

Attachment A

Aetna Medicare Advantage Renewal



MEDICARE ADVANTAGE RATE PROPOSAL

Plan Sponsor Name: Interlocal Health Benefit Committee
 Plan Sponsor Unique ID: 91409000
 Group Number: AE466538, AE466537
 Policy Period Start Date: 1/1/2018
 Policy Period End Date: 12/31/2018
 Medical Plan: Medicare (C04) ESA PPO
 Pharmacy Plan: 1211
 Fitness Rider: Healthways Silver Sneakers

- 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, 2018 will be automatically renewed if we do not hear from you by October 1, 2017.
- Filed benefits (including copayment amounts), value added services and premiums are subject to CMS approval, and are effective January 1, 2018 through December 31, 2018.
- All rates are on a Per Member Per Month (PMPM) basis.
- These rates include commissions in the amount of \$16.67 PMPM. Please refer to the commissions schedule provided to you by your Aetna representative.
- The Patient Protection and Affordable Care Act imposes a new Health Insurer Fee (hereinafter "Fee"). The Fee is effective as of January 1, 2014. This rate quote includes, where permitted, the estimated proportionate allocation of this Fee. Should the HIF remain suspended for 2018, the rates below will be adjusted accordingly:

Medical Health Insurer Fee: \$34.23
 Rx Health Insurer Fee: \$5.78
 Total Health Insurer Fee: \$40.01

	Medical Rate Excluding HIF	Pharmacy Rate Excluding HIF	Total Rate Excluding HIF	Medical Rate Including HIF	Pharmacy Rate Including HIF	Total Rate Including HIF
Current	\$184.39	\$138.85	\$323.24	\$184.39	\$138.85	\$323.24
Proposed	\$181.03	\$158.35	\$339.38	\$215.26	\$164.13	\$379.39
Change	-\$3.36	\$19.50	\$16.14	\$30.87	\$25.28	\$56.15

Total Medicare Eligible Members 37

State	Medicare Eligible Members	Medical Rate Excluding HIF	Pharmacy Rate Excluding HIF	Total Rate Excluding HIF	Medical Rate Including HIF	Pharmacy Rate Including HIF	Total Rate Including HIF
Maryland	1	\$181.03	\$158.35	\$339.38	\$215.26	\$164.13	\$379.39
Tennessee	36	\$181.03	\$158.35	\$339.38	\$215.26	\$164.13	\$379.39

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Effective date

The rates and benefit plan designs provided in this renewal are effective January 1, 2018 through December 31, 2018.

Automatic renewal of your plan if we don't hear from you by October 1, 2017

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, 2017. 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 2018.

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
Medicare Advantage ESA-PPO with Part D Plan	37

We reserve the right to re-rate 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.

- **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 action** – Aetna reserves the right to re-rate or restructure our rating when legislative action causes a material change to:
 - Benefits offered

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- 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 are subject to revision. This offering assumes the contributions for the Aetna plan(s) will be equal to or better than the contributions for other plan offerings.
 - **Blended rates** - For billing purposes and administrative ease, our rating-area level rates have been blended. Due to the anti-selection concerns that are inherent in this billing arrangement, any competing group plan options must also blend across the same regions. Our enrollment assumptions are shown on the rate exhibit.
 - **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 2018. Filed benefits, including cost sharing amounts and premiums, are subject to regulatory approval(s), where applicable, and are effective January 1, 2018 through December 31, 2018.
 - **Medicare Part D** - Aetna reserves the right to re-rate the Medicare Part D premium if any legislative changes are made to the structure of the Medicare Part D program. Such legislative changes may include, but are not limited to, changes to the manufacturer coverage gap discount program or subsidies, such as catastrophic reinsurance.

The Medicare Part D 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 enrollment in the Part D product.

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

- **Health Care Reform** - 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

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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 gradually reduce 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.

- **Affordable Care Act - fees and assessments** - The Affordable Care Act (ACA) imposed several fees/assessments. Still applicable in 2018 are the Health Insurance Provider Fee and the Patient-Centered Outcomes Research Institute Fee. The Patient-Centered Outcomes Research Institute Fee is not applicable to Medicare but is applicable to an Indemnity Plan with 100 percent Medicare Coordination of Benefits (COB) - Traditional Choice[®] (TC).
 - Health Insurance Providers 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. The total assessment increases each year, to an estimated \$14.3 billion in 2018 and will then increase at the rate of industry premium growth thereafter. The Omnibus Bill, signed into law on December 18, 2015 included a one year suspension of the HIF for calendar year 2017. HIF is reinstated for calendar year 2018.
 - Patient-Centered Outcomes Research Institute Fee (PCORI)—This fee is in effect for plans or policy year ending after September 30, 2012, and before October 1, 2019.

This rate quote includes, where permitted, and as applicable, an estimated proportionate allocation of expenses associated with these Fees. Aetna reserves the right to modify these rates, or otherwise recoup such fees, based on future regulatory guidance, subsequent state regulatory approval, or if estimates are materially insufficient.

- **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 (we call these 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-

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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 limited to a 30-day fill, to reduce waste of these high-cost drugs.

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 a 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.
- **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.

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- **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.
- **Run-off claim processing-** Our rates reflect an incurred (mature) 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.
- **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, ("Financial Documents") are part of your group agreement with Aetna to offer fully-insured group 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

New Medicare diabetic prevention program

Beginning in 2018, CMS will require all MA plans to provide a Medicare Diabetic Prevention Program (MDPP) in a community or health care setting. The MDPP program coach will provide each member with a structured program focused on behavioral change. The MDPP will help reduce the incidence of type 2 diabetes through:

- practical training in long-term dietary change
- increased physical activity, and
- problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle

The program will be available to any MA member that meets the participation criteria defined by CMS.

Aetna is currently assessing external suppliers to partner with in order to provide this new program to your retirees. A MDPP supplier and coach must be recognized by the Centers of Disease Control and Prevention (CDC) and must obtain a national Provider Identification (NPI). Many suppliers are still in the process of obtaining these credentials. Aetna will provide your retirees with details of the new MDPP in the Annual Notice of Change (ANOC) mailing.

Aetna changes to your MA plan

LifeScan diabetic monitors and testing supplies

In 2018 Aetna will provide LifeScan test strips and monitors as our exclusive Part B diabetic monitoring system. This will help make the plan more valuable to retirees and increase savings over time. LifeScan, Inc. is a leading maker of blood glucose monitoring systems and offers OneTouch brand products. In the U.S., OneTouch brand products are recommended by more endocrinologists and primary care physicians than any other brand.

- Globally, more than 10 million people depend on OneTouch brand products for simple testing and accurate results to help them manage their diabetes.
- The Verio meters - OneTouch Verio Flex[®], OneTouch Verio[®], OneTouch Verio[®] IQ have ColorSure[™] technology which instantly shows when a user's blood glucose results are in or out of range
 - Color Range Indicator give users a greater understanding of their results with less work
 - Color Range Indicator made their results simple and quick to understand
- After using the OneTouch Verio[®] meter for a week, 94% of people with diabetes said it made their test results simple to understand

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- Some Verio meters can send results to the OneTouch Reveal[®] web app on a PC or Mac computer

Aetna will no longer provide coverage for test strips from other manufacturers unless it is medically necessary and pre-authorized through Aetna.

Members will receive a OneTouch monitor and test strips at a \$0 cost share.

If you do not wish to offer LifeScan products as your exclusive Part B diabetic supply please contact your Aetna sales representative.

Changes to core benefits

Aetna currently offers an annual routine physical exam on your MA plan. This non-Medicare covered service is provided to your members in addition to the annual wellness exam. In 2017, members were eligible to receive this benefit once every twelve months. In 2018 we will remove the frequency limit. Member can receive the annual examination at any time during the year. This will help encourage an ongoing relationship with the members PCP and help identify potential issues early.

We will provide the kidney dialysis training and kidney education services at \$0 member cost share. Currently, your MA plan covers these services at the PCP or specialist cost share. Lowering member cost share will help encourage members with diabetes to receive these services and help improve overall management of the disease. These services will be subject to any deductible that you have on the plan.

Resources for Living[®] will now be included on all new and renewal Aetna Medicare HMO, PPO and PPO/ESA Plans for 2018. Resources For Living consultants provide telephonic consultations to members based on member specific needs, such as caregiver support, household services, eldercare services, activities, and volunteer opportunities. The purpose of the program is to provide members with assistance in locating local community services and resource information for a wide variety of issues. Members who use the program save time, because the program provides research assistance and relevant resources based on the member's specific needs.

In 2018, Aetna will no longer include the healthy lifestyle coaching or the hypertension programs as core benefits of your Medicare Advantage Plan. Healthy lifestyle coaching will be available to you at an additional cost. If you want to keep this program as part of your plan, please contact your Aetna sales representative.

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Fitness Program

We are excited to announce that Aetna will now offer the SilverSneakers® program as our exclusive fitness program. SilverSneakers offers access to 13,000+ gyms and fitness centers, along with 1,000+ community locations. Programming includes exercise classes designed specifically for Baby Boomers and older adults. SilverSneakers promotes a sense of community through community events, social activities, and member engagement initiatives. SilverSneakers Steps kits are also available as a home fitness option.

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 2018

- **PPO:** We worked hard during 2017 to meet CMS network adequacy rules and add to our MA PPO network. We have successfully completed this effort and will be adding **72** counties to our MA PPO network service area in 2018. Please see the [2018 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).

In order to be eligible for the Waiver, at least 51% 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.

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As of June 12, 2017, 100 percent of your members reside in service areas that meet CMS network adequacy requirements. If the total percentage of members falls below 51% 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 2018. For plan details, you can 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:	\$405
Initial Coverage Limit (ICL) has increased from \$3,700 to:	\$3,750
True out-of-pocket limit (TrOOP) has increased from \$4,950 to:	\$5,000
Catastrophic copayments have increased from \$3.30 and \$8.25 to:	\$3.35 for covered generic drugs and \$8.35 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 2018, member cost sharing during the coverage gap phase for covered Part D drugs is to be no more than 44% for generic drugs and 35% for brand-name drugs.

The Medicare Coverage Gap Discount Program provides a 50% manufacturer discounts on covered brand-name drugs to Part D enrollees who have reached the coverage gap and are

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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 2018.

Aetna prescription drug plan changes for 2018

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 2018. 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.

Your formulary includes generic drugs on all tiers

The formulary included with your 2018 plan includes generic drugs on all tiers. This tier structure allows for the grouping of drugs with similar price points in the same tier, regardless of drug type. This allows members to make decisions based upon the drug cost as opposed to the drug type. The resulting savings help to offset annual cost increase trend.

Notification

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

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.

Transitioning your retirees who are approaching age 65

We manage a monthly communications program known as the Medicare "Age-in" program that is focused on your retirees approaching age 65. Our Medicare "Age-in" program is included with your plan at no additional expense.

The Medicare "Age-in" program informs and educates your retirees who are approaching Medicare eligibility with timely information about Aetna Medicare plan(s) you offer.

Our communications highlight important information such as transitioning to Medicare and Aetna Medicare plan advantages.

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Our system data does not indicate members' active/retired status. As a result, our standard age-in mailings are sent based on age only. This means both retired and actively employed age-ins will receive the letter. **Our standard material clearly states that only retirees are eligible.**

We believe our Medicare "Age-in" program can help ease the transition for your retirees who are nearing Medicare eligibility, and help reduce questions to your benefits department.

We are working on establishing a seamless eligibility and enrollment process that will automatically transition your retirees approaching Medicare eligibility from your Aetna commercial plan into your Aetna Medicare group plan. Your members will receive the Aetna Medicare group notification materials 21 days prior to the effective date and have the ability to opt out. This process adheres to CMS requirements. Please contact your Aetna representative if you have questions about this program.

Helping your retirees obtain Medicaid coverage

We're pleased to provide group plan sponsors with an outreach program through Altegra Health™. 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, 2017.

Please Note: If we don't receive your "opt-out" notification by October 1, 2017, your organization will be included in our Medicaid outreach program.

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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.

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.

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).

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- 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.

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, 2018 for the 2017 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.

Compensation

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Broker commissions - The enclosed rates include commissions in the amount of \$16.67 pmpm.

Because Sherrill Morgan Inc. is currently shown as your 'Agent of Record' or 'Broker of Record', we currently pay them a commission as outlined above. Unless we hear otherwise from you by October 1, 2017, we will assume that you wish to maintain this arrangement for the upcoming term of the Group Agreement.

Commissions will only be paid if the broker of record is licensed and appointed in accordance with state law, and has completed and passed, with a score of 90% or better, the Annual Group Medicare Certification. We cannot pay commissions if this certification test is not taken and passed prior to the renewal date. There are no exceptions to this policy. Please note that failure to complete the certification requirements before the renewal date will result in a retroactive change to your billing rates to remove the applicable commission amount(s).

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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2018 Aetna Medicare Advantage PPO network-based expansion counties

We worked hard during 2017 to meet CMS network adequacy rules and add to our MA PPO network. As of January 1, 2018, we will add 72 new network-based counties to our MA PPO service area.

State	County
FL	DeSoto
FL	Highlands
GA	Dooly
GA	Quitman
GA	Randolph
GA	Schley
GA	Taylor
GA	Turner
IL	Bureau
IL	DeKalb
IL	Mercer
IL	Peoria
KS	Franklin
KY	Fayette
KY	Hardin
MA	Essex
MA	Middlesex
MA	Norfolk
MD	Worcester
ME	Aroostook
ME	Knox
MI	Allegan
MI	Arenac
MI	Genesee

State	County
MI	Kalkaska
MI	Missaukee
MI	Ogemaw
MI	Otsego
MI	Roscommon
MI	St. Clair
MO	Benton
MO	Crawford
MO	Henry
MO	Johnson
MO	Ray
MO	Stone
NC	Burke
NC	Cumberland
NC	Sampson
NY	Delaware
NY	Jefferson
NY	St. Lawrence
NY	Steuben
OK	Osage
OK	Seminole
PA	Tioga
PA	Warren
SC	Greenville

State	County
SC	Laurens
SC	York
TN	Fayette
TX	Anderson
TX	Cass
TX	Cherokee
TX	Coryell
TX	DeWitt
TX	Fayette
TX	Gray
TX	Houston
TX	Leon
TX	Morris
TX	Nacogdoches
TX	Red River
TX	Shelby
TX	Tyler
VA	Fluvanna
VA	Greene
VA	Louisa
VA	Madison
VA	Nelson
WI	Sheboygan
WI	Walworth