Lee County
Southwest Florida

BOARD OF COUNTY COMMISSIONERS

October 19, 2018

Ms. Natalie Gonder Jones
Aetna Life Insurance Company
151 Farmington Avenue, RW61
Hartford, CT 06156

SUBJECT: Renewal of Annual Contract No. RFP170337LKD
Group Medicare Advantage Plan

Dear Ms. Jones:

This is to inform you that Lee County agrees to renew the above subject contract for an additional one (1) year period, from 1/1/2019 through 12/31/2019.

We are hereby extending the annual contract for an additional one year period under the Benefits and Premiums Plan Design effective January 1, 2019 through December 31, 2019.

If you have any questions regarding this letter, please contact me at (239) 533-8871.

Sincerely,

Kimberly Urban

Kimberly Urban
Contracts Analyst
Procurement Management Division

C: Project File

Lee County Board of County Commissioners
January 1, 2019 through December 31, 2019 **Plan Sponsor Unique ID 1187771**

Effective date
The rates and benefit plan designs provided in this renewal are effective January 1, 2019 through December 31, 2019.

Definitions
For the purpose of this document: (1) "MA" means a group Medicare Advantage MA HMO and/or PPO plan without Medicare prescription drug coverage; (2) "MAPD" means a group MA HMO and/or PPO plan with Medicare prescription drug coverage; and (3) "PDP" means a group standalone Medicare prescription drug plan.

Automatic renewal of your plan if we don't hear from you by October 1, 2018
If you plan to change or terminate your Aetna Group Medicare Plan you need to notify us in writing as soon as possible. We must hear from you by October 1, 2018. Otherwise, we will assume you consider the information in this renewal to be accurate and you have chosen to renew your Aetna Group Medicare Plan for 2019.

If you do not respond to this renewal we will automatically renew your plan with the benefits, cost sharing, premium rates and terms and conditions described in this renewal and enclosed materials, and in your agreement with Aetna.

The following conditions allow us to assess the potential financial impact and adjust premium rates, subject to applicable state and federal mandates:

- **Pricing and underwriting basis** - The proposed rates assume member enrollment by plan type as outlined below:

Product	Enrolled members
ESA for All with Custom Pharmacy	349

We reserve the right to rerate or restructure our rating if: a) the total enrollment varies by more than 10 percent from the enrollment assumption used in the enclosed rating or, b) if any site's enrolled membership expressed as a percent of total enrolled membership varies by more than +/- 10 percent from that assumed when rating the case. Aetna group retiree coverage does not extend to additional employer groups unless we are able to review supplemental census information and other underwriting information for appropriate financial review.

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- **Slice offering** - This renewal, including the assumptions relating to member enrollment for each plan set forth above, assumes Aetna group retiree benefits are offered as an option for retirees alongside other Medicare based plans. If our group retiree benefits aren't the default plan offering to all current and future retirees, we reserve the right to revise, modify or terminate this proposal and/or rating.

- **Legislative, Regulatory or Enforcement action** – Aetna reserves the right to rerate or restructure our rating when legislative, regulatory or enforcement action causes a material change to:

  - Benefits offered
  - Claim payment requirements or procedures
  - State premium taxes or assessments
  - ACA taxes or fees
  - Any other changes affecting the manner or cost of providing coverage that is required because of legislative or regulatory action
  -

- **Employer contribution requirements** - This offering assumes a minimum employer contribution level of 50 percent of the group premium for the medical/pharmacy plan. If the actual employer contribution differs from this assumed percentage, the medical and/or pharmacy rates and/or the plan offering are subject to revision.

- **Medicare Part D -** Aetna reserves the right to re-rate the Medicare Part D premium, including the Medicare Part D component of the MAPD rate, for the 2019 plan year if any legislative changes are made to the structure of the Medicare Part D program that may include, but are not limited to, the manufacturer coverage gap discount program or subsidies, such as catastrophic reinsurance.

  Pricing effective on or after January 1, 2019 includes changes related to the Bipartisan Budget Act of 2018, passed and signed on February 9, 2018. Coverage Gap Discounts on Brand drugs increase from 50 percent to 70 percent. Coverage Gap Discounts continue to count toward the TrOOP accumulator. For 2019 the maximum cost share for brand drugs in the coverage gap is 25 percent.

  The premium described in this proposal excludes any additional income-related Medicare Part D premium payments required of Medicare-eligible members in order for the member to be eligible for the Part D product.

  Aetna reserves the right to communicate with enrolled members regarding opportunities to reduce out of pocket prescription drug costs.

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- **Rate and benefit approval** -This renewal is subject to Centers for Medicare and Medicaid Services ("CMS") renewal and approval of the plans' current or pending Medicare Advantage and Medicare prescription drug contracts, applications and service areas for calendar year 2019. Filed benefits, including cost sharing amounts and premiums, are subject to regulatory approval(s), where applicable, and are effective January 1, 2019 through December 31, 2019.

- **Legislative Changes** - The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 were signed into law by President Obama in 2010 (PPACA). PPACA includes the following provisions related to the Part D coverage gap: (1) Medicare beneficiaries with Part D coverage will receive a 50 percent discount off the price of brand-name drugs during the coverage gap (the "doughnut hole") starting in 2011, and (2) the coverage gap will be phased out by 2020 by gradually reducing the cost-sharing during the coverage gap for both brand-name and generic drugs until it equals 25 percent of the negotiated price of the drug in 2020 (similar to cost-sharing under the initial coverage limit). These PPACA provisions may impact Part D benefits included in this phase of the plan every year until 2020.

  The Bipartisan Budget Act of 2018 was passed and signed on February 9, 2018. Effective 2019, Coverage Gap Discounts on brand-name drugs will increase from 50 percent to 70 percent and cost-sharing for brand-name drugs will be reduced to 25 percent of the negotiated price.

- **Affordable Care Act - fees and assessments** - The Affordable Care Act (ACA) imposed several fees/assessments:
  - The Health Insurer Fee (HIF) is a recurring, annual, industry fee assessed based on each insurer's share of the fully insured market, as determined by the IRS, that took effect in 2014. A total of $14.3 billion will be collected across the industry for 2018. The total assessment will increase each year thereafter at the rate of industry premium growth. Congress temporarily suspended the HIF for the 2017 and 2019 calendar years, but the HIF will apply for calendar year 2018. After the 2019 suspension, without further legislative action, the HIF will apply again for the 2020 calendar year and beyond.

  Aetna reserves the right to modify these rates, or otherwise recoup such fees, based on future changes to laws, rules and regulations, regulatory guidance, subsequent state regulatory approval, or if estimates are materially insufficient.

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- **Pharmacy plans** - This renewal assumes that where our Medicare Advantage plans with prescription drug coverage (MAPD plans) or standalone Medicare Prescription Drug plan (PDP) is a retiree option alongside any competitor plan, our benefit design is not positioned as the richest pharmacy plan available.

- **Aetna Mail Order and Specialty -** Aetna's mail order benefits are filled by Aetna Rx Home Delivery (ARxHD). This mail order service supplies medications for drugs taken on a regular basis, sometimes referred to as maintenance drugs. Examples of maintenance drugs include medications used to treat chronic conditions such as arthritis, high cholesterol, asthma, or high blood pressure. ARxHD does not supply medications used for short-term illnesses, such as cold medications or antibiotics. Additionally, certain drugs that require special handling may not be available through Aetna Rx Home Delivery. These drugs are sometimes called specialty drugs and may require storage at controlled temperatures or other unique handling requirements which cannot be accommodated through a traditional mail order arrangement. Therefore, most specialty drugs are not available at the mail order benefit (cost share) and instead will pay at the retail benefit (cost share). Also, specialty drugs are generally limited to a 30-day fill, to reduce waste of these high-cost drugs.

- **Premium and Low Income Subsidy ("LIS") Requirements and Late Enrollment Penalty ("LEP")** - Lee County Board of County Commissioners will comply with the following conditions with respect to any subsidization of that portion of premiums paid by Lee County Board of County Commissioners for the Medicare Prescription Drug benefit ("PD Premium") and any required PD Premium contribution by members enrolled in MAPDs or PDPs ("Members"):

  - Direct subsidy payments from CMS to Aetna must be passed through to reduce the amount of any required PD Premium payment by the Member ("Member Contribution") so the Member in no event shall be required to pay more than the sum of: a) the standard Medicare Part D premium, net of the direct subsidy payment from CMS, and b) one hundred percent (100%) for any supplemental coverage selected by the Member.

  Lee County Board of County Commissioners will comply with the following conditions with respect to any LIS payment received from CMS for any LIS-eligible Member:

  - Any monthly LIS payment received from CMS for an LIS-eligible Member shall be used to reduce any Member Contribution. Any remainder may then be used to reduce the amount of the Lee County Board of County Commissioners PD Premium contribution. However, if the sum of the Member Contribution and Lee County

Board of County Commissioners PD Premium is less than the LIS payment, any portion of the LIS payment will be returned to CMS by Aetna.

- If the LIS payment for any LIS-eligible Member is less than the Member Contribution required by such individual (including the Member Contribution for supplemental benefits, if any), Lee County Board of County Commissioners shall communicate with the LIS-eligible Member about the cost of remaining enrolled in Lee County Board of County Commissioners Plan versus obtaining coverage as an individual under another Medicare Part D Prescription Drug plan.

- In the event that the LIS-eligible Member is due a refund of the LIS payment (i.e., there was no upfront reduction of the PD Premium by the LIS amount), such refund shall be completed by Aetna or Lee County Board of County Commissioners, as applicable, within 45 days of the date Aetna receives the LIS payment for that Member from CMS.

Group Billed - If Aetna is billing and collecting the entire plan premium from Lee County Board of County Commissioners and Lee County Board of County Commissioners chooses to receive group list invoices, Aetna will apply LIS subsidy credits and LEP debits to the group invoice. Lee County Board of County Commissioners must apply the LIS subsidy and collect the LEP consistent with applicable law.

Direct Billed - If Lee County Board of County Commissioners chooses direct billing (i.e., Aetna directly bills and collects the entire plan premium from Members), Aetna will apply LIS to the Member invoice and will add LEP debits consistent with applicable law.

Additional financial information

The following are brief descriptions of some of the important features of the group retiree plans quoted in this renewal:

- **Plan eligibility-** This renewal assumes all members are retired and enrolled in Medicare Part A and Part B. If you have retirees that are not eligible for premium free Part A they must be enrolled in an Aetna Medicare Part B only plan.

- **Timely premium payments-** If a premium payment is not paid in full on or before the premium due date, a late payment charge of one and one half percent of the total amount due per month may be added to the amount due, beginning with the premium due date. We also have the right to assess late premium payment and costs of collection of any unpaid premiums or fees, including reasonable attorney's fees and cost of suit.

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- **Medicare Advantage – Premium Requirements** - The following requirements apply only if Aetna is offering a Medicare Advantage HMO or PPO Plan to your members, and you and your members are paying any portion of the premium for the Medicare Advantage benefit ("MA Premium"). CMS requires that we notify you of these requirements. You must comply with the following conditions with respect to any subsidization of MA Premium and any required MA Premium contribution by the member:

    1. You may subsidize different amounts of MA Premium for different classes of members and their dependents, provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried vs. hourly).

    2. MA Premium contribution levels cannot vary for members within a given class.

    3. Direct subsidy payments from CMS to Aetna must be passed through to reduce the amount of any required MA Premium payment by the member.

- **Prospective rating basis-** The enclosed insured medical rates are offered on a prospectively rated basis. No policy year accounting balance will be calculated for these coverages.

- **Run-in claim processing-** Expenses associated with run-in claims from any prior plan (claims incurred before the effective date of our plan) are excluded from the proposed rates.

- **Additional products and services-** We will bill you for the cost of special services that aren't included or assumed in the pricing. For example, you'll be subject to additional charges for customized communication materials. Costs will depend on the actual services performed and are determined at the time the service is requested.

Inaccurate or incomplete information - We're relying on information from you and your representatives in establishing the rates and terms of this renewal. If any of this information is inaccurate or incomplete and has a material impact on the cost of the programs, we reserve the right to adjust our rates and terms.

Conclusion
We present this renewal on the condition that it will be accepted in its entirety. Furthermore, we've assumed that you'll continue to offer all other coverages, products, and services that you purchased previously. If there is a material change in this regard, we

reserve the right to review and reprice this renewal. If you're interested in a subset of our renewal, then we will gladly review and reprice, if necessary. Before accepting the rates in this renewal, you must disclose any material deviation, current or expected, from these assumptions.

The most recent version of this document issued by Aetna to you, including any attachments to this document (collectively, "Financial Documents") are part of your agreement with Aetna to offer Medicare Advantage plans and/or standalone Medicare prescription drug plans ("Group Agreement"). In the event of a conflict between the terms of the Financial Documents and your Group Agreement and the documents incorporated into the Group Agreement, the order of priority shall be as described in your Group Agreement. Any riders, amendments, inserts and attachments shall have the same priority as the document to which they are attached.

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Medicare Advantage - medical plans

CMS changes
Changes to CMS cost sharing thresholds
Each year, CMS sets cost sharing threshold amounts on specific MA plan benefits to ensure access to care and prevent discrimination against certain classes of Medicare beneficiaries.

Beginning in 2018, CMS has increased the cost sharing threshold amount for emergency room care. This means that if the maximum out of pocket limit on the MA plan is less than or equal to $3,400, the cost sharing for emergency room services may be up to $120. If the maximum out of pocket limit on the MA plan is greater than $3,400, the member cost sharing for emergency room services may be up to $90.

CMS also increased the cost sharing thresholds for members receiving skilled nursing facility care for more than 20 days. Plans may charge up to $172 per day cost share for this care. Aetna will be increasing the cost share for these services in certain standard plans. Please see below for more details.

Aetna changes to your MA plan

Notification
We will notify members of medical plan changes in their 'Annual Notice of Change' mailing.

Changes in Aetna Medicare Advantage network-based service areas for 2019

- **PPO:** We worked hard during 2018 to meet CMS network adequacy rules and add to our MA PPO network. We have successfully completed this effort and will be adding **24** counties to our MA PPO network service area in 2019. Please see the 2019 Aetna Medicare Advantage PPO network-based expansion counties exhibit in the Index to this renewal.

Our network providers go through a comprehensive credentialing process before they're included in our Medicare network.

CMS group enrollment waiver
CMS has established a waiver of network service area requirements ("Waiver") for some employer/union groups. Under this waiver, the employer/union may enroll their retirees in an MA HMO or PPO plan even if they reside in a service area that does not have access to network providers. We refer to these non-network service areas as "Extended Service Areas" (ESA).

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In order to be eligible for the Waiver, at least 51 percent of your retirees and dependents must live in a service area that provides adequate access to network providers. Aetna will apply the CMS network requirements when determining if a county or service area meets adequate access requirements.

It is important to know that:

- Members in an ESA plan may not have access to the Aetna network of providers.
- Providers that are not contracted with Aetna are not required to accept the Aetna ESA PPO plan except for emergency and urgently needed care.

We will monitor the network adequacy throughout the year to confirm that standards are met. Our network teams will work to strengthen our provider networks to meet CMS network adequacy requirements to help avoid potential disruption to our members.

As of May 2018, 95.5 percent of your members reside in service areas that meet CMS network adequacy requirements. If the total percentage of members falls below 51 percent by the date of your Aetna MA PPO plan renewal, we cannot offer you our MA PPO ESA plan. However, we will work with you to evaluate other group health plan options that can be offered in these extended service areas to help reduce potential Member disruption.

Prescription drug coverage

Our retiree pharmacy coverage consists of two components: basic Medicare Part D benefits and supplemental benefits.

- We offer Medicare Part D plan coverage pursuant to our contract with the CMS. We receive monthly payments from CMS for the Part D portion of your coverage.
- We offer supplemental coverage that wraps around the basic Medicare Part D benefits, allowing you to offer enhanced pharmacy benefits. We receive monthly premium payments from you and/or your retirees for the supplemental coverage. Depending on your plan design, supplemental coverage may also include benefits for non-Part D covered drugs.

We will report drug claims information to CMS, based on the source of the applicable coverage payment - Medicare Part D, plan sponsor or member.

CMS changes

The CMS Part D benefit parameters will change for 2019. For plan details, you should refer to the plan design document, included with this renewal. These changes, which are listed below, may or may not impact your current plan design.

Deductible cannot exceed:	$415
Initial Coverage Limit (ICL) has increased from	

$3,750 to:	$3,820
True out-of-pocket limit (TrOOP) has increased from $5000 to:	$5,100
Catastrophic copayments have increased from $3.35 and $8.35 to:	$3.40 for covered generic drugs and $8.50 for other drugs (or 5%, whichever is greater)

The reduction of the coverage gap (a component of the Affordable Care Act) may impact the benefits included in this phase of the plan every year until 2020. For 2019, member cost sharing during the coverage gap phase for covered Part D drugs is to be no more than 37 percent for generic drugs and 25 percent for brand-name drugs.

The Medicare Coverage Gap Discount Program provides a 70 percent manufacturer discounts on covered brand-name drugs to Part D enrollees who have reached the coverage gap and are not already receiving "Extra Help." This discount is applied before any supplemental benefits included in the plan.

The Medicare Part D portion of this renewal includes any benefit design modifications needed to be in compliance with minimum CMS Part D program requirements for 2019.

Aetna prescription drug plan changes for 2019
Part D formulary changes
Formularies change on an annual basis. Members should review the formulary that aligns with their plan annually, to determine the tier of coverage and what they will pay for their drugs in 2019. The formulary is included in the 'Annual Notice of Change' mailing that is sent to members each year. The Annual Notice is mailed no later than 15 days prior to the designated open enrollment period or September 30th of each calendar year, whichever is later.

Administration of the open formulary
Newly approved drugs won't be covered until they've undergone internal clinical review as well as external review by our Pharmacy and Therapeutics (P&T) Committee. Following the review, we will determine in which tier the drug will reside, include any applicable utilization management edits as approved by the P&T committee, and release the drug for coverage under open formulary plans.

Notification
We will notify members of changes to their prescription drug plan in their 'Annual Notice of Change' mailing.

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Medicare Part D creditable coverage
If an applicant cannot demonstrate that he/she had prior creditable coverage, the applicant may incur late enrollment penalties, consistent with laws, rules and regulations applicable to the Part D program.

Helping your retirees obtain Medicaid coverage
We're pleased to provide group plan sponsors with an outreach program through Change Healthcare™. The program provides continuous monitoring of social program eligibility and enrollment status to ensure appropriate access to benefits for which members are entitled.

The program includes:
- Initial Outreach
- Enrollment Assistance
- Annual Recertification
- Screen & Electronically Submit for Medicare's Part D Extra Help Program

We believe our Medicaid outreach program provides a valuable service to potentially eligible members by educating them about and screening for Medicaid programs. Medicaid eligibility may help reduce member out-of-pocket cost sharing and premiums. It can also help us reduce annual plan premium increases due to the additional payment we receive from CMS for these beneficiaries.

If your organization doesn't wish to participate and have your retirees contacted by Altegra Health, your organization may "opt-out" of our Medicaid outreach program. To do so, please contact your Aetna representative no later than October 1, 2018.

Please Note: If we don't receive your "opt-out" notification by October 1, 2018, your organization will be included in our Medicaid outreach program.

We will notify members of plan changes as required by CMS
CMS requires that Aetna provide each member enrolled in our group Medicare Advantage plan or standalone Medicare prescription drug plans an Annual Notice of Change (ANOC) letter along with the new plan year Evidence of Coverage (EOC). The ANOC letter must contain a side-by-side chart showing any changes to plan benefits, copayments and coinsurance from year to year. The EOC provides a detail description of the benefits and coverage provisions of the plan. Medicare members must receive detailed benefit information for their current plan no later than 15 days before the start of your annual open enrollment period. If you don't have an open enrollment period, Medicare members must receive this benefit information no later than 15 days before the start of the new plan year.

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If you wish to receive a copy of the EOC(s) issued to your retirees for your records, please reach out to your Aetna account representative.

To meet this CMS requirement, we must hear from you within 30 days of receipt of your renewal or we will automatically renew your plan with the benefits, cost sharing, premium rates and terms and conditions described in this renewal and enclosed materials, and in your agreement with Aetna.

Federal

The Federal Mental Health Parity Provisions of the "Emergency Economic Stabilization Act of 2008" were signed into law in October 2008 and became effective on October 3, 2009 (the "Act"). Interim final regulations ("IFR") governing implementation of this law were published on February 2, 2010 and generally apply to group health plans for plan years beginning on or after July 1, 2010 (with exceptions for collectively bargained plans). Aetna has assessed the anticipated impact of this law and continues to examine the impact of the IFR on our fully insured medical benefit plans. Aetna's analysis included an in-depth comparison of the federal law to each state's regulations pertaining to mental health and substance use disorder benefits. Plan designs have been modified based on our understanding of the intent of the Act. However, Aetna reserves the right to make additional plan design and premium changes for purposes of complying with the Act and its accompanying regulations.

Based on our understanding of the Act and the IFR, Aetna has identified certain plan design guidelines, which we include as a standard part of our fully insured medical benefit plan offering. These guidelines include:

- The member cost share for outpatient behavioral health and/or substance use disorder benefits is equal to (or less than) that applied to the plan's appropriate outpatient medical/surgical benefit as determined by the quantitative treatment limitation test of the IFR (i.e., the "Substantially All" and "Predominant" test).

- The member cost share for inpatient behavioral health and/or substance use disorder benefits is equal to (or less than) that applied to Inpatient Hospital Admissions with no day limits or maximum benefit amounts unless also applied to Inpatient Hospital Admissions

- Any plan level deductibles or out of pocket maximums will be combined across all benefits, including behavioral health and/or substance use disorder benefits.

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

For Medicare plans (including Medicare Advantage), the reporting obligation under Section 6055 is on the Centers for Medicare and Medicaid Services (CMS) to the extent it applies. CMS will report the required information to the IRS about the type and period of coverage provided to each individual member enrolled in these plans, and will furnish the required statements to subscribers.

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

To satisfy the 6056 employer reporting requirements, you must file the required returns with the IRS by no later than February 28 of the year following coverage (if filing on paper) or March 31 (if filing electronically), and furnish a statement to all full-time employees by January 31st of the year following the calendar year to which the return relates (i.e., January 31, 2019 for the 2018 calendar year).

[1] Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna). Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal. Limitations, copayments, and restrictions may apply. Benefits, pharmacy network, provider network, premium and/or co-payments/co-insurance may change on January 1 of each year.

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Broker commissions - The enclosed rates exclude broker commissions.

We honor 'Agent of Record' or 'Broker of Record' letters when an agent, broker, or consultant sells new business or takes over an Aetna case from another agent, broker, or consultant. Please have an appropriate representative from your organization sign the letter using your organization's letterhead. The change will become effective on the first day of the month after our payment unit receives the 'Agent of Record' or 'Broker of Record' letter, unless another future date is designated in the letter.

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2019 Aetna Medicare Advantage PPO network-based expansion counties

We worked hard during 2018 to meet CMS network adequacy rules and add to our MA PPO network. As of January 1, 2019, we will add **24** new network-based counties to our MA PPO service area.

State	County
GA	Glynn
IA	Polk
IA	Scott
IA	Story
IL	Kankakee
IL	Rock Island
IN	Warrick
IN	LaPorte

State	County
IN	St. Joseph
MI	Kalamazoo
MI	St. Joseph
NC	Cleveland
NC	Franklin
NC	Henderson
NC	Hoke
NC	Stanly

State	County
NY	Livingston
NY	Ontario
NY	Saratoga
RI	Kent
RI	Newport
SC	Anderson
SC	Spartanburg
WA	Kitsap

aetna℠

MEDICARE ADVANTAGE RATE PROPOSAL

Plan Sponsor Name:	**Lee County Board of County Commissioners**
Plan Sponsor Unique ID:	**11187771**
Group Number:	**AE467172**
Policy Period Start Date:	**01/01/2019**
Policy Period End Date:	**12/31/2019**
Medical Plan:	**Medicare (V01) ESA PPO**
Pharmacy Plan:	**Custom RX $10/$20/$35/$35**
Hearing Aid Reimb Adjustment:	**$500 / 36 months**
Lens Plan Option:	**Not Covered**
Fitness Rider:	**Tivity Silver Sneakers**
Dental Rider:	**Not Covered**

- Please refer to the Financial Conditions and Plan Design Exhibits for an outline of the level of benefits quoted, as well as the terms and conditions of this proposal.
- Your Aetna Group Medicare Plan for January 1, 2019 will be automatically renewed if we do not hear from you by October 1, 2018.

- Filed benefits (including copayment amounts), value added services and premiums are subject to CMS approval, and are effective January 1, 2019 through December 31, 2019.
- All rates are on a Per Member Per Month (PMPM) basis.
- These rates exclude commissions.
- The Affordable Care Act imposed a Health Insurer Fee (hereinafter 'HIF') that took effect in 2014. The HIF is a recurring, annual, industry fee assessed based on each insurer's share of the fully insured market, as determined by the IRS. The HIF was applied for calendar year 2018 but was temporarily suspended for the 2019 calendar year. If there are no further legislative changes, the rates labeled "Excluding HIF" below will apply for 2019. Without further legislative action, the HIF will apply again for the 2020 calendar year and beyond.

	Medical Rate	Pharmacy Rate	Total Rate
Current	$143.36	$216.45	$359.81
Proposed	$118.24	$219.45	$337.69
Change	-$25.12	$3.00	-$22.12

Total Medicare Eligible Members	349

State	Medicare Eligible Members	Medical Rate Excluding HIF	Pharmacy Rate Excluding HIF	Total Rate Excluding HIF
Arizona	1	$118.24	$219.45	$337.69
Arkansas	3	$118.24	$219.45	$337.69
California	3	$118.24	$219.45	$337.69
Florida	296	$118.24	$219.45	$337.69
Georgia	6	$118.24	$219.45	$337.69
Illinois	2	$118.24	$219.45	$337.69
Indiana	2	$118.24	$219.45	$337.69
Kentucky	1	$118.24	$219.45	$337.69
Michigan	5	$118.24	$219.45	$337.69
Mississippi	0	$118.24	$219.45	$337.69
North Carolina	9	$118.24	$219.45	$337.69
Ohio	5	$118.24	$219.45	$337.69
Pennsylvania	6	$118.24	$219.45	$337.69
South Carolina	3	$118.24	$219.45	$337.69
Tennessee	2	$118.24	$219.45	$337.69
Texas	1	$118.24	$219.45	$337.69
Virginia	4	$118.24	$219.45	$337.69

Signature: Brittney Joyce Date: 9/4/2018
Signature: [signature] Date: 10/18/18
Signature: _____ Date: _____

MPDT: __16617_1 _