Achieving health performance together

An Aetna Proposal for

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

COST PROPRIETARY

August 2019

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August 2019

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6102 Z1, Cost Proposal, REVISION ONE

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RFP NUMBER #6102 Z1
COST PROPOSAL
MEDICAL COST PROPOSAL INSTRUCTIONS

The State of Nebraska's Medical And Rx Administrator
Medical Cost Proposal Instructions

Detailed Claims and Eligibility data is provided for your assessment and analysis in preparing your response to this RFP.
The claims files include service codes, diagnostic data, and other clinical detail.
Monthly enrollments and paid claims data is included to provide historic paid claims levels.

Use the tabs in this spreadsheet for reference and specific instructions in providing proposed Administrative Fees and information regarding your book of business (discounts, membership, etc.) for the membership covered in the program.

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.

Additionally, the State requires a "repriced claim" file as part of your submission.

Please return the detailed medical claim files with the following additional fields appended to the original file:

Allowed Charge
Discount Off Of Allowed
Scheduled Payment Amount (if applicable)
Included in capitated payments (if applicable)
Any other reimbursement methodologies - provide sufficient detail to evaluate
Network Provider Indicator

NOTE: If capitation exists in your network, provide enough detail to sufficiently evaluate the effect on the State's costs, including services, payments and provider types included. Include description as separate attachment with your response.

The State of Nebraska's Medical And Rx Administrator - Medical Administration Fees

BIDDER NAME: Aetna Life Insurance Company

Bidder shall provide the Administrative Services Only (ASO) fees below for each of the three plan designs currently in place The fees must be based on a "per employee per month" (PEPM) composite basis Fees on any other basis, (i e , as a percentage of claims, on a per claim basis or a combination) will NOT be considered **The ASO Fees are to be guaranteed for the three (3) year contract period, July 1, 2020 thru June 30, 2023,** with the option to renew for four (4) additional one (1) year periods as mutually agreed upon by all parties Any ancillary service relating to the administration of the health plan not specifically identified in bidder's proposal is assumed to be included in the ASO fee IF THE **FEE STRUCTURE IS DIFFERENT BY** PLAN, **COMPLETE THIS SCHEDULE FOR EACH PLAN AND LABEL EACH SCHEDULE ACCORDINGLY.**

SELF-FUNDED MEDICAL ADMINISTRATION COSTS	Initial Period			Optional Year One	Optional Year Two	Optional Year Three	Optional Year Four
	7/1/20 - 6/30/21	7/1/21- 6/30/22	7/1/22- 6/30/23	7/1/23 - 6/30/24	7/1/24- 6/30/25	7/1/25- 6/30/26	7/1/26- 6/30/27
Estimated Number of Medical Plan Employees	12,845	12,845	12,845	12,845	12,845	12,845	12,845
Medical ASO Fees to include, but not limited to:							
Plan ASO Fees							
Network Access Fees							
Provider Network Fees							
Out of Network Access Fees							
Subrogation							
Claims Processing and Adjudication							
Internal / External Audits							
Dependent eligibility verification							
Coordination of Benefits							
Customer Service							
Benefit Booklet/SPD (initial and updates)							
Provider Directories							
ID Cards							
Postage/Envelope Costs							
Toll-free Member Services Line							
Interactive Website							
Electronic Eligibility Transmittal and Receipt of Updates and Monthly Reconciliation							
Reporting							
Standard Reporting - Monthly, Quarterly, Annual							
Ad-hoc Reporting							
Annual Accounting of Funds Received vs Claims Paid							
Subrogation							
Start-Up							
Annual Enrollment Session							
Enrollment Communications							
Additional Programs							
Behavioral Health							
Case Management							
Pre-Admission Certification							
Wellness Programming							
Utilization Review							
Per Employee Per Month ASO Fees	$ 29.60	$ 30.49	$ 31.40	$ 32.97	$ 34.62		
Total Monthly ASO Fees	$ 380,212.00	$ 391,618.36	$ 403,366.91	$ 423,535.26	$ 444,712.02	$ -	$ -
Total Annual ASO Fees	$ 4,562,544.00	$ 4,699,420.32	$ 4,840,402.93	$ 5,082,423.08	$ 5,336,544.23	$ -	$ -
Guarantees & Credits	7/1/20- 6/30/21	7/1/21- 6/30/22	7/1/22- 6/30/23	7/1/23- 6/30/24	7/1/24- 6/30/25	7/1/25- 6/30/26	7/1/26- 6/30/27
Enrollment Change Tolerance (+/- XX%)	0%	0%	0%	0%	0%	0%	100%
Implementation Credit ($) ($200,000 if Med & Rx awarded, $100,000 if Med Only)	$ 200,000.00						
Annual Communications/Wellness Credit ($)	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Note:

The Basic Fee is a per employee per month (PEPM) fee for all services and deliverables required under the terms of this Contract and which are not specifically and separately identified elsewhere in the table Such services include but are not limited to claims administration, network access fees, underwriting, standard report production and delivery, claims data extracts, member communication materials, claims fiduciary liability, administration of post-contract run out claims, routine and non-routine production and delivery of ID cards, large case management, etc

The State of Nebraska's Medical And Rx Administrator
Medical Administration Runout Fee Schedule

BIDDER NAME: Aetna Life Insurance Company

Provide the Administrative Services Only (ASO) runout fees below for each of the plan designs currently in place. The fees must be based on a "per employee per month" (PEPM) composite basis. Fees on any other basis, i.e., as a percentage of claims, on a per claim basis or a combination will not be considered. The ASO runout fees are to be based on a runout period of 6 months. **IF YOUR FEE STRUCTURE IS DIFFERENT BY PLAN, COMPLETE THIS SCHEDULE FOR EACH PLAN AND LABEL EACH SCHEDULE ACCORDINGLY.**

PER EMPLOYEE PER MONTH (PEPM) (Composite)	RUNOUT YEAR 1	RUNOUT YEAR 2	RUNOUT YEAR 3
Medical ASO Fees to include, but not limited to:			
Plan Administration Fees			
Provider Network Fees			
Out of Network Access Fees			
Subrogation			
Claims Processing and Adjudication			
Internal / External Audits			
Coordination of Benefits			
Customer Service			
Benefit Booklet/SPD (initial and updates)			
Provider Directories			
ID Cards			
Postage / Envelopes			
Additional Programs			
Behavioral Health			
Case Management			
Pre-Admission Certification			
Utilization Review			
TOTAL	$ -	$ -	$ -

Other:

	$ -	$ -	$ -
	$	$	$
	$	$	$
	$	$	$
	$	$	$

RFP NUMBER #6102 Z1
COST PROPOSAL
MEDICAL COST PROPOSAL INSTRUCTIONS

The State of Nebraska's Medical And Rx Administrator
Medical Claims Repricing

BIDDER NAME: Aetna Life Insurance Company

Reprice claims from the file provided by Segal. The repricing must be based on the submitted/billed charges provided in the file, and 2019 network provider contractual fee arrangements. The claims repricing amounts must be based on actual data and should not include any assumptions regarding projected discounts or expected increases in billed charges.

In the grid, below, provide the sum of all repriced claims by in-network and out-of-network based on the submitted/billed charges.

If proposing multiple networks, complete the Claims Repricing Analysis exhibit separately for each network. Bidder must also include an explanation summarizing how the claims were repriced, noting any and all assumptions made.

Repricing of Medical Claims Data		
	PPO or POS Network	
	Billed Amount *	Repriced Amount **
IN-NETWORK	$254,381,550	$155,611,945
OUT-OF-NETWORK	$8,822,273	$5,162,982
Grand Total From Data File	$269,725,849	$160,774,928
Grand Total Repriced	$263,203,823	$160,774,928

***Billed Amount reflects Submitted/Billed Charges as shown on the Claims Repricing data file.**

****Repriced Amount reflects charges based on application of your 2019 provider-specific discounts.**

RFP NUMBER #6102 Z1
COST PROPOSAL
MEDICAL COST PROPOSAL INSTRUCTIONS

The State of Nebraska's Medical And Rx Administrator
Provider Discounts

BIDDER NAME: Aetna Life Insurance Company

Provide the average discounts off Eligible Charges for Physician and Hospital Inpatient and Outpatient for the following locations commensurate with the repricing file provided in 4A - Medical Repricing.

Aetna considers information concerning fees negotiated with providers to be proprietary, commercially valuable information, which is not in the public domain. Consequently, the information contained herein is to be maintained in a confidential manner, and used solely for the purposes of reviewing this proposal.

Choice POS II

Based on claims incurred between 01/01/2017 and 12/31/2017; paid through 02/28/2018.

3 Digit	Average Discount off Eligible Charges		
Zip Code	Inpatient Hospital	Outpatient Hospital	Physician
693	30.52%	27 52%	36.39%
692	30.71%	28.60%	36.49%
691	30 77%	17.46%	36.01%
690	30.62%	28.48%	36.48%
689	25.72%	26.53%	36.58%
688	32.80%	32.67%	35 52%
687	30.09%	33.33%	39.91%
686	31.45%	25.81%	36.95%
685	39.90%	43.85%	37.23%
684	42 70%	43.73%	36.17%
683	42.19%	40.76%	39.13%
681	49.66%	50.89%	34.51%
680	47.65%	47.46%	33.79%

3 Digit	Average Discount off Eligible Charges		
Zip Code	Inpatient Hospital	Outpatient Hospital	Physician
515	46.35%	50.05%	34.89%
511	34.36%	45.21%	37.74%

Note: Provide separate table for each proposed network, PPO or POS.

RFP NUMBER #6102 Z1
COST PROPOSAL
MEDICAL COST PROPOSAL INSTRUCTIONS

The State of Nebraska's Medical And Rx Administrator
Network Provider Discount Guarantee

BIDDER NAME: Aetna Life Insurance Company

The State of Nebraska (the State) seeks the most favorable discounts from providers in the proposed provider network It is also a requirement of the State, upon completion of each plan year, to have the selected network provide an analysis of actual discounted savings, which were realized over the course of the plan year, and use this analysis to compare the results to the expected discounts 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

1. Indicate the level of discounts that will be guaranteed from year to year over the contract term For example, if inpatient facility discounts are 40% for 7/1/20 - 6/30/21 and it is guaranteed they will increase to 41% in 7/1/21 - 6/30/22, enter "40%" in the cell in the inpatient facility row under the 7/1/20 - 6/30/21 column and "41%" under the 7/1/21 - 6/30/22 column

Service Category	7/1/20- 6/30/21	7/1/21- 6/30/22	7/1/22- 6/30/23	Optional Year 7/1/23- 6/30/24	Optional Year 7/1/24- 6/30/25	Optional Year 7/1/25- 6/30/26	Optional Year 7/1/26- 6/30/27
Guaranteed Overall Inpatient Facility Discounts	39.1%	TBD	TBD	TBD	TBD	TBD	TBD
Guaranteed Overall Outpatient Facility Discounts	39.7%	TBD	TBD	TBD	TBD	TBD	TBD
Guaranteed Overall Professional Discounts	37.2%	TBD	TBD	TBD	TBD	TBD	TBD

2. Using the table below, for the network being proposed, indicate the portion of Administrative fees (as a percentage) to be paid back to the State if the discount guarantees listed above are not achieved The schedule must provide a percentage of ASO fees at risk for not achieving guaranteed discount levels

Service Category	7/1/20- 6/30/21	7/1/21- 6/30/22	7/1/22- 6/30/23	Optional Year 7/1/23- 6/30/24	Optional Year 7/1/24- 6/30/25	Optional Year 7/1/25- 6/30/26	Optional Year 7/1/26- 6/30/27
Percentage of Administrative Fees at Risk for Inpatient Facility Discount Guarantees*	50.0%	TBD	TBD	TBD	TBD	TBD	TBD
Percentage of Administrative Fees at Risk for Outpatient Facility Discount Guarantees*		TBD	TBD	TBD	TBD	TBD	TBD
Percentage of Administrative Fees at Risk for Professional Discount Guarantees*		TBD	TBD	TBD	TBD	TBD	TBD

** paid during the respective plan year*

The State of Nebraska Rx Administrator
Pharmacy Cost Proposal Instructions

Pricing must be on a pass-through basis such that the amount billed to the State for retail claims is equal to the amount reimbursed to retail pharmacies and with 100% of all rebate revenue being passed through to the State.

Pricing shall be based on your **Broadest Network.**

AWP must be sourced from Medi-Span unless another national provider source is explicitly stated in the cost proposal.

All generic drugs, including single-source and brand drugs that function as "house generics" must be classified as generic drugs for pricing purposes.

Bidders are required to complete all financial exhibits as instructed. All administrative fees are required on a per-employee-per-month basis.

All services covered under the fee should be listed.

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.

RFP NUMBER #6101 Z1
COST PROPOSAL
MEDICAL COST PROPOSAL INSTRUCTIONS

The State of Nebraska Rx Administrator
Rx Pricing, Transparent (Broadest Network)

BIDDER NAME: Aetna Life Insurance Company

Instructions: Complete every cell on this worksheet For retail, propose pricing for broadest retail network **Pricing offer must be on a post-AWP rollback basis. Provide cost based on the current plan design. In addition to the aggregate discount guarantees indicated below submit a complete list of specialty drugs, their therapeutic category and discount from AWP.**

RETAIL Broadest Network							
Number of Pharmacies Nationwide	67525						
Bidder must use ingredient Cost Adjudication Formula: Lowest of pharmacy's U&C price, MAC (where applicable), or discounted AWP							
	7/1/20- 6/30/21	7/1/21- 5/30/22	7/1/22- 5/30/23	7/1/23- 6/30/24	7/1/24- 6/30/25	7/1/25- 6/30/26	7/1/26- 6/30/27
Minimum AWP Discount Guarantees							
Brand Drugs	18.30%	18.40%	18.50%	18.60%	18.70%	18.60%	18.90%
Generic Drugs (must include all single-source and "house" generics.)	84.00%	84.20%	84.40%	84.60%	84.80%	85.00%	85.20%
Maximum Dispensing Fee per Paid Claim							
All Claims	$0.50 per script	$0.50 per script	$0.50 per script	$0.50 per script	$0.50 per script	$0.50 per script	$0.50 per script
Compounds							
Ingredient cost adjudication formula	Excluded from guarantees	Excluded from guarantees	Excluded from guarantees	Excluded from guarantees	Excluded from guarantees	Excluded from guarantees	Excluded from guarantees

RETAIL 90 Network Broadest Network							
Number of Pharmacies Nationwide	66632						
Bidder must use Ingredient Cost Adjudication Formula: Lowest of pharmacy's U&C price, MAC (where applicable), or discounted AWP							
	7/1/20- 6/30/21	7/1/21- 6/30/22	7/1/22- 6/30/23	7/1/23- 6/30/24	7/1/24- 6/30/25	7/1/25- 6/30/26	7/1/26- 6/30/27
Minimum AWP Discount Guarantees							
Brand Drugs	19.80%	19.90%	20.00%	20.10%	20.20%	20.30%	20.40%
Generic Drugs (must include all single-source and "house" generics)	84.00%	84.20%	84.40%	84.60%	84.80%	85.00%	85.20%
Maximum Dispensing Fee per Paid Claim							
All Claims	$0.35 per script	$0.35 per script	$0.35 per script	$0.35 per script	$0.35 per script	$0.35 per script	$0.35 per script
Compounds							
Ingredient cost adjudication formula	Excluded from guarantees	Excluded from guarantees	Excluded from guarantees	Excluded from guarantees	Excluded from guarantees	Excluded from guarantees	Excluded from guarantees
MAIL ORDER (EXCLUDING SPECIALTY)							
Bidder must use Ingredient Cost Adjudication Formula: Lower of MAC (where applicable) or discounted AWP							
	7/1/20- 6/30/21	7/1/21- 6/30/22	7/1/22- 6/30/23	7/1/23- 6/30/24	7/1/24- 6/30/25	7/1/25- 6/30/26	7/1/26- 6/30/27
Minimum AWP Discount Guarantees							
Brand Drugs	25.00%	25.10%	25.20%	25.30%	25.40%	25.50%	25.60%
Generic Drugs (must include all single-source and "house" generics)	87.00%	87.20%	87.40%	87.60%	87.80%	88.00%	88.20%
Maximum Dispensing Fee per Paid Claim							
All Claims	$0.00 per script	$0.00 per script	$0.00 per script	$0.00 per script	$0.00 per script	$0.00 per script	$0.00 per script
Compounds							
Ingredient cost adjudication formula	Excluded from guarantees	Excluded from guarantees	Excluded from guarantees	Excluded from guarantees	Excluded from guarantees	Excluded from guarantees	Excluded from guarantees
SPECIALTY DRUGS (AT SPECIALTY PHARMACY) *							
Bidder must use Ingredient Cost Adjudication Formula: Lowest of pharmacy's U&C price, MAC (where applicable), or discounted AWP							
	7/1/20- 6/30/21	7/1/21- 6/30/22	7/1/22- 6/30/23	7/1/23- 6/30/24	7/1/24- 6/30/25	7/1/25- 6/30/26	7/1/26- 6/30/27
Minimum Brand AWP Discount Guarantee							
All Brands	20.00%	20.10%	20.20%	20.30%	20.40%	20.50%	20.60%
All Biosimilars	20.00%	20.10%	20.20%	20.30%	20.40%	20.50%	20.60%
All Generics	20.00%	20.10%	20.20%	20.30%	20.40%	20.50%	20.60%
Maximum Dispensing Fee per Paid Claim							
All Claims	$0.00 per script	$0.00 per script	$0.00 per script	$0.00 per script	$0.00 per script	$0.00 per script	$0.00 per script

SPECIALTY DRUGS (AT RETAIL PHARMACIES) *							
Bidder must use Ingredient Cost Adjudication Formula: Lowest of pharmacy's U&C price, MAC (where applicable), or discounted AWP							
	7/1/20- 6/30/21	7/1/21- 6/30/22	7/1/22- 6/30/23	7/1/23- 6/30/24	7/1/24- 6/30/25	7/1/25- 6/30/26	7/1/26- 6/30/27
Minimum Brand AWP Discount Guarantee							
All Brands	18.30%	18.40%	18.50%	18.60%	18.70%	18.80%	18.90%
All Biosimilars	18.30%	18.40%	18.50%	18.60%	18.70%	18.80%	18.90%
All Generics	84.00%	84.20%	84.40%	84.60%	84.80%	85.00%	85.20%
Maximum Dispensing Fee per Paid Claim							
All Claims	$0.50 per script	$0.50 per script	$0.50 per script	$0.50 per script	$0.50 per script	$0.50 per script	$0.50 per script
	CREDITS						
Implementation Allowance	$ 50,000.00						
Annual Audit Allowance	Included in General Allowance above						
Annual Program Allowance	N/A						
Minimum rebates should be quoted on a per brand claim basis	GUARANTEED REBATES -						
	7/1/20- 6/30/21	7/1/21- 6/30/22	7/1/22- 6/30/23	7/1/23- 6/30/24	7/1/24- 6/30/25	7/1/25- 6/30/26	7/1/26- 6/30/27
Percent Rebate Share All Claims	100%	100%	100%	100%	100%	100%	100%
Retail Brand	Greater of 100% of $209.13 per Brand Script	Greater of 100% of $214.66 per Brand Script	Greater of 100% of $223.03 per Brand Script	TBD in Year 3	TBD in Year 3	TBD in Year 3	TBD in Year 3
Retail 90 Brand	Greater of 100% of $580.06 per Brand Script	Greater of 100% of $682.59 per Brand Script	Greater of 100% of $777.35 per Brand Script	TBD in Year 3	TBD in Year 3	TBD in Year 3	TBD in Year 3
Mail Order Brand	Greater of 100% of $580.06 per Brand Script	Greater of 100% of $582.59 per Brand Script	Greater of 100% of $777.35 per Brand Script	TBD in Year 3	TBD in Year 3	TBD in Year 3	TBD in Year 3
Specialty Brand (Specialty Pharmacy)	Greater of 100% or $1,390.17 per Brand Script (Non-Hep C); $13,885.87 (Hep C)	Greater of 100% or $1,495.16 per Brand Script (Non-Hep C); $13,885.87 (Hep C)	Greater of 100% or $1,593.69 per Brand Script (Non-Hep C); $13,885.37 (Hep C)	TBD in Year 3	TBD in Year 3	TBD in Year 3	TBD in Year 3
Specialty Brand (Retail Pharmacy)	Greater of 100% or $1,390.17 per Brand Script (Non-Hep C); $13,885.87 (Hep C)	Greater of 100% or $1,495.16 per Brand Script (Non-Hep C); $13,885.87 (Hep C)	Greater of 100% or $1,593.69 per Brand Script (Non-Hep C); $13,885.87 (Hep C)	TBD in Year 3	TBD in Year 3	TBD in Year 3	TBD in Year 3
Specialty Biosimilar (Specialty Pharmacy). New to Market Biosimilars are excluded from rebate guarantees.	Greater of 100% or $1,390.17 per Brand Script (Non-Hep C); $13,885.87 (Hep C)	Greater of 100% or $1,495.16 per Brand Script (Non-Hep C); $13,885.87 (Hep C)	Greater of 100% or $1,593.69 per Brand Script (Non-Hep C); $13,885.87 (Hep C)	TBD in Year 3	TBD in Year 3	TBD in Year 3	TBD in Year 3
Specialty Biosimilar (Retail Pharmacy) New to Market Biosimilars are excluded from rebate guarantees.	Greater of 100% or $1,390.17 per Brand Script (Non-Hep C); $13,885.87 (Hep C)	Greater of 100% or $1,495.16 per Brand Script (Non-Hep C); $13,885.87 (Hep C)	Greater of 100% or $1,593.69 per Brand Script (Non-Hep C); $13,885.87 (Hep C)	TBD in Year 3	TBD in Year 3	TBD in Year 3	TBD in Year 3

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COST PROPOSAL
MEDICAL COST PROPOSAL INSTRUCTIONS

The State of Nebraska Rx Administrator
Required Pharmacy Administrative Services Only (ASO) Fees

Bidder Name: ____Aetna Life Insurance Company

Pharmacy ASO Fees to include, but not limited to:	Initial Period			Optional Year One	Optional Year Two	Optional Year Three	Optional Year Four
	7/1/20 - 6/30/21	7/1/21 - 6/30/22	7/1/22 - 6/30/23	7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27
Toll Free Phone Lines							
Monthly Data Feeds to State/Designee(s)							
Prospective /Concurrent DUR							
Standard Reports							
Ad Hoc Reports							
COB Program							
Annual EOB Statements							
Retro Termination Letters							
Drug Notification Letters							
Formulary and Rebate Administration							
Enrollment Packet Mailing							
ID Card Production and Distribution							
Manual Claim Processing							
1st Level Appeals							
2nd Level Appeals							
Urgent Appeals							
E-Prescribing							
Vaccine Services							
Audit Recoveries							
Retro DUR							
Prior Authorization							
Quantity Level Limits							
Dose Optimization							
Medication Management							
Per Employee per Month ASO Fees							
Total Monthly ASO Fees	$1.95	$1.95	$1.95	$1.95	$1.95	$1.95	$1.95
Total Annual ASO Fees	$23	$23	$23	$23	$23	$23	$23
List All Other clinical programs or services and associated fees (if any):	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Self-Funded Financial Package

An Aetna Proposal
Presented to

STATE OF NEBRASKA

July 1, 2020

In an industry that's so intimate, we prefer not to take a one-size fits all approach for you or your employees.

We're asked all the time: **"What is your vision for the future?"** We're more than just an insurance provider - we're a health care company. We join members on their health journey and remove complexities from the experience. We take a holistic view of each member and create personalized plans rather than a cookie cutter approach that uses blanket programs as solutions.

We're transforming. This change is a fundamental shift in how we view health care.

We have tailored solutions to meet your needs. We know the value of each and every employee to help you reach your goals. And we have a plan to take care of each one so they reach their ideal health and live a happy life and productive work life for you.

We want to help you advocate for your workforce. We want to move away from a focus on products and programs – **to focus on people.**

Health care can be overwhelming. So our approach focuses on each person to create a **stronger individual**. And with many stronger individuals comes a **stronger workforce**. When you have a stronger workforce, we can help you achieve your goals and get **stronger results.**

As we transform the health care experience, we're honored to be recognized for our work. Click here to learn more about Aetna's awards and recognitions.

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.

The Aetna companies include:
Aetna Health Inc., Aetna Health of California Inc., Aetna Health of the Carolinas Inc., Aetna Health of Washington Inc., Aetna Health Insurance Company of Connecticut, Aetna Health Insurance Company of New York, Corporate Health Insurance Company; Aetna Life Insurance Company; Aetna Dental Inc.; and/or Aetna Dental of California Inc.; Aetna Health of Utah Inc. Certain dental plans are available only for groups of a certain size in accordance with underwriting guidelines. Managed care plans may not cover all health care expenses. Contracts should be read carefully to determine which health care services are covered. While this material is believed to be accurate as of the print date, it is subject to change. For more specific information about the coverage details, including limitations, exclusions, and other plan requirements, please contact an Aetna representative.

Aetna has various programs for compensating producers (agents, brokers and consultants). If you would like information regarding compensation programs for which your producer is eligible, payments (if any) which Aetna has made to your producer, or other material relationships your producer may have with Aetna, you may contact your producer or your Aetna account representative. Information regarding Aetna's program compensating producers is also available at:
www.aetna.com

The information contained in this proposal is confidential and should not be shared with anyone other than your broker or benefit plan consultant.

STATE OF NEBRASKA

Proposed Cost	Effective Date: July 1, 2020	End Date: June 30, 2021
Estimated Enrollment	**CPH**	**Total Composite**
Estimated Total Employees	13,042	13,042
Service Fee Costs PEPM		
Medical Fees	$29.60	$29.60
Policy Period Fee Cost	$4,632,518	$4,632,518

- Please refer to the Program Summary for a detailed description of our programs & services. Some services may come at an additional cost to the fees shown above.
- We are including a Transitional Allowance of $200,000 should Aetna be the selected vendor for both Medical and Rx
- We are including a Transitional Allowance of $100,000 should Aetna be the selected vendor for Medical only

Programs and Services - Self Funded	Effective Date: July 01, 2020
	CPII
Programs & Services	
Mature Base Service Fee	$29.60
Implementation, Account Management & Plan Administration	
Designated Account Management Team	Included
Designated Implementation Manager	Included
Onsite Open Enrollment Meeting Preparation	Included
Open Enrollment Marketing Material (Standard) Onsite Meeting Preparation	Included
Standard ID Cards	Included
Summary of Benefits and Coverage (SBC)	Included
Claim Fiduciary Option 1	Included
Network Services	
Institutes of Quality® (IOQ) Program	Included
National Medical Excellence Program® - Transplant Coordination	Included
Care Management	
Aetna Compassionate Care℠ Program	Included
MedQuery® Physician Messaging	Included
Personal Health Record	Included
Utilization Management	Included
Transitional Care Management	Included
Member Resources	
Member Website and Mobile Experience	Included
ALEX® (owned by Jellyvision)	Included
MindCheck℠	Included
Wellness	
24/7 Nurse Line - Informed Health® Line	Included
Simple Steps to Healthier Life® Health Assessment	Included
Aetna Healthy Commitments℠ - Enhanced Wellness Package	Included
Allowances	
Implementation/Communication Allowance - $100,000 if we are awarded M	Included
Implementation/Communication Allowance - $200,000 if we are awarded M	Included
3rd Party Dependent Verification Allowance - $100,000	Included
HIGI Machine Allowance - $100,000	Included
Behavioral Health	
Managed Behavioral Health	Included
Behavioral Health Condition Management Program	Included
AbleTo Network - subject to member cost share	Included
Total Fees	**$29.60**

Program Summary - Additional Available Programs & Services

Network Services	
Aetna Whole Health™ (List Locations)	$3.40
Care Management	
Aetna Targeted Care℠ Solutions	$1.95

** Please see the Newtopia Exhibit in this Proposal/Renewal for Program Description and details on Pricing/Rates
(4) Aetna's CareEngine-Powered Personal Health Record requires the purchase of MedQuery either through AHC-DM or on a stand-alone basis.

Program Summary - Programs & Services Included in the Claim Wire	
Network Access	$4.50
National Advantage™ Program	We will retain 50% of savings
Standard Facility Charge Review	We will retain 50% of savings
Itemized Bill Review	We will retain 50% of savings
Data iSight™	Included
Teladoc General Medical Administrative Fee (PMPM)	$0.32
Teladoc Per Consultation Administrative Fee	$3.00 per each Teladoc consultation
Subrogation	37.5% of recovered amount will be retained.
Coordination of Benefits and other contracted services	Up to 37.5% of recovered amounts will be retained.
Third Party Claim and Code Review Program	Up to 37.5% of recovered amounts will be retained.
Enhanced Clinical Review Program– High Tech Imaging (PMPM)	$0.35
Enhanced Clinical Review Program – Diagnostic Cardiac (PMPM)	$0.10
Enhanced Clinical Review Program – Sleep Management (PMPM)	$0.05
Enhanced Clinical Review Program – Cardiac Implantable Devices (PMPM)	$0.05
Enhanced Clinical Review Program – Interventional Pain (PMPM)	$0.10
Enhanced Clinical Review Program – Hip and Knee Arthroplasties (PMPM)	$0.05

Program Summary - Description of Services

Plan Administration

Mature Base Service Fees

The administrative service fees are mature; we have included the cost of processing self-funded run-off claims for 12 months following the termination of our administrative services agreement.

Non-ERISA

For a Non-ERISA plan, the risks and responsibilities are different from those under ERISA plans, since the ERISA preemption and ERISA standard of performance do not apply. Our charge for Non-ERISA plans must take into account the additional liability risk as compared to known risks under an ERISA plan. An additional $0.35 per-employee, per-month is charged for Non-ERISA plans and has been included in our fees as shown on the financial exhibit(s).

Claim Fiduciary Option 1

We will be the Non-ERISA claim fiduciary for medical coverage. As claim fiduciary, Aetna will be responsible for the final claims determination and the legal defense of disputed benefits payments for medical and dental.

Network Services

Network Access

We provide members with access to our network hospitals, physicians and other health care providers (**"Network Providers"**). The Network Providers provide services at agreed upon rates and participate in our applicable network(S) covering your members.

National Medical Excellence Program® - Transplant Coordination

You'll see consistency in the coordination of care for transplants with our National Medical Excellence Program®. This case management program provides our members with:

- Access to care through our nationwide network of participating health care providers and hospitals recognized for successful clinical outcomes
- Specialized case management by nurses experienced with transplants and complex care
- Allowances for transportation and lodging for the patient and one companion may be available if preapproved by National Medical Excellence and the transplant care is received in an Institutes of Excellence™ (IOE) facility more than 100 miles from
- Coordination of follow-up care

Care Management

MedQuery® Physician Messaging

Our MedQuery® program alerts doctors to opportunities for improved patient care. We turn member data into information that can be used to enhance clinical quality, patient safety and financial outcomes.

MedQuery studies a member's claim history, current medical, pharmacy and laboratory claims and demographics and sends evidence-based treatment guidelines to physicians.

MedQuery® Preventive Care Considerations

For members who need vaccinations and have not yet received them, we send paper copies of MedQuery® Preventive Care Considerations (PCCs), preventive exams and screenings. The CareEngine® generates these preventive/wellness alerts only when available information reveals lack of compliance with a clinical risk, condition or demographic-related recommendation.

The PHR pulls every available medical claim, lab result, office visit and filled prescription and compiles them in one place. At the same time, we scan this information — even data that employees enter — and compare it to thousands of the latest medical guidelines. It can improve care by spotting:

- Potential health risks
- Dangerous drug interactions
- Missed procedures and tests
- Appropriate preventive health services

Utilization Management

We offer a state of the art data and analytics experience, to encourage data-driven decision making for optimal plan performance and best wellness. We grant secure access to Analyze-Rethink-Transform (ART), a powerful analytic platform for customers, trusted account teams and supporting resources, and customer-approved advisors, brokers and consultants. ART provides key metrics and trends affecting costs, behaviors and plan performance.

Analytic pathways allow you to derive meaningful insights into opportunities for plan improvements and cost savings, using a self-service business intelligence approach. This means users explore data using an intuitive, point and click environment. With ART, you can save time, and make effective, data-driven improvements to plans to address the constantly evolving needs of members.

Preformatted reports are also available at the customer level by funding arrangement and product type on an incurred claim basis, rolling 12 months with a 2-month claim lag. The reports offer a view of the current year's and the prior year's data, illustrating utilization and financial trends in a concise, graphical format. The reports are available monthly, within 30 days following the end of the reporting period.

Reports can be downloaded into Microsoft Excel for review, analysis and electronic communication. The information is encrypted so your information remains

Additionally you will receive up to 150 hours of consultant analytic support and 150 hours of clinical support from our regionally aligned Plan Sponsor Insights

Member Resources

Member Website and Mobile Experience

Members have 24 hour access to our web and mobile experience, including our secure website and mobile app. Our simple to use, intuitive, on-the-go member website, is an online resource for personalized health and financial information where members can:

- Access personal health benefits
- Review claims status and details
- Compare provider costs and read reviews
- View health history
- Access wellness discounts
- Take health assessment
- Participate in online wellness programs
- Find a doctor

Our free app provides on-the-go capabilities and lets members and their families care for their health easily and simply, from anywhere. We even offer fingerprint login capabilities. With the Mobile app, members can:

- Find a doctor, dentist, hospital or urgent care facility
- View a map of the office location and call the office with the tap of a finger
- Estimate costs of care
- Manage prescriptions
- Search claims
- View health history
- View coverage and benefits
- Access ID card information
- Email member services

Wellness Programs

24/7 Nurse Line - Informed Health® Line

Provides members with telephone and email access to experienced registered nurses who help members make informed health care decisions. Nurses are available through a toll-free telephone number 24/7/365.

Aetna Healthy Commitments℠ Program

Our offer includes the **Enhanced Wellness Package**. Our Enhanced wellness package includes all of the Core offerings, a health assessment and online health coaching programs, discount programs, a 24/7 Nurseline, onsite biometric screenings, our year-long Aetna Get Active℠ fitness and nutrition challenges, incentives for completing the health assessment and one online health coaching program. Please refer to the Aetna Healthy Commitments℠ Packages section included

Behavioral Health

Behavioral Health Condition Management Program Base

The new Aetna Behavioral Health Condition Management program identifies high-risk members who may be open to intensive engagement efforts. Positive member interventions drive productivity and bring better value to you and your organization. The program works through the following steps:

- Defining the at-risk population
- Identify members who may experience adverse medical outcomes, increased utilization and higher cost
- Engage and outreach
- Offering member interventions
- Measuring outcomes
- Reporting value

The embedded base program is available to members of all ages. It's designed to support members who are at the highest risk and who incur the most cost. Triggers include:

- High cost claimant >$100K of Behavioral health costs
- Readmit within 30 days (two or more inpatient stays)
- Five comorbidities (different conditions that occur in the same person, at the same time)

Allowances

Implementation/Communication Allowance

We are including an implementation/communication allowance of up to $100,000 (if we are selected for Medical coverage only) or up to $200,000 (if we are selected for Medical and Pharmacy covereages) that may be used toward implementation/communication related expenses incurred during the July 01, 2020 to June 30, 2021 plan year. These funds will be available as of the effective date of the period. Expenses incurred in the prior year for the open enrollment of the July 01, 2020 to June 30, 2021 policy year will be reimbursed from the July 01, 2020 to June 30, 2021 allowance. This provides the plan sponsor a budget or allowance of money from which they can draw to offset reasonable, identifiable expenses. The plan sponsor cannot draw on more than the amount of the allowance

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
- Handling our subscriber enrollment
- Our Member communications (creating, printing, mailing)
- Our system front-end charges

Our preferred method of payment of implementation/communication-related expenses is directly to the vendor. Payment will be made once the expenses are incurred and invoice(s) are provided. In the event you request us to reimburse you directly, we may agree to do so on an exception basis. In the event the exception is granted, we will require you to submit to us detailed paid receipts from the vendor prior to the payment of the implementation/ communication allowance. Invoices must be submitted to us within 60 days following the close of the plan year.

Expenses incurred in the prior policy year for the open enrollment of the July 01, 2020 to June 30, 2021 policy year will be reimbursed from the July 01, 2020 to June 30, 2021 allowance. Should a customer terminate their policy with us, the allowance cannot be used to fund communication expenses related to the new Any expenses beyond the implementation/communication allowance are the responsibility of the plan sponsor. Any balance of this allowance fund remaining at the end of the policy year will be forfeited. Note that any amounts paid by us to a plan sponsor to offset or reimburse that plan sponsor for expenses incurred as a result of contracting with us for benefits plan administration services will be paid in accordance with applicable law. We advise plan sponsors to determine appropriate accounting for these payments with their own counsel or accountant. Any plan sponsor receiving an Implementation/Communication Allowance or other payments from us that offset or reimburse expenses that would otherwise be paid from plan assets should consult with their ERISA counsel to determine if such allowance must be credited to plan assets. They should also consult with counsel regarding the accounting or reporting of such payments. We assume the funding of any implementation/communication budget is either at the request of your Plan Administrator acting in their fiduciary capacity to your Plan or for the exclusive benefit of your Plan.

Reporting

Utilization Reporting

We offer a state of the art data and analytics experience, to encourage data-driven decision making for optimal plan performance and best wellness. We grant secure access to Analyze-Rethink-Transform (ART), a powerful analytic platform for customers, trusted account teams and supporting resources, and customer-

Analytic pathways allow you to derive meaningful insights into opportunities for plan improvements and cost savings, using a self-service business intelligence approach. This means users explore data using an intuitive, point and click environment. With ART, you can save time, and make effective, data-driven improvements to plans to address the constantly evolving needs of members.

Preformatted reports are also available at the customer level by funding arrangement and product type on an incurred claim basis, rolling 12 months with a 2-month claim lag. The reports offer a view of the current year's and the prior year's data, illustrating utilization and financial trends in a concise, graphical format.

Reports can be downloaded into Microsoft Excel for review, analysis and electronic communication. The information is encrypted so your information remains

Additionally you will receive up to 150 hours of consultant analytic support and 150 hours of clinical support from our regionally aligned Plan Sponsor Insights

Claim Wire Charges

Subrogation

We have entered into an agreement with the firm of Rawlings & Associates to provide comprehensive subrogation services. A contingency fee of 37.5% is retained upon recovery for self-funded customers.

Contracted Services

A contingency fee up to 37.5 percent is paid to a vendor upon recovery of self-funded customers' claims for certain claim overpayment programs such as the following:

- Coordination of Benefits
- Retroactive Termination
- Audits (Hospital, DRG, High Cost Drugs, etc.)
- Duplicate Bills
- Contract Compliance

Third Party Claim and Code Review Program

We utilize external vendors for claim recover on payer liability (e.g. member eligibility verification, COB), coding compliance (e.g. payment policy adherence, duplicate claims), contract compliance (e.g. provider contract adherence) and clinical appropriateness e.g. clinical feasibility and appropriateness of claim, chart review verification of claim. A contingency fee of percent is charged for the claim recoveries. These fees are primarily to support vendor costs and our internal administrative cost associated with these programs.

Out of Network Program and Reimbursement

We have several programs to help you and your members save money when obtaining care out-of-network. Outlined below is the out-of-network program we have included in this proposal.

National Advantage™ Program (NAP)

National AdvantageTM Program including the Contracted Rates, Facility Charge Review and Itemized Bill Review Components. The National Advantage Program includes three components, Contracted Rates, Facility Charge Review and Itemized Bill Review. The Contracted Rates component offers access to contracted rates for many medical claims from non-network providers, including claims for emergency services and claims by hospital-based specialists such as anesthesiologists and radiologists who do not contract with insurers.

National Advantage Program Fees

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

How NAP Fees are Charged

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

- For facility services, the amount billed by the provider.
- For voluntary out-of-network professional services, the 80th percentile of the applicable FAIR Health database.
- For involuntary out-of-network professional services, the amount billed by the provider.
- For claims reviewed under Itemized Bill Review, the in-network rate prior to removal of any non-payable charges identified through the claim review.

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

Facility Charge Review (FCR)

FCR is a component of NAP. This component provides reasonable charge allowance review for most inpatient and outpatient facility claims where a NAP contracted rate is not available. Though many facilities accept the reasonable charge amount as payment in full, others may not and may balance bill the member.

In the event that a member is balance billed, Aetna has a review process and will initiate negotiations with the facility in an attempt to come to a mutually agreeable payment amount. For claims that are to be paid at the preferred/in-network level under the terms of the member's plan of benefits (e.g., emergency services), Aetna will negotiate with the facility so that the member is not responsible for any charges in excess of any applicable deductible and coinsurance/copayments. However, for non-emergency out-of-network services, should Aetna be unable to negotiate a mutually acceptable rate, the member

Even with FCR, if a provider refuses to agree to a negotiated rate, claims may be paid at billed charges in certain circumstances. The program is only available in conjunction with NAP.

Data iSight™

DiS applies to plans with certain out-of-network rates. MultiPlan, one of Aetna's external pricing vendors under NAP, uses the DiS patented methodology to price out-of-network professional claims under a certain threshold, as determined by Aetna, based on typical competitive charges and/or payments for a service, the geography in which the service was provided. In the event a member receives a balance bill from a provider for an out-of-network service, patient advocacy may be available to assist the member in certain circumstances. The DiS patient advocacy program gives members the ability to have an advocate from the vendor negotiate with providers on their behalf.

DiS will contact the provider to start negotiations on a mutually agreeable payment amount with no member balance billing. For claims that are to be paid at the preferred/in-network level under the terms of the member's plan of benefits (e.g., emergency services), DiS will negotiate with the provider so that the member is responsible for charges in excess of any applicable deductible and coinsurance/copayments. However, for voluntary out-of-network services, if DiS can't negotiate a mutually acceptable rate, the member may be responsible for charges in excess of the DiS out-of-network plan rate.

Itemized Bill Review (IBR)

IBR applies to inpatient facility claims submitted by Aetna network providers (directly contracted) if (a) the submitted claim amount exceeds a certain threshold as determined by Aetna; and (b) Aetna's contracted rate with the provider uses a "percentage of billed charges" methodology.

Aetna will forward IBR Claims to a vendor to review and identify any billing inconsistencies and errors. The vendor reports back the amount of eligible charges after adjusting for any identified inconsistencies and errors. Aetna then pays the claim based on the adjusted bill. IBR supplements Aetna's standard bill review procedures prior to claim adjudication, and currently applies to inpatient facility bills with submitted expenses of $20,000.

Teladoc®

Teladoc™ offers 24/7 access to a national network of physicians. They can diagnose, treat and prescribe medication for many common, non-emergency medical issues via phone or online video at a lower cost when visiting a doctor in person is not necessary. Teladoc helps prevent unnecessary visits to the emergency room and urgent care clinics.

Using Teladoc, members can talk with a doctor during their lunch break and then pick up their prescription after work. At only $40 per consultation, Teladoc™ has an average savings of $472 per episode of care.[1] Video consults not available in all states due to state regulations.

And with the recent addition of behavioral health, dermatology and caregiver services to Teladoc, your employees have even more time-saving options available to

With a standard Teladoc setup, member cost follows the underlying medical plan design. The member's cost share is based on either the plan's copay or deductible amount. No customization is allowed to a member's copay. If your plan deviates from the standard, pricing will be adjusted accordingly. Unless we hear from you all the Teladoc programs noted below will be included.

Please note there is a $3.00 Consultation Fee billed via the Claim Wire for each Teladoc® session.

Citation: [1] Teladoc™. 2017. Only Teladoc delivers these episode-of-care savings.
Available at https://www.teladoc.com/businesses/health-plans/
Accessed November 10, 2017.

Wellness Programs Included to Help Members Stay Healthy and Improve Productivity

When it comes to wellness, our competitive advantage is that we offer more than 70 health and wellness programs, resources and tools that help members make better lifestyle choices to stay productive.

Onsite Biometric Screenings

We work with Quest Diagnostics for onsite health screenings that help your employees lower their risk for health concerns. Quest offers unique services to fit your needs and the needs of your employees.

- Provides finger stick or venipuncture options, as well as fasting or non-fasting screenings
- Specializes in metabolic syndrome screenings and can provide customizable reporting
- Screenings available on-site and at patient service centers. Or, employees can submit physician forms or home kits.
- Offers a convenient, online scheduling system
- Requires 30 participants for finger stick screenings and 20 participants for venipuncture screenings
- Program Participation Minimum: A program participation fee of $600 will be charged for any program with less than 100 participants. This will be waived only if participation reaches or exceeds that number.

Health Assessment (Supported by Incentives)

Simple Steps To A Healthier Life®

Simple Steps To A Healthier Life® - Our online, personalized health and wellness program that includes a health assessment and online health coaching programs. Based on information gathered in the health assessment, the participant receives a personalized HealthMap, containing online coaching program recommendations to help them achieve and maintain good health.

Incentives

Plan sponsors can add an option whereby subscribers and their spouses can each earn a $50 gift card after completing both the Health Assessment and a minimum of one Online Health Coaching Program Journey.

Subscribers and their spouses can each earn a $50 gift card after completing both the Health Assessment and a minimum of one Online Health Coaching Program Journey.

Online Wellness Programs

Our online health coaching programs called Journeys®, make engagement simple, and use choice architecture -- a powerful technique derived from behavioral economics. Participants choose a Direction and then answer a few questions to help personalize their Journey experience. Your subscribers will embark on a Journey that is tailored to their unique needs and preferences. Journeys are developed to maximize engagement and positive outcomes through use of:

- Adaptive Technology
- Gaming Mechanics
- Proven behavior science methodology

Available programs include: 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, and Health In A Hurry.

Advocacy & Outreach Programs

24/7 Nurse Line - Informed Health® Line

Our Informed Health® Line provides members with telephone and e-mail access to experienced registered nurses to help them make informed health care decisions. Nurses are available through a toll-free telephone number 24 hours a day, 7 days a week.

While only your doctor can diagnose, prescribe or give medical advice, the Informed Health Line nurses can provide information on more than 5,000 health topics. Contact your doctor first with any questions or concerns regarding your health care needs. Informed Health Line nurses do not diagnose, prescribe or give members medical advice.

Neighborhood Well-being Services

Provides members easy access to face-to-face lifestyle and preventive coaching support in their neighborhood CVS MinuteClinics.

Wellness Programs Included to Help Members Stay Healthy and Improve Productivity

Communications Campaigns and Toolkits

Member Wellness Message Program
Electronic communications for employees that address general health and wellness topics, available in English and Spanish.

Fitness Challenge with Social Networking

Get Active℠
Get Active℠ is an online social network and health challenge platform for your employees. It offers interactive, seasonal challenges to keep people moving and motivated throughout the year. Our team-based curriculum encourages healthy behaviors such as increased physical activity, nutritious eating, weight loss and improved mental well-being.

Aetna Discount Programs

Our discount program helps members save money on a wide variety of products and services for themselves and their family. Members can save on gym memberships, weight loss programs, eyeglasses, LASIK laser eye surgery, massage therapy and much more!

This material is for information only. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. 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. Discount programs provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Information is believed to be accurate as of the production date; however, it is subject to change.
For information about Aetna plans, refer to: www.aetna.com

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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 exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change.
Discount programs provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Information is believed to be accurate as of the production date; however, it is subject to change.
For information about Aetna plans, refer to: www.aetna.com

Policy forms issued in OK include: HMO/OK COC-5 09/07, HMO/OK GA-3 11/01, HMO OK POS RIDER 08/07, GR-23 and/or GR-29/GR-29N.
Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc., Aetna Health of California Inc., Aetna Health Insurance Company of New York, Aetna Health Insurance Company and/or Aetna Life Insurance Company

Caveats - ASC Funding — Effective Date: July 01, 2020

Documentation needed from current carrier(s)

Claims
Updated monthly claims on incumbent carrier letterhead on a rolling 12-month basis with corresponding exposures up to 120 days prior to the effective date.

Assumptions

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

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

Advanced Notification of Fee Change
We will notify Customer of any fee change at least 31 days prior to the effective date of fee change.

Banking Arrangement - Standard Stockpiling
When paid claims have accumulated to more than $20,000, a request will be sent to you and/or your bank requesting funds for the total paid claims from the previous day(s). For most customers, this will mean daily claim wire transfers. In addition, there will be a month end close out request on the first banking day of each subsequent month.
We have assumed you will use no more than three primary banking lines which are shared across all self-funded products, excluding Flexible Spending Accounts (FSA). Additional wire lines and customized banking arrangements will result in an adjustment to the proposed pricing.

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

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

Data Integration (Ongoing)
Options and pricing for integrating claims data from an external vendor into one or more of our systems will vary depending on the scale of the Plan Sponsor's integration needs.

Data Transfer at Termination
Upon contract termination, we agree to cooperate with succeeding administrators in producing and transferring required claim and enrollment data. Data will be transferred within 30 days after determination of specific format and content requirements, subject to a charge that is based on direct labor cost and data processing time.

Eligibility
Our fees assume that union participants meet all eligibility requirements set out in the trust agreement.

Non-ERISA
For a non-ERISA plan, the risks and responsibilities are different from those under ERISA plans, since the ERISA preemption and ERISA standard of performance do not apply. Our charge for non-ERISA plans must take into account the additional liability risk as compared to known risks under an ERISA plan. An additional $0.35 per-employee, per-month is charged for non-ERISA plans and has been included in our fees as shown on the financial exhibit(s).

External Review
External Review is included in our self-funded proposal. External review uses outside vendors who coordinate a medical review through their network of outside physician reviewers. When customers retain claim fiduciary responsibility, we will pass through the actual vendor charges on a direct-charge basis.

First Year Renewal
The first year renewal will be delivered 60-90 days prior to the anniversary date.

Caveats - ASC Funding — Effective Date: July 01, 2020

Late Payment
If the Plan Sponsor fails to provide funds on a timely basis to cover benefit payments as provided in the Agreement, and/or fails to pay service fees on a timely basis as provided in such Agreement, we will assess a late payment charge.
The current charges are:
- late funds to cover benefit payments (e.g., late wire transfers after 24-hour request): 12.0% annual rate
- late payments of service fees after 31 day grace period: 12.0% annual rate

We reserve the right to collect any incurred late payment charges through the claim wire on a monthly basis provided there are no other special payment arrangements in-force to fund any incurred late payment charges. The Plan Sponsor will be notified by us in writing to obtain approval prior to billing any late payment charges through claim wire.

We will provide advance written note to the Plan Sponsor of any change to late payment charges. The late payment charges described in this section are without limitation to any other rights or remedies available to us under the Agreement or at law or in equity for failure to pay.

Mental Health/Substance Abuse
Mental health/chemical dependency benefits are included.

Medical Service Center
Claim administration and member services for the quoted plans will be managed centrally by the Bismarck, ND Service Center. Members will be able to reach the Member Service representatives Monday through Friday, from 8 a.m. to 6 p.m., or local time (based on where the member resides).

Patient Management Center
Patient Management services for the plan sponsor will be administered by our regional Patient Management Center.

Participation
There is a minimum requirement of 150 enrolled subscribers for administration of our self-funded plans. Our financial guarantee is contingent on the total number of covered medical and/or pharmacy lives (i.e., the total number of subscribers enrolled for coverage) quoted in the proposal.

Pharmacy Benefits
Prescription drug benefits are included and will be provided through Aetna Pharmacy Management.
If you terminate your Aetna prescription drug benefits, Aetna will increase the ASC Service Fees and medical trend, and the customer may also be subject to additional charges to integrate data with external Pharmacy vendors.
The medical fees include the cost for Aetna to integrate medical accumulators with the pharmacy administrator.

Plan Design
This proposal response is based on the benefit plan designs, plus any noted deviations. Our standard provisions, contract wording and claim settlement practices will apply for items not specifically outlined.

Policies and Claims Settlement Practices
Our standard contract provisions and claim settlement practices will apply. If a material change is initiated by the Plan Sponsor or by legislative or regulatory action in the claim payment requirements or procedures, account structure, or any changes materially affecting the manner or cost of paying benefits, we reserve the right to adjust our financial package accordingly.

Contract Period
Our pricing takes into account all of the multiple product and programs you have with us. We also assume the quoted products and programs will be in effect for the full 12 months of the plan year.

Pricing and Underwriting Basis
The proposed plan of benefits will be extended to the participant group(s) included on the census file that was submitted with the request for proposal. Our enrollment assumptions are shown on the attached financial exhibit(s).
Coverage will not be extended to additional participant groups without review of supplemental census information and other underwriting information for appropriate financial review.

Caveats - ASC Funding	Effective Date: July 01, 2020
Recovery of Overpayments Aetna's process of recovering overpayments attempts to recoup money in the most accurate, effective, and cost efficient manner. The below provides more detail on how Aetna recovers overpayments. When seeking recovery of overpayments from a provider, Aetna has established the following process: if it is unable to recover the overpayment through other means, Aetna may offset one or more future payments to that provider for services rendered to Plan Participants by an amount equal to the prior overpayment. Aetna may reduce future payments to the provider (including payments made to that provider involving the same or other health and welfare plans that are administered by Aetna) by the amount of the overpayment, and Aetna will credit the recovered amount to the plan that overpaid the provider. By entering into an agreement with Aetna, the Customer is agreeing that its right to recover overpayments shall be governed by this process and that it has no right to recover any specific overpayment unless otherwise provided for in the Agreement.	
Run-In Claims Our proposal excludes run-in claim processing from the prior carrier (claims incurred before the effective date of the plan).	
Run-Off Claims Processing Our fees reflect a paid (immature) claim base and take into account the expenses associated with the processing of run-off claims following cancellation, subject to the conditions of our financial guarantee.	
SPD Modification Our Service Fees include the standard Summary Plan Description language and any customization may require an additional cost.	
Third-Party Audits We do not typically charge to recoup internal costs associated with a third-party audit. We reserve the right to recover these expenses if significant time and materials are required.	
Reasons for Recalculation If any of the changes outlined below occur, we reserve the right to recalculate your guaranteed fees, using the Guarantee Period formulas. If this happens, you will be required to pay any difference between the fees collected and the new fees calculated back to the start of the guarantee period.	
Multi-year Provision The Plan Sponsor places the products and services included in this multi-year fee guarantee out to bid, this guarantee is nullified.	
Ancillary There are any changes to the Aetna programs and services offered to the Plan Sponsor.	
Claim Payment A material change in claims payment requirements or procedures, account structure, or any other change materially affecting the manner or cost of paying benefits (whether initiated by you or by legislative or regulatory action).	
Contract Provisions The final benefit provisions, account structure, claim payment requirements or services change from those proposed.	
Customized Banking You require the need for a customized banking agreement and additional wire lines (administrative fees only).	
Enrollment There is a 15.0% percent decrease in the number of enrolled participants in aggregate from our enrollment assumptions or from any subsequent reset enrollment.	
Legislative Impact Legislation, regulation or requests of government authorities result in material changes to plan benefits, we reserve the right to collect any material fees, costs, assessments, or taxes due to changes in the law even if no benefit or plan changes are mandated.	

STATE OF NEBRASKA

Caveats - ASC Funding | **Effective Date: July 01, 2020**

Maximum Account Structure
If maximum account structure per product exceeds the number of units illustrated in the table below.
Account structure determines the reporting format. During the installation process, we will work with the Plan Sponsor to finalize the account structure and determine which report formats will be most meaningful. Maximum total account structure includes Experience Rating Groups (ERGs), controls, suffixes, billing and claim accounts.

Total Employees	Choice POS II Maximum Total Structure Per Product
10,000 - 19,999	350

Member/Subscriber Ratio
The member-to-employee ratio increases by more than 15% . We have assumed a member-to-employee ratio of:
2.13 for the Choice POS II

NAP
If the National Advantage™ Program (NAP), Facility Charge Review (FCR) or Itemized Bill Review (IBR) programs are changed or terminated.

Plan Change
A material change in the plan of benefits is initiated by the Plan Sponsor or by legislative or regulatory action.

Financial Guarantees
If one or more of the circumstances identified above occurs, then the additional financial guarantees between us including, but not limited to, discount guarantees, rebate guarantees and claim-based performance guarantees may also be modified or terminated in accordance with the financial conditions contained in those documents.

Quoted Benefits
A material change in the plan of benefits offered, or a change in claim payment requirements or procedures, or a change in state premium taxes or assessments, or any other changes affecting the manner or cost of providing coverage that is required because of legislative or regulatory action.

Additional

Additional details for the following topics can be found in our UW Disclosure document located at the following URL:
http://www.aetna.com/legal-notices/documents/2020-1Q-middle-market-public-labor-self-funded-medical-uw-disclosures.pdf.

- Billing of Fees
- Producer compensation
- Claim and Member Services
- Network Services
- Reporting
- Federal Mandates
- State Mandates

Aetna Specialty Pharmacy℠ Program
We will retain (as compensation for our efforts in administering the Preferred Specialty Pharmaceutical Program) all specialty pharmaceutical rebates earned on drug claims that we administer and pay through the medical benefit rather than the pharmacy benefit.

European Union: General Data Protection Regulations (GDPR)
Aetna International has implemented a framework to follow the General Data Protection Regulation (GDPR), which became law in all European Union (EU) and European Economic Area (EEA) countries on May 25, 2018. This law gives people greater protection over their personal data, with the potential for significant fines for privacy breaches. GDPR includes requirements related to data collection, storage and usage among the companies and organizations that process personal data of individuals in the European Union.
Our domestic plans are not in scope. To help support operational requirements of GDPR, members based in the EU and EEA must be enrolled in Aetna International plans.

Health Care Reform Caveats

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

STATE OF NEBRASKA

Guarantee Summary — **Effective Date: July 01, 2020**

ASC Discount Guarantee*

We offer competitive discounts across one of the largest networks of healthcare providers. We demonstrate our confidence in our discount arrangements by providing a Discount Guarantee. The illustrative composite target discounts are below:

Inpatient Hospital Discount	Outpatient Hospital Discount	Physician/Other Discount	Total Composite Discount
39.09%	39.70%	37.21%	38.55%

Total at risk for Network Discounts	50%

- Please refer to our attached guarantee documents for information regarding the measurement criteria and payout schedules
- Based on an illustrative medical fees without optional services
- The discount guarantee is based on the census provided. Final enrollment by market will determine the actual discounts at risk in this guarantee

ASC Claim Target Guarantee*

We are offering a claim target guarantee in order to demonstrate our confidence in our claim projection. This guarantee is illustrated below

Risk Free Corridor	2.0%
Payout Slope	2 to 1

Percent of Fees at Risk	50.0%

Demonstrating Value Scorecard Guarantee

We will place at risk up to 100% of the collected Care Management programs guarantee period administrative service fees.

	Minimum Standard	PEPM at Risk
Financial Performance		
- Care Management ROI	2:1	$5.03
Member Satisfaction Survey		
- AITC, IHL	90%	0.10
Operational Performance - Aetna In Touch Care - Care Advocate Team		
- Engaged of Reach Rate	70%	$0.10
- Depression Screening	90%	$0.10
- Discharge Planning	95%	$0.10
- Case Management Plan	98%	$0.10
- Preadmission Outbound Call	95%	$0.10
- Post Discharge Outbound Call	92%	$0.10
- Case Management High Claimant Screening	95%	$0.10
- UM Touch Rate	90%	$0.10
Clinical Outcome Improvement Rates		
- CAD members using statins	50%	$0.05
- Diabetic members using statins	45%	$0.05
- Diabetic HbA1c improvement	75%	$0.05
- Diabetic HbA1c less than 8%	65%	$0.05
- Diabetic neuropathy	75%	$0.05
- Asthma-controller medications	75%	$0.05
- Diabetic HbA1c greater than 9%	25%	$0.05

Total at risk for ROI Guarantee	$6.28

Total Estimated Annual Amount at Risk	$982,845.12

* In no event will the total collected administrative service fees be adjusted by more than 50.0% due to the result of all guarantees combined. 'Collected fees means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.

Claim Target Guarantee | **Effective Date: July 01, 2020**

Broad		
Year One (July 01, 2020 - June 30, 2021)		
Proposed Aetna enrollment of 3668 subscribers / 7809 members in Broad Projection for the Guarantee Period (2020)		Factors
Base Year Medical Incurred Claims (per member per year)		$3,880
Unit Cost, Med Mgmt / Integration, Trend Factor	X	1.0547
Year 1 Projected Claim Target (per member per year)	=	$4,092
Net Effective Trend		5.5%

Aetna Whole Health CHI		
Year One (July 01, 2020 - June 30, 2021)		
Proposed Aetna enrollment of 9374 subscribers / 19956 members in Aetna Whole Health CHI Projection for the Guarantee Period (2020)		Factors
Base Year Medical Incurred Claims (per member per year)		$3,880
Unit Cost, Med Mgmt / Integration, ACO, Trend Factor	X	0.8828
Year 1 Projected Claim Target (per member per year)	=	$3,425
Net Effective Trend		-11.7%

AGGREGATE - Total Enrollment Based on Scenarios Above		
Year One (July 01, 2020 - June 30, 2021)		
Projection for the Guarantee Period (2020)		Factors
Base Year Medical Incurred Claims (per member per year)		$3,880
Unit Cost, Med Mgmt / Integration, ACO, Trend Factor	X	0.9307
Year 1 Projected Claim Target (per member per year)	=	$3,611
Net Effective Trend		-6.9%

Outlined below are the definitions of the items in the table(s) above.

We guarantee your net effective trend for the 12 month guarantee period from July 01, 2020 through June 30, 2021 and paid through December 30, 2021. Your active,, COBRA, Pre-65 retiree, and disabled subcribers are included in this guarantee. Dollar amounts shown are for clarifying purposes only.

Base Year medical incurred claims: The base year medical incurred claims for year 1 are for the period July 02, 2019 through June 30, 2020 and paid through January 01, 2021.
We will finalize your base year medical incurred claims using the data provided to us by your prior carrier(s).
Please refer to the Addendum for the data needed.

To ensure that we are comparing the base and projection years on the same basis, we adjust base year claims for:

- Differences in member to employee ratios from the baseline period to the projection period
- Changes in plan design from baseline period to projection period
- Changes in demographics and geography
- The increase in medical costs that comes with increases in your, COBRA, Pre-65 retiree, and disabled enrollment

Unit cost relativities: The unit cost relativities refer to the differential between Aetna's and the incumbent carrier's discount (1-Aetna Discount %) / (1- Incumbent Carrier Discount %). We guarantee the unit cost relativities at the time of quotation.

Medical management and integration savings factor: The medical management and integration savings factor accounts for the decrease in medical cost due to:

- Integration of our medical, radiology, behavioral health and pharmacy programs for you; as well as the savings opportunity for pharmacy integration with your Pharmacy Benefits Manager (PBM), if applicable.
- Our clinical and cost management programs (relative to your current vendors and programs)

Trend factor: Your trend factor is guaranteed at the time of quotation.

	Actual Claims PMPY vs. Projected Claims PMPY	Fee Adjustment	Maximum Period Adjustment
Our Payout	> 102%	2.0% fee reduction to the per-employee, per month fee for each full 1.0% of difference of actual claims above the target claims plus the corridor	50%
Risk Free Corridor	< =102%	No Adjustment	N/A

The maximum guarantee for either this Medical Claim Target Guarantee or the Medical Discount Guarantee adjustment is 50 percent of actual collected administrative service fees for the applicable guarantee period.
Administrative service fees exclude any charges for services performed which are not included on the monthly administrative service fee bill as well as the following:

- Program fees at risk in the Aetna Demonstrating Value Scorecard
- ACO and/or Joint Venture Administrative Service Fees
- Implementation/Communication Allowance

Aggregate Maximum:
In no event will total collected administrative service fees be adjusted by more than 50 percent due to the result of this guarantee and all other guarantees combined. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.

Financial assumptions:
Benefit plan conditions for the guarantee
We reserve the right to revise or remove the guarantee if any of the following benefit plan conditions are not met. Your plan design includes:

- Steerage from emergency room to urgent care facilities and/or walk in clinics
- Steerage from hospital based services to free standing facilities
- Steerage to more cost effective radiology providers through our Enhanced Clinical Review program
- Preferential steerage towards network providers that participate in the following:
  - Accountable Care Organization (ACO) network

You include the following Medical Management Program(s):

- MedQuery*
- Personal Health Record

You provide financial incentives to encourage subscribers and eligible family members to take part in yearly health risk assessments and have biometric screenings that are right for them. We'll provide you with the tools. Our online health assessment model is part of your offering. We'll even help you organize onsite biometric screenings and manage the incentives that you choose to offer your subscribers.
You can choose to use an outside vendor for health risk assessment or biometric screenings. However, that vendor must share the results with us through data feeds and support programs such as disease management and MedQuery. Additional charges may apply.

Conditions for the guarantee
We reserve the right to revise or remove the guarantee if any of the following conditions are not met.

- Accurate Information: We rely on information from you and your representatives in creating and reconciling the terms of this guarantee. If any of this information is inaccurate, it may have an impact on the net effective trend.
- Full Replacement: We are the full replacement vendor for medical coverage. and we receive pharmacy data (weekly or monthly) for analysis.
- Minimum Enrollment: A minimum of 13,000 active employees are enrolled in the quoted Aetna self-funded medical products.
- Group Size Variation: The enrolled group does not vary in size by more than 10 percent from the assumption. Our assumption is that 13042 active , COBRA, Pre-65 retiree, and disabledsubscribers will enroll in our medical plans. Post-65 retirees subscribers are not included in this guarantee. In addition, if the combined enrolled, COBRA, Pre-65 retiree, and disabled group does not vary in size by more than two percent or comprise more than five percent of the total Aetna covered group.
- Cost Factor Variation: The change in the projected cost factors related to the combination of geography, age, and gender in any site with at least 100 employees enrolled is less than 5 percent.
- Minimum Contribution Percentage: You contribute at least 50% of the total cost at each tier rate and your contribution percentage does not decline by more than 5 percentage points from the base plan year, 2019 by product.
- Employee Contribution Rates: You set employee contribution rates for each plan according to its benefit value relative to all other plans offered.

- Minimum Plan Participation: At least 75% of eligible employees must participate in your plan or at least 50% when excluding those providing proof of enrollment in a spouse's plan.
- Large Claims: Claims per member per year paid in excess of $100,000 are excluded from the total incurred claims of both the base year and the guarantee period.
- Benefit Plan Changes: There are no changes to the products, programs, current or proposed benefit plans, and there is no change in government laws or regulations that have a material impact on claim cost. Plan design options should provide a suitable number of plan designs that are equal to or less rich than the plan designs offered in the base year.
- Group Composition: You do not have any acquisitions or divestitures.
- Involuntary Terminations: We do not include subscribers whose continuation in Aetna's benefit options stems from an involuntary termination occurring after the effective date in this guarantee.
- In-Network Utilization: Your Aetna medical plans maintain a minimum in-network claim dollar utilization of 90% during the guarantee period.
- Out of network reimbursement: The National Advantage Plan will be included for the guarantee period.
- Pharmacy Claims: Pharmacy and Specialty Pharmacy claims are excluded.
- Subrogation: Our subrogation services through a third party vendor are included.
- Other Included Guarantees: We cannot offer this guarantee with Aggregate Stop Loss coverage
- Data Requirements: The Medical Claim Target Guarantee is considered met if we do not receive all the necessary information by June 15, 2021.
- Coverage Termination: The Medical Claim Target Guarantee is considered met if our medical coverage is terminated by you prior to June 30, 2021.

Claim Target Guarantee — Effective Date: July 01, 2020

You will need to send us information in various stages during your transition to Aetna in order for us to reconcile the Claim Target Guarantee.

We will need the following information **45 days prior** to the effective date:

(1) To ensure effective execution of our medical management programs beginning on the effective date of July 01, 2020 we will need twenty-four months of prior carrier medical and pharmacy claim history. This would be a detailed claim history file by member.
The first file should contain claims incurred and paid July 01, 2018 through April 30, 2020.
(Note a second claim will be required as noted in #4 below.)

(2) Accurate member eligibility file(s) has been submitted to us and in our eligibility system 45 days prior to the effective date. This information is required to match a member's prior carrier medical and pharmacy information with members continuing on our plan.

(3) Summary of Benefits and Coverage (SBC) for each of the plans offered prior to moving to Aetna and any mid-year plan changes (if applicable).

You will need to send us the following information **after the effective date with dates noted** for each.

(4) The second detailed claim history file should contain claims incurred July 01, 2018 through June 30, 2020 and paid through May 01, 2020 through August 31, 2020 That data should be sent to us by September 15, 2020. There should be no gaps in data. As noted in #1 above, this detailed claim history file is to ensure effective execution of our medical management programs.

(5) Summarized claim information - two submissions of claim summary information is outlined in the following grid. The first submission of information is for a preliminary analysis of the data. It is also to make sure that the data given is based on the parameters set forth in this document. The second submission of information is for the actual reconciliation of the guarantee. The files should cover the following timeframes:

	Incurred time period	Paid time period	Date due to Aetna
Initial Request	July 2019 through June 2020	July 2019 through June 2020	September 01, 2020
Second Request	July 2019 through June 2020	July 2019 through December 2020	February 01, 2021

If we find that we need to more closely monitor the experience based on the first summary claim file, we may request an interim claim summary update prior to the final update used for the guarantee reconciliation.
Additional claim information details

- We've included two sample formats (you only need to submit one) on how we would prefer to obtain the claim data. Data would be provided in a summary format, preferably in excel, and would include, by incurred month: paid medical claims, paid capitations (if applicable), subscribers and members. Claim summaries should be provided separately for each plan design (basic, buy up, HMO, POS, PPO, etc.) and prior carrier. Pharmacy and specialty pharmacy claims should not be included.
- Claims should only represent subscriber groups included in this guarantee.
- We require information on large claims by plan for claims in excess of $100,000 per member. You should provide this information on medical claims only and on the same basis as the claim information in the initial and final extracts.

(6) Membership information (in excel), by month (for the base year for the period: July 01, 2019 through June 30, 2020), that includes a listing of members showing gender, date of birth, zip code, plan design, COBRA indicator. In addition:

- Membership needs to represent all members regardless of whether they incurred a claim or not for the specific period.
- The plan design indicator for each member represents the plan design (i.e. basic, buy up, HMO, PPO, etc.) and prior carrier.
- An indicator that allows us to exclude subscriber groups which are excluded from the guarantee, such as post-65 retirees and subscribers on severance or leave of absence.

STATE OF NEBRASKA

Discount Savings Guarantee **Effective Date: July 01, 2020**

We guarantee the discounts that result from our negotiated arrangements with providers that participate in our Choice POS II product(s). This discount guarantee applies to the claims incurred during the period of July 01, 2020 through June 30, 2021. Three months of runout will be included in the reconciliation.

These savings will be calculated on an aggregate basis, taking the service type (hospital inpatient, hospital outpatient physician/other) discounts based upon billed eligible expenses by network. Attachment A shows the discounts by network that We are willing to guarantee. It also summarizes the illustrative discount targets based on book of business service type anc enrollment by market.

How we calculate our discounts: We determine the achieved discount on an aggregate basis, three months after the close of the contract year. First we apply the discounts from Attachment A to your billed eligible charges by network, product and service type. Billed charges prior to application of plan design, discounts and member cost sharing (copays and deductibles).

We calculate the guaranteed discount percentage using the following equation·

$$\frac{\text{In-network provider discounts in dollars (Hospital and Physician)}}{\text{Total in-network billed eligible charges* (Hospital and Physician)}}$$

**excludes duplicate or other ineligible/denied claims, or claims paid by coordination of benefits where we were not primary (including Medicare); includes network claim amounts billed above reasonable & customary levels.*

We calculate the discount using data from our Aetna Informatics data warehouse. The guarantee reconciliation excludes individua each medical case where the claims in that medical case exceed $100,000. A medical case summarizes clinical events by linking or associating all of the claims submitted for a member treatment event. For example, all claims associated with an Inpatient Acute hospital stay or an Outpatient Facility based procedure. Discounts apply to fee for service claims only. Capitations are excluded.

The guarantee results of the Choice POS II products will be combined and reported in aggregate for purposes of this guarantee reconciliation.

Reconciliation: The total aggregated discount savings expected (based on actual enrollment by network and by product, and billed eligible charges by service type) will be compared to the total aggregated discount savings achieved.

Penalty:

We compare the guaranteed discount (based on the actual enrollment by product and network, and billed eligible charges by produc and service type) against the total discount achieved. Based on that outcome, we make any fee adjustments using the table below.

Fee Adjustment	Max Fee Adjustment
2.0% fee reduction for each full 1.0% discount achieved falls below the guaranteed discount.	50.0%
No Adjustment	N/A

Aggregate Maximum

In no event will total collected administrative service fees be adjusted by more than 50.0% percent due to the result of this guarantee and all other guarantees combined. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.

The maximum guarantee for either this Medical Discount Guarantee or the Medical Claim Target Guarantee adjustment is 50 percent of the actual collected administrative service fees for the applicable guarantee period. Administrative service fees exclude any charges for services performed which are not included on the monthly administrative service fee bill as well as the following

- Program fees at risk in the Aetna Demonstrating Value Scorecard
- Implementation/Communication Allowance

Discount Savings Guarantee | **Effective Date: July 01, 2020**

Discount Definition

Eligible charges exclude duplicate or other ineligible/denied claims, claims paid by coordination of benefits where we are not primary (including Medicare), claims on members aged 65 and over, and claims incurred in passive or custom networks, behavioral health claims, mail order pharmacy claims, retail prescription drug claims, dental claims, and vision hardware claims.
Eligible charges include network claim amounts billed above reasonable & customary levels
Any non-facility billed charges (excluding ineligible and not covered charges) at a level equal to or within 3% of the negotiated rates along with some charges where the contract allows us to pay the lesser of the billed amount or the contractual rates, will be excluded from this guarantee.

Additional Assumptions
Some charges where the contract allows us to pay the lesser of the billed amount or the contractual rates, will be excluded from this guarantee.
This guarantee only applies to medical fees and excludes pharmacy.
This guarantee requires that at least 80% of claims paid are in-network claims and that the minimum enrollment in the Choice POS II plan is 500 subscribers.
Subsidiaries or divisions added to STATE OF NEBRASKA after the plan's effective date will not be eligible to participate in this guarantee.
This guarantee applies only to the in-network medical claims that fall into the participating networks shown in Attachment A.
2020 provider billing and reimbursement practices remain consistent with current practices.

Attachment A - Reimbursement Summary

Illustrative Inpatient Hospital	Illustrative Outpatient Hospital	Illustrative Physician/Other	Illustrative Composite Target
39.09%	39.70%	37.21%	38.55%

(1) These discounts are illustrative only as they have been weighted by the distribution of subscribers by network from the current census file

(2) This composite target is illustrative only. The final guaranteed target will depend on the actual enrollment by network and claim service mix known at the end of the guarantee period. For purposes of this illustration, the service mix of network billed eligible claims prior to discount is based on network level assumed utilization of hospital inpatient, hospital outpatient, and physician/other.

(3) Our network discounts are calculated as the difference between the plan eligible charge (i.e., the billed charge less any plan exclusions) and the contracted rate accepted by network providers. The eligible charge does not include non-covered/ineligible expenses or benefit limitations. The contracted rate represents the provider's reimbursement amount, which would include applicable member cost sharing (i.e., coinsurance, copayment and/or deductible), as determined by the member's health plan design. Certain non-facility claims for which the provider bills us the contracted rate are excluded.

We consider information concerning fees negotiated with providers to be proprietary, commercially valuable information, which is not in the public domain. Consequently, the information contained herein is to be maintained in a confidential manner, and used solely for the purposes of reviewing this proposal.

STATE OF NEBRASKA

Discounts by Location

Product	Network Name	Rating Area	Subscribers Within	Hospital Inpatient	Hospital Outpatient	Physician/ Other
CPII	Northern Alabama	AL - Huntsville	1	54.70%	58.80%	55.20%
CPII	Oklahoma City	OK - Oklahoma City Rural	1	57.70%	59.00%	62.40%
CPII	California - Los Angeles	SANTA BARBARA(CA02)	1	67.00%	65.80%	58.90%
CPII	KC Region MC	MO - NW Missouri/Rural KC	3	50.50%	47.90%	55.90%
CPII	Rio Grande Valley	TX - Hidalgo County	2	64.60%	66.10%	64.90%
CPII	MHMO TampaBay/St. Petersburg	Tampa 1 (Central)	1	62.30%	67.60%	63.60%
CPII	Chicago	Cook/DuPage (IL02)	1	61.40%	59.50%	60.60%
CPII	Colorado	Greeley (CO01)	1	62.10%	61.90%	56.20%
CPII	Colorado	Parker (CO01)	1	62.10%	61.90%	56.20%
CPII	Wyoming-First Choice	WY - Wyoming	7	44.50%	41.00%	44.80%
CPII	Colorado Cofinity	CO - Rural	3	43.70%	28.00%	49.40%
CPII	MHMO Hampton Roads HMO	York (VA03)	1	45.10%	41.10%	55.70%
CPII	South Dakota MC	SD - All Others	1	35.40%	29.60%	31.00%
CPII	MHMO Northern Illinois HMO	Carroll Jo Davies Ogle (IL04)	1	63.20%	48.30%	57.50%
CPII	South Carolina HMO	Greenville (SC01)	1	37.40%	35.80%	49.70%
CPII	MHMO Ft. Myers, FL	FL Fort Myers	1	56.00%	62.40%	63.40%
CPII	West Washington	WA - Other	2	43.50%	39.10%	49.30%
CPII	MHMO Orlando (HMO)	FL Orlando	1	61.30%	65.50%	63.60%
CPII	Cent West MI Aetna MC	MI - Central/West	1	34.40%	36.70%	48.60%
CPII	Up State New York	NY - Rochester	1	35.30%	44.30%	43.40%
CPII	Wichita Region MC	KS - Wichita	6	65.90%	67.90%	51.70%
CPII	MHMO Nebraska HMO	TriCity (NB01)	913	31.30%	28.60%	34.00%
CPII	MHMO Nebraska HMO	Omaha (NB01)	1,707	49.50%	48.20%	39.40%
CPII	MHMO Nebraska HMO	Rural Lincoln (NB01)	987	34.60%	30.30%	35.40%
CPII	MHMO Nebraska HMO	Lincoln (NB01)	5,739	40.40%	46.00%	38.30%
CPII	MHMO Nebraska HMO	Rural Omaha (NB01)	443	34.60%	30.30%	35.40%
CPII	MHMO Nebraska HMO	Norfolk/Columbus (NB01)	462	34.60%	30.30%	35.40%
CPII	MHMO Nebraska HMO	Rural Nebraska (NB01)	2,590	34.60%	30.30%	35.40%
CPII	MHMO Nebraska HMO	Rural Nebraska Julian (NB01)	1	34.60%	30.30%	35.40%
CPII	MHMO Council Bluffs IA area	Cass (IA02)	1	49.50%	48.20%	39.40%
CPII	MHMO Council Bluffs IA area	Fremont (IA02)	5	49.50%	48.20%	39.40%
CPII	MHMO Council Bluffs IA area	Harrison (IA02)	10	49.50%	48.20%	39.40%
CPII	MHMO Council Bluffs IA area	Mills (IA02)	18	49.50%	48.20%	39.40%
CPII	MHMO Council Bluffs IA area	Pottawattamie (IA02)	96	49.50%	48.20%	39.40%
CPII	SE South Dakota PPO	SD - All Others	3	35.40%	29.60%	31.00%
CPII	MHMO Topeka HMO Open	Jefferson (KS03)	1	49.10%	51.00%	53.00%
CPII	MHMO Topeka HMO Open	Marshall (KS03)	4	49.10%	51.00%	53.00%
CPII	MHMO Topeka HMO Open	Riley (KS03)	1	49.10%	51.00%	53.00%
CPII	MHMO Topeka HMO Open	Shawnee (KS03)	1	49.10%	51.00%	53.00%
CPII	MHMO Iowa HMO	Guthrie (IA01)	1	41.80%	42.50%	42.00%
CPII	MHMO Iowa HMO	Johnson (IA01)	1	41.80%	42.50%	42.00%
CPII	MHMO Iowa HMO	Plymouth (IA01)	1	41.80%	42.50%	42.00%
CPII	MHMO Iowa HMO	Polk (IA01)	1	41.80%	42.50%	42.00%
CPII	MHMO Iowa HMO	Woodbury (IA01)	15	41.80%	42.50%	42.00%
CPII	MHMO Southern IL HMO	Peoria/Springfield1 (IL05)	1	51.10%	45.60%	53.20%
		Total Subscribers	13,040			

General Performance Guarantee Provisions

Aetna Life Insurance Company, on behalf of itself and its affiliates ("Aetna", "our" or "we") provides health benefits administration and other services (set forth in this document) for the self-funded medical plan(s) operated on behalf of State of Nebraska (also 'you' or 'your').

Performance Objectives

We believe that measuring the activities described below are important indicators of how well we service your account. To reinforce your confidence in our ability to administer your program, we are offering we are offering guarantees for your Care Management programs, which include:

- Financial Performance
- Member Satisfaction Surveys
- Aetna In Touch Care[SM] Solutions
- Clinical Performance

You may receive reporting throughout the year relative to utilization or operational data. The data contained in those reports may differ from the actual performance guarantee results due to the timing of the reports and/or auditing of performance guarantee results.

Guarantee Period

The guarantee period shall be represented as a one-year guarantee for the implementation of the programs and the year immediately following the implementation such as July 01, 2020 through June 30, 2021 and then shall be on an annual basis thereafter, upon the mutual agreement of the parties (hereinafter "guarantee period").

The performance guarantees shown below will apply to the incremental costs for each of the programs administered under the Administrative Services Only arrangement (through a 'Service Agreement' or Master Services Agreement', as the case may be, but each hereinafter referred to as 'Agreement'). The incremental costs for each of the programs are represented in the "amount at risk" column in the Guarantee Summary section of our financial package. These guarantees do not apply to non-Aetna benefits or networks.

Performance guarantees described herein will not apply if Agreement termination occurs prior to the end of the guarantee period. Performance guarantees are subject to enrollment requirements outlined below.

Changes in Clinical Practice Guidelines

Medical knowledge is dynamic and as research progresses the recommendations for evidence-based clinical guidelines change. Such changes may involve:

- A test, service or medication is no longer recommended
- A change in the frequency or intensity of a test or service, or dosage of a medication
- A change in the clinical goal or target
- A change in the specifications for the denominator population

When a recognized national organization changes clinical practice guidelines that impact performance guarantees, we reserve the right to amend or eliminate the performance guarantees. This is necessary because physicians will start to manage their patients in accordance with the revised guidelines. If a test, service or medication is no longer recommended, then the performance guarantee will be eliminated since we cannot recommend to physicians and patients to have a test done or take a medication that is no longer recommended. When the service continues to be recommended, but at a different frequency or with a new target, we will modify the associated metric accordingly.

We will notify you when such changes are being made. It may be necessary to recalculate performance for the baseline year to reflect changes in clinical target or specifications for denominator population. This is required to accurately calculate improvement from baseline.

Demonstrating Value Scorecard Guarantee Maximum

We will place at risk up to $6.28 PEPM of the collected Care Management programs guarantee period administrative service fees. The Care Management guarantee period administrative service fees will be calculated at the end of the respective guarantee period and will be based on the total number of your subscribers enrolled in the underlying medical plans that also offer the services of the programs for each guarantee period.

Aggregate Maximum

In no event will the total collected administrative service fees be adjusted by more than 50% of actual collected fees due to the result of this guarantee and all other guarantees combined. "Collected fees means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.

Financial Conditions

We reserve the right to revise or remove the guarantee if any of the following conditions are not met:

- Actual Aetna medical enrollment stays within 15% of the enrollment assumed within this guarantee.
- Medical and pharmacy programs are administered by us.
- If you utilize an external vendor for onsite biometric screenings or other wellness programs, we require receipt of those external feeds, when data being collected by the external vendor has a material impact on the results of the performance guarantees outlined in this agreement.
- Under age retiree 65 population is structured separately from the over age 65 Medicare prime population for accounting/reporting purposes with us. This guarantee excludes populations that are over age 65 with Medicare primary.
- The average member age of your enrolled Aetna medical plan participants is greater than 34.
- Your member/employee ratio is at least 2:1
- Member eligibility (complete, accurate and viable enrollment data, including member phone numbers) is fully loaded in our eligibility system 35 days prior to the effective date.
- We currently have or will receive a minimum of 24 months of prior carrier medical and pharmacy experience.
- The prior carrier medical and pharmacy data must be received by us in our stated acceptable format for data feeds within 45 days of the program effective date. If we do not receive acceptable file feeds within 45 days of the program effective date, then the basis of the guarantee will be book of business results for the guarantee period.
- If the Aetna In Touch Care program termination occurs within 180 days after the guarantee period, we reserve the right to revert the Return on Investment (ROI) guarantee to book of business results rather than customer specific results.
- The Aetna In Touch Care program requires a 4 month set up lead time. Therefore implementation may be delayed based on the date of award. As a result the measurement and reconciliation timeframe for the guarantees will be adjusted accordingly.

Refund Process

We will provide you with final results for the scorecard when reporting is available after the end of the respective guarantee period. Reporting that outlines associated savings for the contract period is estimated to be available at the end of the third quarter following the close of the respective guarantee period. If the guarantees have not been met, at your sole discretion, we shall (1) provide a cash payment to you for the amount due as a result of our non-compliance within thirty (30) days of your receipt of such results or (2) reduce the following month(s)'s administrative fee payment by the amount due to you. In no event will more than 100% of collected Care Management Program fees be refunded.

Termination Provisions

Termination of the guarantee obligations shall become effective upon written notice by us in the event of one of the following occurrences:

(1) A material change in the plan initiated by you or by legislative action that impacts the claims adjudication process, member services functions, medical management or network management.
(2) Failure to meet your obligations to pay administrative service fees or fund claim payment wires under the Agreement.
(3) Failure to meet your administrative responsibilities (for example, a submission of incorrect or incomplete eligibility information).

These guarantees will not apply if you:

- No guarantee shall apply to any program for which you terminate the program prior to the end of the guarantee period.

- No guarantees will apply for a guarantee period during which the Agreement is terminated by either party prior to the end of such guarantee period.

Financial Performance

Care Management ROI

Guarantee:
We will guarantee that the savings associated with the Care Management Program will be equal to two times the guarantee period administrative service fee of $6.28 per employee per month (PEPM) to a maximum of the total fee. The guarantee fee includes:

- Concurrent review
- Precertification
- Aetna In Touch Care℠ Solutions
- MedQuery

The guarantee will be reconciled annually using the Aetna In Touch Care CC and HEM Report and the Program Savings Report. Customer Specific results will be used.

Penalty and Measurement Criteria:
We will place $5.03 per employee per month of the guarantee period administrative service fees at risk for this metric.

If the guarantee period administrative fees for the Care Management program are $150,000 we will guarantee that the guarantee period Care Management program savings will be two times the fees paid. If actual guarantee period Care Management program savings are $200,000, the guarantee period administrative fee reduction would be $50,000. This $50,000 reduction would lower the service fees paid to $100,000 resulting in a 2:1 ratio of program savings to program costs.

Member Satisfaction Surveys

We will guarantee an overall positive response rate of 90% or better on medical management program surveys administered during the guarantee period. The survey assumes a 5 point scale with the top 3 responses viewed as positive. Member satisfaction surveys will be administered for each individual program and then averaged equally across the surveys to derive one overall members satisfaction survey result for 2020 (for instance, for a customer offering 3 surveys, each result would be blended equally 33.3%). The surveys will be administered on a book of business basis. Results are available on a calendar year basis only.
Customer specific surveys are available for an additional charge. A statistically valid number of responses is required to guarantee customer specific results (usually at least 100 completed surveys). If a statistically valid response is not achieved, the guarantee will default to the book of business result.

A minimum of 2 member satisfaction surveys must be administered. The survey results must be blended together to derive one member satisfaction rate that will apply to all surveys administered. For example: The Aetna In Touch Care survey generates a 92 percent satisfaction level and the Information Health Line survey generates an 88 percent satisfaction level. The guarantee would be considered "met", as the blended average is 90 percent.

Penalty and Measurement Criteria (for all member satisfaction surveys combined):
Member satisfaction surveys will be administered for each individual program and then averaged equally across the surveys to derive one overall member satisfacation survey result for 2020. If the combine result is less than 90%, we will pay $0.10 per employee, per month of the guarantee period administrative service fees back to the customer.

In Touch Care Program Participation Satisfaction

Guarantee:
We will guarantee a positive response rate of 90% or better on the AITC program surveys administered during the guarantee period. The survey assumes a 5 point scale with the top 3 responses viewed as positive. The survey will be administered on a book of business basis. Results are available calendar year basis only. The survey is based on a statistically valid, randomly selected sample size of participants ages 18 to 64 .

Informed Health Line Program Participant Satisfaction

Guarantee:
We will guarantee a blended positive response rate of 90% or better on the program surveys administered during the guarantee period. The survey assumes a 5 point scale with the top 3 responses viewed as positive. The survey is based on a statistically valid, randomly selected sample size of Informed HealthLine participants age 18 to 64.

Operational Performance - Aetna In Touch Care℠ Solutions

Engaged of Reach Rate - Urgent (High Risk) Members

Guarantee:
We will guarantee an engagement rate of 70% or better of those we are successful in reaching in our Aetna In Touch Care Program. Engagement is defined as:

Cumulative nurse engaged year to date*
All members with outreach minus the unable to reach**

* The numerator is calculated as nurse engaged (member or provider) participation level.
** The denominator is calculated as all members targeted for nurse engagement and reached; excludes unable to reach.

Customer specific results will be used to reconcile the guarantee annually using the appropriate performance guarantee report. This guarantee assumes that you will have a minimum of 5,000 medical subscribers and 30 members available to measure for this metric or the guarantee will revert to book of business results.

Penalty and Measurement Criteria:
We will place $0.10 per employee, per month of the guarantee period administrative service fees at risk for this metric as follows:

- > 60 percent - we return 100 percent of the fee allocated to this component
- 60 percent, but < 70 percent - We return 50 percent of the fee allocated to this component

Depression Screening

Guarantee:
We will guarantee that 90% or more of members 18 years or older enrolled that agree to engage in the Care Management program will be screened for depression.
Customer specific results will be used to reconcile the guarantee annually using the appropriate performance guarantee report. This guarantee assumes that you will have a minimum of 5,000 medical subscribers and 30 members available to measure for this metric or the guarantee will revert to book of business results.

Penalty and Measurement Criteria:
We will place $0.10 per employee, per month of the guarantee period administrative service fees at risk for this metric as follows:

- <85 percent - We return 100 percent of the fee allocated to this component
- 85 percent, but <90 percent - We return 50 percent of the fee allocated to this component.

Discharge Planning

Guarantee:
We will guarantee that 95% of cases targeted for discharge planning will have activity documented in our clinical system, for instances where an inpatient length of stay is greater than 3 days. Members managed by other clinical areas (for example, Aetna Maternity) would be managed separately and are not included in this guarantee.
Customer specific results will be used to reconcile the guarantee annually using the appropriate performance guarantee report. This guarantee assumes that you will have a minimum of 5,000 medical subscribers and 30 members available to measure for this metric or the guarantee will revert to book of business results.

Penalty and Measurement Criteria:
We will place $0.10 per employee, per month of the guarantee period administrative service fees at risk for this metric as follows:

- < 80 percent - We return 100 percent of the fee allocated to this component
- 80 percent, but < 90 percent - We return 50 percent of the fee allocated to this component.
- 90 percent, but < 95 percent - We return 20 percent of the fee allocated to this component.

Case Management Plan

Guarantee:
We will guarantee that 98% of cases accepted for case management will have a documented case management plan within 7 business days of the start of the event. Members managed by other clinical areas (for example, Aetna maternity) would be managed separately and are not included in this guarantee.
Customer specific results will be used to reconcile the guarantee annually using the appropriate performance guarantee report. This guarantee assumes that you will have a minimum of 5,000 medical subscribers and 30 members available to measure for this metric or the guarantee will revert to book of business results.

Penalty and Measurement Criteria:
We will place $0.10 per employee, per month of the guarantee period administrative service fees at risk for this metric as follows:

- < 83 percent - We return 100 percent of the fee allocated to this component
- 83 percent, but < 93 percent - We return 50 percent of the fee allocated to this component.
- 93 percent, but < 98 percent - We return 20 percent of the fee allocated to this component.

Preadmission Outbound Call

Guarantee:
We will guarantee 2 outreach attempts and an unable to reach email, chat (if member email or chat is available) letter to 95% of members targed for preadmission call. This applies to all elective admissions when notified 7 business days prior to a scheduled elective inpatient event. This guarantee excludes maternity, newborns, behavioral health, coordination of benefits (COB), Medicare, skilled nursing facility

(SNF), rehabilitation admissions and transplants (members managed through the National Medical Excellence Program).
Customer specific results will be used to reconcile the guarantee annually using the appropriate performance guarantee report. This guarantee assumes that you will have a minimum of 5,000 medical subscribers and 30 members available to measure for this metric or the guarantee will revert to book of business results.

Penalty and Measurement Criteria:
We will place $0.10 per employee, per month of the guarantee period administrative service fees at risk for this metric as follows:

- < 80 percent - We return 100 percent of the fee allocated to this component
- 80 percent, but < 90 percent - We return 50 percent of the fee allocated to this component.
- 90 percent, but < 95 percent - We return 20 percent of the fee allocated to this component.

Post Discharge Outbound Call

Guarantee:
After an inpatient hospitalization, we will guarantee 2 outreach call attempts and an unable to reach email, chat (if member email or chat is available) letter to 92% of members discharged to home. We will update our records within 7 days following the member's documented discharge date to home. This guarantee excludes maternity, newborns, behavioral health, coordination of benefits (COB), Medicare, skilled nursing facility (SNF), rehabilitation admissions and transplants (members managed through the National Medical Excellence Program). This assumes timeliness of notification of a discharge by a facility provider (defined as notification of discharge within 48 hours or first business day, whichever is sooner).
Customer specific results will be used to reconcile the guarantee annually using the appropriate performance guarantee report. This guarantee assumes that you will have a minimum of 5,000 medical subscribers and 30 members available to measure for this metric or the guarantee will revert to book of business results.

Penalty and Measurement Criteria:
We will place $0.10 per employee, per month of the guarantee period administrative service fees at risk for this metric as follows:

- < 77 percent - We return 100 percent of the fee allocated to this component
- 77 percent, but < 87 percent - We return 50 percent of the fee allocated to this component.
- 87 percent, but < 92 percent - We return 20 percent of the fee allocated to this component.

Case Management High Claimant Screening

Guarantee:
We will guarantee that 95% of all unique members with claims in excess of $100,000 will be screened for case management.
Customer specific results will be used to reconcile the guarantee annually using the appropriate performance guarantee report. This guarantee assumes that you will have a minimum of 5,000 medical subscribers and 30 members available to measure for this metric or the guarantee will revert to book of business results.

Penalty and Measurement Criteria:
We will place $0.10 per employee, per month of the guarantee period administrative service fees at risk for this metric as follows:

- < 80 percent - We return 100 percent of the fee allocated to this component
- 80 percent, but < 90 percent - We return 50 percent of the fee allocated to this component.
- 90 percent, but < 95 percent - We return 20 percent of the fee allocated to this component.

Utilization Management Touch Rate

Guarantee:
We will guarantee that 90% of all inpatient stays, excluding non-high risk maternity stays, will be touched by at least one Utilization Management (UM) program.
Customer specific results will be used to reconcile the guarantee annually using the appropriate performance guarantee report. This guarantee assumes that you will have a minimum of 5,000 medical subscribers and 30 members available to measure for this metric or the guarantee will revert to book of business results.

Note: We offer several utilization management programs for members who have been (or will be) admitted to a hospital. A patient may have any, all or none of the programs extended based on a variety of criteria. Despite the possibility of having more than one program administered for a single inpatient stay, the utilization management touch rate only reflects a single program or "touch" by our nurses. For example, if member 1 had concurrent review, member 2 had concurrent review and discharge planning, and member 3 had no programs, then the touch rate would be 2 touched members divided by 3 inpatient stays, or 66.7 percent.

Penalty and Measurement Criteria:
We will place $0.10 per employee, per month of the guarantee period administrative service fees at risk for this metric as follows:

- < 75 percent - We return 100 percent of the fee allocated to this component
- 75 percent, but < 85 percent - We return 50 percent of the fee allocated to this component.
- 85 percent, but < 90 percent - We return 20 percent of the fee allocated to this component.

Demonstrating Value Scorecard Guarantee — Effective Date: July 01, 2020

Clinical Performance

Guarantee:
The clinical guarantees offer a year over year improvement. Since this is the first year of your Aetna In Touch Care program, this year is a reporting only guarantee.
For each of the measures itemized in the table below:

(1) If the measure in the prior year is at the target or higher, we guarantee the target.
(2) If the measure in the prior year is below the target, we guarantee a minimum 5 percent improvement in the difference between the prior year result and the target. The minimum improvement calculation is:

(Target - Prior Year) x 5 percent

To be included in the guarantee measure, members measured during each measurement period must:

- Be participating in the In Touch Care program
- Be enrolled for at least 11 months in the guarantee period
- Be identified as having the chronic condition for at least 6 months.

Guarantee Measure	Minimum Target
CAD members using statins	50%
Diabetic members using statins	45%
Diabetic members receiving an HbA1c Test in the past 12 months	75%
Diabetic members with HbA1c less than 8%	65%
Diabetic members screened for or having evidence of nephropathy in the past 12 months.	75%
Persistent asthmatic members using appropriate controller medications in the past 12 months	75%

Guarantee Measure	Maximum Target
Diabetic members with HbA1c more than 9 percent	25%

Penalty and Measurement Criteria:
We will place $0.05 per employee, per month of the guarantee period administrative service fees at risk for *each* guarantee measure listed above as follows:

- If we achieve the target compliance level, we return none of the fee
- If we do not achieve the target compliance level but do achieve a minimum five percent improvement between the prior year and the target, we return none of the fee.
- If neither of these conditions is met, we will return $0.05 per employee, per month

Reconciliation example for minimum targets:
If the prior year rate is 50 percent and the target compliance rate for the metric is 70 percent, the guarantee will be to improve the rate from the current 50 percent to 51 percent in the following year [50 percent + (70 percent - 50 percent) x 5 percent].

Reconciliation example for maximum targets:
If the prior year rate is 33 percent and the target compliance rate for the metric is 23 percent, the guarantee will be to improve (reduce) the rate from the current 33 percent to 32.5 percent in the following year. [33 percent - (33 percent -23 percent) x 5 percent].

Because you implemented the Aetna In Touch Care program this year, this is a reporting only guarantee. If this guarantee is offered next year, customer specific results will be used to reconcile this guarantee. This guarantee assumes that you will have a minimum of 3,000 medical subscribers and 30 members measured in both the current guarantee period and prior year. Otherwise, Aetna In Touch Care book of business results will be used to reconcile the guarantee.

Self Funded General Description | Effective Date: July 01, 2020

We provide a full range of administrative services for our self-funded customers including plan administration, account management, statistical reporting/analysis, network and medical management, and field representative services. We bill the customer a monthly service charge based on the previous month's number of covered subscribers. The service charge is subject to change based on the caveats listed in the proposal and rate sheets, such as more than a 10 percent variance in lives, more than a 10 percent variance in member/subscriber ratio, etc. Also, additional charges will be billed for non-standard services, such as printing or preparation of non-standard reports.

Banking and Funding

We offer banking services designed for both simplicity and efficiency. We maintain a joint disbursement account for self-funded customers at Bank of America or Citibank. Once the customer executes the banking agreement, we handle all other details concerning participation in this account. Funds are requested and transferred on an as-needed basis for all Issued checks.

Our simplified banking:

- Avoids maintenance charges for separate customer bank accounts and expensive custom-printed check stock.
- Incorporates numerous cash-flow advantages. For example, we clear all checks/EFTs through Bank of America or Citibank. We request funds from the customer's bank when Issued claims total $20,000 or more, with a monthly closeout request on the first banking day of each month. Wire request are administered through a Federal drawdown by Bank of America or Citibank (as instructed by our company).
- Reserve Requirements - The customer retains the health reserve liability.

  The customer is responsible for funding all benefits paid under the plan. All benefits checks/EFTs clear through the joint account. All benefits payments are made in the customer's name, with our company as the paying agent.
  As we identify and approve the check amounts, Bank of America or Citibank requests funds (as instructed by our company) to cover the Issued checks from the customer's designated bank using the Federal Wire Transfer system.

  Proper transfer of funds is monitored closely through the series of audits we perform within our accounting system, as well as the audits between banks.

Standard Services

We provide the following standard services:

- Account Management:
  - Analysis of experience
  - Calculation of reserves
  - Expected cost projections for budgeting purposes
  - Generic subscriber communication materials
  - Installation of the plan and resolution of servicing issues
  - Maintenance of exposure data for consulting/plan design/plan analysis purposes
- Banking/Financial:
  - Central bank account
  - Checks-Issued funding
  - Checks reconciled and recorded on claims reporting system
  - Outgoing wire transfer request charges and bank check handling charges
  - Wire transfer/EFT reconciliation
  - Up to three wire lines per customer

- Claims Administration/Adjudication:
  - Application of COB
  - Application of medical necessity criteria
  - Application of R&C (surgery, common provider services, X-ray, and lab)
  - Bulk payment to improve cash flow
  - Certification of subscriber/dependent eligibility
  - Claim forms and envelopes
  - Claim Check editing of CPT billing practices
  - Claims audits; services of professional auditors
  - Computerized claims payment system
  - Computerized hospital duration guidelines
  - Fraud protection/investigative staff
  - Maintenance of subscriber and dependent data, including eligibility and claims history
  - Maintenance of financial records for seven years
  - Maintenance of plan information for automatic claims calculation
  - Mental/nervous condition claims controls
  - Production and distribution of checks and EOBs, when applicable
  - Provider flags for utilization/fraud control
  - Provider TIN reporting (1099)
  - Investigative staff
- Eligibility Reporting:
  - Flexibility in the transmission media we can accept
  - Online eligibility inquiry and update capabilities
- Medical Services:
  - Wellness Programs
    - Health education
    - Wellness/preventive care reminders
    - Member website
  - Acute Care Management
    - Precertification, utilization management/concurrent review, pre-hospital discharge planning
  - Case Management
    - Catastrophic case management, Women's Health, National Medical Excellence Program®
  - Electronic Total Utilization Management System (eTUMS)
    - Integrated, cross-platform data sharing
    - Wireless communication of real-time patient information
  - The PULSE AIM application – identifies candidates for case management
  - Quality and Patient Safety
    - Participation in Leapfrog initiatives
  - Data Integration/Tools/Resources
    - Healthwise® Knowledgebase
  - Cost Management
    - Audits, COB, duplicate bill elimination, fraud team
- Member Services:
  - Toll-free number for members and providers to access claims and patient management services, ask questions, and resolve problems
  - Enhanced customer servicing framework - puts the member first in every decision and promotes a culture of individual accountability, trust, ownership and empowerment.
- Plan Services
  - Counseling on federal and state regulatory requirements
  - Drafting of plan documents
  - Producing ID cards
  - Underwriting advice for late entrants

- Statistical Reporting and Analysis
  - Annual accounting
  - Claims detail reports (monthly)
  - Health care information reports (cumulative quarterly)
  - Standard coding (CPT-4, PAS, ICD-9, ADA, etc.)
  - In addition to preformatted reports, customers granted two to four prepaid reporting hours to handle other ad hoc reporting requests (Two hours for customers with 300 to 999 covered subscriber; four hours for customers with 1,000 plus covered subscribers.)
- Implementation - We develop an implementation management plan outlining the tasks to be accomplished by both groups and establishing target dates for completion. Throughout the implementation process, team members work together, contributing their specialized skills and talents toward a successful goal.
- Claim History Transfer - These files are used to administer deductible and internal maximums, if any. There is no cost associated with receiving claim history files electronically from the prior carrier. There will be a charge for files received in a format other than electronically; costs are based on the complexity and format of the data.
- ID Cards - Standard ID cards are included. Each member and covered spouse receives a plastic family ID card. The family ID card allows for group family members on one ID card to a maximum of five, with additional members listed on a second family card. It takes about one week from the time we receive the customer's eligibility information to produce the initial order of ID cards.
  Members requesting extra ID cards, for either new or existing Aetna members, will be exclusively available online. A digital ID card is identical to the plastic ID card. It can be viewed, downloaded or printed from the member website, the Mobile app, or Aetna.com from a smartphone or internet browser. For an additional cost, we can customize ID cards to show the customer's logo or special colors or designs. Customers may request that their custom black and white logo be merged with our logo on an ID card or stuffer. There is no longer an additional charge for this service. Production times take about two to six weeks, and subsequent orders can be filled overnight.
- Directories and Other Materials - To alleviate customer expense, protect natural resources, and provide convenient member assistance, we offer many no-charge, Web-based solutions. For example, DocFind™, our online directory of participating providers, helps members find provider information. Aetna Navigator™, our member website, lets members send a secure message to our Member Services, obtain preventive health care schedules, and view eligibility, and benefits-related information, and Explanations of Benefits (EOBs) statements. For those customers who require hardcopy directories, we can include an annual supply equal to 1.2 times the number of subscribers who match our network sites. We can also bulk mail the directories to the customer.

Additional Cost Services

- The quoted fee factors exclude provision for certain additional services that may be requested and any non-recurring charges.
  These services include, but are not limited to, the following:
  - Charge for additional wire lines above three
  - Charges for any available custom reports (including third-party Stop Loss vendor reports)
  - Charges for late payment of fees and/or wires
  - COBRA direct-billing charges
  - Daily advice wire (additional cost not applicable to New Business)
  - HIPAA Certificates
  - Printing expenses
  - Processing of changes in benefits plans
  - Alternative Claim Fiduciary options
  - National Advantage™ Program (NAP)
  - Disease Management Programs – Congestive Heart Failure, Diabetes, Coronary Artery Disease, Asthma

We can also provide special services ranging from printing additional directories, printing other materials (such as PPO Dental directories, booklets, or Summary Plan Descriptions), collating enrollment materials, and mailing materials to subscriber homes for a charge.

Administration charges for any additional services will be billed during the guarantee period, or they will be reconciled in conjunction with the annual accounting process and may result in a year-end adjustment to the final administration charge.

- MedQuery® is a program that uses member data such as medical claims, pharmacy claims, laboratory reports, and demographic information to identify potential gaps in care. This information is shared with physicians to help improve clinical quality and patient safety.

  Based on a review of our book of business data, we are seeing medical cost reductions for customers that have implemented MedQuery. The average ratio of medical cost reduction to fees for the program is 2:1, although customer-specific results vary based on demographics, account size and other factors.

Additional Information

- Billing - We prepare a monthly Administrative Charge Statement based on the number of subscribers covered during the previous month. The customer forwards the service fee to us.
- Processed Claim Transaction (PCT) – For medical and dental benefits, a PCT is any transaction with respect to a benefits request or predetermination of dental benefits for expenses incurred or expected to be incurred by one claimant in any one calendar year for a major line of coverage, including but not limited to, a benefits payment, benefits denial, pended benefits request or decision on an appeal of a denied benefits request.
- Late Charges – If fees or benefit funding is not provided on a timely basis, we will assess a late-payment charge. The current charges are:
  - late funds to cover benefits payments (e.g., late wire transfers): 12.0 percent annual rate
  - late payments of service fees: 12.0 percent annual rate
- Eligibility Information - In order to provide services accurately and efficiently, we must have the most up-to-date, accurate eligibility information on each subscriber and dependent. We gather and maintain this information from data the customer provides. We encourage customers to provide this data by using one of our Internet-based eligibility solutions, including SecureTransport™, Aetna EZConnect™, EZLink™ or EZ*enroll*®. These solutions are not only efficient, they are available to our customers at no additional charge. Non-standard eligibility transmission may generate additional charges.
- Claims Administration Vendors - Some claims services may be performed by vendors in U.S. or in offshore locations. If a payment recovery vendor is used, amounts recovered are credited to the plan net of vendor's fees.
- We use a number of different payment methodologies in its contracts with participating providers, including risk adjustment mechanisms and incentive arrangements. In general, self-funded customers are billed based on actual costs incurred by plan members, but in some cases, costs are allocated on a pro-rata or other basis. In certain cases, PMPM fees are paid to vendors (such as behavioral health vendors) for access to administrative services (such as network development, patient management and claim processing) and for claim costs. The PMPM fees can be passed through as claims transactions.
- We may receive negotiated manufacturers' rebates for certain pharmaceuticals. A portion of these rebates may be shared with certain self-funded customers with more than 500 subscribers. Information regarding the ability to share in these rebates is available from your representative.
- Data produced in the administration of self-funded plans is housed in an Aetna data warehouse and may be accessed in a number of mandatory and/or legally permissible ways, including health care operations and reporting to government agencies.
- Claims Subrogation – We have entered into an agreement with the firm of Rawlings & Associates to provide comprehensive subrogation services. A contingency fee of 37.5% is retained upon recovery for self-funded customers.

Customer Advantages

- Tax and risk charge savings
- Full services (plan administration, actuarial, underwriting, network management, medical management and field representative services)
- Simplified banking
- Cash-flow improvement

Pharmacy Service and Fee Schedule

aetna™

Pharmacy
Service and Fee Schedule
to the Master Services Agreement

Effective July 1, 2020
State of Nebraska

Service and Fee Schedule

Pharmacy Discounts & Fees

Pricing Arrangement	Pass Through at Retail
Network	Aetna National with Extended Day Supply (Retail 90) Network
Employees	13,042

RETAIL			
	07/01/2020	07/01/2021	07/01/2022
Brand Discount	AWP - 18.30%	AWP - 18.40%	AWP - 18.50%
Generic Discount	AWP - 84.00%	AWP - 84.20%	AWP - 84.40%
Dispensing Fee	$0.50 per script	$0.50 per script	$0.50 per script

RETAIL 90			
	07/01/2020	07/01/2021	07/01/2022
Brand Discount	AWP - 19.80%	AWP - 19.90%	AWP – 20.00%
Generic Discount	Included in Retail 30 pricing above		
Dispensing Fee	$0.35 per script	$0.35 per script	$0.35 per script

MAIL ORDER PHARMACY			
Mail Benefit Type	Mail Order Pharmacy		
	07/01/2020	07/01/2021	07/01/2022
Brand Discount	AWP - 25.00%	AWP - 25.10%	AWP - 25.20%
Generic Discount	AWP - 87.00%	AWP - 87.20%	AWP - 87.40%
Dispensing Fee	$0.00 per script	$0.00 per script	$0.00 per script

AETNA SPECIALTY PHARMACY			
Network	Aetna Specialty Network		
Price List	Exclusive Specialty Pharmacy Network		
	07/01/2020	07/01/2021	07/01/2022
Discount	AWP - 20.00%	AWP - 20.10%	AWP - 20.20%
Dispensing Fee	$0.00 per script	$0.00 per script	$0.00 per script

Service and Fee Schedule

ADMINISTRATION FEE			
	07/01/2020	07/01/2021	07/01/2022
Admin Fee	$1.95 PEPM	$1.95 PEPM	$1.95 PEPM

ALLOWANCES/CREDITS			
	07/01/2020	07/01/2021	07/01/2022
General Allowance	$50,000	$50,000	$50,000
External Claim Data Files	Included	Included	Included

We are willing to extend our pharmacy offer through June 30, 2027 using standard increments (.10% on Brands and .20 on Generics) to the discounts listed above. Rebates for Years 4 through 7 will be determined in Year 3. Dispensing Fees and Allowances/Credits will remain flat as noted above.

<u>Rebates</u>

REBATES			
Formulary	Aetna Standard Formulary		
Plan Design	**3 Tier Qualifying (In force today)**		
Rebate Terms	Plan sponsor will receive the following minimum rebates:		
	07/01/2020	07/01/2021	07/01/2022
Retail	Greater of 100% or $209.13 Per Brand Script	Greater of 100% or $214.66 Per Brand Script	Greater of 100% or $223.03 Per Brand Script
Retail 90	Greater of 100% or $580.06 Per Brand Script	Greater of 100% or $682.59 Per Brand Script	Greater of 100% or $777.35 Per Brand Script
Mail	Greater of 100% or $580.06 Per Brand Script	Greater of 100% or $682.59 Per Brand Script	Greater of 100% or $777.35 Per Brand Script
Specialty Non-Hepatitis C	Greater of 100% or $1,390.17 Per Brand Script	Greater of 100% or $1,495.16 Per Brand Script	Greater of 100% or $1,593.69 Per Brand Script
Specialty Hepatitis C	Greater of 100% or $13,885.87 Per Brand Script	Greater of 100% or $13,885.87 Per Brand Script	Greater of 100% or $13,885.87 Per Brand Script

Service and Fee Schedule

REBATES			
Formulary	Aetna Standard Formulary		
Plan Design	**2 Tier (In force today)**		
Rebate Terms	Plan sponsor will receive the following minimum rebates:		
	07/01/2020	**07/01/2021**	**07/01/2022**
Retail	Greater of 100% or $206.19 Per Brand Script	Greater of 100% or $211.35 Per Brand Script	Greater of 100% or $219.55 Per Brand Script
Retail 90	Greater of 100% or $573.47 Per Brand Script	Greater of 100% or $674.61 Per Brand Script	Greater of 100% or $767.95 Per Brand Script
Mail Order	Greater of 100% or $573.47 Per Brand Script	Greater of 100% or $674.61 Per Brand Script	Greater of 100% or $767.95 Per Brand Script
Specialty Non-Hepatitis C	Greater of 100% or $1,390.17 Per Brand Script	Greater of 100% or $1,495.16 Per Brand Script	Greater of 100% or $1,593.69 Per Brand Script
Specialty Hepatitis C	Greater of 100% or $13,885.87 Per Brand Script	Greater of 100% or $13,885.87 Per Brand Script	Greater of 100% or $13,885.87 Per Brand Script

Service and Fee Schedule

Terms & Conditions

The pricing and services set forth herein are subject to the following Terms & Conditions:

- To the extent the pricing and services outlined in this document are part of a proposal to the Customer, the pricing set forth herein is valid for 90 days from the date of such offer.
- Our proposal assumes that Aetna administers both the medical and pharmacy benefits for Customer on an integrated basis. If Customer elects to use a different vendor to provide medical benefits, then Aetna reserves the right to adjust the pricing contained in this proposalThe pricing and services contained herein are limited to prescription drugs dispensed by a Participating Pharmacy to Plan Participants.
- Prescriptions dispensed by a Participating Retail Pharmacy shall be processed at the lower of the pharmacy's submitted Usual & Customary Retail Price, MAC (where applicable) plus a Dispensing Fee, or discounted AWP cost plus a Dispensing Fee.
- MAC Pricing applies at Mail Order.
- Cost Share will be calculated on the basis of the rates charged to the Customer by Aetna for Covered Services, except for fixed copays or where required by law to be otherwise.
- Discounts and Dispensing Fees contained in this Service and Fee Schedule are guaranteed on an annual basis, subject to the following conditions:
  - Discount and Dispensing Fee guarantees are measured and reconciled individually; surpluses in one or more component guarantees may not be used to offset shortages in other component guarantees.
  - Discount and Dispensing Fee guarantees shall be reconciled and reported to Customer within ninety (90) days following the guarantee period.
  - Discount guarantees are calculated on ingredient cost prior to the application of Plan Participant copay and include zero balance due claims.
  - The following types of Prescription Drug claims are excluded from the Discount and Dispensing Fee guarantees contained herein: compound drug claims, direct Plan Participant reimbursement / out-of-network claims, over-the-counter products, in-house pharmacy claims, and vaccines. In addition, we do not identify or administer any claims for 340B.
  - Retail pricing guarantees include claims that reflect the Usual & Customary Retail Price.
  - Prescriptions dispensed by Aetna Specialty Pharmacy are included in the Aetna Specialty Pharmacy Discount guarantee listed above.
  - Aetna has assumed 0% in-house pharmacy utilization. Aetna reserves the right to re-evaluate the proposed pricing if the actual in-house pharmacy utilization varies from this assumption.
- Pricing and terms in this proposal assume the Customer has elected the Aetna Standard Formulary and the Choose Generics program.

Service and Fee Schedule

- The Extended Day Supply (EDS-90) Network requires the associated Retail copays must be stepped as follows: 1-30ds = 1x, 31-60ds = 2x and 61-90ds = 3x.
- Our financial offer does not assume any adoption of the Livongo Diabetes Program. If customer offers a Diabetes Management program, either by Aetna or another vendor, the proposed rebates will need to be re-evaluated.
- The proposed formulary includes certain preferred Brand Drugs where the Tier 1 cost share shall be assessed to Members.
- Aetna Specialty Network means that Plan Participants are required to use the Aetna Specialty Pharmacy (no fills at retail allowed).
- Rebate guarantees will exclude the claims noted below; however, any Rebate collected by Aetna for such claims will be passed through to the Customer in accordance with the Rebate terms described herein.
- 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. A surplus in one or more component Rebate guarantees may be used to offset shortages in other component Rebate guarantees.
- Rebate guarantees may be subject to:
  - The adoption of utilization management edits for Specialty Products, including for example, Prior Authorization (PA) and Quantity Limits.
  - The adoption and maintenance of a biosimilar first plan design for Specialty Products.
  - Plan performance that is materially the same as the baseline data provided by Customer and relied upon by Aetna, including information regarding enrollment and utilization of pharmacy services.
  - Rebate guarantees assume that products that are not Specialty Products will not be subject to precertification or step therapy requirements, and that all drug classes included on the Aetna Standard Formulary be covered.
- The above rebate guarantees exclude:
  - Over the Counter (OTC) Claims
  - Exclusive Distribution and Limited Distribution Drug (LDD) Claims
  - 340B Claims
  - Compound Drug Claims
  - Paper or Member Submitted Claims
  - Coordination of Benefits (COB) or secondary payor Claims
  - Vaccine and vaccine administration Claims
  - New to Market Biosimilar Claims
- Rebate guarantees assume alignment with proposed formulary, including utilization management programs to support formulary strategy, and standard prior authorization/utilization management criteria.

Service and Fee Schedule

- Rebate guarantees assume Advanced Control Specialty Formulary.
- Specialty rebate guarantees apply to specialty drug claims at all channels.
- Brand drug claims in the HIV therapeutic category are included in the retail rebate guarantees.
- To receive the rebate guarantees noted above:
  - Two-tier qualifying plan designs - will consist of an open plan design, with the first tier comprised of Generic Drugs and the second tier comprised of Brand Drugs. There are no requirements for a minimum Cost Share differential between these tiers. The plan design may need to implement formulary interventions recommended by Aetna.
  - Three-tier qualifying plan designs – maintains a first tier comprised of Generic Drugs, a second tier comprised of preferred Brand Drugs, and a third tier comprised of non-preferred Brand Drugs. The plan design maintains at least a $15.00 co-payment differential between preferred and non-preferred Brand Drugs, at least a $15.00 differential in the minimum co-payment for coinsurance, or a differential of coinsurance 1.5 times or 50 percentage points between the preferred and non-preferred Brand Drugs (for example, if preferred brand coinsurance was 20%, non-preferred brand would need to be 30% to qualify).
- We are providing a separate rebate guarantee for the specialty brand drug claims within the Hepatitis C therapeutic class. Rebate guarantees are conditioned upon Harvoni, Epclusa, and Vosevi as the preferred formulary drugs for Hepatitis C treatment with at least 95% drug claim share, all other drugs are excluded or non-preferred, coverage is provided for all fibrosis scores (F0/F1-F4), utilization management criteria aligns with drug labeling, and client is not utilizing starter or split fill programs.

Service and Fee Schedule

Allowances

Allowances will be available as of the Effective Date of the pharmacy services schedule. Aetna will pay related expenses directly to a third party vendor once the Customer sends the invoice(s) outlining the expenses incurred to Aetna. Invoices must be submitted before the end of each Plan year otherwise the Customer forfeits the funds. Any unused allowance monies at the end of each Plan year will be forfeited.

General Allowance

Aetna is including a General Allowance up to $50,000 annually. The Customer can use this allowance to pay for Implementation, Pre-Implementation Audit, Annual Audit and Communication related expenses.

External Claim Data Files

In addition to the General Allowance, our pricing includes biweekly (every 2 weeks) external claim files sent to five chosen vendors.

Service and Fee Schedule

Market Check

During the second quarter of the second contract year, and at Client's reasonable request, Aetna may review the financial terms of Client 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 Client is entitled to such revised pricing terms: (i) the aggregate pricing terms of such applicable clients 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 clients; and (iii) the plan design of such clients, which may include plan formulary, brand/generic utilization information and mail and retail utilization information, available to Aetna. If Client and Aetna agree to any revisions to the financial terms as a result 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. A legal document must be signed by Client and returned to Aetna 90 days prior to pricing effective date.

Service and Fee Schedule

Additional Disclosures

The Customer acknowledges that the Retail Discounts and Dispensing Fees contained in this agreement reflect a Transparent or Pass Through pricing arrangement. Transparent or Pass-Through Pricing means the amount charged to the Customer and Plan Participants for retail network claims shall equal the amount paid to Participating Retail Pharmacy. Maintenance Choice claims dispensed at CVS/pharmacy, if applicable, are exempt from the Transparent Pricing requirements under this Agreement.

Aetna reserves the right to make appropriate changes to these price points if any event materially impacts Aetna's 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 Aetna's pharmacy network or in Aetna's pharmacy network contract compensation rates with its pharmacy network subcontractor, CVS Health, (iii) a change in government laws or regulations, (iv) a change in the Plan that is initiated by Customer, (v) AWP is discontinued or modified in whole or in part, or (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 was assumed at the time of underwriting. Aetna shall provide the Customer 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, Aetna shall provide written notice as soon as practicable.

Aetna reserves the right to modify its 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.

Rebate Payment Terms

Rebates will be distributed on a quarterly basis by claim wire credit. 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. Rebates are paid on Prescription Drugs dispensed by Participating Pharmacies and covered under Customer's Plan. Rebates are not available for Claims arising from Participating Pharmacies dispensing Prescription Drugs subject to either their (i) own manufacturer Rebate contracts or (ii) participation in the 340B Drug Pricing Program codified as Section 340B of the Public Health Service Act or other Federal government pharmaceutical purchasing program. The Customer shall adopt the formulary indicated in the rebates section of this Service and Fee Schedule in order to be eligible to receive Rebates.

Service and Fee Schedule

The rebate schedule will be as follows:

- Rebate calculations related to the first quarter will be paid in September of the same year
- Rebate calculations related to the second quarter will be paid in December of the same year
- Rebate calculations related to the third quarter will be paid in March of the following year
- Rebate calculations related to the fourth quarter will be paid in June of the following year

If this Agreement is terminated by Aetna for the Customer's failure to meet its obligations to fund benefits or pay administrative fees (medical or pharmacy) under the Agreement, Aetna shall be entitled to deduct deferred administrative fees or other plan expenses from any future rebate payments due to the Customer following the termination date.

Formulary Management

Aetna offers several versions of formulary options ("Formulary") for Customer to consider and adopt as Customer's Formulary. The formulary options made available to Customer will be determined and communicated by Aetna prior to the implementation date. Customer agrees and acknowledges that it is adopting the Formulary as a matter of its plan design and that Aetna has granted Customer the right to use one of its Formulary options during the term of the Agreement solely in connection with the Plan, and to distribute or make the Formulary available to Plan Participants. As such, Customer acknowledges and agrees that it has sole discretion and authority to accept or reject the Formulary that will be used in connection with the Plan. Customer further understands and agrees that from time to time Aetna may propose modifications to the drugs and supplies included on the Formulary as a result of factors, including but not limited to, market conditions, clinical information, cost, rebates and other factors. Customer also acknowledges and agrees that the Formulary options provided to it by Aetna is the business confidential information of Aetna and is subject to the requirements set forth in the Agreement.

Other Payments

The term "Rebates" as defined in the Prescription Drug Services Schedule does not mean or include any manufacturer administrative fees that may be paid by pharmaceutical manufacturers to cover the costs related to the reporting and administration of the pharmaceutical manufacturer agreements. Such manufacturer administrative fees are not shared with Customer hereunder.

Aetna may also receive other payments from drug manufacturers and other organizations that are not Rebates. These payments are generally for one of two purposes: (i) to compensate Aetna for bona fide services it performs, such as the analysis or provision of aggregated data or (ii) to reimburse Aetna for the cost of various educational and other related programs, such as programs to educate physicians and members about clinical guidelines, disease management and other effective therapies. These payments are not considered Rebates and are not included in Rebate sharing arrangements with plan sponsors, including without limitation, Customer.

Service and Fee Schedule

Aetna's PBM subcontractor may also receive network transmission fees from its network pharmacies for services it provides for them. These amounts are not considered Rebates and are not shared with plan sponsors. These amounts are also not considered part of the calculation of claims expense for purposes of Discount Guarantees.

Customer agrees that the amounts described above are not compensation for services provided under this Agreement by either Aetna or Aetna's PBM subcontractor, and instead are received by Aetna in connection with network contracting, provider education and other activities Aetna conducts across its book of business. Customer further agrees that the amounts described above belong exclusively to Aetna or Aetna's PBM subcontractor, and Customer has no right to, or legal interest in, any portion of the aforesaid amounts received by Aetna or Aetna's PBM subcontractor.

Rebates for Specialty Products that are administered and paid through the Plan Participant's medical benefit rather than the Plan Participant's pharmacy benefit will be retained by Aetna as compensation for Aetna's efforts in administering the preferred Specialty Products program. Payments or rebates from drug manufacturers that compensate Aetna for the cost of developing and administering value-based rebate contracting arrangements when drug therapies underperform thereunder also will be retained by Aetna.

Early Termination

Subject to the terms of the Agreement, either party may terminate the Agreement with or without cause anytime with 90 Days' prior written notice.

Late Payment Charges

If the Customer fails to provide funds on a timely basis to cover benefit payments and/or fails to pay service fees on a timely basis as required in the Agreement, Aetna will assess a late payment charge. The current charges are outlined below:

i. Late funds to cover benefit payments (e.g., late wire transfers): 12.0% annual rate
ii. Late payments of Service Fees: 12.0%, annual rate

In addition, Aetna will make a charge to recover its costs of collection including reasonable attorney's fees. We will notify the Customer of any changes in late payment interest rates. The late payment charges described in this section are without limitation to any other rights or remedies available to Aetna under the Service and Fee Schedule or at law or in equity for failure to pay.

Service and Fee Schedule

Pharmacy Audit Rights and Limitations

Customer is entitled to one annual Rebate audit, subject to the audit terms and conditions outlined in the pharmacy services schedule.

Customer is entitled to an annual electronic claim audit subject to standard pharmacy benefit audit practices and audit terms and conditions outlined in the pharmacy services schedule.

Pharmacy audits shall be conducted at the Customer's own expense unless otherwise agreed to between the Customer and Aetna.

Aetna Specialty Pharmacy

Discounts and Dispensing Fees for Specialty Products that are covered under the pharmacy plan and dispensed to Plan Participants through Aetna Specialty Pharmacy (ASRx) are indicated on the Specialty Pharmacy Addendum. A copy of the Customer's Specialty Pharmacy Addendum will be provided at renewal and upon request and may be modified by Aetna from time to time.

Limited Distribution Specialty Products

Certain Specialty Products may not be available at Aetna Specialty Pharmacy (ASRx) due to restricted or limited distribution requirements. These Specialty Products are referred to as Limited Distribution Specialty Products. Aetna has contracted with other network pharmacies to dispense Limited Distribution Specialty Products which are excluded from the pricing and terms contained in this Agreement. A copy of the current list of Limited Distribution Specialty Products may be obtained from Aetna upon request.

State of Nebraska - Aetna Specialty Fee Schedule

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STATE OF NEBRASKA		Exclusive	
Drug Therapy	Drug Name	AWP Discount	Notes
Acromegaly	octreotide	35.00%	
Acromegaly	SANDOSTATIN	16.25%	
Acromegaly	SOMATULINE	16.50%	
Acromegaly	SOMAVERT	15.25%	
Additional Products	LYNPARZA	17.50%	
Allergic Asthma	CINQAIR	13.50%	
Allergic Asthma	FASENRA	14.50%	
Allergic Asthma	NUCALA	15.75%	
Allergic Asthma	XOLAIR	15.00%	
Alpha-1 Antitrypsin Deficiency	ARALAST NP	10.00%	***
Alpha-1 Antitrypsin Deficiency	GLASSIA	10.00%	***
Alpha-1 Antitrypsin Deficiency	ZEMAIRA	10.00%	***
Anemia	ARANESP	10.00%	
Anemia	EPOGEN	10.50%	
Anemia	PROCRIT	13.75%	
Anemia	RETACRIT	11.00%	
Atopic Dermatitis	DUPIXENT	16.00%	
Cardiac Disorders	dofetilide	30.00%	
Cardiac Disorders	TIKOSYN	12.75%	
Coagulation Disorders	CEPROTIN	15.75%	
Cryopyrin Associated Periodic Syndromes	ARCALYST	16.00%	
Cryopyrin Associated Periodic Syndromes	ILARIS	16.75%	
Cystic Fibrosis	BETHKIS	16.00%	
Cystic Fibrosis	KITABIS PAK	15.75%	
Cystic Fibrosis	PULMOZYME	15.50%	
Cystic Fibrosis	TOBI	16.25%	
Cystic Fibrosis	TOBI PODHALER	16.25%	
Cystic Fibrosis	tobramycin	Estimated MAC Discount of AWP-30.00%	
Electrolyte Disorders	SAMSCA	16.50%	
Gastrointestinal	GATTEX	15.25%	
Gastrointestinal	OCALIVA	13.50%	
Gastrointestinal	SOLESTA	13.50%	
Gout	KRYSTEXXA	16.50%	
Growth Hormone	GENOTROPIN	15.50%	
Growth Hormone	HUMATROPE	23.00%	
Growth Hormone	INCRELEX	16.75%	
Growth Hormone	NORDITROPIN	23.00%	
Growth Hormone	NUTROPIN	15.00%	
Growth Hormone	OMNITROPE	14.75%	
Growth Hormone	SAIZEN	15.75%	
Growth Hormone	SEROSTIM	16.00%	
Growth Hormone	ZOMACTON	13.25%	
Growth Hormone	ZORBTIVE	16.25%	
Hematopoietics	MOZOBIL	16.50%	
Hemophilia	ADVATE	33.25%	
Hemophilia	ADYNOVATE	25.25%	
Hemophilia	AFSTYLA	29.50%	
Hemophilia	ALPHANATE	33.25%	
Hemophilia	ALPHANINE SD	30.75%	
Hemophilia	ALPROLIX	16.50%	
Hemophilia	BEBULIN	15.50%	
Hemophilia	BENEFIX	10.25%	
Hemophilia	CORIFACT	22.00%	
Hemophilia	ELOCTATE	17.25%	
Hemophilia	FEIBA	19.75%	
Hemophilia	FIBRYGA	12.00%	
Hemophilia	HELIXATE	32.25%	
Hemophilia	HEMLIBRA	17.00%	

Hemophilia	HEMOFIL M	32.75%	
Hemophilia	HUMATE-P	25.25%	
Hemophilia	IDELVION	13.00%	
Hemophilia	IXINITY	21.00%	
Hemophilia	JIVI	15.50%	
Hemophilia	KOATE	35.75%	
Hemophilia	KOGENATE	34.25%	
Hemophilia	KOVALTRY	34.25%	
Hemophilia	MONOCLATE	22.00%	
Hemophilia	MONONINE	17.25%	
Hemophilia	NOVOEIGHT	31.25%	
Hemophilia	NOVOSEVEN RT	21.00%	
Hemophilia	NUWIQ	27.25%	
Hemophilia	OBIZUR	8.00%	
Hemophilia	PROFILNINE SD	18.00%	
Hemophilia	REBINYN	17.00%	
Hemophilia	RECOMBINATE	30.75%	
Hemophilia	RIASTAP	16.75%	
Hemophilia	RIXUBIS	20.00%	
Hemophilia	STIMATE	14.50%	
Hemophilia	TRETTEN	15.00%	
Hemophilia	VONVENDI	8.00%	
Hemophilia	WILATE	34.25%	
Hemophilia	XYNTHA	30.75%	
Hepatitis B	adefovir dipivoxil	35.00%	
Hepatitis B	BARACLUDE	15.25%	
Hepatitis B	entecavir	Estimated MAC Discount of AWP-30.00%	
Hepatitis B	EPIVIR HBV	10.00%	
Hepatitis B	HEPSERA	15.00%	
Hepatitis B	lamivudine_hepb	Estimated MAC Discount of AWP-25.00%	
Hepatitis B	TYZEKA	15.00%	
Hepatitis B	VEMLIDY	13.00%	
Hepatitis C	COPEGUS	15.50%	
Hepatitis C	DAKLINZA	16.00%	
Hepatitis C	EPCLUSA	16.00%	
Hepatitis C	HARVONI	16.00%	
Hepatitis C	LEDIPASVIR/SOFOSBUVIR	16.00%	
Hepatitis C	MAVYRET	16.00%	
Hepatitis C	MODERIBA	24.00%	
Hepatitis C	PEGASYS	15.75%	
Hepatitis C	PEG-INTRON	16.00%	
Hepatitis C	REBETOL	17.50%	
Hepatitis C	RIBAPAK	10.75%	
Hepatitis C	ribasphere	Estimated MAC Discount of AWP-60.00%	
Hepatitis C	ribavirin	Estimated MAC Discount of AWP-60.00%	
Hepatitis C	SOFOSBUVIR/VELPATASVIR	16.00%	
Hepatitis C	SOVALDI	16.00%	
Hepatitis C	TECHNIVIE	16.00%	
Hepatitis C	VIEKIRA PAK	15.50%	
Hepatitis C	VOSEVI	16.00%	
Hepatitis C	ZEPATIER	16.00%	
Hereditary Angioedema	BERINERT	16.00%	
Hereditary Angioedema	CINRYZE	8.00%	
Hereditary Angioedema	FIRAZYR	15.00%	
Hereditary Angioedema	HAEGARDA	8.00%	
Hereditary Angioedema	KALBITOR	8.00%	
Hereditary Angioedema	RUCONEST	15.50%	
Hereditary Angioedema	TAKHZYRO	8.00%	

HIV	abacavir	Estimated MAC Discount of AWP-35.00%	
HIV	abacavir sulfate-lamivudine	26.00%	
HIV	abacavir sulfate-lamivudine-zidovudine	35.00%	
HIV	APTIVUS	15.50%	
HIV	atazanavir sulfate	26.00%	
HIV	ATRIPLA	16.00%	
HIV	BIKTARVY	15.50%	
HIV	CIMDUO	10.75%	
HIV	COMBIVIR	14.50%	
HIV	COMPLERA	16.00%	
HIV	CRIXIVAN	12.50%	
HIV	DELSTRIGO	14.00%	
HIV	DESCOVY	15.50%	
HIV	didanosine	Estimated MAC Discount of AWP-25.00%	
HIV	EDURANT	14.50%	
HIV	efavirenz	Estimated MAC Discount of AWP-35.00%	
HIV	EGRIFTA	16.00%	
HIV	EMTRIVA	13.00%	
HIV	EPIVIR	8.00%	
HIV	EPZICOM	15.25%	
HIV	EVOTAZ	15.50%	
HIV	fosamprenavir	26.00%	
HIV	FUZEON	16.00%	
HIV	GENVOYA	16.00%	
HIV	INTELENCE	15.00%	
HIV	INVIRASE	14.75%	
HIV	ISENTRESS	15.25%	
HIV	JULUCA	15.50%	
HIV	KALETRA	14.75%	
HIV	lamivudine/zidovudine	Estimated MAC Discount of AWP-60.00%	
HIV	lamivudine_hiv	Estimated MAC Discount of AWP-25.00%	
HIV	LEXIVA	15.50%	
HIV	lopinavir/ritonavir	14.75%	
HIV	nevirapine	Estimated MAC Discount of AWP-60.00%	
HIV	NORVIR	10.75%	
HIV	ODEFSEY	16.00%	
HIV	PIFELTRO	13.00%	
HIV	PREZCOBIX	15.50%	
HIV	PREZISTA	15.25%	
HIV	RESCRIPTOR	10.25%	
HIV	RETROVIR	11.00%	
HIV	REYATAZ	15.50%	
HIV	ritonavir	26.00%	
HIV	SELZENTRY	15.50%	
HIV	stavudine	Estimated MAC Discount of AWP-60.00%	
HIV	STRIBILD	16.00%	
HIV	SUSTIVA	14.75%	
HIV	SYMFI	14.75%	
HIV	tenofovir disoproxil fuma	Estimated MAC Discount of AWP-35.00%	
HIV	TIVICAY	15.50%	
HIV	TRIUMEQ	16.00%	
HIV	TRIZIVIR	15.75%	
HIV	TRUVADA	15.50%	
HIV	TYBOST	8.25%	
HIV	VIDEX	10.25%	

HIV	VIRACEPT	15.00%	
HIV	VIRAMUNE	14.75%	
HIV	VIRAMUNE XR	14.25%	
HIV	VIREAD	15.00%	
HIV	ZERIT	12.50%	
HIV	ZIAGEN	12.00%	
HIV	zidovudine	Estimated MAC Discount of AWP-60.00%	
Hormonal Therapies	AVEED	12.00%	
Hormonal Therapies	ELIGARD	14.50%	
Hormonal Therapies	FIRMAGON	11.75%	
Hormonal Therapies	leuprolide acetate	35.00%	
Hormonal Therapies	LUPANETA PACK	15.25%	
Hormonal Therapies	LUPRON DEPOT	15.75%	
Hormonal Therapies	NATPARA	15.00%	
Hormonal Therapies	SUPPRELIN	17.00%	
Hormonal Therapies	TRELSTAR	15.25%	
Hormonal Therapies	VANTAS	15.75%	
Hormonal Therapies	ZOLADEX	12.50%	
I.V.I.G.	BIVIGAM	22.00%	
I.V.I.G.	CARIMUNE	23.00%	
I.V.I.G.	CUVITRU	16.00%	
I.V.I.G.	CYTOGAM	8.00%	
I.V.I.G.	FLEBOGAMMA	17.25%	
I.V.I.G.	GAMASTAN S/D	17.50%	
I.V.I.G.	GAMMAGARD	23.00%	
I.V.I.G.	GAMMAGARD LIQUID	24.00%	
I.V.I.G.	GAMMAKED	15.75%	
I.V.I.G.	GAMMAPLEX	24.00%	
I.V.I.G.	GAMUNEX	23.00%	
I.V.I.G.	HEPAGAM B	17.50%	
I.V.I.G.	HIZENTRA	25.00%	
I.V.I.G.	HYPERHEP B	17.50%	
I.V.I.G.	HYPERRHO S/D	17.50%	
I.V.I.G.	HYQVIA	22.00%	
I.V.I.G.	MICRHOGAM	17.50%	
I.V.I.G.	NABI-HB	14.75%	
I.V.I.G.	OCTAGAM	14.75%	
I.V.I.G.	PANZYGA	14.75%	
I.V.I.G.	PRIVIGEN	24.00%	
I.V.I.G.	RHOGAM	17.50%	
I.V.I.G.	RHOPHYLAC	17.50%	
I.V.I.G.	VARIZIG	17.50%	
I.V.I.G.	WINRHO	14.50%	
Infectious Disease	ACTIMMUNE	17.00%	
Infectious Disease	ALFERON N	10.00%	
Infertility	BRAVELLE	15.50%	
Infertility	CETROTIDE	11.50%	
Infertility	CHORIONIC GONADOTROPIN	17.50%	
Infertility	FOLLISTIM AQ	15.50%	
Infertility	GANIRELIX ACETATE	13.50%	
Infertility	GONAL-F	15.50%	
Infertility	MENOPUR	15.00%	
Infertility	NOVAREL	17.50%	
Infertility	OVIDREL	17.50%	
Infertility	PREGNYL	17.50%	
Inflammatory Bowel Disease	CIMZIA	17.00%	
Inflammatory Bowel Disease	ENTYVIO	15.75%	
Inflammatory Bowel Disease	RENFLEXIS	18.00%	
Iron Overload	deferoxamine	17.50%	
Iron Overload	DESFERAL	15.25%	
Iron Overload	EXJADE	16.25%	
Iron Overload	JADENU	16.25%	

Lysosomal Storage Diseases	ALDURAZYME	16.00%	***
Lysosomal Storage Diseases	CERDELGA	14.25%	
Lysosomal Storage Diseases	CEREZYME	16.00%	***
Lysosomal Storage Diseases	CYSTAGON	17.50%	
Lysosomal Storage Diseases	ELAPRASE	14.75%	***
Lysosomal Storage Diseases	ELELYSO	15.00%	***
Lysosomal Storage Diseases	FABRAZYME	15.25%	***
Lysosomal Storage Diseases	KANUMA	15.50%	***
Lysosomal Storage Diseases	LUMIZYME	16.25%	***
Lysosomal Storage Diseases	miglustat	30.00%	
Lysosomal Storage Diseases	NAGLAZYME	14.75%	***
Lysosomal Storage Diseases	VIMIZIM	14.75%	***
Lysosomal Storage Diseases	VPRIV	14.50%	***
Movement Disorders	APOKYN	17.50%	
Movement Disorders	AUSTEDO	15.75%	
Movement Disorders	NORTHERA	15.75%	
Movement Disorders	NUPLAZID	17.00%	
Movement Disorders	tetrabenazine	Estimated MAC Discount of AWP-30.00%	
Movement Disorders	XENAZINE	16.00%	
Multiple Sclerosis	AMPYRA	14.00%	
Multiple Sclerosis	AUBAGIO	17.00%	
Multiple Sclerosis	AVONEX	17.00%	
Multiple Sclerosis	BETASERON	17.00%	
Multiple Sclerosis	COPAXONE 20	16.75%	
Multiple Sclerosis	COPAXONE 40	16.75%	
Multiple Sclerosis	dalfampridine	Estimated MAC Discount of AWP-60.00%	
Multiple Sclerosis	EXTAVIA	17.00%	
Multiple Sclerosis	GILENYA	19.75%	
Multiple Sclerosis	glatiramer acetate 20	23.00%	
Multiple Sclerosis	glatiramer acetate 40	23.00%	
Multiple Sclerosis	glatopa 20	23.00%	
Multiple Sclerosis	glatopa 40	23.00%	
Multiple Sclerosis	LEMTRADA	17.00%	
Multiple Sclerosis	mitoxantrone	17.50%	
Multiple Sclerosis	OCREVUS	15.50%	
Multiple Sclerosis	PLEGRIDY	17.00%	
Multiple Sclerosis	REBIF	16.50%	
Multiple Sclerosis	TECFIDERA	17.00%	
Multiple Sclerosis	TYSABRI	16.00%	
Neutropenia	FULPHILA	16.00%	
Neutropenia	GRANIX	15.00%	
Neutropenia	LEUKINE	15.75%	
Neutropenia	NEULASTA	16.00%	
Neutropenia	NEUPOGEN	15.50%	
Neutropenia	NIVESTYM	14.25%	
Neutropenia	ZARXIO	14.50%	
Oncology - Injectable	ADCETRIS	16.25%	
Oncology - Injectable	ARZERRA	16.00%	
Oncology - Injectable	AVASTIN	15.50%	
Oncology - Injectable	azacitidine	30.00%	
Oncology - Injectable	BAVENCIO	17.50%	
Oncology - Injectable	BELEODAQ	16.25%	
Oncology - Injectable	BENDEKA	16.50%	
Oncology - Injectable	BLINCYTO	17.50%	***
Oncology - Injectable	CYRAMZA	15.50%	
Oncology - Injectable	DACOGEN	16.25%	
Oncology - Injectable	DARZALEX	16.50%	
Oncology - Injectable	decitabine	20.00%	
Oncology - Injectable	EMPLICITI	16.50%	
Oncology - Injectable	ERBITUX	16.25%	
Oncology - Injectable	EVOMELA	16.00%	

Oncology - Injectable	FOLOTYN	16.25%	
Oncology - Injectable	FUSILEV	15.00%	
Oncology - Injectable	GAZYVA	16.50%	
Oncology - Injectable	HALAVEN	16.00%	
Oncology - Injectable	HERCEPTIN	16.00%	
Oncology - Injectable	IMFINZI	15.50%	
Oncology - Injectable	INTRON A	17.50%	
Oncology - Injectable	ISTODAX	16.50%	
Oncology - Injectable	IXEMPRA	16.00%	
Oncology - Injectable	JEVTANA	16.00%	
Oncology - Injectable	KADCYLA	16.00%	
Oncology - Injectable	KEYTRUDA	16.25%	
Oncology - Injectable	KYPROLIS	16.50%	
Oncology - Injectable	LEVOLEUCOVORIN CALCIUM	12.00%	
Oncology - Injectable	LUMOXITI	10.00%	
Oncology - Injectable	ONCASPAR	16.25%	
Oncology - Injectable	OPDIVO	16.25%	
Oncology - Injectable	PERJETA	16.00%	
Oncology - Injectable	PORTRAZZA	16.25%	
Oncology - Injectable	POTELIGEO	10.00%	
Oncology - Injectable	PROLEUKIN	16.25%	
Oncology - Injectable	RITUXAN	16.50%	
Oncology - Injectable	ROMIDEPSIN	15.75%	
Oncology - Injectable	SYLATRON	17.75%	
Oncology - Injectable	SYLVANT	15.00%	
Oncology - Injectable	TECENTRIQ	16.00%	
Oncology - Injectable	TEMODAR (INJECTABLE)	16.00%	
Oncology - Injectable	TEPADINA	17.50%	
Oncology - Injectable	THYROGEN	15.25%	
Oncology - Injectable	TORISEL	16.25%	
Oncology - Injectable	TREANDA	16.00%	
Oncology - Injectable	VALSTAR	16.00%	
Oncology - Injectable	VECTIBIX	16.00%	
Oncology - Injectable	VELCADE	16.00%	
Oncology - Injectable	VIDAZA	12.00%	
Oncology - Injectable	XGEVA	14.75%	
Oncology - Injectable	YERVOY	16.50%	
Oncology - Injectable	YONDELIS	16.00%	
Oncology - Injectable	ZALTRAP	16.25%	
Oncology - Injectable	zoledronic acid_onc	35.50%	
Oncology - Injectable	ZOMETA	12.00%	
Oncology - Oral	abiraterone acetate	Estimated MAC Discount of AWP-25.00%	
Oncology - Oral	AFINITOR	16.25%	
Oncology - Oral	ALECENSA	16.25%	
Oncology - Oral	ALUNBRIG	15.00%	
Oncology - Oral	bexarotene cap	30.00%	
Oncology - Oral	BOSULIF	16.25%	
Oncology - Oral	CABOMETYX	15.00%	
Oncology - Oral	capecitabine	Estimated MAC Discount of AWP-25.00%	
Oncology - Oral	COTELLIC	15.75%	
Oncology - Oral	DAURISMO	16.50%	
Oncology - Oral	ERIVEDGE	16.25%	
Oncology - Oral	ERLEADA	16.50%	
Oncology - Oral	FARYDAK	16.00%	
Oncology - Oral	GLEEVEC	16.50%	
Oncology - Oral	HYCAMTIN	16.00%	
Oncology - Oral	IBRANCE	16.50%	
Oncology - Oral	IDHIFA	13.50%	
Oncology - Oral	imatinib mesylate	Estimated MAC Discount of AWP-60.00%	
Oncology - Oral	INLYTA	16.50%	

Oncology - Oral	IRESSA	16.00%	
Oncology - Oral	JAKAFI	15.00%	
Oncology - Oral	KISQALI	16.50%	
Oncology - Oral	LENVIMA	12.00%	
Oncology - Oral	LONSURF	15.00%	
Oncology - Oral	LORBRENA	16.50%	
Oncology - Oral	MEKINIST	16.25%	
Oncology - Oral	MUGARD	16.00%	
Oncology - Oral	NERLYNX	13.50%	
Oncology - Oral	NEXAVAR	15.00%	
Oncology - Oral	NINLARO	15.00%	
Oncology - Oral	ODOMZO	16.25%	
Oncology - Oral	POMALYST	15.00%	
Oncology - Oral	PURIXAN	13.00%	
Oncology - Oral	REVLIMID	15.00%	
Oncology - Oral	RUBRACA	15.25%	
Oncology - Oral	RYDAPT	13.00%	
Oncology - Oral	SPRYCEL	16.50%	
Oncology - Oral	STIVARGA	15.00%	
Oncology - Oral	SUTENT	16.25%	
Oncology - Oral	TAFINLAR	16.25%	
Oncology - Oral	TAGRISSO	16.00%	
Oncology - Oral	TALZENNA	16.50%	
Oncology - Oral	TARCEVA	16.00%	
Oncology - Oral	TARGRETIN	16.50%	
Oncology - Oral	TASIGNA	16.25%	
Oncology - Oral	TEMODAR (ORAL)	16.75%	
Oncology - Oral	temozolomide	Estimated MAC Discount of AWP-25.00%	
Oncology - Oral	THALOMID	14.75%	
Oncology - Oral	TYKERB	16.00%	
Oncology - Oral	VERZENIO	16.25%	
Oncology - Oral	VITRAKVI	15.00%	
Oncology - Oral	VIZIMPRO	16.50%	
Oncology - Oral	VOTRIENT	16.25%	
Oncology - Oral	XALKORI	16.25%	
Oncology - Oral	XELODA	15.50%	
Oncology - Oral	XTANDI	16.25%	
Oncology - Oral	YONSA	15.75%	
Oncology - Oral	ZELBORAF	16.25%	
Oncology - Oral	ZOLINZA	16.25%	
Oncology - Oral	ZYDELIG	13.25%	
Oncology - Oral	ZYKADIA	16.25%	
Oncology - Oral	ZYTIGA	16.25%	
Osteoporosis	FORTEO	15.00%	
Osteoporosis	PROLIA	11.75%	
Osteoporosis	RECLAST	9.00%	
Osteoporosis	TYMLOS	15.00%	
Osteoporosis	zoledronic acid_ost	Estimated MAC Discount of AWP-30.00%	
Paroxysmal Nocturnal Hemoglobinuria	SOLIRIS	16.25%	
Phenylketonuria	KUVAN	15.00%	
Pre-Term Birth	hydroxyprogesterone capro	30.00%	
Pre-Term Birth	MAKENA	14.50%	
Psoriasis	COSENTYX	16.25%	
Psoriasis	ILUMYA	15.75%	
Psoriasis	OTEZLA	17.50%	
Psoriasis	SILIQ	14.25%	
Psoriasis	STELARA	19.00%	
Psoriasis	TALTZ	13.25%	
Psoriasis	TREMFYA	16.50%	
Pulmonary Arterial Hypertension	ADCIRCA	15.00%	
Pulmonary Arterial Hypertension	ADEMPAS	15.00%	

Pulmonary Arterial Hypertension	epoprostenol	15.00%	*
Pulmonary Arterial Hypertension	FLOLAN	12.50%	*
Pulmonary Arterial Hypertension	LETAIRIS	15.25%	
Pulmonary Arterial Hypertension	OPSUMIT	15.00%	
Pulmonary Arterial Hypertension	ORENITRAM	15.00%	
Pulmonary Arterial Hypertension	REMODULIN	10.00%	*
Pulmonary Arterial Hypertension	REVATIO	15.50%	
Pulmonary Arterial Hypertension	sildenafil citrate	Estimated MAC Discount of AWP-60.00%	
Pulmonary Arterial Hypertension	tadalafil	25.00%	
Pulmonary Arterial Hypertension	TRACLEER	15.25%	
Pulmonary Arterial Hypertension	TYVASO	9.00%	
Pulmonary Arterial Hypertension	UPTRAVI	15.00%	
Pulmonary Arterial Hypertension	VELETRI	9.00%	*
Pulmonary Arterial Hypertension	VENTAVIS	8.00%	**
Pulmonary Disorders	ESBRIET	15.75%	
Pulmonary Disorders	OFEV	15.00%	
Rare Disorders	CRYSVITA	14.50%	
Renal Disease	PARSABIV	14.50%	
Renal Disease	SENSIPAR	14.75%	
Retinal Disorders	EYLEA	16.25%	
Retinal Disorders	ILUVIEN	16.25%	
Retinal Disorders	LUCENTIS	16.00%	
Retinal Disorders	MACUGEN	14.00%	
Retinal Disorders	OZURDEX	14.75%	
Retinal Disorders	RETISERT	16.25%	
Retinal Disorders	VISUDYNE	11.75%	
Rheumatoid Arthritis	ACTEMRA	15.25%	
Rheumatoid Arthritis	ENBREL	20.50%	
Rheumatoid Arthritis	HUMIRA	20.50%	
Rheumatoid Arthritis	INFLECTRA	14.75%	
Rheumatoid Arthritis	KEVZARA	14.50%	
Rheumatoid Arthritis	OLUMIANT	16.00%	
Rheumatoid Arthritis	ORENCIA	16.25%	
Rheumatoid Arthritis	OTREXUP	11.00%	
Rheumatoid Arthritis	RASUVO	10.00%	
Rheumatoid Arthritis	REMICADE	16.25%	
Rheumatoid Arthritis	SIMPONI	16.25%	
Rheumatoid Arthritis	XELJANZ	16.00%	
RSV	SYNAGIS	16.25%	
Seizure Disorders	EPIDIOLEX	13.50%	
Seizure Disorders	HP ACTHAR GEL	15.25%	
Seizure Disorders	SABRIL	16.00%	
Seizure Disorders	vigabatrin	23.00%	
Systemic Lupus Erythematosus	BENLYSTA	15.50%	
Thrombocytopenia	DOPTELET	15.00%	
Thrombocytopenia	MULPLETA	15.75%	
Thrombocytopenia	NPLATE	16.50%	
Thrombocytopenia	PROMACTA	16.50%	
Transplant	ASTAGRAF XL	12.50%	
Transplant	CELLCEPT	15.25%	
Transplant	cyclosporine	Estimated MAC Discount of AWP-30.00%	
Transplant	ENVARSUS XR	10.50%	
Transplant	gengraf	Estimated MAC Discount of AWP-30.00%	
Transplant	mycophenolate mofetil	Estimated MAC Discount of AWP-60.00%	
Transplant	mycophenolic acid	26.00%	
Transplant	MYFORTIC	14.50%	
Transplant	NEORAL	13.00%	
Transplant	NULOJIX	15.25%	
Transplant	PROGRAF	13.50%	

Transplant	RAPAMUNE	15.50%	
Transplant	SANDIMMUNE	14.00%	
Transplant	sirolimus	30.00%	
Transplant	tacrolimus	Estimated MAC Discount of AWP-60.00%	
Transplant	ZORTRESS	16.00%	
Urea Cycle Disorders	BUPHENYL	14.75%	
Urea Cycle Disorders	RAVICTI	15.25%	
Urea Cycle Disorders	sodium phenylbutyrate	25.00%	
	Default Rate:	17.50%	
	Overall Effective Discount (OED):	**20.00%**	
	Dispensing Fee:	$0.00	

NOTES:

The Overall Effective Discount (OED) offer is conditioned on (i) Aetna being the exclusive provider of Specialty Services, with the exception of the HIV class; and (ii) The State of Nebraska implements and maintains a generics first plan design for specialty. All initial and refill specialty prescriptions are limited to dispensing from Aetna and CVS specialty pharmacies and retail CVS/pharmacy locations, except the HIV class. Aetna may amend the individual Specialty Drug discounts from time to time to manage the OED commitment. The OED is measured and reconciled annually across all Specialty Drugs dispensed from a Aetna or CVS specialty owned or affiliated pharmacy. The rates quoted herein apply to specialty products dispensed from Aetna or CVS Specialty pharmacies owned or affiliated with Aetna/CVS. The following are excluded from the OED guarantee and will be priced as stated below:

- New to market Specialty Brand drugs
- Limited Distribution and exclusive distribution drugs
- Biosimilars

The following are priced as stated below:

- New to market Specialty drugs will priced at AWP - 15.00% or MAC, if applicable
- New to market Limited Distribution drugs will be priced at AWP – 10.00%

The exclusive specialty offer includes the provision by Aetna of nurse-based rare condition care management services for Engaged Members (defined below) with the following rare conditions pursuant to the AccordantCare Specialty program established by Aetna, as may be amended by Aetna from time to time: Crohn's Disease, Cystic Fibrosis, Gauchers Disease, Hemophilia, Lupus, Multiple Sclerosis, Rheumatoid Arthritis, and Ulcerative Colitis (the 'AccordantCare Specialty Program'). Pursuant to the AccordantCare Specialty Program, The State of Nebraska acknowledges that Aetna will utilize those Specialty Drug Claims that are filled by Aetna's specialty pharmacy to identify and outreach to Members that Aetna determines are likely to have one of the above listed rare conditions (each an 'Eligible Member'), and Aetna may communicate with medical and other healthcare providers and any health plans providing benefits to Engaged Members. The State of Nebraska acknowledges that the AccordantCare Specialty Program is intended solely to provide education of, and support to, Engaged Members in the diagnosis and treatment provided by their healthcare providers. 'Engaged Member' means an Eligible Member who elects to receive and receives AccordantCare Specialty Program services.

MAC: Certain dosage forms and strengths may not be included on the MAC list and shall be priced at the specialty default rate.

PER DIEMS, NURSING & EQUIPMENT:

* Remodulin, Veletri & Epoprostenol Sodium for Injection: $60 per day
**Ventavis: The State of Nebraska acknowledges and agrees an I-Neb is necessary for the administration of Ventavis. For each I-Neb provided to Member, upon the initiation of therapy or in the event a replacement I-Neb is necessary, The State of Nebraska shall reimburse Aetna $1,811 for each I-Neb.
*** Unless otherwise stated above: $75 per dose

Nursing Charges: $225.00 per visit up to 2 hours, $110.00 for each hour thereafter. Alternatively, Aetna can refer any medically necessary nursing services to The State of Nebraska's contracted nursing agency, in which case nursing services will be billed separately by those agencies.

In further consideration of the fees and charges to be paid to Aetna under the Agreement, Aetna will bill any applicable nursing and equipment charges and per diems to the member's medical benefit. In the event it is not possible to bill such nursing and equipment charges and per diems to the member's medical benefit or it is determined there is no coverage, Aetna shall bill The State of Nebraska directly for any nursing and equipment charges and per diem associated with specialty drugs.

Routine ancillary supplies (e.g., syringes, alcohol swabs, cotton balls) are included in the specialty drug prices set forth in this Specialty Fee Schedule, unless otherwise indicated on in this Specialty Fee Schedule as being charged separately as part of an equipment fee or per diem.

PRODUCT SHORTAGE:
In the event of an industry-wide product shortage, Aetna reserves the right to adjust pricing upon notice to The State of Nebraska.

CONFIDENTIALITY:
The State of Nebraska acknowledges and agrees that the information included is confidential, proprietary and trade secret to Aetna and will agree to protect the information from disclosure.

Rebate Statement Sample

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Effective 10/1/2018 (4Q18) we transitioned to CVS paymen[illegible]tem. Company 304 represents the active Aetna Legacy ZAC Commerical cases copied into the CVS side of the System and assigned CVS code 304 which replaces ZAC company code.

Aetna Pharmacy Management

REBATE DISTRIBUTION SUMMARY

Date Produced: 05/29/2019

Rebate ID: 00123456

Client Name: ABC COMPANY

Company/Vendor: 304 - 999999

Invoice&Collection Summary Inv qtr		Total Collections To-Date	[illegible]	[illegible]
2018Q4		$196,008.27	100.00%	$196,008.27
Total	–	**$196,008.27**	--	**$196,008.27**

Distribution Summary Inv qtr	Client Collections	Amount Due	Prior Distribution	Current Distribution	Undistributed
2018Q4	$196,008.27	$196,008.27	$0.00	$196,008.27	$0.00
Total	**$196,008.27**	**$196,008.27**	**$0.00**	**$196,008.27**	**$0.00**

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6102 Z1, Attachment D State of Nebraska Performance Guarantees

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ATTACHMENT D

The State of Nebraska (the State) and the Contractor will enter into a performance agreement with the standards and guarantees/penalties outlined below at risk each year for the duration of the Contract based on actual performance. The following describes the minimum performance guarantees that the State will include in the contract with the Contractor. The Contractor will self-report results and the State will utilize their decision support vendor and other partners and internal staff to validate reported baseline and results for these outcomes. Contractor agrees to the State's right to independently audit and confirm all results. **All measurements and standards are specific to the State's services, and not to be based on Contractor's performance for their book of business, or any other group that includes non-State members.**

	Service Level	Measurement	Service Level Target	Frequency of Measurement and Assessment	Assessments	MEDICAL Underwriting	PHARMACY Underwriting
Implementation and Go Live Dates							
1	All services outlined in the RFP shall take effect/ go live and be fully operational on the Initial go live date(s) as specified in the Contract (excluding ID cards)	Measured and reported no later than one month after the go live date. Per the RFP, the standards for measurement shall include, but not be limited to: i. Adherence to Implementation timeline ii. Readiness of claims and customer service systems iii. Readiness of eligibility system iv. Completion of plan documents	100% of services outlined in the RFP will take effect and be fully operational on the go live date(s) as specified in the Contract. There shall be no systems errors. The State Wellness and Benefits team along with IT Support shall have online access to all tools no less than 30 days prior to the effective date.	One-time	$20,000 for the first day and $2,000 for each subsequent calendar day the deadline that the administrative services are not fully operational.	Agree. The maximum medical service performance guarantee penalty adjustment in aggregate will be equal to 50 percent of the actual collected administrative service fees. Administrative service fees will exclude: - Program fees at risk in the Demonstrating Value Scorecard - Allowances - Charges for services performed which are not included on the monthly administrative service fee bill In no event will the total collected administrative service fees be adjusted by more than 50 percent due to the results of this guarantee and all other guarantees combine. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.	Agree subject to a maximum amount at risk of $10,000.
2	All services outlined in the RFP shall take effect/ go live and be fully operational on the annual go live date for each plan year. (excluding ID cards)	Measured and reported no later than one month after the go live date. Per the RFP, the standards for measurement shall include, but not be limited to: i. Adherence to annual enrollment timeline ii. Readiness of claims and customer service systems iii. Readiness of eligibility system iv. Completion of plan documents The response level must be maintained each month.	100% of services outlined in the RFP will take effect and be fully operational on the go live date(s) as specified in the Contract. There shall be no systems errors. The State Wellness and Benefits team along with IT Support shall have online access to all tools no less than 30 days prior to the effective date.	Annually	$10,000 for the first day and $1,000 for each subsequent calendar day the deadline that the administrative services are not fully operational.	Agree. The maximum medical service performance guarantee penalty adjustment in aggregate will be equal to 50 percent of the actual collected administrative service fees. Administrative service fees will exclude: - Program fees at risk in the Demonstrating Value Scorecard - Allowances - Charges for services performed which are not included on the monthly administrative service fee bill In no event will the total collected administrative service fees be adjusted by more than 50 percent due to the results of this guarantee and all other guarantees combine. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.	Agree subject to a maximum amount at risk of $10,000.

	Service Level	Measurement	Service Level Target	Frequency of Measurement and Assessment	Assessments	MEDICAL Underwriting	PHARMACY Underwriting
Claims Processing							
3	Claims Processing (self-funded medical plan for non-Medicare members): Turnaround Time (TAT)	TAT will be calculated using all claims received each month, including any that need review, and results will be based on aggregate statistics for the applicable period. Contractor will submit Claims Time to Process and Claims Inventory reports monthly. A clean claim is defined as original submission with all requested information.	95% of all clean claims will be paid or denied within 12 Business days. 99% of all claims shall be paid or denied within 45 calendar days of receipt (excluding claims subject to appeal or medical review).	Measured Monthly and Assessed Quarterly	$2,500 for each percentage below the standard for clean claims and $2,500 for each half percentage below the standard for all claims.	Guarantee: We will guarantee that the claim turnaround time during the guarantee period will not exceed 14 calendar days for 90.0% and will not exceed 45 days for 99.0%of the processed claims on a cumulative basis each year. Definition: We measure turnaround time from the claimant's viewpoint; that is, from the date the claim is received in the service center to the date that it is processed (paid, denied or pended). Turnaround time excludes those claims identified as rework. Weekends and holidays are included in turnaround time. This guarantee may not apply and a penalty may not be paid, if results are not achieved due to severe weather events which directly or indirectly impact performance during the guarantee period. Penalty and Measurement: We will agree to report quarterly and to be assessed annually, not quarterly. In no event will the total collected administrative service fees be adjusted by more than 50 percent due to the results of this guarantee and all other guarantees combine. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.	Agree subject to a maximum amount at risk of $10,000.
4	Financial accuracy of claims processed	To determine the financial accuracy rate, the total payment amount reviewed minus the absolute value of overpayments and underpayments is divided by the total amount reviewed.	99.55% or greater	Measured Quarterly and Assessed Quarterly	$2,500 for each tenth of a percentage below the standard.	Guarantee: We will guarantee that the guarantee period dollar accuracy of the claim payment dollars will be 98.0% or higher. Definition: Financial accuracy is measured using industry accepted stratified audit methodology. The results are calculated by calculating the financial accuracy for a subset of claims (a stratum) based on the following equation: Penalty and Measurement: We will agree to report quarterly and to be assessed annually, not quarterly. In no event will the total collected administrative service fees be adjusted by more than 50 percent due to the results of this guarantee and all other guarantees combine. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.	Agree subject to a maximum amount at risk of $10,000.

	Service Level	Measurement	Service Level Target	Frequency of Measurement and Assessment	Assessments	MEDICAL Underwriting	PHARMACY Underwriting
5	Claims Processing (self-funded medical plan for non-Medicare members): Accurately implement annual Benefits or Program Changes.	Contractor will accurately and correctly implement and administer any annual benefit or program changes. Contractor will provide report documenting implementation of benefit or program changes within 15 calendar days of benefit or program change requests.	100%	Ongoing/ per occurrence	Administrator will reimburse the State 100% of the value of the error(s) if the Administrator's error results in a loss to the State or its non-Medicare members. If the Administrator's error results in a loss to the Administrator, the State will not be responsible for making the Administrator whole for the resulting loss Additionally, $1,000 per day will be assessed, measured from the date the Administrator was notified, or self-identified, the error until the date the error is accurately corrected in the Administrator(s) system(s).	Agree. Penalty and Measurement: The maximum medical service performance guarantee penalty adjustment in aggregate will be equal to 50 percent of the actual collected administrative service fees. Administrative service fees will exclude: - Program fees at risk in the Demonstrating Value Scorecard - Allowances - Charges for services performed which are not included on the monthly administrative service fee bill In no event will the total collected administrative service fees be adjusted by more than 50 percent due to the results of this guarantee and all other guarantees combine. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.	Agree subject to a maximum amount at risk of $10,000.
6	Mail Service Non-Financial Accuracy	Contractor will accurately and correctly dispense prescriptions at mail service pharmacies. Retail Paper Claim; Processing 98% of clean claims requiring no intervention processed within an annual average of 5 business days. 99.9% of clean claims requiring no intervention processed within an annual average of 10 business days. Mail Order Average Dispensing Time 95% in an average of 2 days for clean prescription orders or prescription orders requiring no intervention. 90% in an average of 4 days for prescription orders requiring intervention - measured annually.	The mail service pharmacy shall guarantee dispensing accuracy of at least 99.996% (correct participant name, correct participant address, correct drug, correct dosage form, and correct strength)	Measured Quarterly and Assessed Quarterly	$2,500 for each tenth of a percentage below the standard.	Refer to Pharmacy.	Agree subject to a maximum amount at risk of $10,000 for the mail order dispensing accuracy.
7	On-line availability of Contractor's claims adjudication and related system platforms	Downtime is any time a Contractor's system (adjudication or related system such as eligibility, etc.) is unavailable for any reason other than scheduled maintenance downtime for which the State has received prior notice in accordance with the terms of this Contract. Contractor will provide quarterly reports to the State for review.	System available at least 99.5% of the time, excluding scheduled maintenance downtime.	Measured Quarterly and Assessed Quarterly	$2,500 for each tenth of a percentage below the standard.	Guarantee: We guarantee that the Aetna Navigator availability rate will be 99.0 percent or higher. Our Aetna Navigator website typically experiences approximately 360 minutes of downtime per quarter, or up to approximately 120 minutes of downtime per month. This is due to scheduled maintenance (typically performed one Sunday a month between 6am and 7am ET and does not include database maintenance.) Book-of-business measurements are used. Penalty and Measurement: The maximum medical service performance guarantee penalty adjustment in aggregate will be equal to 50 percent of the actual collected administrative service fees. Administrative service fees will exclude: - Program fees at risk in the Demonstrating Value Scorecard - Allowances - Charges for services performed which are not included on the monthly administrative service fee bill In no event will the total collected administrative service fees be adjusted by more than 50 percent due to the results of this guarantee and all other guarantees combine. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.	Agree subject to a maximum amount at risk of $10,000. We are able to offer 99.0% instead of the requested 99.5% on this guarantee.
8	Overall system downtime (for the State view only access)	Downtime is any time a Contractor's system (adjudication or related system such as eligibility, etc) is unavailable for any reason other than scheduled maintenance downtime for which the State has received prior notice in accordance with the terms of this contract. Contractor will provide quarterly reports to the State for review.	The State will have access to Contractor's system (view only access to claims processing, eligibility, etc - as stipulated in the RFP and your response) at least 99.5% of the time, except for scheduled maintenance.	Measured Quarterly and Assessed Quarterly	$2,500 for each tenth of a percentage below the standard.	Refer to our response to #7.	We can agree to Adjudication System Availability at 99.50% subject to a maximum amount at risk of $10,000.

	Service Level	Measurement	Service Level Target	Frequency of Measurement and Assessment	Assessments	MEDICAL Underwriting	PHARMACY Underwriting
Eligibility							
9	Eligibility Loads (Initial and Open Enrollment)	Initial and Open Enrollment clean eligibility files will be loaded within 3 business days of receipt.	Loaded accurately, in use, and notification transmitted to the State following 3 business days of receipt.	Ongoing/ per occurrence	$5,000 for each business day that the standard is not met.	Guarantee: We guarantee that 97.0 percent of non-Open Enrollment eligibility updates (defined as the number of electronic eligibility files updated) are processed within 2 business days of receipt of complete and accurate data. We also guarantee that 100 percent of non-Open Enrollment eligibility updates will be processed within 5 business days of receipt of complete, accurate and viable data (if a file requires adjustments the customer will be notified by e-mail as soon as the need is identified). Definition: Complete enrollment/eligibility data is defined as employee name, address, provider selection, DOB, SSN and covered dependent information (if applicable) as well as mutually agreed upon eligibility specifications. This guarantee is contingent upon the file being transmitted successfully to us (files received after noon ET will be considered as having been received on the next business day). Any eligibility file received which must be adjusted by us using a file fix will not be included in the reconciliation. The Electronic Report (ELR) is used to determine the completeness of the data provided by you. Penalty and Measurement: The maximum medical service performance guarantee penalty adjustment in aggregate will be equal to 50 percent of the actual collected administrative service fees. Administrative service fees will exclude: - Program fees at risk in the Demonstrating Value Scorecard - Allowances - Charges for services performed which are not included on the monthly administrative service fee bill In no event will the total collected administrative service fees be adjusted by more than 50 percent due to the results of this guarantee and all other guarantees combine. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.	Agree subject to a maximum amount at risk of $10,000.
10	Eligibility updates (weekly)	Weekly clean eligibility files will be loaded in the same business day the State or its data partner transmits the data.	Loaded accurately, in use, and notification transmitted to the State in the same business day the data was transmitted.	Measured Monthly and Assessed Quarterly	$1,000 for each business day that the standard is not met.	Guarantee: We guarantee that 97.0 percent of non-Open Enrollment eligibility updates (defined as the number of electronic eligibility files updated) are processed within 2 business days of receipt of complete and accurate data. We also guarantee that 100 percent of non-Open Enrollment eligibility updates will be processed within 5 business days of receipt of complete, accurate and viable data (if a file requires adjustments the customer will be notified by e-mail as soon as the need is identified). Definition: Complete enrollment/eligibility data is defined as employee name, address, provider selection, DOB, SSN and covered dependent information (if applicable) as well as mutually agreed upon eligibility specifications. This guarantee is contingent upon the file being transmitted successfully to us (files received after noon ET will be considered as having been received on the next business day). Any eligibility file received which must be adjusted by us using a file fix will not be included in the reconciliation. The Electronic Report (ELR) is used to determine the completeness of the data provided by you. Penalty and Measurement: The maximum medical service performance guarantee penalty adjustment in aggregate will be equal to 50 percent of the actual collected administrative service fees. Administrative service fees will exclude: - Program fees at risk in the Demonstrating Value Scorecard - Allowances - Charges for services performed which are not included on the monthly administrative service fee bill In no event will the total collected administrative service fees be adjusted by more than 50 percent due to the results of this guarantee and all other guarantees combine. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.	We can agree to loading the files within an average of 36 hours of Aetna's receipt subject to a maximum amount at risk of $10,000.
11	ID Cards	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.	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.	Measured Daily and Assessed Quarterly	$5,000 for each business day that the standard is not met.	Guarantee: We guarantee that 97.0 percent of Open Enrollment ID Cards will be produced and mailed to your members within 15 business days following the receipt of complete, accurate & viable electronic enrollment files. Penalty and Measurement: The maximum medical service performance guarantee penalty adjustment in aggregate will be equal to 50 percent of the actual collected administrative service fees. Administrative service fees will exclude: - Program fees at risk in the Demonstrating Value Scorecard - Allowances - Charges for services performed which are not included on the monthly administrative service fee bill In no event will the total collected administrative service fees be adjusted by more than 50 percent due to the results of this guarantee and all other guarantees combine. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.	Refer to Medical.

	Service Level	Measurement	Service Level Target	Frequency of Measurement and Assessment	Assessments	MEDICAL Underwriting	PHARMACY Underwriting
Network							
12	Compliance with Access Standards	Contractor shall submit Geo Access reports demonstrating compliance with Provider access standards as defined in the Provider Network section of the RFP.	A minimum of 90% of plan members will have access to network providers as defined in the RFP.	Measured and Assessed Quarterly	$2,500 for each percentage below the standard.	Guarantee: We guarantee that 85% of your employee population will have network access based upon specified access standards. Employee access to physicians and hospitals is measured using a radius report defining each employee's zip code according to the following recommended access criteria: Urban 2 PCP's within 10 miles 2 Pediatricians within 10 miles 2 OB/GYNs within 10 miles 2 Specialists within 10 miles 1 Hospital within 15 miles Suburban 2 PCP's within 20 miles 2 Pediatricians within 20 miles 2 OB/GYNs within 20 miles 2 Specialists within 20 miles 1 Hospital within 25 miles Rural 2 PCP's within 30 miles 2 Pediatricians within 30 miles 2 OB/GYNs within 30 miles 2 Specialists within 30 miles 1 Hospital within 40 miles Penalty and Measurement: The maximum medical service performance guarantee penalty adjustment in aggregate will be equal to 50 percent of the actual collected administrative service fees. Administrative service fees will exclude:	Agree subject to a maximum amount at risk of $10,000.
13	Provider Turnover	Contractor will monitor turnover rates and provide notice to State staff and members of all Provider Turnover within 30 days of termination. Notice includes complete terminations of providers from the network as well as notice of providers ceasing to offer services at a specific location but remaining in the network and practicing at other locations	100% of Provider Turnover reported to State staff and members within 30 days of termination	Reported Quarterly, Assessed Annually	$2,500 for each percentage below the standard.	Guarantee. We will notify you in a timely manner regarding significant network changes in Aetna networks resulting from physician group and/or hospital terminations that impact 100 or more members within 30 days of effective date. Definition: "Timely manner" means we will notify you at least 30 days prior to the effective date of the significant network changes. The guarantee is only for those network changes that are communicated to the Account Management Team within the 30-day timeframe. When circumstances surrounding the change make prior notification unreasonable (i.e. Aetna needs to be sensitive to Network Management's negotiation strategy with terminating facility/physician group or the provider group has not notified Aetna of their intent to terminate), the Account Manager will notify you of the termination as soon as possible. Penalty and Measurement. The maximum medical service performance guarantee penalty adjustment in aggregate will be equal to 50 percent of the actual collected administrative service fees. Administrative service fees will exclude: - Program fees at risk in the Demonstrating Value Scorecard - Allowances - Charges for services performed which are not included on the monthly administrative service fee bill In no event will the total collected administrative service fees be adjusted by more than 50 percent due to the results of this guarantee and all other guarantees combine. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.	We will agree to the following performance guarantee subject to a maximum amount at risk of $10,000: Changes to Provider Network. Aetna guarantees that 100% of all provider changes to Aetna's Provider Network will be reflected on Aetna's Web site no later than 5 business days following the date on within the deletion or addition takes effect. This is measured and reported on a calendar quarter and Client specific basis.
14	Retail Network Access	To ensure that State members have sufficient access to a stable pharmacy network of providers, Contractor shall submit Geo Access reports demonstrating compliance with pharmacy network provider access standards as defined in the RFP.	Less than 5% of retail network pharmacies will leave the network quoted in the RFP.	Measured Quarterly and Assessed Annually	$2,500 for each percentage below the standard.	Refer to Pharmacy.	We will agree to less than 20% of retail network pharmacies will leave the network quoted in the RFP subject to a maximum amount at risk of $10,000.

	Service Level	Measurement	Service Level Target	Frequency of Measurement and Assessment	Assessments	MEDICAL Underwriting	PHARMACY Underwriting
15	Balance Billing	Contractor will monitor member reports to ensure network providers and pharmacies do not balance bill members.	Network providers will not balance-bill members	Reported per Occurrence, Assessed Annually	$1,000 for each occurrence of balance billing.	Refer to Pharmacy.	We are not able to offer this guarantee as balance billing is prohibited under our provider agreements and any violation would not be evident in our systems.
Member Service							
16	Average Speed of Answer (ASA)	The response level must be maintained each month. ASA will be measured by Contractor's standard internal call reports produced by Contractor's automated phone system for all State Member calls. These reports shall be submitted to the State weekly for monitoring purposes and standard will be measured monthly and summarized in quarterly reports.	95% of all inbound Member calls selecting the IVR will be answered within 10 seconds or less on average, and 30 seconds for member calls selecting a live Member Service Representative (MSR). This excludes calls abandoned before answering.	Measured Monthly and Assessed Quarterly	$2,500 for each percentage point below the threshold for a month, measured separately for IVR and live MSR inbound calls	Guarantee: We will guarantee that the average speed of answer for the skill(s) providing your member services will not exceed 30 seconds. Definition: On an ongoing basis, we measure telephone response time through monitoring equipment that produces a report on the average speed of answer. Average speed of answer is defined as the amount of time that elapses between the time a call is received into the telephone system and the time a representative responds to the call. The result expresses the sum of all waiting times for all calls answered by the skill divided by the number of incoming calls answered. Interactive Voice Response (IVR) system calls are not included in the measurement of ASA. In the event there is an outage or when experiencing peak volumes, calls may be transferred to other Aetna call centers. This guarantee may not apply and a penalty may not be paid, if results are not achieved due to severe weather events which directly or indirectly impact performance during the guarantee period. We will not agree to being measured monthly. We will agree to report quarterly and to be assessed annually, not quarterly. Penalty and Measurement: The maximum medical service performance guarantee penalty adjustment in aggregate will be equal to 50 percent of the actual collected administrative service fees. Administrative service fees will exclude: - Program fees at risk in the Demonstrating Value Scorecard - Allowances - Charges for services performed which are not included on the monthly administrative service fee bill In no event will the total collected administrative service fees be adjusted by more than 50 percent due to the results of this guarantee and all other guarantees combine. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.	We can agree to 30 second average ASA for calls excluding IVR subject to a maximum amount at risk of $10,000
17	Telephone Abandonment Rate	The response level must be maintained each month. The abandonment rate will be measured by Contractor's standard internal call reports produced by Contractor's automated phone system for all member calls. These reports shall be submitted to the State monthly for monitoring purposes and summarized in quarterly reports.	Average call abandonment rate will be equal to or less than 3%.	Measured Monthly and Assessed Quarterly	$2,500 for each percentage point below the threshold for a month	Guarantee: We will guarantee that the average rate of telephone abandonment for the unit providing your member services will not exceed 3.0%. Definition: On an ongoing basis, we measure telephone response time through monitoring equipment that produces a report on the average abandonment rate. The abandonment rate measures the total number of calls abandoned divided by the number of calls accepted into the skill. In the event there is an outage or when experiencing peak volumes, calls may be transferred to other Aetna call centers. This guarantee may not apply and a penalty may not be paid, if results are not achieved due to severe weather events which directly or indirectly impact performance during the guarantee period. We will not agree to being measured monthly. We will agree to report quarterly and to be assessed annually, not quarterly. Penalty and Measurement: The maximum medical service performance guarantee penalty adjustment in aggregate will be equal to 50 percent of the actual collected administrative service fees. Administrative service fees will exclude: - Program fees at risk in the Demonstrating Value Scorecard - Allowances - Charges for services performed which are not included on the monthly administrative service fee bill In no event will the total collected administrative service fees be adjusted by more than 50 percent due to the results of this guarantee and all other guarantees combine. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.	Agree subject to a maximum amount at risk of $10,000.

	Service Level	Measurement	Service Level Target	Frequency of Measurement and Assessment	Assessments	MEDICAL Underwriting	PHARMACY Underwriting
18	First Call Resolution	The response level must be maintained each month. The rate of the number of calls that are resolved with one phone call to Member Services will be measured by the Contractor's internal reports which will be submitted to the State monthly for monitoring purposes.	90% of calls to Member Services shall be resolved on the First Call	Measured Monthly and Assessed Quarterly	$2,500 for each percentage point below the threshold for a month	Guarantee: We will guarantee that the First Call Resolution rate will be 90% or higher. Definition: On an annual basis, we will share with you the First Call Resolution results from the accountable unit or business segment level that services you. We define the first call resolution rate as the percentage of member calls resolved on the first call as reported by the member, utilizing the Aetna member survey process, in effect at the time of the member's call. We will not agree to being measured monthly. We will agree to report quarterly and to be assessed annually, not quarterly. Penalty and Measurement: The maximum medical service performance guarantee penalty adjustment in aggregate will be equal to 50 percent of the actual collected administrative service fees. Administrative service fees will exclude: - Program fees at risk in the Demonstrating Value Scorecard - Allowances - Charges for services performed which are not included on the monthly administrative service fee bill In no event will the total collected administrative service fees be adjusted by more than 50 percent due to the results of this guarantee and all other guarantees combine. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.	Agree subject to a maximum amount at risk of $10,000. We are able to offer 95% instead of the requested 90.00% on this guarantee.
19	Written Inquiries	Contractor must maintain the service level target each month.	Administrator will resolve 98% of all written inquiries within 10 business days of receipt of inquiry.	Measured Monthly and Assessed Annually	$2,500 for each percentage point below the threshold for a month.	Guarantee: We guarantee we will resolve 90.0 percent of all written inquiried within 14 business days of receipt. Definition: We measure writtin inquiry turnaround time from the time the inquiry is received in the service center to the time that the inquiry is responded to. We will not agree to being measured monthly. We will agree to report quarterly. Penalty and Measurement: The maximum medical service performance guarantee penalty adjustment in aggregate will be equal to 50 percent of the actual collected administrative service fees. Administrative service fees will exclude: - Program fees at risk in the Demonstrating Value Scorecard - Allowances - Charges for services performed which are not included on the monthly administrative service fee bill In no event will the total collected administrative service fees be adjusted by more than 50 percent due to the results of this guarantee and all other guarantees combine. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.	We agree to offer the written inquiries guarantee with State of Nebraska set up with their own carrier subject to a maximum amount at risk of $10,000.
20	Timeliness of resolution for grievances, complaints and appeals	The response level must be maintained each month. All grievances, complaints and appeals will be addressed and resolved in a timely manner as reported by Contractor's standard reports submitted to the State on a monthly basis for monitoring purposes.	95% of grievances, complaints and appeals will be resolved within 30 calendar days per the Department of Labor (DOL) standard.	Measured Monthly and Assessed Quarterly	$2,500 for each percentage point below the threshold for a month.	Guarantee: We guarantee we will provide you with member appeals reports (account specific line item reports) within 45 days after the close of the quarter. Definition: Within 45 days of the quarter close, we will provide you with account specific line item member appeals reports. This guarantee excludes provider appeals that are the responsibility of the plan sponsor or a vendor. Penalty and Measurement: The maximum medical service performance guarantee penalty adjustment in aggregate will be equal to 50 percent of the actual collected administrative service fees. Administrative service fees will exclude: - Program fees at risk in the Demonstrating Value Scorecard - Allowances - Charges for services performed which are not included on the monthly administrative service fee bill In no event will the total collected administrative service fees be adjusted by more than 50 percent due to the results of this guarantee and all other guarantees combine. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.	Agree subject to a maximum amount at risk of $10,000.
21	Mail Turnaround – Prescriptions not requiring intervention	Contractor must maintain the service level target each month.	95% of prescriptions dispensed within average of 2 business days and 100% within average of 3 business days.	Measured Monthly and Assessed Annually	$2,500 for each percentage point below the threshold for a month.	Refer to Pharmacy.	Agree subject to a maximum amount at risk of $10,000.
22	Mail Turnaround – Prescriptions requiring intervention	Contractor must maintain the service level target each month.	95% of prescriptions dispensed within average of 4 business days and 100% within average of 5 business days.	Measured Monthly and Assessed Annually	$2,500 for each percentage point below the threshold for a month	Refer to Pharmacy.	Agree subject to a maximum amount at risk of $10,000.

	Service Level	Measurement	Service Level Target	Frequency of Measurement and Assessment	Assessments	MEDICAL Underwriting	PHARMACY Underwriting
23	Paper Claims Turnaround	Contractor must maintain the service level target each month.	95% of prescriptions reimbursed within average of 10 business days and 100% within average of 14 business days	Measured Monthly and Assessed Annually	$2,500 for each percentage point below the threshold for a month.	Refer to Pharmacy.	Agree subject to a maximum amount at risk of $10,000.
24	Dispensing Accuracy Rate	Specialty pharmacy prescriptions dispensed with the correct drug and strength.	99.99%	Measured Monthly and Assessed Quarterly	$2,500 for each percentage point below the threshold for a month.	Refer to Pharmacy.	Agree subject to a maximum amount at risk of $10,000.
25	Prior Authorization	Prescriptions that are subject to prior authorization review according to the benefit rules will trigger an authorization review	99%	Measured Monthly and Assessed Quarterly	$2,500 for each percentage point below the threshold for a month	Refer to Pharmacy.	Agree subject to a maximum amount at risk of $10,000.
26	Prior Authorization (PA) Request Turnaround Time	Contractor shall submit monthly reports of PA activity to the State and results will be based on PA request and appeals meeting the turnaround standard 100% of the time each month Standard measured monthly.	100% of initial requests must be completed within 24 calendar hours of time of receipt and 100% of first level appeals within 3 business days of receipt of all necessary information.	Measured Monthly and Assessed Quarterly	$2,500 for each percentage point below the threshold for a month.	Refer to Pharmacy.	Agree to offer the following performance guarantee subject to a maximum amount at risk of $10,000: Aetna guarantees that it will respond to Non-Urgent prior authorization requests within an average of three (3) Business Days once all clinical information is received and Urgent prior authorization requests within an average of one (1) business day once all clinical information is received.
27	Generic Fill Rate	Contractor will provide the State with a generic potential fill rate guaranteed level. Upon the State's acceptance of the Contractor's proposed Generic Fill Rate, the Contractor will achieve the generic fill rate target upon the State's approval of Contractor's proposed programs. Contractor will provide annual report. Standard measured annually. FORMULA: The number of generic Rxs divided by ALL Rxs [generic + Multiple Source Brand (MSB) + Single Source Brand (SSB)]* *This guarantee excludes compounds	Annually the Contractor will improve the State's generic fill rate by a rate that is mutually agreed to by Contractor and the State.	Measured Annually and Assessed Annually	$5,000 for each percentage point below the target rate for each contract year.	Refer to Pharmacy.	Agree based on the following percentages for 7/1/20: Retail 84.25% and Mail Order 85.00%. The GDR guarantee is based upon plan design, membership, and demographics as represented by Client, and changes to these aspects may materially affect Aetna's ability to meet the GDR guarantees. In the event of a change to the Plan design, or the Plan's demographics, both parties agree to work in good faith to determine if the GDR guarantee(s) should be adjusted to account for such change, whether higher or lower, depending on the actual impact of such change An example of this would be situations where generically available

	Service Level	Measurement	Service Level Target	Frequency of Measurement and Assessment	Assessments	MEDICAL Underwriting	PHARMACY Underwriting
Data Transmittal							
28	Transmittal of Claims and Other Data	Contractor must provide transmittal of claims and other relevent data to any third parties as identified by the State. This standard shall be reported to the State monthly and measured in concurrence with the data feed frequencies.	Contractor will provide accurate data feeds within mutually agreed to time frame(s) to be determined after assessing the needs of the State and its vendors	Measured Monthly and Assessed Quarterly	$5,000 for each occurrence in which an agreed upon time frame is not met.	Guarantee: We will guarantee delivery of the quarterly data files to a specified vendor no later than the 25th of the month after the end of the quarter. If the 25th falls on a weekend, the delivery would be no later than end of business the following Monday. Definition: We send quarterly medical files to a specified vendor based upon a pre-determined cycle. If the specified vendor cannot process our data files, and the files are deemed accurate and not corrupted, the specified vendor will be responsible for the re-creation of the data files, and we will not be penalized for a later delivery. Penalty and Measurement: The maximum medical service performance guarantee penalty adjustment in aggregate will be equal to 50 percent of the actual collected administrative service fees. Administrative service fees will exclude: - Program fees at risk in the Demonstrating Value Scorecard - Allowances - Charges for services performed which are not included on the monthly administrative service fee bill In no event will the total collected administrative service fees be adjusted by more than 50 percent due to the results of this guarantee and all other guarantees combine. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.	Agree subject to a maximum amount at risk of $10,000.
29	Contractor will provide access to data required to properly process claims in coordination with the HSA and any relevant benefit components.	Contractor will provide access to data required to properly process claims in coordination with the HSA and any relevant benefit components. HSA information includes the daily exchange of both medical and pharmacy related claims data from the Administrator to the HSA vendor.	This standard shall be reported to the State monthly and measured daily, subject to an annual review/audit by the State, or an agent selected by the State	Measured Daily and Assessed Quarterly	$1,000 for each occurrence in which access to data is not provided per the mutually agreed upon time frame.	Refer to Pharmacy.	We agree to offer the following guarantee on a Book of Business basis subject to a maximum amount at risk of $10,000: Aetna guarantees that the CDH systems will be available to process pharmacy and medical claim transaction exchanges 99% of the scheduled up-time. CDH Systems availability is measured as Actual Availability (when system can exchange pharmacy and medical transactions) divided by Scheduled Availability where: Scheduled availability = (24 hours times number of days in reporting period) minus (total number of hours of Scheduled or Pre-Approved maintenance windows in reporting
Communications							
30	Approval of Communications	Correspondence and information (whether written, electronic, telephonic, or in any other medium or form) developed by the Contractor and intended for Members, (e.g., open enrollment materials, network changes) must be reviewed and approved by the State prior to dissemination. This standard will be measured quarterly if any communications materials were developed during the previous quarter.	Contractor will submit correspondence and information to the State for review and approval prior to dissemination.	Measured and Assessed Quarterly	$5,000 for each occurrence any communication is disseminated without review and prior approval	Agree. The maximum medical service performance guarantee penalty adjustment in aggregate will be equal to 50 percent of the actual collected administrative service fees. Administrative service fees will exclude: - Program fees at risk in the Demonstrating Value Scorecard - Allowances - Charges for services performed which are not included on the monthly administrative service fee bill In no event will the total collected administrative service fees be adjusted by more than 50 percent due to the results of this guarantee and all other guarantees combine. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.	Agree subject to a maximum amount at risk of $10,000.

	Service Level	Measurement	Service Level Target	Frequency of Measurement and Assessment	Assessments	MEDICAL Underwriting	PHARMACY Underwriting
Website							
31	The Contractor's website for the State members will offer online, real-time access, except for scheduled maintenance.	This standard shall be reported to the State monthly and measured monthly.	Contractor website for the State members available and fully operational 100% of the time, except for scheduled maintenance.	Measured Monthly and Assessed Monthly	$5,000 for each percentage point below the threshold for a month.	Guarantee: We guarantee that the Aetna Navigator availability rate will be 99.0 percent or higher. Our Aetna Navigator website typically experiences approximately 360 minutes of downtime per quarter, or up to approximately 120 minutes of downtime per month. This is due to scheduled maintenance (typically performed one Sunday a month between 6am and 7am ET and does not include database maintenance.) Book-of-business measurements are used. Penalty and Measurement: The maximum medical service performance guarantee penalty adjustment in aggregate will be equal to 50 percent of the actual collected administrative service fees. Administrative service fees will exclude: - Program fees at risk in the Demonstrating Value Scorecard - Allowances - Charges for services performed which are not included on the monthly administrative service fee bill In no event will the total collected administrative service fees be adjusted by more than 50 percent due to the results of this guarantee and all other guarantees combine. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.	Agree subject to a maximum amount at risk of $10,000.
Reporting							
32	Create and deliver Standard Management Reports for medical and pharmacy benefits reporting as described in the RFP	Contractor must provide Standard Management Reports for medical and pharmacy benefits reporting as described in the RFP by the specified timeframes.	98% of standard reports will be delivered to the State within 3 business days of the request and/or no later than 30 days following the end of the reporting period (i.e., quarterly, monthly, annually).	Measured by the specified report receivable timeframe and Assessed Annually	$5,000 per day for each business day that the standard is not met.	Refer to Pharmacy.	Agree subject to a maximum amount at risk of $10,000.
33	Accuracy of Standard Medical Reports	Contractor must provide accurate Standard Medical Reports as described in the RFP.	All standard medical reports provided will be 100% accurate.	Measured by the specified report receivable timeframe and Assessed Annually	$5,000 per day for each business day that the standard is not met.	Agree. The maximum medical service performance guarantee penalty adjustment in aggregate will be equal to 50 percent of the actual collected administrative service fees. Administrative service fees will exclude: - Program fees at risk in the Demonstrating Value Scorecard - Allowances - Charges for services performed which are not included on the monthly administrative service fee bill In no event will the total collected administrative service fees be adjusted by more than 50 percent due to the results of this guarantee and all other guarantees combine. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.	Refer to Medical
34	Ad-hoc Reports	Contractor must provide requested ad-hoc reports by the specified timeframe.	90% of Ad-hoc reports will be delivered to State within 7 business days of the request. Ad-hoc reports are defined as reports that are not part of the vendor's standard reporting package	Measured by the specified report receivable timeframe and Assessed Annually	$5,000 per day for each business day that the standard is not met.	Agree. The maximum medical service performance guarantee penalty adjustment in aggregate will be equal to 50 percent of the actual collected administrative service fees. Administrative service fees will exclude: - Program fees at risk in the Demonstrating Value Scorecard - Allowances - Charges for services performed which are not included on the monthly administrative service fee bill In no event will the total collected administrative service fees be adjusted by more than 50 percent due to the results of this guarantee and all other guarantees combine. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.	We would agree subject to the maximum amount at risk of $10,000 as long as the reports are mutually agreed upon.
35	Online Reporting Data Availability	Contractor must provide real-time access to online reporting data.	Online reporting data will be available within an annual average of fifteen (15) business days after the billing cycle that contains the last day of the month.	Measured Quarterly and Assessed Annually	$2,500 per day for each business day that the standard is not met.	Guarantee: We guarantee that the processed claim information will be available on the Aetna Health Information Advantage™ ("AHIA") website within 45 days after the end of the reporting period. Incurred claims information will be available on the website within 90 days after the end of the reporting period. Penalty and Measurement: The maximum medical service performance guarantee penalty adjustment in aggregate will be equal to 50 percent of the actual collected administrative service fees. Administrative service fees will exclude: - Program fees at risk in the Demonstrating Value Scorecard - Allowances - Charges for services performed which are not included on the monthly administrative service fee bill In no event will the total collected administrative service fees be adjusted by more than 50 percent due to the results of this guarantee and all other guarantees combine. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.	We would agree subject to the maximum amount at risk of $10,000 as long as the reports are mutually agreed upon.

	Service Level	Measurement	Service Level Target	Frequency of Measurement and Assessment	Assessments	MEDICAL Underwriting	PHARMACY Underwriting
Satisfaction							
36	Client Satisfaction	Achieve satisfaction (defined as "top two-box" satisfaction/ approval using an approved standard 5 pt. survey tool) on a survey completed by State staff members assessing satisfaction with the client services team, the medical management team, overall implementation, reporting and analytics. The survey should specifically assess satisfaction with the Contractor's Operations Director and Implementation Manager.	90% or better satisfaction rate	Measured Quarterly and Assessed Annually	$5,000 for each percentage point below the threshold	Guarantee: We guarantee a positive response rate of 87 percent or better on the following question 'please rate your overall satisfaction.' Definition: The survey assumes a 5 point scale with the top 3 responses viewed as positive. The survey is based on a statistically valid, randomly selected sample of actively enrolled members aged 18-64. Interviews are conducted on a continuous basis throughout the year. The survey will be administered on a book-of-business basis. Penalty and Measurement: The maximum medical service performance guarantee penalty adjustment in aggregate will be equal to 50 percent of the actual collected administrative service fees. Administrative service fees will exclude: - Program fees at risk in the Demonstrating Value Scorecard - Allowances - Charges for services performed which are not included on the monthly administrative service fee bill In no event will the total collected administrative service fees be adjusted by more than 50 percent due to the results of this guarantee and all other guarantees combine. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.	Agree subject to a maximum amount at risk of $10,000.
37	Member Satisfaction	Achieve member satisfaction (defined as "top two-box" satisfaction/ approval using an approved standard 5 pt. survey tool) with program. The survey will be sent to all participants and based upon the State's specific results.	90% or better satisfaction rate	Measured Quarterly and Assessed Annually	$5,000 for each percentage point below the threshold	Guarantee: We guarantee a positive response rate of 87 percent or better on the following question 'please rate your overall satisfaction.' Definition: The survey assumes a 5 point scale with the top 3 responses viewed as positive. The survey is based on a statistically valid, randomly selected sample of actively enrolled members aged 18-64. Interviews are conducted on a continuous basis throughout the year. The survey will be administered on a book-of-business basis. Penalty and Measurement: The maximum medical service performance guarantee penalty adjustment in aggregate will be equal to 50 percent of the actual collected administrative service fees. Administrative service fees will exclude: - Program fees at risk in the Demonstrating Value Scorecard - Allowances - Charges for services performed which are not included on the monthly administrative service fee bill In no event will the total collected administrative service fees be adjusted by more than 50 percent due to the results of this guarantee and all other guarantees combine. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.	Agree subject to a maximum amount at risk of $10,000.
38	Contract Drafting Cooperation	Contractor will respond to recommended contract language changes within the appropriate timeframe.	Response to recommended contract language changes within 10 business days.	Measured bi-weekly until contract is signed and fully executed	$1,000 per day for each business day that the standard is not met.	While we are not in a position to support a Performance Guarantee at this time for Contracts, Booklets or Schedule of Benefits or SPDs, our goal is to provide these documents within 90 Calendar Days of all benefit setup completed within our system.	We agree to offer the following subject to a maximum amount at risk of $10,000: Respond to complete and understandable recommended contract language changes within 15 business days of receipt by Aetna's Customer Contracting Team; unless the complexity/volume of such changes would be reasonably considered to require a longer number of days response time as agreed to in writing by the parties at such time as the complete and understandable recommended changes

	Service Level	Measurement	Service Level Target	Frequency of Measurement and Assessment	Assessments	MEDICAL Underwriting	PHARMACY Underwriting
Data and Security							
39	SOC1 Report (type 2)	Contractor is required to submit Service Organization Control reports, as outlined in the RFP, based upon service(s) performed on behalf of the State.	The required SOC 1 report will be delivered by the 5th business day of December by 12:00 PM CT.	Annually	$5,000 per business day that each SOC report is late. $10,000 for each report that is not delivered by the 10th business day of December.	Guarantee: We will guarantee delivery of the quarterly data files to a specified vendor no later than the 25th of the month after the end of the quarter. If the 25th falls on a weekend, the delivery would be no later than end of business the following Monday. Definition: We send quarterly medical files to a specified vendor based upon a pre-determined cycle. If the specified vendor cannot process our data files, and the files are deemed accurate and not corrupted, the specified vendor will be responsible for the re-creation of the data files, and we will not be penalized for a later delivery. Penalty and Measurement. The maximum medical service performance guarantee penalty adjustment in aggregate will be equal to 50 percent of the actual collected administrative service fees. Administrative service fees will exclude: - Program fees at risk in the Demonstrating Value Scorecard - Allowances - Charges for services performed which are not included on the monthly administrative service fee bill In no event will the total collected administrative service fees be adjusted by more than 50 percent due to the results of this guarantee and all other guarantees combine. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.	Agree subject to a maximum amount at risk of $10,000.
External Audits							
40	Provide Complete Response to Data Request	Contractor shall provide complete response to data requested by the State or its third-party audit partner.	Within 30 days of request.	Measured and Assessed 30 days after the audit is completed.	$2,500 per day, for each day the standard is not met.	Agree. The maximum medical service performance guarantee penalty adjustment in aggregate will be equal to 50 percent of the actual collected administrative service fees. Administrative service fees will exclude: - Program fees at risk in the Demonstrating Value Scorecard - Allowances - Charges for services performed which are not included on the monthly administrative service fee bill In no event will the total collected administrative service fees be adjusted by more than 50 percent due to the results of this guarantee and all other guarantees combine. "Collected fees" means those fees collected for the guarantee period	We are not offering this performance guarantee as it pertains to external audit. See Ad-Hoc reporting guarantee above.
41	Responding to Data Reconciliation Requests	Contractor shall provide data reconciliation requested by the State or its third-party audit partner.	Within 10 business days of request	Measured and Assessed 30 days after the audit is completed.	$2,500 per day, for each day the standard is not met.	Agree. The maximum medical service performance guarantee penalty adjustment in aggregate will be equal to 50 percent of the actual collected administrative service fees. Administrative service fees will exclude: - Program fees at risk in the Demonstrating Value Scorecard - Allowances - Charges for services performed which are not included on the monthly administrative service fee bill In no event will the total collected administrative service fees be adjusted by more than 50 percent due to the results of this guarantee and all other guarantees combine. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.	We can agree to a mutually agreed upon timeframe for responding to Data Reconciliation Requests subject to a maximum amount at risk of $10,000.
42	Audit Resolution	Within 6 months of identification and notification to Contractor by the State or its designee.	100%	Measured and Assessed 30 days after the audit is completed.	$2,500 for each percentage point below the threshold	Agree. The maximum medical service performance guarantee penalty adjustment in aggregate will be equal to 50 percent of the actual collected administrative service fees. Administrative service fees will exclude: - Program fees at risk in the Demonstrating Value Scorecard - Allowances - Charges for services performed which are not included on the monthly administrative service fee bill In no event will the total collected administrative service fees be adjusted by more than 50 percent due to the results of this guarantee and all other guarantees combine. "Collected fees" means those fees collected for the guarantee period	We can agree to the following guarantee subject to a maximum amount at risk of $10,000: Recoveries identified as a result of Pharmacy Audits will be resolved within 45 days after audit finalizes.

HSA Proposal

aetna™

FINANCIAL HEALTH CARE ACCOUNT ADMINISTRATION

State of Nebraska

Patrick Fanshaw | Senior Sales Executive
(O): 630.222.9197 | FanshawP@aetna.com

August 5, 2019

PAYFLEX®

SAY "HELLO" TO PAYFLEX

Since 1987, PayFlex has been committed to paving the way through technology and innovation for account-based benefits administration. We're dedicated to exploring, developing and implementing solutions to improve the "member experience" and help us meet the high-service expectations for you and your members.

We designed our suite of products to help members make the right decisions for their health and financial wellbeing. We have the experience, expertise and drive to support and evolve your health care strategy.

Our technology platform administers a full portfolio of financial health care accounts. So you can add to your benefits offering with ease — all while maintaining a consistent experience for your members. And PayFlex can easily integrate with any health plan, Rx or dental carrier, so you have complete flexibility as your health care strategy evolves.

One technology solution.

PayFlex Debit Card

Dedicated Account Management Expertise

PayFlex Mobile® app

PAYFLEX®

- Health Savings Account (HSA)
- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account (FSA)
- Limited Purpose Flexible Spending Account
- Incentive Accounts
- COBRA Administration
- Direct / Retiree Billing
- Commuter/Transit Administration
- Tuition Reimbursement
- Adoption Reimbursement

Health Reimbursement Arrangement
Commercial | Retiree | Wellness

Financial wellness made simple.

WHAT MAKES US DIFFERENT?

At PayFlex, our vision is to make saving and paying for health care simple. Because when your employees are happy, healthy and financially secure – they're free to bring their best to work every day.

As you carefully weigh your options, we know you have your employees' best interests in mind, as well as the financial health of your organization. And there's a lot to consider. We want to make your decision-making process a little easier.

So here are the top five things to know about partnering with PayFlex:

Single Integrated Platform

We're the only service administrator with an integrated offering, holding both IRS custodian status and reimbursement products on a **single, proprietary platform** that can work with any health plan – backed by more than 30 years' dedicated expertise in our industry.

Industry-leading Security & Compliance

Our solid "A" rating is **the best in the industry** and consistently exceeds industry benchmarks against competitors in highly-regulated industries.[1] Including financial institutions.[2]

Our Approach to Health Savings Accounts

We believe in empowering health care consumers as **Savers,** connecting members to health care advocates who can help lower their costs today. And save more for tomorrow.

Service Excellence

We put our customers at the center of everything we do. PayFlex proudly **serves over 5,500 clients** with a 97% retention rate.[3] And our EMPOWER service model ignites a 94.2% satisfaction rate from members when engaging with PayFlex customer service consultants.[4]

Best-in-class Culture

Integrity, Trust and **Teamwork** are ingrained in our workplace values. *Why does this matter?* Because world-class culture fosters innovation, empowering employees to be the change to best serve our PayFlex customers and members.

[1] Securityscorecard.com
[2] Gartner Inc. 2017 Controls Maturity Benchmarking report NIST 800-53. Aetna Inc.
[3] PayFlex book of business (2018)
[4] PayFlex Customer Service Pilot survey (2017)

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SUPERIOR SECURITY WITH PAYFLEX

Exceeding industry benchmarks[1]

connectyourcare.com — [illegible]

Grade	Score	Category
F	51%	Application Security
D	64%	DNS Health
A	99%	IP Reputation
A	95%	Network Security
A	99%	Endpoint Security
A	99%	Hacker Chatter
A	99%	Leaked Information
A	99%	Cubit Score
D	[illegible]	Patching Cadence
A	99%	Social Engineering

healthequity.com — [illegible]

Grade	Score	Category
A	99%	Application Security
C	78%	DNS Health
A	99%	IP Reputation
D	[illegible]	Network Security
C	[illegible]	Endpoint Security
A	99%	Hacker Chatter
A	99%	Leaked Information
A	99%	Cubit Score
C	79%	Patching Cadence
A	99%	Social Engineering

mybenefitwallet.com — A 95%

Grade	Score	Category
[illegible]	[illegible]	Application Security
[illegible]	[illegible]	DNS Health
A	99%	IP Reputation
[illegible]	[illegible]	Network Security
A	99%	Endpoint Security
A	99%	Hacker Chatter
A	99%	Leaked Information
A	99%	Cubit Score
A	[illegible]	Patching Cadence
A	99%	Social Engineering

fidelity.com — D [illegible]

Grade	Score	Category
F	51%	Application Security
D	[illegible]	DNS Health
[illegible]	85%	IP Reputation
F	50%	Network Security
D	[illegible]	Endpoint Security
A	99%	Hacker Chatter
C	[illegible]	Leaked Information
A	99%	Cubit Score
F	[illegible]	Patching Cadence
A	99%	Social Engineering

payflex.com — **A 99%**

Grade	Score	Category
A	99%	APPLICATION SECURITY
A	99%	DNS HEALTH
A	99%	IP REPUTATION
A	99%	NETWORK SECURITY
A	99%	ENDPOINT SECURITY
A	99%	HACKER CHATTER
A	99%	LEAKED INFORMATION
A	99%	CUBIT SCORE
A	99%	PATCHING CADENCE
A	99%	SOCIAL ENGINEERING

[1] Securityscorecard.com

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THE PAYFLEX CARD®

PayFlex adopted debit card technology in 1999. As a result, we now have more debit card experience than any other administrator.

The debit card is easy to use, with no claim filing for eligible out-of-pocket costs. The card automatically uses available account funds to pay for eligible expenses.

In addition, our "stacking" capability means members enjoy the ease of using one card when enrolled in multiple PayFlex accounts.

MASTERCARD® ID THEFT ALERTS™

Safeguarding personal information is extremely important. That's why the PayFlex card comes with ID Theft Alerts and expert resolution services – at no extra cost. Signing up online or from the PayFlex Mobile app is easy.

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MEMBER ENGAGEMENT SOLUTIONS

We continue to push ourselves to deliver engagement tools and solutions to help you and your members before, during and beyond the open enrollment season.

PayFlex Website
PayFlex.com is our public website. This is a central platform for your members to:
- Log in to their PayFlex member account
- Learn about our products and services
- Access helpful tools and resources
- And so much more

Educational Member Videos

Our videos are great for members who want to learn more. We make it easy for plan sponsors to download these videos and use in their own company communications or on Intranet sites.

- Health care FSA
- Dependent care FSA
- HSA vs FSA: which is for you?
- Benefits of an HSA
- Investing with your HSA
- Using your PayFlex Card
- Manage your commuter benefits online

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PAYFLEX WEBSITES

THE PAYFLEX PUBLIC WEBSITE: PAYFLEX.COM

Our website allows members to learn in a variety of ways, and for plan sponsors to leverage these tools as they see fit. We are meeting our members where they are, with the tools and resources to help them learn in multiple ways — by either reading materials, watching videos, using online tools, etc. Check out the experience here!

PayFlex.com is the "front door" to log in and access account information, additional tools and resources (i.e. calculators, reporting). The following pages outline some of the key website services available to members and plan sponsors.

The PayFlex website gives our members full access to the tools needed to have a positive user experience to their account.

- Learn about our products and services
- File a claim
- Enroll in direct deposit
- View upcoming payments and history
- Upload and submit documentation
- View list of eligible expenses
- Sign up for electronic notifications
- Check account balance
- Review debit card transactions
- Review account alerts
- View the latest industry news and upcoming events

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THE PAYFLEX PLAN SPONSOR WEBSITE

Plan sponsors have access to a comprehensive and secure website dedicated to your members' plan information. The website offers a variety of services to make your plan administration easier than ever... along with complete program transparency and visibility.

PAYFLEX

PayFlex.com
Your plan sponsor website

HSA Dashboard

Contribution Profile

Company Profile

Recent Transactions

Employee Profile

- Snapshot view of member's plan information and usage
- Renewal history
- Review member demographic and claims information
- Real-time funding register data
- Download archived plan and funding reports
- On-demand reports
- Request member materials and build enrollment toolkit

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PAYFLEX MOBILE® APP

The PayFlex Mobile app is the easiest and most convenient way for members to manage their PayFlex account(s) on the go:

- Manage account(s) with ease
- Make payments, withdrawals and deposits
- View important , personalized alerts
- Snap a photo of a document to submit claims
- Log in with Secure Touch ID
- Download the app for free

Saving and paying for health care made simple

- **In-app guidance** for personalized support
- **Enhanced security** and complimentary fraud protection
- **Easier navigation** to get what you need, fast

ACCOUNT ALERTS AND NOTIFICATIONS

We encourage all members to sign up for electronic communications. This way, they can easily stay connected to their PayFlex account(s). Signing up to receive account alerts is easy via the Web, email or text.

Alerts include:

- Balance reminder
- Contribution maximum received
- Eligible to enroll in HSA investments
- Low balance reminder
- Tax documents ready
- Statements ready
- Rejected deposit
- Recurring transaction
- Scheduled transaction

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EDUCATIONAL MATERIALS AT YOUR FINGERTIPS

We have a passion for creating clear, simple and easy-to-understand material for our members. Our goal is to help your members make the best decision for themselves and their families.

Visit our website to check out the expansive library of collateral we make readily available to help members make the most of their money.

Build a PayFlex Enrollment Toolkit	We know you play a big role in keeping your members "in the know." That's why we make it easy to build your own toolkit to use during enrollment, and beyond. You can choose to download resources like our videos and flyers. You can also take advantage of our ready-to-use email series. Or place an online order for printed materials. These options and more are located within the "**Employers**" page on payflex.com.

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ACCOUNT ADMINISTRATION

PayFlex provides an end-to-end outsourcing solution. We conform to all federal and industry regulatory requirements, including HIPAA compliance. Choosing PayFlex means plan sponsors can concentrate on their core businesses. We will manage their benefit programs and we'll do it professionally, efficiently and with the utmost emphasis on creating an easy experience for our members.

OUR STANDARD ADMINISTRATION INCLUDES:

- Account balance management
- Reimbursement to members via direct deposit or check payment
- Reimbursement direct to provider via website
- Member communication options via email
- Communication materials for member engagement
- PayFlex Debit card administration
- PayFlex Mobile® app
- Member IVR and Call Center plan sponsor Service
- Employer website
- Comprehensive reporting package with on-demand feature
- Single point of contact account management support
- Compliance resources for legislative updates

YOUR PAYFLEX TEAM

PayFlex's account management philosophy is to work with you to create a stellar experience. We stress open communication and going the extra mile to meet everyone's needs.

Upon your selection of PayFlex as your Administrator, we will assign an implementation manager (IM). Your IM serves as your point of contact for all implementation activities. We will also assign an account manager (AM).

Your AM will be your **single point of contact** – responsible for ongoing account management and renewal activities for all products we administer for you. In addition, your AM provides complete alignment with our overall Account Management team. Their goal is to be your strategic partner and ensure your needs are met in the most proactive, timely and efficient way possible.

A few focus areas include:

- Sharing early stage innovations and service enhancements
- Working with you to gain a deep understanding of your organization's goals, as well as your short and long-term benefits strategies
- Delivering insightful analytics, trends, and consultative recommendations for your membership
- Gathering your feedback to drive continued process and product improvement

Your AM will engage resources throughout the PayFlex organization as needed including IT resources, file transmission experts and operational management team members.

This team approach will ensure a successful relationship with you.

HSA

HEALTH SAVINGS ACCOUNT ADMINISTRATION

THE PAYFLEX HSA END-TO-END SOLUTION

We currently manage over $2.0 billion in assets. And we believe our HSA works better for members and plan sponsors than any other available in the market. Why? It's because we serve as both the non-bank custodian and trustee for our HSAs. This isn't a common pairing in the industry.

PayFlex is committed to offering products that maximize value to our plan sponsors and their members. We offer a highly flexible and integrated member experience along with trusted partnerships.

NON-BANK CUSTODIAN

+

TRUSTEE

PAYFLEX HSA INVESTMENT OPTIONS

Initial HSA contributions go into a Federal Deposit Insurance Corporation (FDIC) insured, interest-bearing account. Once a member reaches the minimum balance in their account – typically $1,000 - they can open an investment account.

We offer a variety of mutual funds, with convenient tools/resources to help members manage their investments. Our partners trade all funds presented to the member at Net Asset Value with **$0 trading** fees.

EXTRA HELP FOR HSA MEMBERS, WHEN THEY NEED IT

At PayFlex, we believe in the power of consumerism. We know the right level of education and support empowers members to own their financial wellbeing. We also believe fostering a healthy consumer mindset can set your company up for success as you introduce or transition to consumer driven health plans.

That's why we offer HSA clients an optional concierge program – **HSA Advantage**. When coupled with HSA administration from PayFlex, your employees can have additional support to help them save more in their tax-advantaged accounts by spending less on health care.

With HSA Advantage, your eligible employees get help from experienced advocates for the following services:

- Bill Negotiator®
- Healthcare Navigator®
- Surgery Cost Saver®

For more information about this valuable program, **click here** to download the flyer.

PLEASE NOTE: *If you are a current Aetna A1A concierge customer, adding this program will result in some service redundancies for your Aetna members.*

HEALTH SAVINGS ACCOUNT ADMINISTRATION

PayFlex provides an end-to-end outsourcing solution. We conform to all federal and industry regulatory requirements, including HIPAA compliance. Choosing PayFlex means plan sponsors can concentrate on their core businesses. We will manage their benefit programs and we'll do it professionally, efficiently and with the utmost emphasis on creating a positive member experience. Check out the HSA experience here!

Standard administration includes:	
Account balance management	PayFlex Mobile® app
Reimbursement to members via direct deposit or check payment	Member IVR and call center customer service
Reimbursement direct to provider via website	Plan sponsor website
Member email communication options	Comprehensive plan sponsor reporting with on-demand feature
Communication material for member support	Compliance resources for legislative updates
PayFlex debit card administration	

Optional services include:

- Onsite or webinar open enrollment support

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PAYMENT FEATURES

1 | **PAY PROVIDERS DIRECTLY**

Members have a simple solution to pay providers directly from their PayFlex account. We call it the "Make a Payment" feature.

2 | **PAYMENT TO MEMBERS**

Members can use the "Make a Withdrawal" feature to reimburse themselves via a linked personal checking or savings account.

3 | **CONNECTED CLAIMS**

The connected claims solution helps members better manage their health care bills. Health care claims data and health care account transactions in available to view in one place. Then, members can choose how to handle the expense by either paying the provider, reimbursing themselves or taking no action and simply archiving the data.

HSA FUNDING

PAYROLL DEDUCTION: PayFlex accepts contribution-funding files based on the schedule required by our employers, reporting payroll deductions and/or employer contributions. The deposit date reported on the funding files dictate when PayFlex is allowed to post funds to open HSAs. Funds post to open accounts on the deposit date as long as we receive the successful file and matching funding before the deposit date. If we receive the successful file and matching funds after the deposit date, we post funds to open accounts immediately. The deposit date can be a weekend or holiday. Funds post to open accounts on the deposit date as long as we receive the successful file and matching funding before the weekend or holiday.

MEMBER POST TAX DEDUCTION: Members can make deposits with a linked bank account or deposit coupon and check.

TRUSTEE TRANSFERS

Our HSA Agents help members move their HSA from their existing administrator to PayFlex. These members need special attention. It's because the transfer process is often manual and can take several steps. We work with our plan sponsors to outline a process that helps minimize the impact to the member.

REPORTING

PayFlex provides a standard suite of reports that documents member plan activity. Reports are available through the employer website. Plan sponsors can view reports in PDF or CSV format (depending on the specific report), print or download. The nature of the report dictates the frequency: daily, weekly, monthly or annually.

HSA REPORTING DASHBOARD

The dashboard is available if you have (or ever had) 10 or more pending or open HSAs. This feature provides monthly online report views across the following reporting categories:

- Program summary (home page)
- Account balances
- Contributions
- Distributions
- Expense analysis
- Investment analysis
- Spender/saver analysis

HSA DEPOSIT REGISTER

Produced at the same time we process your contribution file, this report shows both plan sponsor and member (payroll deduction) contributions.

PENDING CONTRIBUTIONS REPORT

Produced each business day in concert with our contributions events, this report shows contributions not yet posted to your members' accounts.

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Reporting (continued)

YEAR-TO-DATE CONTRIBUTIONS REPORT

Produced on a monthly basis. It shows contribution totals at the member and plan sponsor levels.

ACCOUNTS OPENED AND CLOSED REPORT

Produced on a monthly basis. It shows a list of accounts that your members opened or closed during the reporting month. Plan sponsor-level totals are included too.

In addition, **On-Demand Reports** enable customers to request specific reports across plan sponsor-defined intervals. We then send the requested reports to the plan sponsor website.

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HSA
FEE SCHEDULE

SUMMARY OF FEES

PayFlex has designed a competitive pricing structure customized to your requested plan.

Health savings account (HSA) Administrative services pricing	
Implementation fee	Waived
Annual fee	Waived
Monthly administration fee per participant per month (PPPM) • Debit card included	$1.95
• Contract period — three years • Pricing quotations expire 90 days after the initial proposal publication date	

Summary of fees (continued)

Plan Sponsor Optional Services	
Customized participant materials, co-branded debit card, and other custom communication requests	$150 per hour. Statement of Work required.
Open Enrollment Meeting Support	TBD based on requirements
Paper Account Statements	Available free online, or $0.50/quarterly; $1.50/monthly PPPM for mailed paper statements
Ad-hoc reporting	$150 per hour. Statement of Work required.
Rejected/NSF Customer Funding ACH transactions	$50.00/occurrence
HSA Advantage Program	$1,500 OOP Threshold required, $0.10 PPPM

Member Paid Per Transaction Fees: (Paid by the Member) Fees such as insufficient funds, account closure and administrative fees are subject to a 30-day change notice.	
Monthly service charge if not enrolled in an employer sponsored HDHP	$5.00
Account Closing Fee	$25.00/transaction
Trustee Transfers	$25.00/transaction
Stop Payment (Per Check)	$25.00/transaction
NSF Fee (Overdraft)	$25.00/transaction
Deposit Item Returned	$25.00/transaction

There may be fees associated with a Health Savings Account ("HSA"). These are the same types of fees you may pay for checking account transactions. Please see the HSA fee schedule in your HSA enrollment materials for more information.

This material is for informational purposes only and is not an offer of coverage. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. It does not contain legal or tax advice. You should contact your legal counsel if you have any questions or if you need additional information. In case of a conflict between your plan documents and the information in this material, the plan documents will govern. Eligible expenses may vary from employer to employer. Please refer to your employer's Summary Plan Description ("SPD") for more information about your covered benefits. Information is believed to be accurate as of the production date; however, it is subject to change. PayFlex cannot and shall not provide any payment or service in violation of any United States (US) economic or trade sanctions. For more information about PayFlex, go to payflex.com.

Investment services are independently offered through a third party financial institution. By transferring funds into an HSA investment account you can potentially benefit from capital appreciation in the value of mutual fund holdings. However, you will also be exposed to a number of risks, including the loss of principal, and you should always read the prospectuses for the mutual funds you intend on purchasing to familiarize yourself with these risks.

The HSA investment account is an optional, self-directed service. We do not provide investment advice for HSA investment account participants. You are solely responsible for any investment account decisions you make. Mutual funds and brokerage investments are not FDIC-insured and are subject to investment risk, including fluctuations in value and the possible loss of the principal amount invested. The prospectus describes the funds' investment objectives and strategies, their fees and expenses, and the risks inherent to investing in each fund. Investors should always read the prospectus carefully before making any investment decision. System response and account access times may vary due to a variety of factors, including trading volumes, market conditions, system performance, and other factors.

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PAYFLEX — A PARTNER YOU CAN TRUST

We currently serve over 30% of the Fortune 500 companies. In order to meet the needs of our plan sponsors, our foundation must be trustworthy and robust. When you combine PayFlex with industry leaders, you gain one of the top financial management organizations the industry has to offer.

Let's create the future... together
We hope this information gives you confidence that PayFlex will make an excellent partner. We welcome the opportunity to share our commitment to your employees' financial wellness.

As you evaluate your options, please feel free to call us at any time. We're happy to answer your questions and demonstrate our ability to offer your organization outstanding value and service.

We're excited about the possibility of working with you and your members.

— The PayFlex Team

This material is for informational purposes only. It does not contain legal or tax advice. You should contact your legal counsel or your tax advisor if you have any questions or if you need additional information. Information is believed to be accurate as of the production date; however, it is subject to change. PayFlex cannot and shall not provide any payment or service in violation of any United States (US) economic or trade sanctions.

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Repricing Cover Letter

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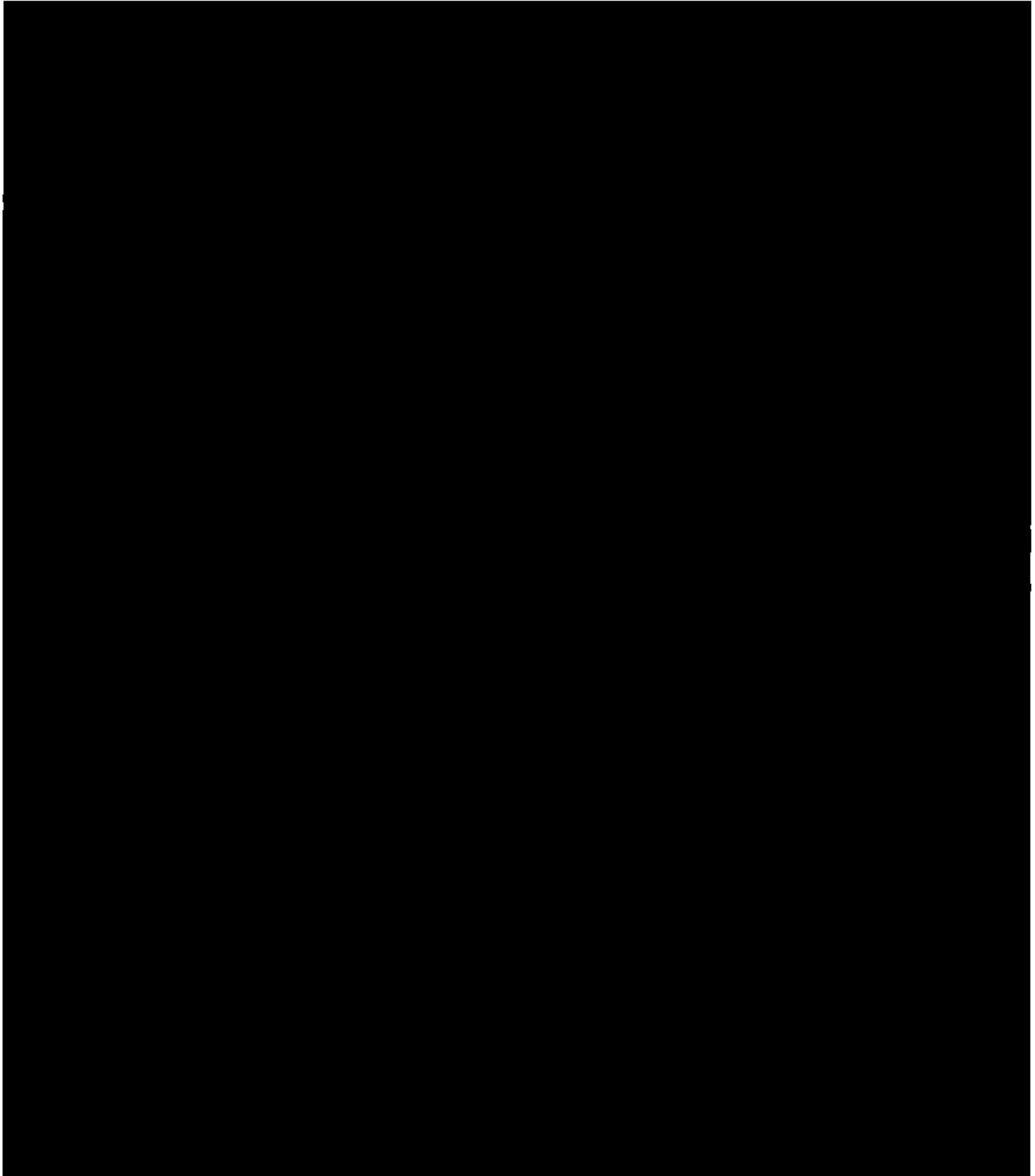
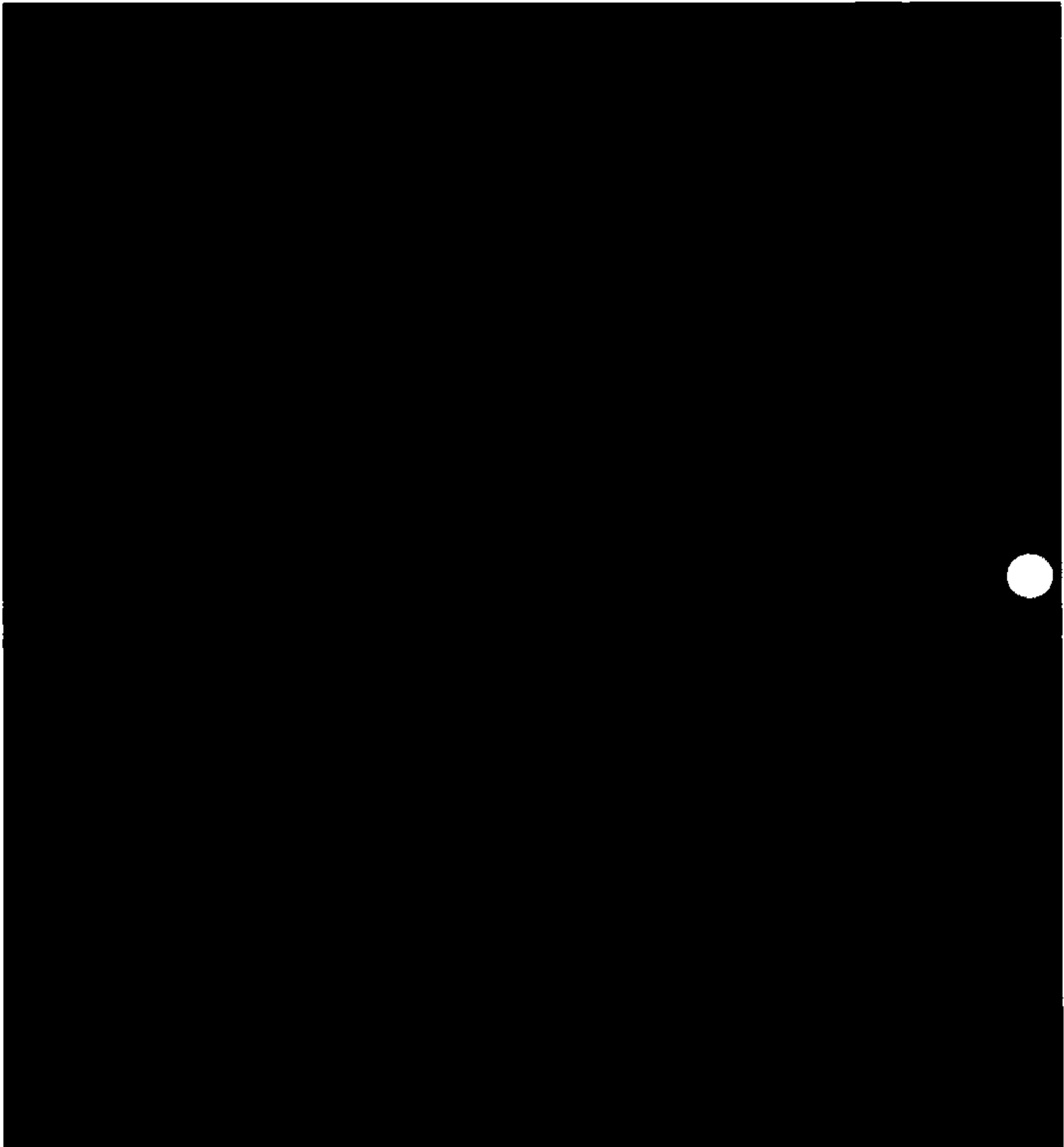
Medical Claim Re-pricing Summary



Medical Claim Re-pricing Summary



CONFIDENTIAL

Medical Claim Re-pricing Summary

Repricing Summary Choice POS II

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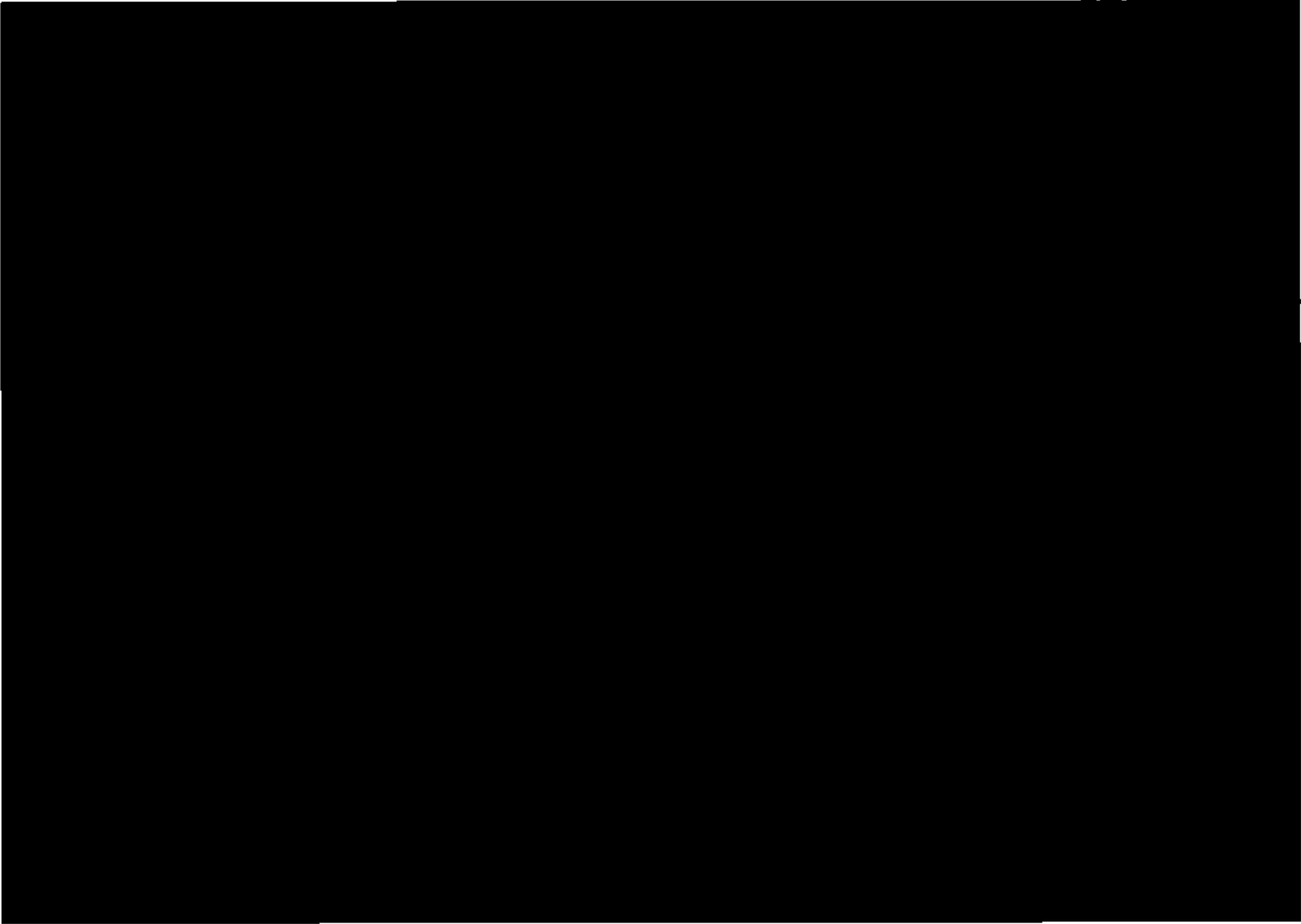
Network Discount Analysis Results for State of Nebraska.



Repricing Summary CHI ACO

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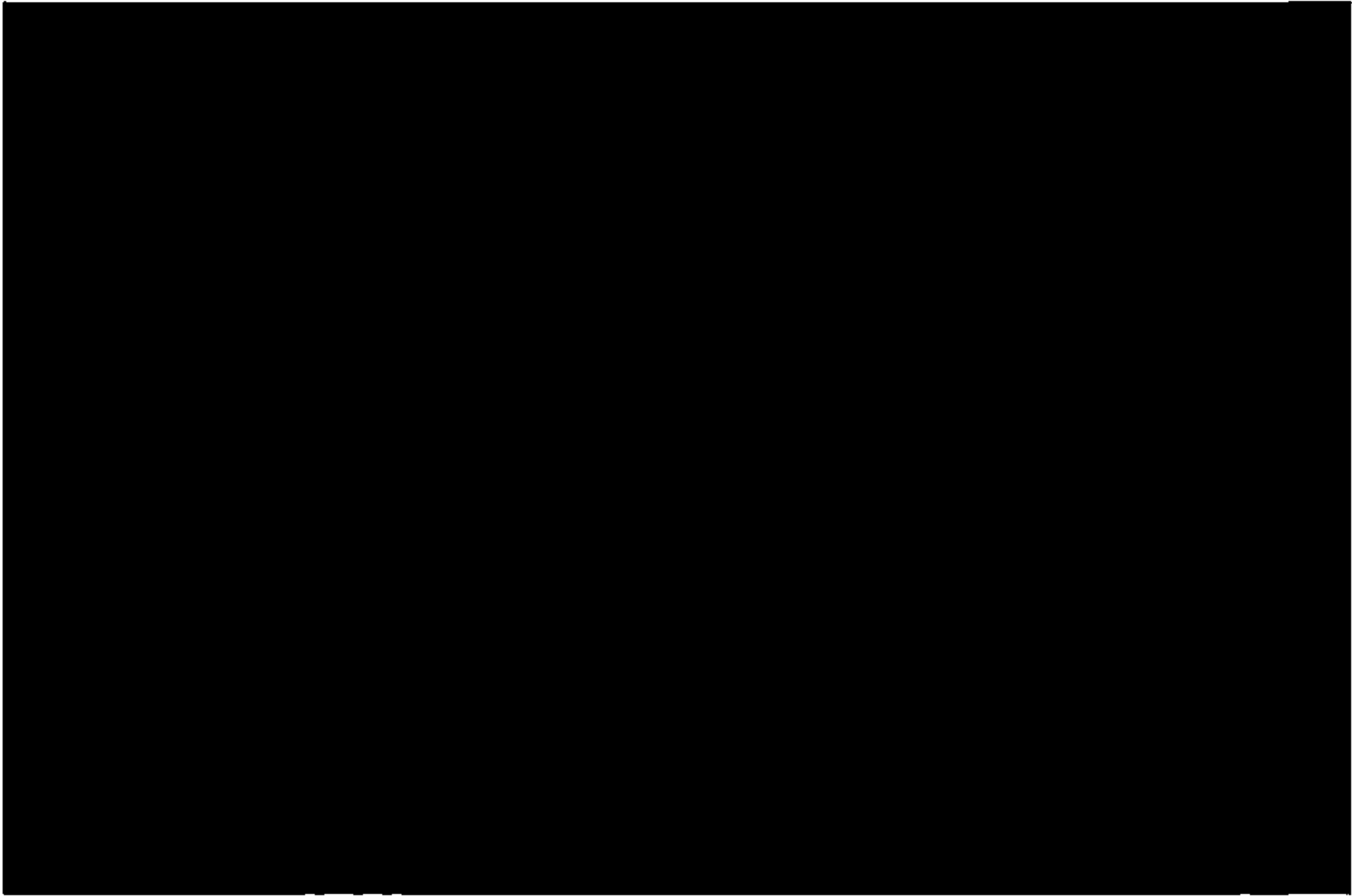
Network Discount Analysis Results for State of Nebraska



Repricing Line by Line Results – Sent Via Email

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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;

Aetna is claiming this information as Confidential:

Document	Page and/or Section	Reasoning
Repricing Cover Letter	Network Information / Entire Document	Aetna's negotiated average network discounts are confidential and a competitive differentiator in the industry. Our provider contracts and negotiations include that Aetna will not make this information available in a public format.
Repricing Summary Choice POS II / CHI ACO	Network Information / Entire Document	Aetna's negotiated average network discounts are confidential and a competitive differentiator in the industry. Our provider contracts and negotiations include that Aetna will not make this information available in a public format.
Repricing Line by Line *(Sent via Email)*	Network Information / Entire Document	Aetna's negotiated average network discounts are confidential and a competitive differentiator in the industry. Our provider contracts and negotiations include that Aetna will not make this information available in a public format.