data to understand utilization trends and health risks. We do this so we can lay a solid foundation for a customized wellness strategy based on member health status, demographics and individual preferences and behaviors.

2. **Define goals and objectives-** Armed with this knowledge, we work with you to pinpoint behaviors you would like to change, such as raising the rates of preventive care visits or health assessment completion. Then we help you decide which programs and services best support your benefits philosophy. And, because we know you want a strategy grounded in results, we define how we will measure success.

3. **Design a health and wellness strategy-**When we help you create your customized health and wellness solution, we recommend programs that align with your defined goals and objectives, not ours. We also identify and recommend ideas to address other workplace challenges to healthy behavior, such as cafeteria menu selections, access to fitness facilities and smoke free environments.

4. **Develop an implementation plan-**We help you execute this strategy by using our expertise to successfully launch the program. Most importantly, we help
you develop a communications campaign that reflects strong management
support. Experience has taught us that ongoing communications are key to program adoption and sustained member engagement.

5. **Evaluate outcomes and refine strategy-**A successful health and wellness strategy continually evolves to meet the changing needs of your employees and their families. We use our technology and clinical expertise to report results and measure outcomes against your program goals and objectives. We work with you to refine your plans and prepare for future opportunities.

Our goal is to help empower your employees and their families to lead healthier lives. We will work with you to create a customized strategy with innovative solutions that provide your employees and their families with personalized engagement opportunities that deliver results.

1.231	Describe the program that manages gaps in clinical care, beginning with the identification process and concluding with outcome.

Response:

Our MedQuery® program, powered by the CareEngine® alerts physicians to opportunities for improved patient care by turning our member data into information that can be used to enhance clinical quality, patient safety and financial outcomes. In 2018, we found 379 opportunities for health improvement per 1,000 providers.1

Our program's technology helps it all run smoothly. What makes our technology different is that it is built to focus on people, not conditions. We constantly analyze our entire population using this technology to pinpoint specific, evidence-based opportunities to improve care for individuals.

Our MedQuery program uses close to 1,200 evidence-based clinical alerts spanning over 200 unique conditions. It applies nearly 9,000 clinical rules and member data including:

- Biometric screening data
- Wearable and medical device data
- Medical claims (current and historical)
- Behavioral health claims
- Dental and visions claims (received as medical claims)
- Pharmacy claims
- Laboratory claims
- Demographics
- Self-reported health record and health assessment data

The program continually scans the data and identifies potential errors, omissions or commissions in care. MedQuery helps us turn clinical intelligence into actionable information with 98 percent accuracy2 and ultimately results in 5 percent reduction in medical costs.3 It finds members in need, engages a health care professional who can provide help and engages members to take action to improve their health
MedQuery sorts its findings into severity levels.

Ve alert the member's physician by faxing the Care Considerations to their office within 24 hours of it generating. If the physician would like to speak directly with a clinician, they may call the toll-free number on the bottom of the Care Consideration. We will arrange for a clinician or medical director (upon request) to call the physician.

- Level 1 – a potentially serious issue where communication with the treating physician could have a significant impact and the situation should be addressed immediately. In 2018, book-of-business results show 70.3 percent compliance with Level 1 Care Considerations.[1]
- Level 2 – a potentially serious, but non-urgent issue. 2018 results show 49.3 percent compliance with Care Considerations.[2]
- Level 3 – a less-serious issue.

Increased compliance results in savings of $8.40 PMPM/$15.62 PEPM.[3]

Preventive Care Considerations

MedQuery® includes electronic Preventive Care Considerations (PCCs), which enhance our program through the delivery of wellness and preventive services alerts directly to members. The PCCs are sent to members who need, but who have not received, necessary vaccinations, preventive exams and screenings, according to our claims records.

[1]Aetna book-of-business results for self-funded and fully insured customers from Q4 2018 report (severity 1,2).
[2]Wei H. et al. Clinical Validity of Alerts Generated by the CareEngine Claims-Driven Decision-Support Engine. AMIA Annu Symp Proc. 2008. Nov 6: 1171.
[3]Aetna Commercial 2017 book-of-business study.

1.232	Describe successful outcomes of the current wellness programs offered as pertaining to the following: a. Eligibility b. Centralized electronic medical records c. Medical Community integration processes and program details d. Education materials e. Identification, participation, engagement f. Risk stratification methodology g. Predictive modeling capabilities h. Including individuals in the disease management program once a member's paid claims exceed $50,000

Response:

The case study below demonstrates successful outcomes of our wellness programs for an employer.

One of our long-term customers is in the health sciences industry and has a diverse workforce of over 9,000 U.S. employees. They wanted to enhance wellness offerings and expand participation across operating units, while keeping employees and their families healthy and productive. We partnered with them to zero in on top cost drivers, consistently drive engagement and keep their program fresh.

Our customer strongly believes in the value of investing in employee well-being. They've built a comprehensive health and wellness program to empower employees and their families to live their best lives. Several years ago, the medical plan included a high-touch concierge service and clinically robust care management programs.

Employees had access to a personal health record, a 24-hour nurseline and a suite of online tools. The company also increased preventive care with a variety of incentives. At corporate headquarters, they changed the environment to support healthy choices by adding:

- An onsite fitness center
- Wellness screenings
- Webinars
- Healthy dining
- Rooms for nursing mothers
- A child care center
- Walking paths

At first, engagement was strong. Onsite events and screenings were popular. But by 2012, participation was dwindling. Human resource (HR) leaders felt the wellness program needed a change.

A focused approach

More wellness is not necessarily better. Employees found the variety of wellness choices confusing and overwhelming. With the help of Aetna and their consultant, the company took a close look at their data to assess next steps. They decided to focus on a big cost driver — metabolic syndrome. This condition can lead to more serious chronic conditions like diabetes and heart disease. Most people don't know they have or are susceptible to these conditions.

With a stable but aging population, these conditions were likely to rise. They worked with us to offer metabolic syndrome screening with a participation based incentive of $500 for covered employees and an additional $200 for covered spouses and partners.

The team tapped us to teach employees about the conditions and offer programs to help them manage their risks. But they wanted to do it in a way that respected the company's culture. The HR team knew success meant meeting members where they are, whether that was researching in a lab or manufacturing products in a factory.

Overcoming obstacles

Our benefits team faced many challenges when implementing this new approach.

- A diverse employee population with varying geography, culture and demographics
- No regular access to email for a portion of the population
- Communications overload that made getting attention tricky
- Personal and professional schedules that made prioritizing wellness difficult

The customer's HR team thought carefully about how to communicate and deploy this new wellness offering. We designed a communications plan and we learned that persistence and perseverance pays off. Our customer stayed the course even though initial engagement in screenings was low. Through simple and consistent messaging, using every available communication channel, participation in the metabolic syndrome screenings steadily grew year after year, as employees became more aware and trusted that the company had their best interests in mind.

Improving colorectal cancer screenings

When you create a true culture of wellness, it's easier to address unique issues. For this CEO, that issue was cancer. As a member of CEOs Against Cancer, he committed the company to one of the group's loftiest goals — an 80 percent screening rate for colorectal cancer by 2018.

The company's wellness champions worked with us to create a screening initiative that increased awareness and improved colorectal screening rates to over 70 percent. (Aetna's book of business colorectal screening rate is approximately 38 percent.)

Evolving for success

Creating a culture of well-being is not a one-and-done proposition. The company's well-being program continues to evolve. Their wellness leaders keep tabs on what's working. They also strengthened the network of more than 30 people across the enterprise who serve as a wellness focus group. Every month, the group gathers to talk about how wellness efforts are working locally and what can be improved. Keeping a pulse on what employees think is helping the company enhance its wellness solutions.

When leaders lead

Leaders have to demonstrate a commitment to well-being for a company's efforts to be successful. When leaders demonstrate the importance of wellness, employees are more likely to take the time to participate in the program. This company's efforts are supported from the executive suite down. Leaders at all levels are encouraged to promote a culture of well-being.

Measuring value on investment

Several recent studies have looked at the value of building a culture of health and well-being. They compared the stock prices of companies that have won awards for their strong cultures of health with the S&P 500.1 Each study demonstrated that companies committed to well-being have stock prices that outperform the S&P 500. While this does not imply causation, it is certainly an interesting correlation.

The company described in our case study has measurable results:

- Average medical trend of less than 2percent per year for the past four years, compared with a national average of 5 percent for large companies[2]
- Employee participation rates in health risk assessments and metabolic syndrome screening of 59.8 percent for HSA plans and 41.8 percent for all plans in 2017[3]
- Preventive visits for children (Age 2-19, Non-HEDIS) 27.4 percent higher than benchmark in 2017[3]
- Adult preventive visits increased by 15 percent from 2013 to 2017[3]
- 2017 mammography rates were 12.2 percent higher than benchmark[3]
- Colorectal cancer screening rates of 74 percent (compared with Aetna's book of business rate of 38percent)[3]

Keys to success

The right wellness solution is different for each organization, but here are the key areas of focus that led to this company's success.

- **Be persistent** — Gather feedback, analyze data and don't be afraid to try new things. A successful wellness strategy may take several alterations and adjustments.
- **Know your audience** — Your workforce is unique. Create a program that embraces and addresses their distinct preferences, geographies, health ambitions and challenges.
- **Create a culture** — From embracing wellness at the leadership level to encouraging employee feedback, build well-being into the culture of your organization.

As this company learned, creating a culture of well-being can bring tremendous benefits.

[1] Stock price sources: Fabius et. al. JOEM, Volume 55, Number 9, September 2013; Grossmeier et. al. JOEM, Volume 58, Number 1, January 2016; Goetzel et. al. JOEM, Volume 58, Number 1, January 2016

[2] National Business Group on Health, Large Employers' 2018 Health Care Strategy and Plan Design Survey

[3] Aetna Informatics (now known as Plan Sponsor Insights), 2017/2018

1.233	Describe the following tools and services available to Members via the Member portal: a. Health Risk Assessment. b. Wellness tools and trackers. c. Health promotion and health education tools. d. Any other web tools to support Wellness activities. e. Health services related to member cost

Response:

We believe it is our role to promote wellness and preventive services that help get our members to and keep them at healthy. Our member website provides access to a variety health education resources designed to engage members in managing their health care. Our available tools and resources include:

- Health assessment and health actions – Our health assessment reviews a member's individual risk level and provides actionable steps that can help them make positive changes in their overall health.
- Incentive tracking – We offer incentive administration for members who complete a variety of health-related activities.
- Health trackers – We offer members the option to track a variety of health metrics including activity, calories and more through self-reporting or device integration.
- Device integration - We offer integration with a variety of app and device manufacturers, enabling members to synchronize data from activity monitors, pedometers, blood pressure cuffs and weight scales.

- Healthwise® Knowledgebase – The Healthwise Knowledgebase offers clinical information on various health topics including medical tests and procedures, support groups and medications.
- Health Decision Support - Health Decision Support is a library of online learning programs that give members the information they need to make better decisions about their health. It helps them understand a variety of conditions and treatments and explains procedures, tests and surgery options. After learning more about their options, members are better able to select the course of action right for them and discuss those options with their doctor
- Online coaching – Our online coaching provides member education and support for chronic conditions and lifestyle management.
- Personal health record – Our personal health record helps members maintain accurate records of their most important health data.
- Social Communities – Our social communities allow members to interact with other individuals facing similar health challenges and goals. Members can ask questions on various topics such as diabetes, depression, cancer, high blood pressure and cholesterol.

We never stop looking for innovative and meaningful ways to give your employees access to engaging, convenient and cost-effective health and wellness resources.

1.234	What sets this organization apart from other competitors?

Response:

We understand that employees and their families often experience health challenges. But even with an ongoing condition, engaged employees can lead healthier lives. That is where the Aetna difference comes in. We engage members where they are and in a way that is most comfortable and convenient for them.

In fact, we use the same tools our members use and package trusted health information in a way that they can easily understand.

Get a personalized health "to do" list

We motivate employees and their families to lead healthier lives with personalized "to do" lists. For example, the member may be encouraged to eat more fruits and vegetables, be reminded about a preventive care screening or flu shot or talk with their provider about certain medications.

Promote health through social media/networking

People are spending more time on social media sites, so we are increasing our social media presence to promote health and wellness. This allows us to be where our members are, gain market insights and develop online communities. We continue to expand our capabilities around different types of online communities and social media. Some examples include:

- Twitter. We have a corporate handle on Twitter: @Aetna, along with a customer service handle: @AetnaHelp. Together, they signal a clear message about our commitment to fostering a tighter connection with the people we serve by engaging in conversations and adding value to the social dialogue about health and wellness.

We also use Twitter to post relevant content to followers in our Aetna Student Health℠ and Aetna International plans. This includes health and wellness content, along with global updates for members living outside of the country.

- Facebook. To date, we have two corporate Facebook pages: Aetna Student Health, Aetna International. Each page includes information relevant to people whose interests fall within those areas.

- Blogs. Blogs help us to interact with members by posting relevant content and questions. Members can respond and add their own content and questions. Blog topics may include healthy cooking and eating, healthcare reform and others. Blog content is monitored by Aetna resources.

Find trusted health information on the go

Our members expect fast access to health information whenever they want it, from wherever they are. We offer a mobile web version of our member website and our Aetna Health app that allows members to access key health and wellness information on the go.

Continuous innovation

We never stop looking for engaging and meaningful ways to provide our customers and their employees with access to convenient, cost-effective health and wellness resources. We often pilot promising resources with our own employees.

1.235	Describe engagement strategies that are innovative and unique.

Response:

We maximize engagement by delivering a personalized wellness experience. This means that we're meeting members where they are on their health journey with a variety of tools and programs they can select based on their needs and preferences. This includes:

- Online engagement
- Local support
- Incentives to motivate and reward behavior change

Online engagement

We provide members with access to a variety of online tools and programs they can use whenever and wherever they are. This includes:

- A health assessment to learn about health risks and actions that can be taken to improve those risks
- Online coaching that helps members learn about certain health and wellness conditions on their own time
- Our Personal Health Record to keep track of key health metrics
- Health Decision Support to help members pick the treatment options that are right for them
- Online challenges that keep employees motivated throughout the year by pairing social networking and competition.

The more members use these tools, the more information we have to personalize additional online and telephonic outreach. For example, completing the health assessment can trigger outreach for a coaching program. Once engaged, our nurses and coaches can assign tools to try out and see how members are doing on their care plans.

Local support

We've give members easy access to well-being services right where they live and work through MinuteClinic, the walk-in medical clinic inside select CVS Pharmacy locations. It's a fast and easy way for members to focus on their health, right in their neighborhood and at a time that works best for them. They can register at the MinuteClinic at any time with no appointment necessary.

MinuteClinic clinicians provide in-person, one-on-one wellness services to Aetna medical members for biometric screening counseling, weight management, tobacco cessation coaching and chronic condition monitoring*.

*While preventive coaching sessions are available to members at no or little additional cost, chronic condition monitoring sessions are not considered preventive under member benefit plans and may be an added cost. We encourage members to check their benefit plan for any out-of-pocket cost.

Incentives that motivate and reward

Incentives are a great way to improve morale and get more employees involved.
Our incentive program rewards employees who complete health activities such as:

- Completing a health assessment or online health coaching program
- Participating in telephonic coaching, disease management, maternity management or Aetna In Touch Care program
- Receiving a preventive care screening

We know that long-term commitment is the key to long-term success. To that end, we have developed a range of programs to not only get members engaged in their care, but also to keep them motivated and involved.

1.236	The State has employees throughout the state. Describe the strategy for engaging individuals in remote locations?

Response:

As noted above, we maximize engagement by delivering a personalized wellness experience. This means that we're meeting members where they are on their health journey with a variety of tools and programs they can select based on their needs and preferences and can be completed no matter where they are located. This includes:

- Online engagement
- Local Support
- Incentives to motivate and reward behavior change

1.237	How will this program help the State be successful in evolving its culture of health in the workplace and engaging members into programs?

Response:

We never stop looking for engaging and meaningful ways to provide our customers and their employees with access to convenient, cost-effective health and wellness resources. Healthy behavior change is at the core of any successful health and wellness strategy. Because we know this change usually takes place in small steps, we understand the benefits of a progressive approach. We work with you to define your health and wellness goals and then propose a creative, multi-year solution to drive and sustain healthy lifestyle changes. This results in:

- Healthier employees and their families
- Higher employee productivity
- Lower medical costs over time

Our experience shows that the success of our online health and wellness programs, is largely dependent on certain supporting factors. These include:

- Management support
- A strong communication strategy
- Incentives and rewards

We have found that that dedicating resources to these three factors can help you attain a high percentage of participation in our program.

Management support

The success of any wellness program begins with management support. We recommend that the State takes the following steps to ensure the success of our online wellness programs.

Gain management support

Support from top management may be the single most important thing for long-term program success. To do this, we suggest that you:

- Inform management about the program and how it supports a healthy workforce
- Identify internal champions
- Update management with program progress and upcoming initiatives
- Look for opportunities to involve management in communications about the program through an employee memo, email or a message within an employee newsletter

Create a wellness team

We advise that you identify key players within your organization who are stakeholders in employee health and well-being and can support a successful program implementation. These might include individuals from a variety of health-related business areas, such as:

- Employee benefits
- Health promotion
- Fitness
- Disability
- Workers' compensation
- Ergonomics
- Work/life programs
- Employee assistance programs
- Occupational health and safety

Other business areas that may provide valuable support include human resources, food management, communications and marketing. Your wellness team helps make decisions about program strategies and builds greater ownership and support.

Integrate your program with other company activities

We recommend you integrate our online wellness programs into your other company initiatives. For example, you can incorporate the program into the following:

- Benefit fairs
- Business meetings
- Social activities
- Community events
- Employee campaigns and celebrations

This not only helps increase engagement in our program, but it can also help support your other business goals.

Communication strategy

We believe that the promotion and internal support you give greatly influences participation in the program. To help you communicate the program and promote participation, we provide you with our Member Engagement Toolkit. This turn-key solution helps you customize the communication campaign to meet your specific health and wellness needs.

Our Member Engagement Toolkit includes a variety of communication and promotional templates that you can use with consideration to your corporate culture, technical capabilities and budget. This online toolkit includes:

Communication guide

We provide you with an online communication guide to help you plan a comprehensive communication campaign. Topics include:

- Getting started – includes getting management buy-in, deciding how our program fits with your other wellness programs and thinking about employee reception to an online program
- Developing your communication plan – covers phasing communications year round, timing, number of communications and proper mix of print and electronic media
- Communication materials – describes the electronic communications available, such as e-cards, postcards, posters, flyers, web buttons and graphics
- Incentives – includes types of rewards and our recommended guidelines for offering incentives
- Broadcast messaging – explains how you can customize our wellness website
- Goals and achieving success – covers setting your participation goals, how often to re-evaluate them and the factors that affect participation rates

Communication assessment

We'll help you evaluate your target audience and rank your employees' preferred communication methods. For example, you'll be asked to provide information on:

- The number of employees who will have access to the program
- Which employees are offered the program (i.e. all employees or Aetna members)
- Percentage of employees who have email at work
- Whether employees are located in one place or multiple locations
- The types of communication methods you use and their effectiveness

Using this information, we'll help you decide what types of communications to send and how many you'll need. We'll also use it to determine if an onsite event is a feasible solution.

Communication plan template

Our communication plan template lists specific communications with their purpose and target audience. It also includes a suggested timeframe for delivering each communication. You simply add who is responsible for each and the actual release date.

Communications library

We can provide you with convenient online access to the following electronic communications:

- Kick-off emails / articles
- Reminder emails / articles
- Site tour
- Postcards
- Poster
- Flyers
- Web buttons
- Visual graphics

In addition, your account team adds support and advice – from help developing core messages to coordinating incentive programs. Your account team also provides ongoing promotion support after implementation. The key to effective, ongoing communication is to use multiple communications methods rather than rely on a single marketing tool. That's why we support you with email, posters, flyers, direct or interoffice mail and suggestions for showcase displays to vary the communication strategy. By keeping the message fresh, you continue to attract new members and keep current participants engaged.

Incentives and rewards

A well-designed incentive program can boost overall participation, engage those who may not typically participate in wellness activities and reward those who have taken positive steps to enhance their health and well-being. Even modest incentives can have a positive impact in achieving program goals. They can also add creativity and fun, which help build enthusiasm and support for the program.

We have found that the average utilization rate of our online wellness programs is approximately 18 percent amongst customers who offer an incentive/reward program. However, this does not take into account the amount or type of communications or the amount of management support. Customers that communicate the health assessment or the program very little or only once and do not offer incentives, is less than 3 percent.

1.238	Describe the web-based digital platform capabilities with respect to wellness programs and data aggregation. Include the ability for programs from other vendors to be "plugged into" the platform and describe the tools included in the digital platform.

Response:

Our wellness platform is the digital gateway to health. We've packaged all of your digital tools, programs and resources neatly into a comprehensive online experience. It includes visuals and graphics that prompt members' interest and enthusiasm. And it houses a health assessment, online health coaching programs and decision support tools that are presented in a fun and engaging way.

The wellness platform makes it easy for members to manage their health. They can integrate devices and schedule appointments so members can conveniently reach us. Plus, they can connect with other people through social networks. Optional tools include our Rewards Center that coordinates incentive administration and challenges that promote better nutrition, physical activity and weight management.

Our member website contains links to external websites that can help members make informed health decisions. Some of these links display based on the State's design and/or the member's individual plan. Examples of the external websites a member can access include:

- Discount program websites (dependent on the plan design)
- Healthwise® Knowledgebase
- Health Decision Support

1.239	Describe how members are provided with personalized guidance and a longitudinal view of the member's health, healthcare and benefit needs.

Response:

Upon completion of the Simple Steps To A Healthier Life health assessment, the participant receives:

• A Health Risk Score - Computed using a scientific algorithm, the score is designed to predict the relative level of health risk a participant may have, compared to other people of the same age and gender.

• Tailored Health Reports – The tailored health reports address specific individual health risk factors for developing certain conditions. Within the reports, risk for diseases is broken into modifiable and non-modifiable components and ranked as low, moderate, high or very high. This helps the participant focus on how to improve their chances for remaining healthy and productive. The health reports cover the following areas:

- Overall health risk
- Heart disease
- Stroke
- Diabetes
- Depression
- Colon cancer
- Breast cancer (for men and women)
- Prostate cancer (for men)
- Skin cancer
- Strategies for success

• Health Summary Report – We encourage participants to print out the health summary to share with their doctor, dentist or other healthcare provider. Through the health summary report, participants are able to keep, record and compare their results over time.

Action plan

After completing the health assessment, participants may click on a link to access their action plan, which is specifically designed to address common health/wellness concerns, such as:

- Weight loss
- Nutrition
- Stress management
- Smoking cessation

Those who elect to close out after reviewing their health assessment results may receive a personalized email that invites them to access their action plan and participate in the online health coaching programs.

Personal Health Record

Our Personal Health Record (PHR) automatically sends health alerts and tasks (reminder messages) that inform members of potential health risks and ways to improve their medical care.

Personalized health alerts and reminders

The PHR sends alerts to members based on the member's profile, claims history and health assessment results. Our PHR uses patented CareEngine® technology to constantly review the information in each record to uncover gaps in care and opportunities for improved care based on medical best practices. *The PHR delivers:*

- Targeted alerts that inform members of opportunities to improve their health and well-being. Alerts may encourage use of alternative therapies and/or warn them of potentially dangerous health situations. They also give people actionable steps that can help them reduce health risks and lead healthier lives.

- Personalized reminders, based on member needs, which encourage immunizations and age-appropriate preventive exams and screenings that can help identify health issues early on.

- Member-specific tasks, assigned by Aetna clinicians and health coaches, to further encourage members to actively manage their health issues. When the PHR is offered with Aetna care management programs, our clinicians and coaches can send these "From Your Coach" messages to a member's PHR.

If a health risk or opportunity to improve health is uncovered, we send an email to the PHR user. The member provides their email address when they register for our member website. Members can also add a different email address for these alerts by updating their PHR profile. To view the message, members simply click the PHR link in their email and login to the site at the prompt. The Alerts & Tasks page appears, showing the member's new health messages.

Members can also see if they have an alert or reminder when they visit our member website. A message regarding new activities or alerts appears immediately upon login within the "Your Messages" box on the website home page. Members can then click the message to view the activities and alerts in their PHR.

Levels of alerts and reminders

There are three levels of alerts and reminders. The level depends on the severity of the health issue. Members can tell which messages are more critical based on the number of stars next to them. More stars mean more criticality.

Taking action on alerts and reminders

We ask that members take action on an alert by selecting from a response menu. Members move an alert or activity to the Completed section of the (Alerts & Tasks page) by providing a response that indicates either:

- The action was completed, or
- They do not plan to complete it.

The response options offered often define the reason for not completing the action (e.g., "My doctor told me not to").

All open alerts remain on display in the Alerts & Tasks page as long as the health risk remains, regardless of the date posted.

For urgent alerts, our PHR sends two follow-up emails. For all other alerts, there is only one follow-up email.

Informing providers about health issues

If more serious health issues are identified, we send a message to members and their providers in as timely a manner as possible.

Our PHR informs providers electronically, by telephone or fax, depending upon the severity if the issue. When urgent alerts are generated, the physician typically notifies the member by telephone.

If a member chooses to share the entire PHR with a provider through online delegation, the provider can see the whole PHR along with the activity or alert. This delegated access helps close any gaps in care.

We deliver electronic Care Considerations to physicians through our secure provider website. We have contracted with NaviNet® to host this website for providers and their office staff. NaviNet's free, web-based communication platform helps link providers with health plans. All physicians registered for our provider website through NaviNet can receive online Care Considerations.

PHR subscribers have the ability to stop receiving email messages with alerts & tasks. However, if the PHR finds a critical health risk, it may send an alert to the doctor even if the member has not agreed to share their PHR online.

1.240	Describe all-in-one experience for members to access medical benefits and programs available, as well as to find the best and most cost-efficient care.

Response:
Our website is a user-friendly information touch point for each member. No matter where they are on the health spectrum, they can find the tools and information needed to manage their health. We do this by ensuring the member experience is:

Always On

Our member website and Aetna Health mobile app are available 24/7 — whether they're at home, work or on the go — to meet our members' needs.

Personal and relevant

Not only do we customize the information on our website for the State's plan, be more personally relevant by ensuring each touch is informed by what we know about the member. We use proprietary algorithms to deliver a personalized member experience. As they share their health history and habits, we provide personalized health tips and actionable items to maximize benefits – all unique to the user.

For example, if we know that a member is located in an area affected by wildfires and air quality is impacted, we can alert the member with specific tips on how to manage the situation. Or, we can alert a member that there is a walk-in clinic offering flu shots on their way home from work, just before they leave work for the day.

Integrated and predictable

Our member website delivers consistent experiences across all benefits and interfaces, for example, claims, HSA, pharmacy and wellness benefits all in one place.

Simple

Through a seamless user experience, our members have the ability to:

- Find quality and cost-efficient care
- Manage benefits
- Access tools for health and wellness

Wherever possible, we've integrated functionality to make the process as simple as possible. For example, as members search for providers, they are given the option to check prices, schedule an appointment and see quality information all in one place.

High Touch

Our website offers high-tech and high-touch support for everything from medical information to benefits support. For example, we offer members the ability to ask registered nurses health questions by email or chat.

1.241	Can individuals be tracked and rewarded for showing progression and build that activity into the incentive design? Explain.

Response:

Yes. We have the ability to reward members for completing an onsite biometric screening through Quest Diagnostics, Inc. when we act as the incentive/rewards administrator.

We receive participation data from Quest in a specific format so that we can upload and integrate it into our Incentive Management System. The system then rewards the member accordingly, based on your specifications. The information is integrated into the CareEngine and may trigger Care Considerations and outreach from our Healthy Lifestyle Coaching program, if appropriate (and included in the plan design).

You may provide incentives to your employee population for completing the following actions:

- Participating in an onsite metabolic syndrome or biometric screening program. Tracking participation for incentive administration is available at no additional cost by Quest. Aetna incentive administration charges may apply.

- Achieving in-range results or outcomes-based incentives. Customers can use Quest's standard measurement for in-range results or customize in-range metrics based on their own wellness incentive strategy. For example, in a metabolic syndrome screening package, customers may opt to incent their population (aged 18+) for achieving nationally accepted metrics in three out of five tests for metabolic syndrome. Or, they can customize the number of tests required (e.g., two instead of three) or even the specific test metrics themselves in determining what constitutes in-range results. Additional Quest and Aetna incentive administration charges may apply.

  It is important to note that blood pressure results cannot be individually identified for improvement, only for in-range achievement. This is due to the nature of blood pressure results being two separate measurements.

- Improving results. This outcomes-based incentive option lets you provide incentives to your employee population for improving their screening results on a year-over-year basis. Similar to the in-range incentive option, you may choose a specific measure of improvement as an incentive metric. Or, Quest can track improvement on those who may have been out-of-range the prior year but now have in-range results. Additional Quest and Aetna incentive administration charges may apply.

It is important to note that outcomes or improvement based incentives now require that a customer offer a reasonable alternative for members not being able to complete the activity due to a medical factor. We can assist our customers in identifying a reasonable alternative program activity. And, we can help in administering the reasonable alternative.

Aetna Get Active!

We also offer incentives to drive program participation In Aetna Get Active. Aetna Get ActiveSM is an online wellness program that offers interactive, seasonal challenges to keep people moving and motivated throughout the year. This worksite health program drives engagement and helps create lasting behavior change by incorporating team challenges with social networking and competition. Virgin Pulse, an industry leader in the wellness arena, powers our Aetna-branded program.

The power of teamwork, social networking and online tracking

Teamwork is the foundation of the Get Active strategy. The program features a team-based competition with activities that build off the camaraderie formed when participants work towards a common goal with peers and friends at work. Through personal involvement and friendly competition, employees motivate each other to begin or increase physical activity and adopt healthy habits.

The State may choose to reward participants during the fitness or nutrition competition or throughout the program year.

Attain

Developed in collaboration with Apple, Attain by Aetna^{SM} is the next step in our journey to transforming the consumer health care experience. It's a unique health experience that enables us to connect with members using the mobile devices they already use. Powered by real-time sensors in the Apple Watch® and each member's unique health history, the Attain app:

- Helps members set and achieve personalized activity goals
- Encourages actions that improve overall health
- Provides personalized health notifications at key moments
- Rewards members for taking actions to improve their well-being

We give members options to use Attain in the way that works for them. Members can choose to use Attain to purchase an Apple Watch over 24 months, or they can connect their current Apple Watch. As they complete their activity goals and take action on the recommended healthy actions, participants earn reward points using the Attain app. Members can choose use their points to reduce the cost of their monthly payment for their Apple Watch or redeem them for electronic gift cards to many popular national retailers.

Attain helps members achieve healthier lives through a personalized experience driven by their health history and backed by the power of the Apple Watch. Combining the convenience and unmatched user experience of Apple products and our health care expertise gives us the opportunity to create simple, intuitive and personalized technology solutions like Attain that can help our members achieve their health goals.

Additional Incentives

We can also provide incentives and tracking for:

- Completing our health assessment
- Completing an online coaching program

- Completing routine preventive care services such as:
  Well Adult (includes well adult visits, Prostate Specific Antigen (PSA) test, routine hearing exam and routine X-ray)
  - Well Baby/Well Child
  - Immunization
  - Flu Shot
  - Well Woman (includes Routine OB/Gyn and Routine Pap/Radiologist/Pathologist and Lab)
  - Mammogram
  - Routine Eye Exam
  - Colonoscopy
  - Sigmoidoscopy
- Participating in a care management program
- Participating in our Aetna Maternity Program and completing the pregnancy risk survey
- Completing a maternity program postpartum survey
- Completing the Personal Health Record Walk-Me-Through tool
- Using tracker tools and devices to track physical activity
- Completing recommended actions in the wellness portal
- Indicating tobacco use status
- Participating in a wellness challenge
- Participating in a mindfulness program

1.242	Describe any such initiatives currently offered to self-funded groups such as the State, which are available within the State of Nebraska. Describe how these Nebraska initiatives can be implemented in the State's health plans and the incremental costs of the ASO fees. If any of these innovative Nebraska-based initiatives are in development or in the planning stages for the future, provide any information available to allow the State to understand concepts for developing each initiative. Include information on the expected implementation of such initiatives in Nebraska, when available to the State plans and the expected impact on program costs. Such initiatives may include, but are not limited, to the following: a. High Performance Networks or narrow networks, b. Patient-Centered Medical Home models, c. Accountable Care Organizations, d. Telemedicine/Virtual Visits (which also includes Behavioral Health); e. Other value-added services.

Response:

Accountable Care Organizations

Our Aetna Whole Health – CHI (AWH CHI) Accountable Care Network is a collaboration between Aetna and CHI Health. This product model ACO through the CHI network is a significant differentiator and would be a great option for the State's members. The AWH CHI ACO provides access to 72 percent of the State's employees, based on the census that was provided. AWH CHI is lower in price than the broad network that we are also offering and provides an average savings that ranges from 13-16 percent.

We have designed the plan to offer improved quality, outcomes, efficiency and member experience. Our locally based accountable care model centers on the relationship between the primary care doctor and the patient. Through that, we strive to reach members where, when and how they live.

Our Aetna Whole Health CHI plan offers member-focused, doctor-driven health care. CHI sends welcome letters to members, introducing the Aetna Whole Health plan's unique coordinated care services and providing a dedicated phone number to reach CHI Health's care coordination team.

The CHI Health Accountable Care Network will provide members with highly coordinated care through their clinically integrated network. The overall network includes:

- More than 800 primary care doctors
- More than 4,500 specialists
- 28 acute care hospitals
- 7 quick care locations
- 21 urgent care centers

Members are strongly encouraged to select a primary care doctor who will help to guide them when making important health care decisions and direct them to the care they need at the right time in the right setting.

Aetna Whole Health delivers a new health care model to consumers, providing members access to efficient and highly coordinated care.

Better Health, Better Care and Better Cost

Our collaboration is designed to provide member-focused, doctor-driven health care that delivers:

- An efficient health care model that meets the needs of employers to effectively control medical costs
- Accountable and results-driven doctors to deliver highly coordinated care, centered around the patient
- Doctors who use appropriate technology and data to both assess and increase quality to reduce costs, while improving care
- Convenient appointments with participating providers – many offering evening and weekend hours
- Nationally recognized track record of ongoing care management and quality of patient care
- Patient navigators to help patients with complex needs get the care they need quickly and easily
- Convenient patient portal to request appointments, check lab work, request prescription refills and more

With Aetna Whole Health – CHI Health Accountable Care Network, our customers can save up to 13-16 percent of aggregate medical costs, compared to broad network plans, in the first year alone – with an enhanced care model that can result in year-over-year savings.

Nationally, we have more than 1,900 value-based contracts (VBCs), including over 140 ACO agreements and five joint ventures, which span all regions. Our contracted ACOs include some of the most advanced and efficient systems in the country. Today, 60% of our claim payments go to providers who deliver value-based care, with 61% of those payments aligned with our commercial ACOs and joint ventures. Our goal is to have 75% of all medical spend in VBC arrangements by 2020.

*Actual results may vary, depending on the specifics of the ACO contract.

High Performance Networks

Aetna Premier Care Network Plus is a simplified solution to savings. It's a single, national network that has one plan design and uses the best network configuration in each market. For your employees, it makes maximizing their benefits as easy as selecting an in-network provider. And for you, the consistent network design across your entire population produces sustainable cost savings.

The Aetna Premier Care Network Plus consists of performance networks and accountable care organizations (ACOs) in 55 markets for 2020 and the standard broad network in all other Aetna markets. This enables you to provide a single, simplified solution to all your employees.

In Nebraska, we offer our Nebraska Health Network. This network offers:

- Over 375 primary care doctors
- Over 1,200 specialists
- 5 hospitals
- 8 urgent care centers

Our high performance networks offer:

- A single national network strategy, focused on the best provider network possible for member care.
- A single national benefits and communication strategy, allowing streamlined messaging to employees and their families.
- Lasting savings to achieve long-term sustainability.

A plan design that is easy to understand and communicate to employees

Aetna Premier Care Network Plus's two-tier, concentric plan design makes it possible for members to maximize value by simply staying in the network. Our provider search makes it easy for members by simply including all Aetna Premier Care Network Plus ACO providers, designated hospitals and designated specialists in the in-network results, creating a seamless experience for members.

Network composition

We developed Aetna Premier Care Network Plus to make it easy for you and your employees to take advantage of the performance networks that we operate, as well as our broad networks in all other markets across the country.

Performance networks

In the performance markets, Aetna Premier Care Network Plus uses the network configuration that produces the greatest medical cost savings through high quality and clinically efficient providers, while still satisfying geographic coverage needs.

To accomplish this, we included the best network solution in each market based on our experience in developing performance network programs. Aetna Premier Care Network Plus includes three types of performance networks:
ACOs:

- Transformational provider payment models in:

- 30 market areas for 2020. Including five joint venture health plans with Sutter Health Aetna, Innovation Health, Banner Health Aetna, Texas Health Health and Allina Aetna.

- Hospital and specialist narrow networks in:
- 17 performance network markets for 2020
- Specialist only narrow networks in:
- 7 performance network markets for 2020

Only one network program is selected for each market. That means your employees see it as simply "Aetna Premier Care Network Plus," where providers are either in-network or out-of-network.

Telemedicine/ Virtual Visits (including Behavioral Health)

We offer phone and online-video consultations with physicians to members through Teladoc, Inc. (based in Lewisville, TX and Purchase, NY). Teladoc provides access to a national network of board-certified physicians. These physicians can diagnose, recommend treatment and write short-term prescriptions for members by phone. The network includes family practitioners, internal medicine physicians, emergency medicine physicians and pediatricians.

To arrange a consultation, members can call a toll-free number or visit the Teladoc website at **www.teladoc.com/aetna** or use the Teladoc mobile app There is no referral or appointment required. The member's financial responsibility for a covered consultation through Teladoc is the same as it is when visiting a network PCP or specialist, as determined by the member's plan design.

For an illness or injury that is not an emergency, this service is a convenient, cost-effective alternative to hospital emergency rooms and urgent care clinics. Teladoc is not intended to replace a member's physician but provides access to health care when reaching the physician is not possible.

Teladoc benefits:

- Convenience of 24 hour, 7 day access by phone
- Online video consultations available 7 a.m. to 9 p.m. in each time zone
- Shorter wait times (physician call backs average 15 minutes)
- Less out-of-pocket expense
- No appointment or referral required
- Talk directly with a U.S. board-certified physician

Response:

We offer behavioral health tele-video services to customers as part of their in-network outpatient benefit. Aetna Behavioral Health enables members who need behavioral health services—but can't get to their provider's office—the ability to have a session with a behavioral health provider using their computers, laptops, smartphones or any mobile device.

Tele-video provides online face-to-face access with clinical specialists such as: social workers, counselors, psychologists, marriage and family therapists and psychiatrists.

There is no impact on the number of face-to-face sessions offered within a member's plan. Members can receive behavioral health services face-to-face with a provider, in their office or through tele-video. No precertification is required. We reimburse tele-video services at the same rate as in-person face to face services. Claims will be applied towards the plan benefit under in-network outpatient counseling and will auto adjudicate.

Depending on where the member lives, Inpathy, MDLive or Arcadian Telepsychiatry will provide tele-video services.

Technical needs - In order to receive tele-video services, a member must have all of the following:

- High-speed internet
- Web cam
- Email – to receive a HIPAA compliant tele-video link

Benefits of offering a tele-video option to our members include:

- In urban areas, tele-video helps members who may have difficulty making their appointments due to traffic, parking and long work hours.

- In rural areas, tele-video helps members who have a very limited number of providers in their area or no providers within a reasonable distance.

- Given the growing demands on families, tele-video can help members who may have childcare constraints and can't travel outside the home for a private session.

AbleTo

Undiagnosed and untreated, behavioral health issues can make it difficult for people to follow their doctors' advice. Like taking medicine, eating healthier, getting some exercise. This can make their health conditions even worse - and lead to higher-cost hospital care down the road.

The AbleTo program makes it easy for your members to get the behavioral health help they need — before it can complicate the health conditions they are already dealing with and before it can drive up overall medical costs.

Our AbleTo offering identifies members with specific conditions or life events that could benefit from behavioral health support. Members are then invited to join one of the AbleTo programs. Each program includes eight weeks of personal professional support through web-based video conferencing or by telephone.

AbleTo provides support for the following health care conditions and life changes:

- Cardiac events
- Diabetes
- Breast cancer recovery
- Prostate cancer recovery
- Pain management
- Depression and anxiety
- Postpartum depression
- Stress related to the care of another adult
- Loss of a loved one
- Anxiety and panic
- GI health
- Respiratory
- Caregiver for adults
- Caregiver support for children
- Caregiver support for autism

Members meet with behavioral professionals through web-based video conferencing or by telephone. This removes the time and hassle of having to drive to appointments. Even more convenient, they schedule their appointments based on their schedule. The AbleTo professionals are available to meet during the daytime, evening and even on the weekend.

Members work with two AbleTo specialists for the first seven weeks:

- Once a week with a therapist, who uses evidence-based approaches to address emotional challenges, like depression, stress and anxiety, that can come with their diagnosis

- Once a week with a behavior coach, to identify health goals and develop an action plan for members to follow and help keep them on track

That's two sessions a week and a final meeting with the therapist - 15 sessions in total. All for one copay a week. The participant meets with the therapist for a final consultation in the eighth week.

The therapist helps the member address the emotional challenges – like depression, anxiety and stress – that can come with a medical diagnosis. The behavior coach works with the participant to identify personal health goals and develop an activity plan to help keep on track.

CVS HealthHUB

CVS Health and Aetna are transforming the consumer health experience with a new model designed to make health care easier to use and less expensive. HealthHUB® locations at CVS Pharmacy® are test and learn pilots to create a new retail health engagement model.

HealthHUB locations are an innovative health experience dedicated to help improve consumer well-being and answering questions about health, prescription drugs and health care benefits — all under one roof. A test concept, the HealthHUB locations are the first- of-their-kind, community-based stores focused on helping consumers get well — and stay well They offer a broader range of health care services, wellness products, trusted advice and personalized care — all conveniently located within a local CVS Pharmacy.

HealthHUB locations provide health care services in a more convenient, accessible and holistic manner, including:

- Personalized pharmacy support programs and MinuteClinic ® services, such as phlebotomy, diabetic screenings and sleep apnea assessments.

- Pathways to nutritional health with one- on -one and group counseling delivered by an in-store dietitian, as well as access to a free weight loss digital app.

- A care concierge acts as the connection point inside the store and is responsible for customer engagement, new service offerings education and navigating in-store services and events.

- Community spaces and digitally-enabled offerings, including wellness rooms that are available for CVS professionals and community partners to host group events, including health classes, nutritional seminars, yoga and benefits education.

Together, we are bringing local care to your neighborhood. By engaging consumers on their individual health care journey and using our holistic solutions to help them achieve their health goals, we're helping members on the path to better health. We plan to have a total of 1,500 HealthHUB locations operating by the end of 2021.

Attain

We never stop looking for innovative and meaningful ways to give members access to engaging, convenient and cost-effective health and wellness resources. Developed in collaboration with Apple, Attain by AetnaSM is the next step in our journey to transforming the consumer health care experience. It's a unique health experience that enables us to connect with members using the mobile devices they already use. Powered by sensors in the Apple Watch® and each member's unique health history, the Attain app:

- Helps members set and achieve personalized activity goals
- Encourages actions that improve overall health
- Provides personalized health notifications at key moments
- Rewards members for taking actions to improve their well-being

Participants obtain an Apple Watch through the program or use their own. Activity from the Apple Watch— along with Aetna health history — powers the program. Attain provides personalized goals, based on age, weight and sex. Participants can earn reward points by reaching activity goals, completing healthy actions or joining health challenges. Participants then can redeem these points to reduce the cost of an Apple Watch or get electronic gift cards from popular retailers.

Higi Machines

In addition to our wellness programs noted above, we are providing a $100,000 allowance for HIGI machines.

higi is a consumer health engagement company making it easier for consumers to measure, track and act on their health data through a free nationwide network of over 10,000 FDA-cleared self-screening smart health stations located in pharmacy retailers and other community points of trust, such as corporate office locations. Enhanced by over 80 different third-party integrations (i.e. apps, devices, monitors, EHRs and more), higi's smart health stations connect across the existing healthcare ecosystem, bridging station activity with digital tools to interact with consumers on the go and extend engagement, making it easier for consumers to remain active in their health. Healthcare stakeholders use higi as a new access point to better reach, connect with and activate targeted populations into appropriate condition management programs; collect biometric and other health determinant data to stratify and prioritize; motivate consumers to take specific actions at a point of care or within the expanding care ecosystem activated by higi connectivity. To date, more than 56 million people have used a higi station to conduct over 322 million biometric tests. For more information, visit us at www.higi.com.

The higi platform qualifies and refers employees to employer-sponsored benefits through self-service biometric screening and configurable risk assessment survey tools. Payers and employers leverage the higi network and platform to digitally inform populations about available benefits, screen and identify the highest risk individuals for triage into appropriate condition management programs and targeted health services. Ongoing participation is encouraged and monitored to understand population health risks and the efficacy and utilization of programs and offerings.

Benefit Review Document

aetna™

Benefit Review Document

We have reviewed State of Nebraska's requested medical plan designs and matched them as closely as possible to Aetna's Choice POS II and Aetna's Health Fund Choice POS II - H.S.A. medical plan designs.

We have listed here those benefit design features that we cannot administer exactly as requested. Where benefits are not specified, we have assumed Aetna's standard benefit provisions will apply. We have assumed Aetna's standard claim policies, schedule frequencies, definitions, limitations and exclusions will also apply unless otherwise noted.

All plans and benefits are subject to and governed by applicable contracts, policies and government regulations. The information herein is believed to be accurate as of the date of submission and is subject to change without notice. All benefits of the plan are subject to coordination of benefits and the terms (including exclusions) of the Agreement.

This plan review is based on a self insured contract. Plan features and product availability are subject to federal requirements as applicable.

Benefit Review Document

Clarifications

*The SBC's indicate that Hearing Aids are covered under the plan under the section for "Other Covered Services". We need details on the Hearing aid benefit, such as dollar limits, frequency limits, etc, in order to determine if the benefit can be supported.
*This review may not reflect the impact of all of the passed health care reform legislation, nor the regulations that may be issued to clarify and revise the law. Certain provisions of the law and regulations may have a material impact on this review.
*Aetna is using the South Carolina benchmark plan as the model for Essential Health Benefits (EHB) compliance.
* All in-network member cost sharing must reduce the in-network out-of-pocket maximum, including in-network prescription drug plan copays or other cost sharing, for all medical plans that are subject to ACA. ACA caps 2019 out-of-pocket maximums at $7,900 for self only coverage and $15,800 for family coverage ($6,750/$13,500 for HSA-qualified HDHPs).
*The following is the link to Aetna's Clinical Policy Bulletins: http://www.aetna.com/healthcare-professionals/policies-guidelines/clinical_policy_bulletins.html.
*Aetna's clinical policies will replace the current carrier's.
*Aetna's standard programs including Disease Management, Case Management, Wellness Incentives will replace any existing programs.
*Aetna's Precertification Lists will replace the current precertification requirements: https://www.aetna.com/health-care-professionals/precertification/precertification-lists.html
*Aetna's standard transplant guidelines through the National Medical Excellence Program/Institute of Excellence Transplant Network will apply. Institutes of Excellence facilities have been contracted on a transplant specific basis and are considered participating only for the specific transplant for which they are contracted.
*Aetna will include our standard Teladoc administration as a replacement to any existing telemedicine, virtual, or online health programs or providers.

Benefit Review Document

Plan Design	RFP/SPD Ref	Benefit Category	Requested Benefit	Benefit Alternatives
Aetna Choice POS II / ASC; Aetna Health Fund® Choice POS II - HSA / ASC	Well Nebraska Incentive Plan; Well Nebraska Plan; Consumer Focused - H.S.A. Plan; Regular Plan	Cardiac Rehabilitation – Outpatient – In and Out of Network	36 visits per calendar year.	**Better Than/Equal To:** Our standard medical plan policy allows for a member to participate in a medically supervised outpatient cardiac rehabilitation program when certain medical criteria are met. Medically necessary frequency and duration of rehabilitation is determined by the member's level of sick
Aetna Choice POS II / ASC	Well Nebraska Incentive Plan	Cardiac Rehabilitation – Outpatient – In and Out of Network	$35 PCP copay applies to in-network visits.	**Better Than/Equal To/Clarification:** The cost share will be based on the type of service performed and the place of service where it is rendered.
Aetna Choice POS II / ASC	Well Nebraska Plan; Regular Plan	Cardiac Rehabilitation – Outpatient – In and Out of Network	20% member cost-share applies to in-network visits.	**Better Than/Equal To/Clarification:** The cost share will be based on the type of service performed and the place of service where it is rendered.
Aetna Health Fund® Choice POS II - HSA / ASC	Consumer Focused - H.S.A. Plan	Deductible – In Network	Deductible are embedded/traditional style.In-network $2600 individual/$5200 family.	**Compliance/Less Than:** If offering a traditional embedded style deductible, for an HDHP to be H.S.A. compliant, IRS regulations require that the "embedded" individual deductible amount must be equal to or greater than the minimum family deductible limit defined by the IRS each year. ($2800 for 2020.)
Aetna Choice POS II / ASC; Aetna Health Fund® Choice POS II - HSA / ASC	Well Nebraska Incentive Plan; Well Nebraska Plan; Consumer Focused - H.S.A. Plan; Regular Plan	Durable Medical Equipment – Outpatient – In and Out of Network	Prior authorization required non-network for DME devices that cost more than $1,000 per device (Purchase or cumulative rental.)	**Better Than/Equal To:** Contracted providers are required to precertify prosthetics and the more expensive durable medical equipment (DME) items such as electric scooters, and motorized wheelchairs. For out of network, dollar thresholds don't apply. However, we will pend certain items for Clinical Claim Review (CCR) medical necessity review.
Aetna Choice POS II / ASC	Well Nebraska Incentive Plan; Well Nebraska Plan; Regular Plan	Family Planning – Maternity Coverage -In and Out of Network	PCP copay applies to initial visit to confirm pregnancy and to non-preventive maternity visits.	**Equal To/Clarification:** If the initial visit or any other visit is not billed as prenatal, well-woman or preventive counseling, then the applicable visit copay will apply. For OB-GYN visits, the specialist copay will apply.

Benefit Review Document

Plan Design	RFP/SPD Ref	Benefit Category	Requested Benefit	Benefit Alternatives
Aetna Choice POS II / ASC	Well Nebraska Incentive Plan; Well Nebraska Plan; Regular Plan	Mental Health and Substance Abuse-Outpatient -In and Out Of Network	$35 copay applies to all outpatient mental health and substance abuse services.	**Compliance/Better Than/Equal To:** We can support this copay for office visits, however, due to concerns that benefit cost shares impacted by Behavioral Health medical/surgical testing would cause the plan to be out of compliance , we would recommend that Outpatient All Other expenses be covered at 100%, no deductible
Aetna Health Fund® Choice POS II - HSA / ASC	Consumer Focused - H.S.A. Plan	Mental Health and Substance Abuse-Outpatient -In Network	All outpatient mental health and substance abuse services are covered at 80% after deductible.	**Compliance/Better Than/Equal To:** We can support office visits at plan coinsurance after deductible. However, we recommend in-network Behavioral Health "All Other" be covered at 100%, after deductible
Aetna Choice POS II / ASC; Aetna Health Fund® Choice POS II - HSA / ASC	Well Nebraska Incentive Plan; Well Nebraska Plan; Consumer Focused - H.S.A. Plan; Regular Plan	Pulmonary Rehabilitation – Outpatient – In and Out of Network	20 visits per calendar year for pulmonary rehab.	**Better Than/Equal To:** Our standard medical plan policy allows for a member to participate in a medically supervised outpatient pulmonary/respiratory rehabilitation program when certain medical criteria are met. Medically necessary frequency and duration of rehabilitation is determined by the member's level of risk. We are unable to administer customer specific limitations.
Aetna Choice POS II / ASC	Well Nebraska Incentive Plan	Pulmonary Rehabilitation – Outpatient – In Network	$35 PCP copay applies to in-network visits.	**Better Than/Equal To/Clarification:** We recommend that the member's cost sharing be based on the type of service performed and the place of service where it is rendered. We are unable to apply a unique cost sharing feature
Aetna Choice POS II / ASC	Well Nebraska Plan; Regular Plan	Pulmonary Rehabilitation – Outpatient – In Network	20% member cost-share applies to in-network visits.	**Better Than/Equal To/Clarification:** We recommend that the member's cost sharing be based on the type of service performed and the place of service where it is rendered. We are unable to apply a unique cost sharing feature
Aetna Choice POS II / ASC	Well Nebraska Incentive Plan	Routine Eye Exam – In and Out of Network	Routine eye exams are covered for adults but excluded for children.	**Better Than/Equal To:** If we cover routine eye exams for adults, we must cover them for all members on the plan. We recommend a frequency of 1 per 12 months or 1 per 24 months for all adults and children on the plan

Benefit Review Document

Plan Design	RFP/SPD Ref	Benefit Category	Requested Benefit	Benefit Alternatives
Aetna Choice POS II / ASC; Aetna Health Fund® Choice POS II - HSA / ASC	Well Nebraska Incentive Plan; Well Nebraska Plan; Consumer Focused - H.S.A. Plan; Regular Plan	Short Term Rehabilitation (No Spinal) -In and Out Of Network	20 visits each physical therapy, occupational therapy, cognitive therapy and speech therapy.	**Better Than/Equal To:** We will administer a 20 visit maximum for each physical, speech, occupational therapies only. Coverage of outpatient cognitive rehabilitation is subject to applicable benefit plan terms and limitations for physical and occupational therapy. (We can increase the maximum for physical and occupational therapies if the customer wishes.)
Aetna Choice POS II / ASC	Well Nebraska Incentive Plan; Well Nebraska Plan; Regular Plan	Telehealth/Telemedicine (Teladoc) -In and Out Of Network	Virtual visit by a designated virtual network provider is covered at 100%.	**Less Than/Clarification:** We recommend that our standard Teladoc program be offered. The PCP copay will apply.

WellNebraska Plan Choice POS II Plan Design - Incentive

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State of Nebraska
Proposed Effective Date: 01-01-2020
Aetna Choice® POS II -- ASC

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Benefit Limitations - For any service or supply that is subject to a maximum visit, day, or dollar limitation on a per year basis, the benefit year begins on January 1st unless otherwise mandated. Refer to your plan documents for more information.		
Deductible (per calendar year)	$800 Individual $1,600 Family	$1,600 Individual $3,200 Family
All covered expenses accumulate separately toward the in-network or out-of-network Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Deductible amount.		
Member Coinsurance Applies to all expenses unless otherwise stated.	20%	30%
Payment Limit (per calendar year)	$2,700 Individual $5,400 Family	$5,400 Individual $10,800 Family
All covered expenses accumulate separately toward the in-network or out-of-network Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. Pharmacy expenses apply towards the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.		
Lifetime Maximum Unlimited except where otherwise indicated.		
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	Covered 100%; deductible waived	30%; after deductible
Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	Covered 100%; deductible waived	30%; after deductible
Routine Gynecological Care Exams 1 exam and pap smear per calendar year, includes related fees.	Covered 100%; deductible waived	30%; after deductible

Routine Mammograms	Covered 100%; deductible waived	30%; after deductible
Women's Health	Covered 100%; deductible waived	30%; after deductible
Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.		
Routine Digital Rectal Exam	Covered 100%; deductible waived	30%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	30%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered under Routine Adult Exams
Recommended: For all members age 45 and over.		
Routine Eye Exams	Covered 100%; deductible waived	Not Covered
1 routine exam per 24 months.		
Routine Hearing Screening	Covered 100%; deductible waived	30%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Non-Specialist	$35 copay; deductible waived	30%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	$50 copay; deductible waived	30%; after deductible
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	30%; after deductible
Walk-in Clinics	**Designated Walk-in Clinics** Covered 100%; deductible waived **All Other Network Providers** $35 copay; deductible waived	30%; after deductible
Walk-in Clinics are free-standing health care facilities that (a) may be located in or with a pharmacy, drug store, supermarket or other retail store; and (b) provide limited medical care and services on a scheduled or unscheduled basis. Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices are not considered to be Walk-in Clinics.		
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	20%; after deductible	30%; after deductible
(other than Complex Imaging Services) If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic Laboratory	20%; after deductible	30%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

Diagnostic Complex Imaging	20%; after deductible	30%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$50 copay; deductible waived	30%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	20%; deductible waived	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100%; deductible waived	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	20%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	20%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	20%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	20%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	20%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	20%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	$35 copay; deductible waived	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	Covered 100%; deductible waived	30%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	20%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	20%; after deductible	30%; after deductible
Substance Abuse Office Visits	$35 copay; deductible waived	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	Covered 100%; deductible waived	30%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility Limited to 60 days per year	20%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	20%; after deductible	30%; after deductible
Hospice Care - Inpatient	20%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	20%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing	Not Covered	Not Covered
Spinal Manipulation Therapy	$35 copay; deductible waived	30%; after deductible

Limited to 30 visits per year		
Outpatient Short-Term Rehabilitation	$35 copay; deductible waived	30%; after deductible
Includes speech, physical, occupational therapy; limited to 20 visits per year		
Habilitative Physical Therapy	Not Covered	Not Covered
Habilitative Occupational Therapy	Not Covered	Not Covered
Habilitative Speech Therapy	Not Covered	Not Covered
Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Combined with outpatient mental health visits		
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Covered same as any other Outpatient Mental Health All Other benefit		
Autism Physical Therapy	$35 copay; deductible waived	30%; after deductible
Autism Occupational Therapy	$35 copay; deductible waived	30%; after deductible
Autism Speech Therapy	$35 copay; deductible waived	30%; after deductible
Durable Medical Equipment	20%; after deductible	30%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Not Covered	Not Covered
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other medical expense.
Infusion Therapy Administered in the home or physician's office	20%; after deductible	30%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	20%; after deductible	30%; after deductible
Vision Eyewear	Not Covered	Not Covered
Transplants	20%; after deductible Preferred coverage is provided at an IOE contracted facility only.	30%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Diagnosis and treatment of the underlying medical condition only.		
Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation induction		
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery		
Vasectomy	Your cost sharing is based on the type of service and where it is performed	30%; after deductible
Tubal Ligation	Covered 100%; deductible waived	30%; after deductible

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy Plan Type	Aetna Standard Open Formulary	
Pharmacy Payment Limit	$2,000 Individual $4,000 Family	
Generic Drugs		
Retail	$5 copay	30% of submitted cost; after applicable copay
Mail Order	$10 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$30 copay	30% of submitted cost; after applicable copay
Mail Order	$60 copay	Not Applicable
Non-Preferred Brand-Name Drugs		
Retail	$50 copay	30% of submitted cost; after applicable copay
Mail Order	$100 copay	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna National Network	
Mail Order	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy	
Specialty	Up to a 30 day supply All prescription fills must be through our preferred specialty pharmacy network. Aetna Specialty Performance Network Aetna Standard Plan Drug List	

Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.
Exclude copay differential from applying to Coinsurance Limit

Plan Includes: Diabetic supplies, blood glucose monitors, prescription weight loss drugs and contraceptive drugs and devices obtainable from a pharmacy.
Includes sexual dysfunction drugs for females and males, including daily dose, additional 8 tablets a month for males for erectile dysfunction.
Oral fertility drugs included.
Precertification for specialty drugs included
Seasonal Vaccinations covered 100% in-network
Preventive Vaccinations covered 100% in-network
Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

GENERAL PROVISIONS

Dependents Eligibility Spouse, children from birth to age 26 regardless of student status.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.
Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.
The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids
- Home births
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna, or its affiliate(s), receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates may reduce the amount a member pays the pharmacy for covered prescriptions.
Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.
In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.
Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862.**
Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**
Plan features and availability may vary by location and group size.
For more information about Aetna plans, refer to **www.aetna.com.**
Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are both within the CVS Health family.

WellNebraska Plan Choice POS II Plan Design – Without Incentive

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PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Benefit Limitations - For any service or supply that is subject to a maximum visit, day, or dollar limitation on a per year basis, the benefit year begins on January 1st unless otherwise mandated. Refer to your plan documents for more information.		
Deductible (per calendar year)	$1,400 Individual $2,600 Family	$2,800 Individual $5,200 Family
All covered expenses accumulate separately toward the in-network or out-of-network Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Deductible amount.		
Member Coinsurance Applies to all expenses unless otherwise stated.	20%	40%
Payment Limit (per calendar year)	$4,000 Individual $8,000 Family	$8,000 Individual $16,000 Family
All covered expenses accumulate separately toward the in-network or out-of-network Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. Pharmacy expenses apply towards the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.		
Lifetime Maximum Unlimited except where otherwise indicated.		
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	Covered 100%; deductible waived	40%; after deductible
Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	Covered 100%; deductible waived	40%; after deductible
Routine Gynecological Care Exams 1 exam and pap smear per calendar year, includes related fees.	Covered 100%; deductible waived	40%; after deductible
Routine Mammograms	Covered 100%; deductible waived	40%; after deductible
Women's Health Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	Covered 100%; deductible waived	40%; after deductible

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

Routine Digital Rectal Exam Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	40%; after deductible
Prostate-specific Antigen Test Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	40%; after deductible
Colorectal Cancer Screening Recommended: For all members age 45 and over.	Covered 100%; deductible waived	Covered under Routine Adult Exams
Routine Eye Exams 1 routine exam per 24 months.	Covered 100%; deductible waived	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	40%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician.	$45 copay; deductible waived	40%; after deductible
Specialist Office Visits	$55 copay; deductible waived	40%; after deductible
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	40%; after deductible
Walk-in Clinics Walk-in Clinics are free-standing health care facilities that (a) may be located in or with a pharmacy, drug store, supermarket or other retail store; and (b) provide limited medical care and services on a scheduled or unscheduled basis. Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices are not considered to be Walk-in Clinics.	**Designated Walk-in Clinics** Covered 100%; deductible waived **All Other Network Providers** $45 copay; deductible waived	40%; after deductible
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray (other than Complex Imaging Services) If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	20%; after deductible	40%; after deductible
Diagnostic Laboratory If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	20%; after deductible	40%; after deductible
Diagnostic Complex Imaging If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	20%; after deductible	40%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$55 copay; deductible waived	40%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	20%; deductible waived	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	20%; deductible waived	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Coverage	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	$45 copay; deductible waived	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	Covered 100%; deductible waived	40%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	20%; after deductible	40%; after deductible
Substance Abuse Office Visits	$45 copay; deductible waived	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	Covered 100%; deductible waived	40%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility Limited to 60 days per year	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	20%; after deductible	40%; after deductible
Hospice Care - Inpatient	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing	Not Covered	Not Covered
Spinal Manipulation Therapy Limited to 30 visits per year	$45 copay; deductible waived	40%; after deductible
Outpatient Short-Term Rehabilitation	$45 copay; deductible waived	40%; after deductible
Includes speech, physical, occupational therapy; limited to 20 visits per year		
Habilitative Physical Therapy	Not Covered	Not Covered
Habilitative Occupational Therapy	Not Covered	Not Covered
Habilitative Speech Therapy	Not Covered	Not Covered
Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Combined with outpatient mental health visits		

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health All Other benefit	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Autism Physical Therapy	$45 copay; deductible waived	40%; after deductible
Autism Occupational Therapy	$45 copay; deductible waived	40%; after deductible
Autism Speech Therapy	$45 copay; deductible waived	40%; after deductible
Durable Medical Equipment	20%; after deductible	40%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Not Covered	Not Covered
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other medical expense.
Infusion Therapy Administered in the home or physician's office	20%; after deductible	40%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	20%; after deductible	40%; after deductible
Vision Eyewear	Not Covered	Not Covered
Transplants	20%; after deductible Preferred coverage is provided at an IOE contracted facility only.	40%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	Not Covered	Not Covered
Vasectomy	Your cost sharing is based on the type of service and where it is performed	40%; after deductible
Tubal Ligation	Covered 100%; deductible waived	40%; after deductible

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy Plan Type	Aetna Standard Open Formulary	
Pharmacy Payment Limit	$2,000 Individual $4,000 Family	
Generic Drugs		
Retail	$5 copay	40% of submitted cost; after applicable copay
Mail Order	$10 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$40 copay	40% of submitted cost; after applicable copay
Mail Order	$80 copay	Not Applicable
Non-Preferred Brand-Name Drugs		
Retail	$60 copay	40% of submitted cost; after applicable copay
Mail Order	$120 copay	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna National Network	
Mail Order	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy	
Specialty	Up to a 30 day supply All prescription fills must be through our preferred specialty pharmacy network. Aetna Specialty Performance Network Aetna Standard Plan Drug List	

Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.
Exclude copay differential from applying to Coinsurance Limit

Plan Includes: Diabetic supplies, blood glucose monitors, prescription weight loss drugs and contraceptive drugs and devices obtainable from a pharmacy.
Includes sexual dysfunction drugs for females and males, including daily dose, additional 8 tablets a month for males for erectile dysfunction.
Oral fertility drugs included.
Precertification for specialty drugs included
Seasonal Vaccinations covered 100% in-network
Preventive Vaccinations covered 100% in-network
Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.
Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.
The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids
- Home births
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna, or its affiliate(s), receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates may reduce the amount a member pays the pharmacy for covered prescriptions.
Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.
In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.
Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862.**
Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**
Plan features and availability may vary by location and group size.
For more information about Aetna plans, refer to **www.aetna.com.**
Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are both within the CVS Health family.

Consumer Focused Plan Choice POS II HSA Plan Design

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PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Benefit Limitations - For any service or supply that is subject to a maximum visit, day, or dollar limitation on a per year basis, the benefit year begins on January 1st unless otherwise mandated. Refer to your plan documents for more information.		
Deductible (per calendar year)	$2,600 Individual $5,200 Family	$5,200 Individual $10,400 Family
All covered expenses accumulate separately toward the in-network or out-of-network Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses apply towards the Deductible. Once Family Deductible is met, all family members will be considered as having met their Deductible. There is no Individual Deductible to satisfy within the Family Deductible.		
Member Coinsurance Applies to all expenses unless otherwise stated.	20%	40%
Payment Limit (per calendar year)	$4,100 Individual $8,200 Family	$8,200 Individual $16,400 Family
All covered expenses accumulate separately toward the in-network or out-of-network Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. Pharmacy expenses apply towards the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.		
Lifetime Maximum Unlimited except where otherwise indicated.		
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	Covered 100%; deductible waived	40%; after deductible
Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	Covered 100%; deductible waived	40%; after deductible
Routine Gynecological Care Exams 1 exam and pap smear per calendar year, includes related fees.	Covered 100%; deductible waived	40%; after deductible
Routine Mammograms	Covered 100%; deductible waived	40%; after deductible
Women's Health Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	Covered 100%; deductible waived	40%; after deductible

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

Routine Digital Rectal Exam Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	40%; after deductible
Prostate-specific Antigen Test Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	40%; after deductible
Colorectal Cancer Screening Recommended: For all members age 45 and over.	Covered 100%; deductible waived	Covered under Routine Adult Exams
Routine Eye Exams 1 routine exam per 24 months.	Covered 100%; deductible waived	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	40%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician.	20%; after deductible	40%; after deductible
Specialist Office Visits	20%; after deductible	40%; after deductible
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	40%; after deductible
Walk-in Clinics	**Designated Walk-in Clinics** Covered 100%; after deductible **All Other Network Providers** 20%; after deductible	40%; after deductible
Walk-in Clinics are free-standing health care facilities that (a) may be located in or with a pharmacy, drug store, supermarket or other retail store; and (b) provide limited medical care and services on a scheduled or unscheduled basis. Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices are not considered to be Walk-in Clinics.		
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
[illegible]	[illegible]	[illegible]
Diagnostic X-ray (other than Complex Imaging Services) If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	20%; after deductible	40%; after deductible
Diagnostic Laboratory If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	20%; after deductible	40%; after deductible
Diagnostic Complex Imaging If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	20%; after deductible	40%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	20%; after deductible	40%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	20%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	20%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Coverage	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	20%; after deductible	40%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	20%; after deductible	40%; after deductible
Substance Abuse Office Visits	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	20%; after deductible	40%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility Limited to 60 days per year	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	20%; after deductible	40%; after deductible
Hospice Care - Inpatient	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing	Not Covered	Not Covered
Spinal Manipulation Therapy Limited to 30 visits per year	20%; after deductible	40%; after deductible
Outpatient Short-Term Rehabilitation	20%; after deductible	40%; after deductible
Includes speech, physical, occupational therapy; limited to 20 visits per year		
Habilitative Physical Therapy	20%; after deductible	40%; after deductible
Habilitative Occupational Therapy	20%; after deductible	40%; after deductible
Habilitative Speech Therapy	20%; after deductible	40%; after deductible
Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Combined with outpatient mental health visits		

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health All Other benefit	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Autism Physical Therapy	20%; after deductible	40%; after deductible
Autism Occupational Therapy	20%; after deductible	40%; after deductible
Autism Speech Therapy	20%; after deductible	40%; after deductible
Durable Medical Equipment	20%; after deductible	40%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Not Covered	Not Covered
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other medical expense.
Infusion Therapy Administered in the home or physician's office	20%; after deductible	40%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	20%; after deductible	40%; after deductible
Vision Eyewear	Not Covered	Not Covered
Transplants	20%; after deductible Preferred coverage is provided at an IOE contracted facility only.	40%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	Not Covered	Not Covered
Vasectomy	Your cost sharing is based on the type of service and where it is performed	40%; after deductible
Tubal Ligation	Covered 100%; deductible waived	40%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**

The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

Pharmacy Plan Type	Aetna Standard Open Formulary	
Generic Drugs		
Retail	Covered 100%	40% of submitted cost; after applicable copay
Mail Order	Covered 100%	Not Applicable
Preferred Brand-Name Drugs		
Retail	$25 copay	40% of submitted cost; after applicable copay
Mail Order	$25 copay	Not Applicable
Non-Preferred Brand-Name Drugs		
Retail	$50 copay	40% of submitted cost; after applicable copay
Mail Order	$50 copay	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna National Network	
Mail Order	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy	
Specialty	Up to a 30 day supply All prescription fills must be through our preferred specialty pharmacy network. Aetna Specialty Performance Network Aetna Standard Plan Drug List	

Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.
Exclude copay differential from applying to Coinsurance Limit

Plan Includes: Diabetic supplies, blood glucose monitors, prescription weight loss drugs and contraceptive drugs and devices obtainable from a pharmacy.
Includes sexual dysfunction drugs for females and males, including daily dose, additional 8 tablets a month for males for erectile dysfunction.
Oral fertility drugs included.
Precertification for specialty drugs included
Seasonal Vaccinations covered 100% in-network
Preventive Vaccinations covered 100% in-network
Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.
Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.
The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids
- Home births
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

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Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.
In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.
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Plan features and availability may vary by location and group size.
For more information about Aetna plans, refer to **www.aetna.com.**
Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are both within the CVS Health family.

Regular Plan Choice POS II Plan Design

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PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Benefit Limitations - For any service or supply that is subject to a maximum visit, day, or dollar limitation on a per year basis, the benefit year begins on January 1st unless otherwise mandated. Refer to your plan documents for more information.		
Deductible (per calendar year)	$1,400 Individual $2,600 Family	$2,800 Individual $5,200 Family
All covered expenses accumulate separately toward the in-network or out-of-network Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Deductible amount.		
Member Coinsurance Applies to all expenses unless otherwise stated.	20%	40%
Payment Limit (per calendar year)	$4,000 Individual $8,000 Family	$8,000 Individual $16,000 Family
All covered expenses accumulate separately toward the in-network or out-of-network Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. Pharmacy expenses apply towards the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.		
Lifetime Maximum Unlimited except where otherwise indicated.		
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	Covered 100%; deductible waived	40%; after deductible
Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	Covered 100%; deductible waived	40%; after deductible
Routine Gynecological Care Exams 1 exam and pap smear per calendar year, includes related fees.	Covered 100%; deductible waived	40%; after deductible
Routine Mammograms	Covered 100%; deductible waived	40%; after deductible
Women's Health Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	Covered 100%; deductible waived	40%; after deductible

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

Routine Digital Rectal Exam Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	40%; after deductible
Prostate-specific Antigen Test Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	40%; after deductible
Colorectal Cancer Screening Recommended: For all members age 45 and over.	Covered 100%; deductible waived	Covered under Routine Adult Exams
Routine Eye Exams 1 routine exam per 24 months.	Covered 100%; deductible waived	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	40%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician.	$45 copay; deductible waived	40%; after deductible
Specialist Office Visits	$55 copay; deductible waived	40%; after deductible
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	40%; after deductible
Walk-in Clinics Walk-in Clinics are free-standing health care facilities that (a) may be located in or with a pharmacy, drug store, supermarket or other retail store; and (b) provide limited medical care and services on a scheduled or unscheduled basis. Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices are not considered to be Walk-in Clinics.	**Designated Walk-in Clinics** Covered 100%; deductible waived **All Other Network Providers** $45 copay; deductible waived	40%; after deductible
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray (other than Complex Imaging Services) If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	20%; after deductible	40%; after deductible
Diagnostic Laboratory If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	20%; after deductible	40%; after deductible
Diagnostic Complex Imaging If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	20%; after deductible	40%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$55 copay; deductible waived	40%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	20%; deductible waived	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	20%; deductible waived	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

HOSPITAL CARE	IN-NETWORK	OUT-OF-NETWORK
Inpatient Coverage	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	$45 copay; deductible waived	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	Covered 100%; deductible waived	40%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	20%; after deductible	40%; after deductible
Substance Abuse Office Visits	$45 copay; deductible waived	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	Covered 100%; deductible waived	40%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility Limited to 60 days per year	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	20%; after deductible	40%; after deductible
Hospice Care - Inpatient	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	20%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing	Not Covered	Not Covered
Spinal Manipulation Therapy Limited to 30 visits per year	$45 copay; deductible waived	40%; after deductible
Outpatient Short-Term Rehabilitation	$45 copay; deductible waived	40%; after deductible
Includes speech, physical, occupational therapy; limited to 20 visits per year		
Habilitative Physical Therapy	Not Covered	Not Covered
Habilitative Occupational Therapy	Not Covered	Not Covered
Habilitative Speech Therapy	Not Covered	Not Covered
Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Combined with outpatient mental health visits		

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Covered same as any other Outpatient Mental Health All Other benefit		
Autism Physical Therapy	$45 copay; deductible waived	40%; after deductible
Autism Occupational Therapy	$45 copay; deductible waived	40%; after deductible
Autism Speech Therapy	$45 copay; deductible waived	40%; after deductible
Durable Medical Equipment	20%; after deductible	40%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Not Covered	Not Covered
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other medical expense.
Infusion Therapy Administered in the home or physician's office	20%; after deductible	40%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	20%; after deductible	40%; after deductible
Vision Eyewear	Not Covered	Not Covered
Transplants	20%; after deductible Preferred coverage is provided at an IOE contracted facility only.	40%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Diagnosis and treatment of the underlying medical condition only.		
Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery		
Vasectomy	Your cost sharing is based on the type of service and where it is performed	40%; after deductible
Tubal Ligation	Covered 100%; deductible waived	40%; after deductible

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy Plan Type	Aetna Standard Open Formulary	
Pharmacy Payment Limit	$2,000 Individual $4,000 Family	
Generic Drugs		
Retail	$5 copay	40% of submitted cost; after applicable copay
Mail Order	$10 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$40 copay	40% of submitted cost; after applicable copay
Mail Order	$80 copay	Not Applicable
Non-Preferred Brand-Name Drugs		
Retail	$60 copay	40% of submitted cost; after applicable copay
Mail Order	$120 copay	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna National Network	
Mail Order	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy	
Specialty	Up to a 30 day supply All prescription fills must be through our preferred specialty pharmacy network. Aetna Specialty Performance Network Aetna Standard Plan Drug List	

Choose Generics - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.
Exclude copay differential from applying to Coinsurance Limit

Plan Includes: Diabetic supplies, blood glucose monitors, prescription weight loss drugs and contraceptive drugs and devices obtainable from a pharmacy.
Includes sexual dysfunction drugs for females and males, including daily dose, additional 8 tablets a month for males for erectile dysfunction.
Oral fertility drugs included.
Precertification for specialty drugs included
Seasonal Vaccinations covered 100% in-network
Preventive Vaccinations covered 100% in-network
Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.
Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.
The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids
- Home births
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna, or its affiliate(s), receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates may reduce the amount a member pays the pharmacy for covered prescriptions.
Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.
In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.
Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862.**
Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**
Plan features and availability may vary by location and group size.
For more information about Aetna plans, refer to **www.aetna.com.**
Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are both within the CVS Health family.

This section has been provided on CD-ROM

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Submitted to

State of Nebraska

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Table of Contents

The proactive implementation team approach **3-5**

What we do, why we do it and how we do it

The Implementation Team

Roles and Responsibilities

Assumptions **6**

Project management tools – descriptions and exhibits **7**

Key Events

Implementation Management Plan

Gantt Chart

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The proactive implementation team approach

We understand that implementing new health benefits packages can present many challenges. That's why we provide you with a whole team of experts to help guide you through a smooth transition.

You will have many questions along the way, including:

- How are business and member deliverables managed?
- How and when are benefit changes communicated to employees?
- What is the timing of the open enrollment period?
- How is the exchange of key information facilitated?

We help you address these questions by combining a team of experts supported by effective project management tools. This approach, in place for over 30 years and refined annually through our continuous quality initiatives, sets the foundation for a long lasting relationship with you.

Collaboration and accountability

Our implementation team approach establishes a collaborative environment through the partnership we create with you and your business partners. Your Implementation Manager leads a team of our subject matter experts and State of Nebraska representatives. While each member of the implementation team contributes his or her unique talents to ensure a seamless transition, the Implementation Manager has overall accountability to you.

Your Implementation Manager develops an Implementation Management Plan that outlines tasks and target completion dates specific to each team member. The Implementation Manager carefully monitors the progress using this plan and other project management tools. Through regularly scheduled meetings and conference calls, the team provides updates and the status and resolution of issues raised during the transition.

Continuous commitment

We remain committed in our service to you. Several members of the implementation team remain actively involved with the ongoing service of your account.

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The implementation team – roles and responsibilities

The implementation team members work together throughout the duration of the project toward a seamless transition of your benefits program. This team includes the following representatives:

The State of Nebraska team

We recommend that the implementation team includes State of Nebraska representatives from the following areas:

- Employee benefits
- Eligibility
- Finance
- Human resources
- Communications

In addition, we recommend including Segal Consulting, your contact.

The Aetna team

Your implementation team includes the following Aetna members:

- Michael Boden, Senior Sales Executive

- Account Executive/Account Manager

  - Primary Aetna contact throughout implementation
  - Coordinates open enrollment activities
  - Provides ongoing account management after the plan effective date

- Tami Polsonetti, Proposal Director
  Pamela Heeps, Strategic Proposal Consultant

  - Provides initial details of sale, rates, special procedures
  - Prepares and documents the Letter of Understanding

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- Bismarck, ND Member Service Center
  - Provides member services support
  - Processes claims
  - Coordinates audits
- Implementation Manager
  - Directs implementation activities
  - Oversees activities of all Aetna areas
- Plan Benefit Set-Up
  - Reviews benefits plans
  - Codes benefits and structure into Aetna systems
  - Distributes documents to appropriate departments
- Contracts/Agreements
  - Drafts contracts
  - Prepares funding agreements
  - Drafts employee Booklets and/or Certificates of Coverage, if applicable
- Eligibility
  - Maintains member eligibility data
  - Coordinates production and ID card mailings
- Billing
  - Codes billing rates into Aetna systems
  - Prepares billing statements

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Assumptions

We have created the project management tools (Key Events, Implementation Management Plan and Gantt Chart) based upon the information and assumptions provided.

- The decision to implement the proposed benefits program will be made by 11/01/2019
- The effective date will be 07/01/2020
- Benefits will be those described in the proposal
- Eligibility certification:
  - Aetna will certify eligibility for medical and pharmacy claims
  - State of Nebraska will report eligibility via electronic file
- Funding arrangements:
  - The Choice POS II plan will be on a self-funded basis
  - The Retail Pharmacy plan will be on a self-funded basis
- Billing methods:
  - Service Charge Bill
- Aetna pays claims incurred on and after the effective date of 07/01/2020
- United will pay claims runoff incurred prior to 07/01/2020

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Project management tools

We manage implementation of your plan with the help of the tools listed below. All dates are approximate and will be modified as priorities are determined.

Key Events

The Key Events view of the implementation plan highlights the important milestones and dates that the team focuses on during the implementation.

State of Nebraska_KeyEvents

Implementation Management Plan

The Implementation Management Plan provides an ongoing status report on the team's progress and identifies the following:

- Tasks to be completed
- The individual(s) responsible
- A scheduled start and finish date

This plan is updated throughout the implementation and distributed to all implementation team members.

State of Nebraska_IMP.pdf

Gantt Chart

The Gantt Chart is a high-level timeline of the implementation.

State of Nebraska_GanttChar

State of Nebraska
Key Events

Task	Responsibility	Scheduled	Actual
Notification of Business Awarded	Pamela Heeps,Michael Boden	11/01/19	NA
Project Strategy and Scope		***11/04/19***	***NA***
Conduct Kick-Off Strategy Call and Confirm Scope	Michael Boden,Impl. Mgr.	11/04/19	NA
Conduct Implementation Meeting	Impl. Mgr.,State of Nebraska	11/11/19	NA
Public Sector & Labor		***11/05/19***	***NA***
Determine if Sale Ratified and use of Entity Name	Michael Boden,Pamela Heeps	11/05/19	NA
Confirm if ID Card Stock with Union Bug Required	Acct. Manager,Product Cons.	11/12/19	NA
Confirm Non-Standard Banking Requirements (if applicable)	Acct. Team,Banking Cons.,Underwriter	11/12/19	NA
Confirm Non-Standard Billing Requirements	Acct. Team,Billing Prem. Consultant	11/12/19	NA
Customer/Vendor Relationships		***11/12/19***	***NA***
Determine Information Exchange Requirements	Impl. Mgr.,Acct. Team	12/10/19	NA
Member Enrollment/Communication Strategy		***11/12/19***	***NA***
Outline Strategy Activities and Timetable	State of Nebraska	11/12/19	NA
Order Enrollment Materials	Acct. Manager	03/25/20	NA
Conduct Open Enrollment	State of Nebraska	04/15/20	NA
Medical Products		***11/12/19***	***NA***
Choice POS II - Finalize Sites	Acct. Team	11/12/19	NA
Medicare Direct Administration		***11/12/19***	***NA***
Update Medicare Direct System with Eligibility	Medicare Direct Unit	07/09/20	NA
Aetna Concierge		***11/12/19***	***NA***
Develop & Finalize AVA Call Flows with Business Partners	Service Center,State of Nebraska,Acct. Team	11/22/19	NA
Confirm Service Center Readiness for Open Enrollment	Impl. Mgr.,PSL	04/08/20	NA
Confirm Site Readiness	Training Team,Site Manager	06/17/20	NA
Informed Health Line		***11/12/19***	***NA***
Confirm if Nurseline Only or Buy-Up Option	Acct. Team	11/12/19	NA
Provide Communication Schedule (Buy-Up only)	IHL Acct. Mgr.	01/21/20	NA
Aetna In Touch Care		***11/12/19***	***NA***
Complete Sales & Staffing Outcomes (SSO) Tool	Pamela Heeps,Underwriter	11/12/19	NA
Confirm CCI Coding Completed	Plan Coord. Cons.,Clinical PM	03/19/20	NA
Transfer Open Medical Management Cases to Aetna	PM Director	06/17/20	NA
Eligibility/ID Cards		***11/12/19***	***NA***
Electronic Reporting		***11/12/19***	***NA***
Provide Generic File Specifications	Eligibility Consultant	11/12/19	NA
Obtain Approval to Complete Front-End Programming	IT Billables,Elig. Cons.	11/25/19	NA

Task	Responsibility	Scheduled	Actual
Provide/Review Coding Supplement	Eligibility Consultant	12/27/19	NA
Submit Test File(s) for Data Format and System Testing	State of Nebraska	03/20/20	NA
Submit Production File	State of Nebraska	05/14/20	NA
Update Production File	Eligibility Consultant	05/20/20	NA
Confirm Eligibility Update and Enrollment Numbers	Eligibility Cons.,Acct. Manager	05/22/20	NA
Electronic Data Interchange (EDI) 834		***11/12/19***	***NA***
Discuss EDI Testing Results and Obtain Signoff	State of Nebraska,Elig. Cons.,Appl. Developer	04/01/20	NA
ID Cards		***11/12/19***	***NA***
Review ID Card Requirements	State of Nebraska,Product Cons.	11/12/19	NA
Confirm ID Cards and/or Welcome Letters Mailed	Product Consultant	06/03/20	NA
Secure Transport		***11/19/19***	***NA***
Submit Request to Initiate Setup	Eligibility Consultant	12/27/19	NA
Coordinate Production File Transmission	Electronic Services	05/14/20	NA
Member Enrollment Application/Product Support		***01/21/20***	***NA***
Code Product Screens and Release Pend Online	Product Cons.	01/21/20	NA
Claim Funding/Banking Arrangements		***11/12/19***	***NA***
Confirm Banking Arrangement(s) with Customer	Acct. Team	12/27/19	NA
Booklets/Summary Plan Descriptions		***11/12/19***	***NA***
Determine Customer Needs for Booklets/SOCs/SPD Reviews	State of Nebraska,IM,Acct. Manager	11/12/19	NA
Plan Setup		***11/13/19***	***NA***
Request Policyholder/Control Number	Plan Coord. Cons.	11/13/19	NA
Review and Provide Signoff on Account Structure	State of Nebraska	11/26/19	NA
Submit ODI for Account Structure & Obtain Approvals	Acct. Manager,PCC,Underwriter	12/13/19	NA
Provide Signoff on Benefits (Single Source Document)	State of Nebraska	12/31/19	NA
Code Plan Designs in PE/RS	Plan Coord. Cons.	01/22/20	NA
Release Final Structure and Benefits to CCI	Plan Coord. Cons.	03/19/20	NA
Documents and Agreements		***11/18/19***	***NA***
Aetna Internal Documents		***11/18/19***	***NA***
Complete the eHealth NB094 Online Tool	Acct. Manager	11/18/19	NA
Complete and Submit NB733 (if applicable)	Acct. Manager	11/26/19	NA
Submit Subrogation Checklist (NB505)	Acct. Manager	12/05/19	NA
Submit EOB Form (NB010)	Acct. Manager	12/16/19	NA
Submit Self Insured Claim Reporting Form (NB602)	Acct. Manager	12/18/19	NA
Submit and Finalize Online Document Intake Tool (ODI)	Acct. Manager,PCC	01/03/20	NA

State of Nebraska
Key Events

Task	Responsibility	Scheduled	Actual
Confirm ODI and All Forms Submitted by Deadline	Implementation Mgr.	06/01/20	NA
Contracts/Agreements/Signature Documents		***11/19/19***	***NA***
Determine & Provide Reqd Signature Documents to Customer	Acct. Manager	11/19/19	NA
Execute/Return 'Retiree-Only Certification Form' (if appl)	Acct. Manager,State of Nebraska	11/26/19	NA
Distribute Finalized Letter of Understanding/Renewal Letter	Michael Boden,AE,Underwriter	12/05/19	NA
Finalize Performance Guarantees and Distribute to Team	Michael Boden,AE	12/05/19	NA
Initiate Single Case Filing Process (if applicable)	Pamela Heeps,Acct. Team	12/11/19	NA
Execute/Return MSA to Benefit Consultant	State of Nebraska,Acct. Team	04/16/20	NA
Execute and Return Claim Fiduciary Letter to Benefit Cons	State of Nebraska,Acct. Manager	05/19/20	NA
Return Executed New York HCRA Election Letter NB474	State of Nebraska	05/19/20	NA
Return Executed Plan Sponsor Letter Agreement	State of Nebraska	05/19/20	NA
Return Executed Business Associate Agreement	State of Nebraska	05/19/20	NA
Return Executed Banking Consent Form	State of Nebraska	05/19/20	NA
Return Executed Escheat Services Election Form	State of Nebraska	05/19/20	NA
Update PHI Tool with Signed Agreements	Acct. Team	06/10/20	NA
Master Services Agreement (MSA)		***01/21/20***	***NA***
Provide MSA to Account Team for Forwarding to Customer	Benefit Consultant,Acct. Team	03/16/20	NA
Pharmacy Management		***11/18/19***	***NA***
Finalize Rx Plan Design (Single Source Document)	Pharmacy Management	11/18/19	NA
Confirm Eligibility Interface to Pharmacy System	Pharmacy Management	06/17/20	NA
Behavioral Health		***11/19/19***	***NA***
Define Transition Policy with Existing Vendors	State of Nebraska,BH Acct. Exec.	12/02/19	NA
Service Center		***11/19/19***	***NA***
Determine Claim Address, Toll-Free No. & Phone Prompts	Service Center,Acct. Team	11/19/19	NA
Begin Processing Post-Effective Date Claims	Service Center	07/01/20	NA
Billing		***12/05/19***	***NA***
Discuss Billing Type/Requirements	State of Nebraska,Billing Prem. Consultant	12/05/19	NA
Review and Approve Self-Billing Format (if appl)	Billing Prem. Consultant	12/26/19	NA
Produce and Mail Invoice/Bill	Billing Prem. Consultant	06/24/20	NA
Reporting		***12/27/19***	***NA***
Determine Reporting Requirements	State of Nebraska,Acct. Team	12/27/19	NA
Confirm Reporting Requests Submitted	Implementation Mgr.,Acct. Mgr.	03/02/20	NA
Employer Secure Website		***02/03/20***	***NA***
Confirm Website Setup Complete and Notify Account Team	Product Development	03/03/20	NA

State of Nebraska
Key Events

Task	Responsibility	Scheduled	Actual
Claim Setup, Auditing and Testing		***03/20/20***	***NA***
Conduct ACAS Plan Testing and Sign Off	Service Center,ACAS Plan Testing	04/17/20	NA
Release Control from Gateway Hold to Production	Service Center	06/01/20	NA
Effective Date		07/01/20	NA
Implementation Signoff		***07/30/20***	***NA***
Conduct Post-Implementation Conference Call/Meeting	Implementation Mgr.	07/30/20	NA

State of Nebraska
Implementation Management Plan

Task	Sched. Start	Sched. Finish	Responsibility
Notification of Business Awarded	11/01/19	11/01/19	Pamela Heeps,Michael Boden
Project Strategy and Scope	***11/04/19***	***11/14/19***	
Conduct Kick-Off Strategy Call and Confirm Scope	11/04/19	11/07/19	Michael Boden,Impl. Mgr.
Confirm if Statement of Work is Applicable	11/07/19	11/12/19	Michael Boden
Confirm Sold Networks	11/07/19	11/14/19	Michael Boden,Impl. Mgr.,Underwriter
Notify Product, Program and Service Areas of Sale	11/07/19	11/14/19	Michael Boden,Impl. Mgr.,PCC
Conduct Implementation Meeting	11/11/19	11/12/19	Impl. Mgr.,State of Nebraska
Public Sector & Labor	***11/05/19***	***12/16/19***	
Determine if Sale Ratified and use of Entity Name	11/05/19	11/11/19	Michael Boden,Pamela Heeps
Determine Standard or Custom Contracts & Req'd Timeframes	11/05/19	11/11/19	Benefit Consultant,Acct. Team
Determine if Aetna is Required to Utilize Union Vendors	11/05/19	11/11/19	Acct. Team
Confirm if Aetna is Required to Utilize a DBE/WBE/MBE	11/05/19	11/11/19	Acct. Team
Determine Restrictions on External Vendors	11/05/19	11/08/19	Acct. Team
Determine Customer Intent to use ERISA Language	11/05/19	11/11/19	Benefit Consultant,Acct. Team
Complete Vendor Profile (if applicable)	11/05/19	11/13/19	Acct. Team
Confirm Customer Requirements for SPD/COC Production	11/11/19	11/18/19	Acct. Team,Benefit Consultant
Confirm if ID Card Stock with Union Bug Required	11/12/19	11/14/19	Acct. Manager,Product Cons.
Confirm "Equal or Better" Benefit Requirement	11/12/19	11/14/19	Acct. Team,PCC,Underwriter
Confirm Non-Standard Banking Requirements (if applicable)	11/12/19	11/22/19	Acct. Team,Banking Cons.,Underwriter
Confirm Non-Standard Billing Requirements	11/12/19	11/22/19	Acct. Team,Billing Prem. Consultant
Set Up Escrow Sub-Account (if applicable)	11/22/19	12/09/19	Banking Cons.
Advise Internal Team of Customer Subsegment	12/11/19	12/16/19	Plan Coord. Cons.
Customer/Vendor Relationships	***11/12/19***	***12/19/19***	
Identify Vendor(s) and Their Responsibilities	11/12/19	11/22/19	State of Nebraska,Acct. Team
Determine if "Outsourcing Restrictions Board" Review is Req'd	11/22/19	12/19/19	Acct. Team
Determine Aetna Procurement Involvement	11/22/19	12/09/19	Acct. Team,Underwriter
Determine Information Exchange Requirements	12/10/19	12/17/19	Impl. Mgr.,Acct. Team
Member Enrollment/Communication Strategy	***11/12/19***	***05/05/20***	
Outline Strategy Activities and Timetable	11/12/19	11/19/19	State of Nebraska
Determine Method of EE Enrollment (Online, Voice, Paper)	11/12/19	11/19/19	State of Nebraska
Review OE Member Communication Materials	11/21/19	12/02/19	Acct. Team
Complete Open Enrollment Meeting System Request	11/22/19	12/06/19	Acct. Manager
Discuss Consumer Tools and Provider Search	11/22/19	11/27/19	Acct. Team,State of Nebraska
Order Enrollment Materials	03/25/20	03/26/20	Acct. Manager

Task	Sched. Start	Sched. Finish	Responsibility
Conduct Open Enrollment	04/15/20	05/05/20	State of Nebraska
Medical Products	***11/12/19***	***11/21/19***	
Choice POS II - Finalize Sites	11/12/19	11/21/19	Acct. Team
Medicare Direct Administration	***11/12/19***	***07/10/20***	
Determine if Medicare Direct Administration Applies	11/12/19	11/14/19	Acct. Team
Complete Medicare Direct Implementation Checklist	12/02/19	12/05/19	Acct. Manager
Update Medicare Direct System with Eligibility	07/09/20	07/10/20	Medicare Direct Unit
Aetna Concierge	***11/12/19***	***06/22/20***	
Confirm Program Components and Locations	11/12/19	11/22/19	State of Nebraska,Acct. Team
Confirm Dedicated Service Center/Claim Key	11/22/19	12/09/19	Aetna One Operations
Determine Integration Level with Outside Vendors	11/22/19	12/09/19	State of Nebraska,Acct. Team
Develop & Finalize AVA Call Flows with Business Partners	11/22/19	01/01/20	Service Center,State of Nebraska,Acct. Team
Develop and Finalize Transfer Grid for all Vendors	01/01/20	03/10/20	Acct. Team,Call Mgmt.,PSL
Update 360 Tool & Create Link for Customer-Specific Details	03/18/20	06/17/20	PSL,Program Leads
Hold Customer Culture Training/Site Visit	04/01/20	04/06/20	PSL,State of Nebraska,Clinical Lead
Confirm Service Center Readiness for Open Enrollment	04/08/20	04/09/20	Impl. Mgr.,PSL
Confirm Site Readiness	06/17/20	06/22/20	Training Team,Site Manager
Informed Health Line	***11/12/19***	***01/28/20***	
Confirm if Nurseline Only or Buy-Up Option	11/12/19	11/19/19	Acct. Team
Provide Communication Schedule (Buy-Up only)	01/21/20	01/28/20	IHL Acct. Mgr.
Aetna In Touch Care	***11/12/19***	***07/10/20***	
Complete Sales & Staffing Outcomes (SSO) Tool	11/12/19	11/18/19	Pamela Heeps,Underwriter
Obtain and Set up Clinical Phone Number and Scripting	11/18/19	01/06/20	IM,AVA Consultant,Clinical PM
Determine Recruitment/Hiring Needs	11/18/19	01/29/20	PM Director,Acct. Team
Discuss Transition of Care Request Process/Form Distribution	11/18/19	12/12/19	PSL,Acct. Manager
Determine Operation/Program Considerations	11/18/19	12/24/19	PM Director
Complete Aetna Total Clinical View (ATV) Configuration Form	11/25/19	12/09/19	Clinical PM
Provide Medical Mgmt Transfer Template to Prior Carrier	12/18/19	12/19/19	Acct. Manager,Implementation Mgr.
Determine Operational System Considerations	12/24/19	03/26/20	PM Director
Provide Training to Team if Applicable	01/29/20	05/11/20	PM Director
Confirm CCI Coding Completed	03/19/20	03/20/20	Plan Coord. Cons.,Clinical PM
Transfer Open Medical Management Cases to Aetna	06/17/20	07/10/20	PM Director
Eligibility/ID Cards	***11/12/19***	***06/04/20***	
Electronic Reporting	***11/12/19***	***05/28/20***	

Task	Sched. Start	Sched. Finish	Responsibility
Provide Generic File Specifications	11/12/19	11/14/19	Eligibility Consultant
Discuss Generic File Specifications	11/20/19	11/22/19	Eligibility Consultant
Establish Eligibility Schedule	11/22/19	11/25/19	State of Nebraska,Eligibility Consultant
Determine Need for Front-End Programming	11/22/19	11/25/19	Eligibility Consultant
Obtain Approval to Complete Front-End Programming	11/25/19	12/09/19	IT Billables,Elig. Cons.
Provide/Review Coding Supplement	12/27/19	01/08/20	Eligibility Consultant
Complete Front-End Programming (if applicable)	01/08/20	02/25/20	Elec. Enroll. Mgmt.
Submit Test File(s) for Data Format and System Testing	03/20/20	04/01/20	State of Nebraska
Conduct Testing of File(s) and Provide Results	03/23/20	04/02/20	Eligibility Consultant
Submit Production File	05/14/20	05/15/20	State of Nebraska
Edit Production File/Provide Results	05/15/20	05/20/20	Eligibility Consultant
Update Production File	05/20/20	05/22/20	Eligibility Consultant
Confirm Eligibility Update and Enrollment Numbers	05/22/20	05/28/20	Eligibility Cons.,Acct. Manager
Electronic Data Interchange (EDI) 834	***11/12/19***	***05/07/20***	
Identify Application Developr	11/12/19	11/18/19	Eligibility Consultant
Identify Customer's Business and Technical Contacts	11/18/19	11/22/19	Implementation Mgr.,Acct. Team,EC
Provide EDI 834 Guide	11/22/19	12/09/19	Appl. Developer
Discuss EDI 834 Guide and Coding Supplement	11/22/19	12/09/19	Appl. Developer,State of Nebraska,Elig. Cons.
Complete System Setup in Preparation for 834 Testing	01/08/20	02/25/20	Appl. Developer
Discuss EDI Testing Results and Obtain Signoff	04/01/20	04/13/20	State of Nebraska,Elig. Cons.,Appl. Developer
Request TP Master Map be Placed into Production	04/24/20	05/07/20	Appl. Developer
ID Cards	***11/12/19***	***06/04/20***	
Review ID Card Requirements	11/12/19	11/18/19	State of Nebraska,Product Cons.
Request Camera Ready Logo and Associated Prompts	11/18/19	11/22/19	Product Consultant
Obtain Customer Signoff on Logo & Send to "ID Cards" Email box	12/03/19	12/16/19	Product Consultant
Approve ID Card Data Elements	12/04/19	12/10/19	State of Nebraska,Acct. Team
Obtain Legal and CQR Approval of Customization (if appl)	12/18/19	01/10/20	Product Consultant
Complete ID Card Coding	12/31/19	01/03/20	Product Consultant
Generate ID Card File and Request QR Pull	05/22/20	05/27/20	Product Consultant
Perform Online Quality Review/Release ID Cards	05/27/20	06/01/20	Acct. Manager,Product Cons.
Confirm ID Cards and/or Welcome Letters Mailed	06/03/20	06/04/20	Product Consultant
Secure Transport	***11/19/19***	***05/15/20***	
Notify Electronic Services and Team of Connectivity Request	11/19/19	11/21/19	Eligibility Consultant
Submit Request to Initiate Setup	12/27/19	12/31/19	Eligibility Consultant

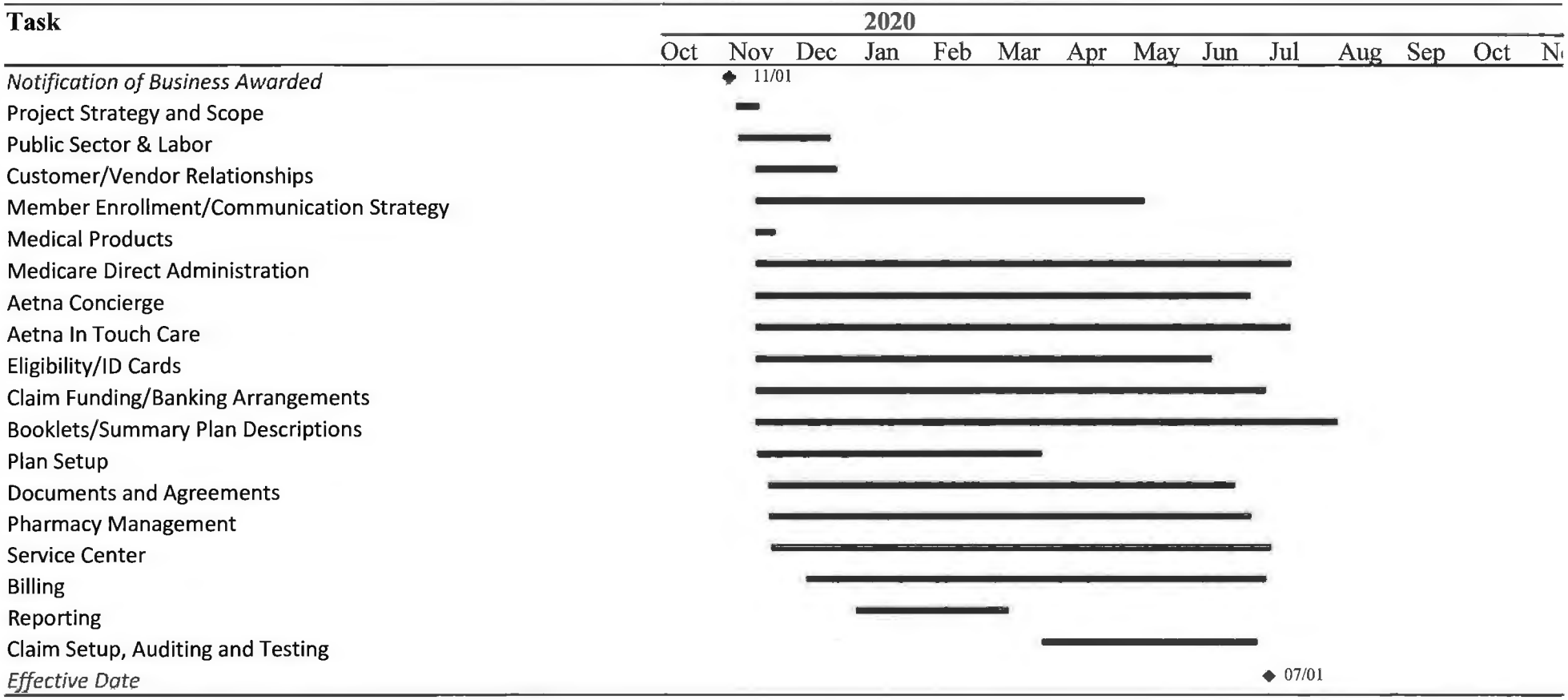
Task	Sched. Start	Sched. Finish	Responsibility
Coordinate Signoff on Technical Requirements	12/31/19	01/10/20	Eligibility Consultant
Provide Customer w/License Agreement and Client Software	01/10/20	01/17/20	Electronic Services
Coordinate Establishment of Security ID and Password	01/23/20	02/04/20	Electronic Services
Coordinate Testing with Customer and Eligibility Consultant	02/25/20	03/06/20	Electronic Services
Coordinate Production File Transmission	05/14/20	05/15/20	Electronic Services
Member Enrollment Application/Product Support	***01/21/20***	***01/28/20***	
Code Product Screens and Release Pend Online	01/21/20	01/28/20	Product Cons.
Claim Funding/Banking Arrangements	***11/12/19***	***06/29/20***	
Provide Banking Information to Customer for Review	11/12/19	11/14/19	Acct. Team
Determine if Aetna's Escheatment Services Required	12/16/19	12/18/19	Acct. Team,Underwriter
Determine if Alternate Stockpiling Applies	12/16/19	12/27/19	Acct. Team,Underwriter
Confirm Banking Arrangement(s) with Customer	12/27/19	01/08/20	Acct. Team
Establish Banking Arrangement(s)/Confirm Wire Line Setup	06/17/20	06/29/20	Banking Services
Booklets/Summary Plan Descriptions	***11/12/19***	***07/31/20***	
Determine Customer Needs for Booklets/SOCs/SPD Reviews	11/12/19	11/14/19	State of Nebraska,IM,Acct. Manager
Determine Whether Aetna or Customer Will Produce SBCs	11/12/19	11/14/19	State of Nebraska,Acct. Manager
Draft Booklets/SOCs/COCs/SPDs	04/10/20	05/21/20	Benefit Consultant
Provide Final SBC (if applicable)	04/13/20	04/16/20	Acct. Manager
Review and Finalize Booklets/SOCs/COCs/SPDs	05/21/20	06/26/20	Benefit Consultant,Acct. Manager
Provide Booklets/SOCs/COCs/SPDs	06/26/20	07/31/20	Benefit Consultant
Provide Copy of SPD to Subrogation/Reimbursement Vendor	06/26/20	06/29/20	Acct. Team
Plan Setup	***11/13/19***	***03/20/20***	
Request Policyholder/Control Number	11/13/19	11/14/19	Plan Coord. Cons.
Develop Plan and Account Structure	11/14/19	11/26/19	Plan Coord. Cons.
Develop Benefits Review Tool/Single Source Document	11/14/19	12/11/19	Plan Coord. Cons.
Notify "NA ACAS New Business" Email box of Sale	11/15/19	11/19/19	Plan Coord. Cons.
Submit & Obtain Approval for Plan Deviations (if appl)	11/21/19	12/11/19	ACAS Regional Liaison,SMU,AM,PCC
Review and Provide Signoff on Account Structure	11/26/19	12/11/19	State of Nebraska
Review Single Source Document with Customer	12/11/19	12/31/19	State of Nebraska,Acct. Team,PCC
Submit ODI for Account Structure & Obtain Approvals	12/13/19	12/31/19	Acct. Manager,PCC,Underwriter
Complete & Distribute Restructure Action Notice (RAN), if appl	12/18/19	12/23/19	Plan Coord. Cons.
Release Skeletal Account Structure to CCI	12/23/19	12/27/19	Plan Coord. Cons.
Provide Signoff on Benefits (Single Source Document)	12/31/19	01/03/20	State of Nebraska
Submit ODI for Plan Design & Obtain Approvals	01/06/20	01/22/20	Acct. Manager,PCC,Underwriter

Task	Sched. Start	Sched. Finish	Responsibility
Submit Plan Reference Table Update	01/21/20	01/23/20	Plan Coord. Cons.
Code Plan Designs in PE/RS	01/22/20	02/13/20	Plan Coord. Cons.
Confirm Audit Signoff	02/13/20	02/25/20	Plan Coord. Cons.
Review CCI and Finalize Plan Discrepancies	02/25/20	03/19/20	PSL,Plan Coord. Cons.
Release Final Structure and Benefits to CCI	03/19/20	03/20/20	Plan Coord. Cons.
Documents and Agreements	***11/18/19***	***06/15/20***	
Aetna Internal Documents	***11/18/19***	***06/02/20***	
Complete the eHealth NB094 Online Tool	11/18/19	11/19/19	Acct. Manager
Complete and Submit NB733 (if applicable)	11/26/19	12/05/19	Acct. Manager
Submit Subrogation Checklist (NB505)	12/05/19	12/12/19	Acct. Manager
Submit EOB Form (NB010)	12/16/19	12/19/19	Acct. Manager
Submit Self Insured Claim Reporting Form (NB602)	12/18/19	12/19/19	Acct. Manager
Submit and Finalize Online Document Intake Tool (ODI)	01/03/20	01/21/20	Acct. Manager,PCC
Notify Sales and Financial Areas of Additional Svcs/Charges	02/03/20	02/04/20	Acct. Team
Send Final PGs to PG Email box for Input into Tracking Database	05/19/20	05/20/20	Pamela Heeps,Underwriter
Confirm ODI and All Forms Submitted by Deadline	06/01/20	06/02/20	Implementation Mgr.
Contracts/Agreements/Signature Documents	***11/19/19***	***06/15/20***	
Determine & Provide Reqd Signature Documents to Customer	11/19/19	12/03/19	Acct. Manager
Execute/Return 'Retiree-Only Certification Form' (if appl)	11/26/19	12/10/19	Acct. Manager,State of Nebraska
Distribute Finalized Letter of Understanding/Renewal Letter	12/05/19	12/12/19	Michael Boden,AE,Underwriter
Finalize Performance Guarantees and Distribute to Team	12/05/19	12/23/19	Michael Boden,AE
Initiate Single Case Filing Process (if applicable)	12/11/19	12/16/19	Pamela Heeps,Acct. Team
Execute/Return MSA to Benefit Consultant	04/16/20	05/08/20	State of Nebraska,Acct. Team
Execute and Return Claim Fiduciary Letter to Benefit Cons	05/19/20	06/01/20	State of Nebraska,Acct. Manager
Return Executed New York HCRA Election Letter NB474	05/19/20	06/01/20	State of Nebraska
Return Executed Plan Sponsor Letter Agreement	05/19/20	06/01/20	State of Nebraska
Return Executed Business Associate Agreement	05/19/20	06/01/20	State of Nebraska
Return Executed Banking Consent Form	05/19/20	06/01/20	State of Nebraska
Return Executed Escheat Services Election Form	05/19/20	06/01/20	State of Nebraska
Update PHI Tool with Signed Agreements	06/10/20	06/15/20	Acct. Team
Master Services Agreement (MSA)	***01/21/20***	***03/19/20***	
Draft Master Services Agreement/Amendment	01/21/20	03/05/20	Benefit Consultant
Provide MSA to Account Team for Forwarding to Customer	03/16/20	03/19/20	Benefit Consultant,Acct. Team
Pharmacy Management	***11/18/19***	***06/22/20***	

Task	Sched. Start	Sched. Finish	Responsibility
Finalize Rx Plan Design (Single Source Document)	11/18/19	12/02/19	Pharmacy Management
Identify Data Integration Rqmts (Data Integration Section)	12/02/19	12/13/19	Acct. Team,IM
Confirm if Open Refill or Prior Authorization will Transfer	12/02/19	12/04/19	Pharmacy Management,State of Nebraska
Request Data on Utilization and Specialty Rx (if applicable)	12/13/19	12/19/19	Pharmacy Management,State of Nebraska
Code Plan Design, Test and Confirm Readiness	03/27/20	06/17/20	Pharmacy Management
Confirm Eligibility Interface to Pharmacy System	06/17/20	06/22/20	Pharmacy Management
Behavioral Health	***11/19/19***	***12/12/19***	
Identify Customer EAP Vendor	11/19/19	11/26/19	BH Acct. Exec.
Confirm Pre-Certification Requirements	11/21/19	12/02/19	BH Acct. Exec.
Define Transition Policy with Existing Vendors	12/02/19	12/09/19	State of Nebraska,BH Acct. Exec.
Determine if External Accumulators Apply	12/02/19	12/12/19	BH Acct. Exec.
Service Center	***11/19/19***	***07/01/20***	
Determine Claim Address, Toll-Free No. & Phone Prompts	11/19/19	12/16/19	Service Center,Acct. Team
Determine Customer-Specific Claim Requirements	01/03/20	02/19/20	Acct. Team,PSL
Create/Revise Plan Sponsor Tool	04/01/20	04/07/20	Plan Sponsor Liaison
Begin Processing Post-Effective Date Claims	07/01/20	07/01/20	Service Center
Billing	***12/05/19***	***06/29/20***	
Discuss Billing Type/Requirements	12/05/19	12/11/19	State of Nebraska,Billing Prem. Consultant
Determine Payment Method for Fees/Premium	12/11/19	12/12/19	State of Nebraska,Billing Prem. Consultant
Provide Wire Transfer/Lock Box Instructions	12/12/19	12/17/19	Billing Prem. Consultant
Review and Approve Self-Billing Format (if appl)	12/26/19	01/07/20	Billing Prem. Consultant
Submit ODI Rate Communication	05/27/20	05/28/20	Underwriter
Code Rates/Fees into Billing System(s)	06/10/20	06/15/20	Billing Prem. Consultant
Produce and Mail Invoice/Bill	06/24/20	06/29/20	Billing Prem. Consultant
Reporting	***12/27/19***	***03/05/20***	
Determine Reporting Requirements	12/27/19	02/03/20	State of Nebraska,Acct. Team
Confirm Reporting Requests Submitted	03/02/20	03/05/20	Implementation Mgr.,Acct. Mgr.
Employer Secure Website	***02/03/20***	***05/19/20***	
Discuss, Demonstrate and Confirm Website Content	02/03/20	02/13/20	Acct. Team
Complete and Submit Installation Checklist	02/13/20	02/18/20	Acct. Manager
Confirm Website Setup Complete and Notify Account Team	03/03/20	04/16/20	Product Development
Complete Website Registration Within 14 Days	04/16/20	05/09/20	Acct. Team,State of Nebraska
Train Customer on Website Usage	05/18/20	05/19/20	Acct. Team
Claim Setup, Auditing and Testing	***03/20/20***	***06/25/20***	

Task	Sched. Start	Sched. Finish	Responsibility
Conduct ACAS Pre-Build Audit	03/20/20	03/25/20	ACAS Regional Liaison
Complete ACAS Build and Distribute Completion Email	03/25/20	04/17/20	Claim Data Specialist
Conduct ACAS Plan Testing and Sign Off	04/17/20	05/29/20	Service Center,ACAS Plan Testing
Submit System Deviations and Rules	05/29/20	06/01/20	Plan Sponsor Liaison
Release Control from Gateway Hold to Production	06/01/20	06/03/20	Service Center
Ensure Rx Integration Operational (if applicable)	06/24/20	06/25/20	Claim Data Specialist,ACAS Regional Liaison
Effective Date	07/01/20	07/01/20	
Implementation Signoff	***07/30/20***	***08/11/20***	
Conduct Post-Implementation Conference Call/Meeting	07/30/20	07/31/20	Implementation Mgr.
Distribute Signoff Letter and Final Implementation Tools	08/07/20	08/11/20	Implementation Mgr.
Update CIMS Application and Mark Complete	08/07/20	08/11/20	Implementation Mgr.

State of Nebraska
Gantt Chart



State Insurance License

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STATE OF NEBRASKA

DEPARTMENT OF INSURANCE

CERTIFICATE OF AUTHORITY

AETNA LIFE INSURANCE COMPANY

DOMICILED IN THE STATE OF CONNECTICUT

IS HEREBY AUTHORIZED AND LICENSED TO TRANSACT THE BUSINESS OF INSURANCE IN THE STATE OF NEBRASKA AS DESCRIBED BY THE FOLLOWING SUB-SECTION(S) OF SECTION 44-201 OF THE STATUTES OF NEBRASKA:

01 Life Insurance
03 Variable Annuities
04 Sickness and Accident Insurance

146878	May 1, 2019	April 30, 2020
NEBRASKA IDENTIFICATION NUMBER	**DATE ISSUED**	**DATE EXPIRES**

SIGNED AT LINCOLN, NEBRASKA

GREAT SEAL OF THE STATE OF NEBRASKA
MARCH 1ST 1867

Bruce R. Ramge
DIRECTOR OF INSURANCE

Certificate of Good Standing

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Office of the Secretary of the State of Connecticut

I, the Connecticut Secretary of the State, and keeper of the seal thereof, DO HEREBY CERTIFY, that

AETNA LIFE INSURANCE COMPANY

is a specially chartered domestic corporation by virtue of a Special Act of the General Assembly passed in 1853.

A certificate of dissolution has not been filed. Insofar as indicated by the records of this office, such corporation is in existence.

Secretary of the State

Date Issued: July 23, 2019

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Litigation History Response

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Aetna Life Insurance Company (ALIC) and its subsidiaries/affiliates are routinely involved in non-material litigation regarding the administration of health and dental plans. Most of this litigation involves a single claim for benefits or payment for provider services.

ALIC is a wholly-owned subsidiary of Aetna Inc. (Aetna). On November 28, 2018, Aetna Inc. and each of its subsidiaries, including ALIC, became a wholly-owned subsidiary of CVS Health Corporation. All material litigation was reported in Aetna's public filings. Attached is the litigation proceeding section from Aetna's Form 10-Q for the quarterly period ended September 30, 2018.

Other Litigation and Regulatory Proceedings

We are involved in numerous other lawsuits arising, for the most part, in the ordinary course of our business operations, including claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits in our Health Care and divested group insurance businesses (including our post-payment audit and collection practices and reductions in payments to providers due to sequestration), provider network structure (including the use of performance-based networks and termination of provider contracts), provider directory accuracy, rescission of insurance coverage, improper disclosure of personal information, anticompetitive practices, intellectual property litigation, other legal proceedings in our Health Care and divested group insurance businesses and employment litigation. Some of these other lawsuits are or are purported to be class actions. We intend to defend ourselves vigorously against the claims brought in these matters.

Awards to us and others of certain government contracts, particularly Medicaid contracts and contracts with government customers in our Commercial business, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to us being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect our operating results. We will continue to defend vigorously contract awards we receive.

In addition, our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, CMS, the U.S. Department of Health and Human Services, various state insurance and health care regulatory authorities, state attorneys general, treasurers and offices of inspector general, the Center for Consumer Information and Insurance Oversight, the OIG, the Office of Personnel Management, the U.S. Department of Labor, the U.S. Department of the Treasury, the U.S. Food and Drug Administration, committees, subcommittees and members of the U.S. Congress, the DOJ, the Federal Trade Commission, U.S. attorneys and other state, federal and international governmental authorities. These government actions include inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding the CVS Health Transaction, our withdrawal from certain states' Public Exchanges for 2017, certain of our current and past business practices, including our overall claims processing and payment practices, our business practices with respect to our small group products, student health products or individual customers (such as market withdrawals, rating information, premium increases and medical benefit ratios), executive compensation matters and travel and entertainment expenses, as well as the investigations by, and subpoenas and requests from, attorneys general and others described above under "Out-of-Network Benefit

Proceedings." We also have produced documents and information to the Civil Division of the DOJ in cooperation with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

A significant number of states are investigating life insurers' claims payment and related escheat practices. These investigations have resulted in significant charges to earnings by other life insurers in connection with related settlements. We have received requests for information from a number of states, and certain of our subsidiaries are being audited, with respect to our life insurance claim payment and related escheat practices. In the fourth quarter of 2013, we made changes to our life insurance claim payment practices (including related escheatment practices) based on evolving industry practices and regulatory expectations and interpretations, including expanding our existing use of the Social Security Administration's Death Master File to identify additional potentially unclaimed death benefits and locate applicable beneficiaries. Given the judicial, legislative and regulatory uncertainty with respect to life insurance claim payment and related escheat practices, it is reasonably possible that we may incur liability related to those practices, whether as a result of litigation, government actions or otherwise, which could adversely affect our operating results and cash flows.

There also continues to be a heightened level of review and/or audit by regulatory authorities of, and increased litigation regarding, our and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers).

As a leading national health and related benefits company, we regularly are the subject of government actions of the types described above. These government actions may prevent or delay us from implementing planned premium rate increases and may result, and have resulted, in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to us by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

Estimating the probable losses or a range of probable losses resulting from litigation, government actions and other legal proceedings is inherently difficult and requires an extensive degree of judgment, particularly where the matters involve indeterminate claims for monetary damages, involve claims for injunctive relief, may involve fines, penalties or punitive damages that are discretionary in amount, involve a large number of claimants or regulatory authorities, represent a change in regulatory policy, present novel legal theories, are in the early stages of the proceedings, are subject to appeal or could result in changes in business practices. In addition, because most legal proceedings are resolved over long periods of time, potential losses are subject to change due to, among other things, new developments, changes in litigation strategy, the outcome of intermediate procedural and substantive rulings and other parties' settlement posture and their evaluation of the strength or weakness of their

case against us. Except as specifically noted above under "Other Litigation and Regulatory Proceedings," we are currently unable to predict the ultimate outcome of, or reasonably estimate the losses or a range of losses resulting from, the matters described above under "Litigation and Regulatory Proceedings", and it is reasonably possible that their outcome could be material to us.

Legal Deviations

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STATE OF NEBRASKA – SF (ASC) MED/Rx/HSA 08/06 – Contract Deviations Summary

Requirement	Aetna Response
II. TERMS AND CONDITIONS	
If a conflict or ambiguity arises after the Addendum to Contract Award have been negotiated and agreed to, the Addendum to Contract Award shall be interpreted as follows: **1. If only one Party has a particular clause then that clause shall control;** **2. If both Parties have a similar clause, but the clauses do not conflict, the clauses shall be read together;** **3. If both Parties have a similar clause, but the clauses conflict, the State's clause shall control.**	Noted. However, our Administrative Service Agreement which would be the highest level of priority and would govern in the event of a conflict. Aetna is willing to work with the State of Nebraska to include any additional provisions the State would require in a contract between the parties.
The contract resulting from this RFP shall incorporate the following documents: **1. Request for Proposal and Addenda;** **2. Amendments to the RFP;** **3. Questions and Answers;** **4. Contractor's proposal (RFP and properly submitted documents);** **5. The executed Contract, and Addendum One to Contract (if applicable) ; and,** **6. Amendments/Addendums to the Contract.** **These documents constitute the entirety of the contract.** **Unless otherwise specifically stated in a future contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all**	We can agree as long as the Administrative Services Contract between the parties is at the highest level of priority and governs in the event of any conflict between these documents. Further, any of Aetna's responses to the listed documents take precedence over the initially submitted copies of these documents. The order of precedence would be as follows: 1. ASC Agreement 2. Aetna's response to the RFP, Notice of Intent of Contract, etc. 3. Any change the customer makes to the RFP.

other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to the executed Contract with the most recent dated amendment having the highest priority, 2) executed Contract and any attached Addenda, 3) Amendments to RFP and any Questions and Answers, 4) the original RFP document and any Addenda, and 5) the Contractor's submitted Proposal. Any ambiguity or conflict in the contract discovered after its execution, not otherwise addressed herein, shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.	
G. BREACH Either Party may terminate the contract, in whole or in part, if the other Party breaches its duty to perform its obligations under the contract in a timely and proper manner. Termination requires written notice of default and a thirty (30) calendar day (or longer at the non-breaching Party's discretion considering the gravity and nature of the default) cure period. Said notice shall be delivered by Certified Mail, Return Receipt Requested, or in person with proof of delivery. Allowing time to cure a failure or breach of contract does not waive the right to immediately terminate the contract for the same or different contract breach which may occur at a different time. In case of default of the Contractor, the State may contract the service from other sources and hold the Contractor responsible for any excess cost occasioned thereby. The State's failure to make payment shall not be a breach, and the Contractor shall retain all available statutory remedies and protections.	Noted. Unless otherwise agreed or required by law, either party can cancel by sending a written notice to the other at least 31 days in advance. We can terminate the arrangement sooner under certain circumstances. These include the enactment of new laws or regulations that do not allow us to write such a plan or the failure of the customer to pay amounts owed when due, or within any applicable grace period. Termination requirements are the same regardless if the plan terminates on or off anniversary.

J. INDEMNIFICATION **1. GENERAL** **The Contractor agrees to defend, indemnify, and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all third party claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State for personal injury, death, or property loss or damage, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Contractor, its employees, Subcontractors, consultants, representatives, and agents, resulting from this contract, except to the extent such Contractor liability is attenuated by any action of the State which directly and proximately contributed to the claims.** **2. INTELLECTUAL PROPERTY** **The Contractor agrees it will, at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Contractor or its employees, Subcontractors, consultants, representatives, and agents; provided, however, the State gives the Contractor prompt notice in writing of the claim. The Contractor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.**	**Your Indemnification language is generally acceptable. However, we wish to clarify the following:** **(1) Aetna can agree to indemnify the State of Nebraska on a comparative negligence theory, but we are not prepared to indemnify the State for 100% of a loss if Aetna is only partially at fault. As such, the words "that portion of" should be inserted before "any and all third claims" in the first line.** **(2) Consistent with the last comment, a standard of care should be introduced so that Aetna would only be liable for conduct deemed to be negligent. We are prepared to discuss other formulations of the standard of care, but we do not believe it is appropriate to omit the standard of care altogether in this paragraph.** **(3) Neither the State of Nebraska nor Aetna is responsible for the health care delivered by health care providers, whether network or non-network. The indemnification obligation set forth above would not apply to any portion of any claim, demand or legal action caused by the acts or omissions of health care providers with respect to Members.** **<u>INTELLECTUAL PROPERTY</u>** **Aetna can agree to indemnify the State of Nebraska for all costs, expenses, judgments, and damages that the City may have to pay or incur, and would like to clarify that this obligation of indemnification will not apply where the State has modified or misused the equipment, hardware or software and the claim of infringement, is based on the modification or misuse.**

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Contractor has indemnified the State, the Contractor shall, at the Contractor's sole cost and expense, promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Contractor, and the State may receive the remedies provided under this RFP. 3. PERSONNEL The Contractor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel, including subcontractor's and their employees, provided by the Contractor. 4. SELF-INSURANCE The State of Nebraska is self-insured for any loss and purchases excess insurance coverage pursuant to Neb. Rev. Stat. § 81-8,239.01 (Reissue 2008). If there is a presumed loss under the provisions of this agreement, Contractor may file a claim with the Office of Risk Management pursuant to Neb. Rev. Stat. §§ 81-8,829 – 81-8,306 for review by the State Claims Board. The State retains all rights and immunities under the State Miscellaneous (Section 81-8,294), Tort (Section 81-8,209), and Contract Claim Acts (Section 81-8,302), as outlined in Neb. Rev. Stat. § 81-8,209 et seq. and under any other provisions of law and accepts liability under this agreement to the extent provided by law.	

5. The Parties acknowledge that Attorney General for the State of Nebraska is required by statute to represent the legal interests of the State, and that any provision of this indemnity clause is subject to the statutory authority of the Attorney General.	
K. ATTORNEY'S FEES In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Parties agree to pay all expenses of such action, as permitted by law and if order by the court, including attorney's fees and costs, if the other Party prevails.	We agree to pay attorney fees under our obligation of indemnification, but we would look to the court to determine which party is responsible for attorney fees in all other matters.
N. CONTRACTING WITH OTHER NEBRASKA POLITICAL SUB-DIVISIONS The Contractor may, but shall not be required to, allow agencies, as defined in Neb. Rev. Stat. §81-145, to use this contract. The terms and conditions, including price, of the contract may not be amended. The State shall not be contractually obligated or liable for any contract entered into pursuant to this clause. A listing of Nebraska political subdivisions may be found at the website of the Nebraska Auditor of Public Accounts.	Aetna's fees/premiums quoted are unique to the State of Nebraska and cannot be extended. We would be pleased to work with other governmental entities to determine whether these terms can be extended to them, but each case would need to be individually underwritten.
Q. EARLY TERMINATION The contract may be terminated as follows: 1. The State and the Contractor, by mutual written agreement, may terminate the contract at any time. 2. The State, in its sole discretion, may terminate the contract for any reason upon thirty (30) calendar day's written notice to the Contractor. Such termination shall not relieve the Contractor of warranty or other service obligations incurred	Unless otherwise agreed or required by law, either party can cancel by sending a written notice to the other at least 30 days in advance. We can terminate the arrangement sooner under certain circumstances. These include the enactment of new laws or regulations that do not allow us to write such a plan or the failure of the customer to pay amounts owed when due, or within any applicable grace period. Termination requirements are the same regardless if the plan terminates on or off anniversary.

under the terms of the contract. In the event of termination the Contractor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided. 3. The State may terminate the contract immediately for the following reasons: a. if directed to do so by statute; b. Contractor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business; c. a trustee or receiver of the Contractor or of any substantial part of the Contractor's assets has been appointed by a court; d. fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Contractor, its employees, officers, directors, or shareholders; e. an involuntary proceeding has been commenced by any Party against the Contractor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) the Contractor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Contractor has been decreed or adjudged a debtor; f. a voluntary petition has been filed by the Contractor under any of the chapters of Title 11 of the United States Code; g. Contractor intentionally discloses confidential information; h. Contractor has or announces it will discontinue support of the deliverable; and, i. In the event funding is no longer available.	

III. CONTRACTOR DUTIES	
A. INDEPENDENT CONTRACTOR / OBLIGATIONS	
It is agreed that the Contractor is an independent contractor and that nothing contained herein is intended or should be construed as creating or establishing a relationship of employment, agency, or a partnership. **The Contractor is solely responsible for fulfilling the contract. The Contractor or the Contractor's representative shall be the sole point of contact regarding all contractual matters.** **The Contractor shall secure, at its own expense, all personnel required to perform the services under the contract. The personnel the Contractor uses to fulfill the contract shall have no contractual or other legal relationship with the State; they shall not be considered employees of the State and shall not be entitled to any compensation, rights or benefits from the State, including but not limited to, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.** **By-name personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State. Replacement of these personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.**	We use a variety of vendors to perform specific services and we require those vendors to meet all of our performance standards. Aetna is responsible for performance of all work under this agreement if done by Aetna or any one of Aetna's vendors. Because we subcontract on behalf of an entire book of business, we cannot agree to your specific language in our agreements. In lieu of proactively providing notice of a new or a change in subcontractors, Aetna can offer to provide the Tier 1 and Tier 2 subcontractor lists on a frequency requested by the client (not to exceed once/month). If clients note a new subcontractor on the lists, they can have the opportunity to discuss/object to Aetna's use of such subcontractor.

All personnel assigned by the Contractor to the contract shall be employees of the Contractor or a subcontractor and shall be fully qualified to perform the work required herein. Personnel employed by the Contractor or a subcontractor to fulfill the terms of the contract shall remain under the sole direction and control of the Contractor or the subcontractor respectively. **With respect to its employees, the Contractor agrees to be solely responsible for the following:** **1. Any and all pay, benefits, and employment taxes and/or other payroll withholding;** **2. Any and all vehicles used by the Contractor's employees, including all insurance required by state law;** **3. Damages incurred by Contractor's employees within the scope of their duties under the contract;** **4. Maintaining Workers' Compensation and health insurance that complies with state and federal law and submitting any reports on such insurance to the extent required by governing law; and** **5. Determining the hours to be worked and the duties to be performed by the Contractor's employees.** **6. All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination alleged against the Contractor, its officers, agents, or subcontractors or subcontractor's employees)** **If the Contractor intends to utilize any subcontractor, the subcontractor's level of effort, tasks, and time allocation should be clearly defined in the bidder's proposal. The Contractor shall agree that it will not utilize any subcontractors not specifically included in its proposal in the performance of the contract without the prior written authorization of the State.**	

The State reserves the right to require the Contractor to reassign or remove from the project any Contractor or subcontractor employee. **Contractor shall insure that the terms and conditions contained in any contract with a subcontractor does not conflict with the terms and conditions of this contract.** **The Contractor shall include a similar provision, for the protection of the State, in the contract with any Subcontractor engaged to perform work on this contract.**	
G. OWNERSHIP OF INFORMATION AND DATA / DELIVERABLES **The State shall have the unlimited right to publish, duplicate, use, and disclose all information and data developed or obtained by the Contractor on behalf of the State pursuant to this contract.** **All eligibility and claims records are the sole property of the State, and must be made available upon request to the State and its representatives. Selling of the State's data to ANY outside entities must be approved in advance, reported on a monthly basis and all income derived must be disclosed and shared per agreement with the State. Even if Contractor has not "sold" the data, they are NOT free to use the data for analyses that they publish or provide at a fee to outside industries.** **The State shall own and hold exclusive title to any deliverable developed as a result of this contract. Contractor shall have no ownership interest or title, and shall not patent, license, or copyright, duplicate, transfer, sell, or exchange, the design, specifications, concept, or deliverable.**	Aetna can agree if the Goods or Services are Customized, which means (i) based on the Customer's written specifications, (ii) paid for separately by the Customer to Aetna, and (iii) pursuant to a written statement of work signed by both parties.

STATE OF NEBRASKA – SF (ASC) MED/Rx/HSA 08/06 – Contract Deviations Summary

E. INSPECTION AND APPROVAL **Final inspection and approval of all work required under the contract shall be performed by the designated State officials.** **The State and/or its authorized representatives shall have the right to enter any premises where the Contractor or Subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.**	Inspections shall be subject to mutual agreement as to nature, scope, format, structure and cost as applicable.
V PROJECT DESCRIPTION AND SCOPE OF WORK	
16. Will not release any information related to the State of Nebraska health plans or claims in detail or in aggregate unless authorized by the Director of Administrative Services.	Confirmed. Aetna can agree with this provision provided we retain the ability to use the data in accordance with HIPAA.
III CONTRACTOR DUTIES	
H. INSURANCE REQUIREMENTS **The Contractor shall throughout the term of the contract maintain insurance as specified herein and provide the State a current Certificate of Insurance/Acord Form (COI) verifying the coverage. The Contractor shall not commence work on the contract until the insurance is in place. If Contractor subcontracts any portion of the Contract the Contractor must, throughout the term of the contract, either:**	**H. INSURANCE REQUIREMENTS** **The Contractor shall throughout the term of the contract maintain insurance as specified herein and provide the State a current Certificate of Insurance/Acord Form (COI) verifying the coverage. The Contractor shall not commence work on the contract until the insurance is in place. If Contractor subcontracts any portion of the Contract the Contractor must, throughout the term of the contract, either:**

STATE OF NEBRASKA – SF (ASC) MED/Rx/HSA 08/06 – Contract Deviations Summary

1. ; 2. , 3. Provide the State with copies of each subcontractor's Certificate of Insurance evidencing adequate insurance coverage commensurate to the scope of work they are to perform. The Contractor shall not allow any Subcontractor to commence work until the Subcontractor has adequate insurance. The failure of the State to require a COI, or the failure of the Contractor to provide a COI or require subcontractor insurance shall not limit, relieve, or decrease the liability of the Contractor hereunder. In the event that any policy written on a claims-made basis terminates or is canceled during the term of the contract or within one (1) year of termination or expiration of the contract, the contractor shall obtain an extended discovery or reporting period, or a new insurance policy, providing coverage required by this contract for the term of the contract and evaluated by Corporate Risk Management as needed. If by the terms of any insurance a mandatory deductible is required, or if the Contractor elects to increase the mandatory deductible amount, the Contractor shall be responsible for payment of the amount of the deductible in the event of a paid claim. Notwithstanding any other clause in this Contract, the State may recover up to the liability limits of the insurance policies required herein. 1. WORKERS' COMPENSATION INSURANCE The Contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and	1. Provide the State with copies of each subcontractor's Certificate of Insurance evidencing adequate insurance coverage commensurate to the scope of work they are to perform. The Contractor shall not allow any Subcontractor to commence work until the Subcontractor has adequate insurance. The failure of the State to require a COI, or the failure of the Contractor to provide a COI or require subcontractor insurance shall not limit, relieve, or decrease the liability of the Contractor hereunder. In the event that any policy written on a claims-made basis terminates or is canceled during the term of the contract or within one (1) year of termination or expiration of the contract, the contractor shall obtain an extended discovery or reporting period, or a new insurance policy, providing coverage required by this contract for the term of the contract and evaluated by Corporate Risk Management as needed. If by the terms of any insurance a mandatory deductible is required, or if the Contractor elects to increase the mandatory deductible amount, the Contractor shall be responsible for payment of the amount of the deductible in the event of a paid claim. Notwithstanding any other clause in this Contract, the State may recover up to the liability limits of the insurance policies required herein. 1. WORKERS' COMPENSATION INSURANCE The Contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the Contractor shall require the Subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the Subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work

Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the Contractor shall require the Subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the Subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. The policy shall include a waiver of subrogation in favor of the State. The COI shall contain the mandatory COI subrogation waiver language found hereinafter. The amounts of such insurance shall not be less than the limits stated hereinafter. For employees working in the State of Nebraska, the policy must be written by an entity authorized by the State of Nebraska Department of Insurance to write Workers' Compensation and Employer's Liability Insurance for Nebraska employees. 2. COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE The Contractor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Contractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Contractor or by anyone directly employed, and the amounts of such insurance shall not be less than limits stated hereinafter. The Commercial General Liability Insurance shall be written on an occurrence basis, and provide Premises/Operations, Products/Completed Operations, , Personal Injury, and Contractual Liability coverage. The policy shall include the State, and others as required by the contract	is to be performed, including Occupational Disease. The policy shall include a waiver of subrogation in favor of the State. The COI shall contain the mandatory COI subrogation waiver language found hereinafter. The amounts of such insurance shall not be less than the limits stated hereinafter. For employees working in the State of Nebraska, the policy must be written by an entity authorized by the State of Nebraska Department of Insurance to write Workers' Compensation and Employer's Liability Insurance for Nebraska employees. 2. COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE The Contractor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Contractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Contractor or by anyone directly employed, and the amounts of such insurance shall not be less than limits stated hereinafter. The Commercial General Liability Insurance shall be written on an occurrence basis, and provide Premises/Operations, Products/Completed Operations, , Personal Injury, and Contractual Liability coverage. The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). As an additional insured this policy shall be primary, and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory. The COI shall contain the mandatory COI liability waiver language found hereinafter. The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned, and Hired vehicles. REQUIRED INSURANCE COVERAGE COMMERCIAL GENERAL LIABILITY

documents, as Additional Insured(s). As an additional insured this policy shall be primary, and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory. The COI shall contain the mandatory COI liability waiver language found hereinafter. The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned, and Hired vehicles.

REQUIRED INSURANCE COVERAGE
COMMERCIAL GENERAL LIABILITY
General Aggregate $2,000,000
Products/Completed Operations Aggregate $2,000,000
Personal/Advertising Injury $1,000,000 per occurrence
Bodily Injury/Property Damage $1,000,000 per occurrence

Damage to Rented Premises (Fire) $300,000 each occurrence
Contractual Included
If higher limits are required, the Umbrella/Excess Liability limits are allowed to satisfy the higher limit.
WORKER'S COMPENSATION
Employers Liability Limits $500K/$500K/$500K
Statutory Limits- All States Statutory - State of Nebraska
Voluntary Compensation Statutory
COMMERCIAL AUTOMOBILE LIABILITY
Bodily Injury/Property Damage $1,000,000 combined single limit
Include All Owned, Hired & Non-Owned Automobile liability Included
Motor Carrier Act Endorsement Where Applicable
UMBRELLA/EXCESS LIABILITY
Over Primary Insurance $5,000,000 per occurrence
General Aggregate $2,000,000
Products/Completed Operations Aggregate $2,000,000
Personal/Advertising Injury $1,000,000 per occurrence
Bodily Injury/Property Damage $1,000,000 per occurrence

Damage to Rented Premises (Fire) $300,000 each occurrence
Contractual Included
If higher limits are required, the Umbrella/Excess Liability limits are allowed to satisfy the higher limit.
WORKER'S COMPENSATION
Employers Liability Limits $500K/$500K/$500K
Statutory Limits- All States Statutory - State of Nebraska
Voluntary Compensation Statutory
COMMERCIAL AUTOMOBILE LIABILITY
Bodily Injury/Property Damage $1,000,000 combined single limit
Include All Owned, Hired & Non-Owned Automobile liability Included
Motor Carrier Act Endorsement Where Applicable
UMBRELLA/EXCESS LIABILITY
Over Primary Insurance $5,000,000 per occurrence
PROFESSIONAL LIABILITY
Professional liability (Medical Malpractice) $10,000,000 per claim
$10,000,000 Aggregate
Qualification Under Nebraska Excess Fund
All Other Professional Liability (Errors & Omissions) $1,000,000 Per Claim / Aggregate
COMMERCIAL CRIME
Crime/Employee Dishonesty Including 3rd Party Fidelity $2,000,000
CYBER LIABILITY
Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties $20,000,000 per claim
MANDATORY COI SUBROGATION WAIVER LANGUAGE
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."
MANDATORY COI LIABILITY WAIVER LANGUAGE

STATE OF NEBRASKA – SF (ASC) MED/Rx/HSA 08/06 – Contract Deviations Summary

PROFESSIONAL LIABILITY Professional liability (Medical Malpractice) $10,000,000 per claim $10,000,000 Aggregate Qualification Under Nebraska Excess Fund All Other Professional Liability (Errors & Omissions) $1,000,000 Per Claim / Aggregate COMMERCIAL CRIME Crime/Employee Dishonesty Including 3rd Party Fidelity $2,000,000 CYBER LIABILITY Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties $20,000,000 per claim MANDATORY COI SUBROGATION WAIVER LANGUAGE "Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska." MANDATORY COI LIABILITY WAIVER LANGUAGE "Commercial General Liability & Commercial Automobile Liability policies shall include the State of Nebraska as an Additional Insured and the policies shall be primary and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory as additionally insured." If the mandatory COI subrogation waiver language or mandatory COI liability waiver language on the COI states that the waiver is subject to, condition upon, or otherwise limit by the insurance policy, a copy of the relevant sections of the policy must be submitted with the COI so the State can review the limitations imposed by the insurance policy. 3. EVIDENCE OF COVERAGE The Contractor shall furnish the Contract Manager, with a certificate of insurance coverage complying with the above requirements prior to beginning work at:	"Commercial General Liability & Commercial Automobile Liability policies shall include the State of Nebraska as an Additional Insured and the policies shall be primary and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory as additionally insured." If the mandatory COI subrogation waiver language or mandatory COI liability waiver language on the COI states that the waiver is subject to, condition upon, or otherwise limit by the insurance policy, a copy of the relevant sections of the policy must be submitted with the COI so the State can review the limitations imposed by the insurance policy. 3. EVIDENCE OF COVERAGE The Contractor shall furnish the Contract Manager, with a certificate of insurance coverage complying with the above requirements prior to beginning work at: Administrative Services Attn: Wellness & Benefits Administrator 1526 K Street, Suite 110 Lincoln, NE 68508 These certificates or the cover sheet shall reference the RFP number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Contractor shall be responsible for all reasonable costs properly attributable thereto. Reasonable notice of cancellation of any required insurance policy must be submitted to the contract manager as listed above when issued and a new certificate of insurance shall be submitted up to ten (10) days after the expiration to ensure no break in coverage.

Administrative Services Attn: Wellness & Benefits Administrator 1526 K Street, Suite 110 Lincoln, NE 68508 These certificates or the cover sheet shall reference the RFP number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Contractor shall be responsible for all reasonable costs properly attributable thereto. Reasonable notice of cancellation of any required insurance policy must be submitted to the contract manager as listed above when issued and a new certificate of insurance shall be submitted up to ten (10) days after the expiration to ensure no break in coverage. 4. DEVIATIONS The insurance requirements are subject to limited negotiation. Negotiation typically includes, but is not necessarily limited to, the correct type of coverage, necessity for Workers' Compensation, and the type of automobile coverage carried by the Contractor.	4. DEVIATIONS The insurance requirements are subject to limited negotiation. Negotiation typically includes, but is not necessarily limited to, the correct type of coverage, necessity for Workers' Compensation, and the type of automobile coverage carried by the Contractor.

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