aetna™

An Aetna Renewal
Presented to

City Of Hallandale Beach

Financial Renewal Overview: October 01, 2020 through September 30, 2021
Control Number: 00143062, 00143729, 00487581

Gabrielle Dimitrakis
Account Executive
261 N University Drive
Plantation, FL 33324
Phone: 954-858-3139
gkdimitrakis@aetna.com

June 11, 2020

City Of Hallandale Beach
Radu Dodea
400 S. Federal Hwy
Hallandale Beach, FL 33009

To Whom It May Concern:

Thank you for allowing us to serve your health insurance and health benefit needs during the past year. This package provides information to help you develop the future benefits program for City Of Hallandale Beach. As we approach the anniversary of our relationship in the journey to better health, we are pleased to present you with this renewal for your 2020 policy period.

It's important to understand the full financial picture of your benefit plan.
Therefore, the enclosed package provides the following important information about the cost of your current program and the value we bring to you and your company.

- **Future Program Costs**
  This section illustrates the cost projections to operate your current benefit program for the period 10/1/2020 through 9/30/2021.
- **Fully Insured Medical Plans**
  For the period 10/1/2020 through 9/30/2021 the cost to operate your current medical plans will increase 6.00% compared to the current rate.
  This renewal reflects both the premium and commission.
- **Programs and Services**
  This section provides a summary of services included in your plan of benefits.
- **Caveats**
  Our renewal offer is contingent upon the parameters outlined here. It is important to note that deviations from these assumptions may result in additional charges and/or adjustments on our Medical quotations. Please review this section thoroughly.

If there are no changes that impact the conditions of this renewal as outlined in our Caveats section, the rates will remain in effect through September 30, 2021. This renewal package is considered an amendment to your existing agreement. Continuance of your benefit plan and payment of rates constitutes an agreement to this renewal.

Please review the additional important information found at the following URL:
http://www.aetna.com/legal-notices/documents/2020-middle-market-public-labor-insured-medical-uw-disclosures-03.15.20.pdf

This information is incorporated in and is a part of this proposal. This quote is subject to all the terms and conditions set forth in this URL. In the event that any information contained herein conflicts or is inconsistent with the information in the Underwriter Disclosure document, the information in your Package shall prevail.

If you'd like to make any plan changes or if you have any questions, please contact me by September 01, 2020 at 954-858-3139. It's been a pleasure working with you and I look forward to our continued relationship.

Sincerely,

Gabrielle Dimitrakis
Account Executive

Gregory Poll
Underwriting Consultant

Each insurer has sole financial responsibility for its own products.

Health benefits and health insurance plans contain limitations and exclusions.

City Of Hallandale Beach

Aetna's Value Story **Effective Date: October 01, 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. 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.

City Of Hallandale Beach

Contact Information

Account Manager:	Gabrielle Dimitrakis	Email:	gkdimitrakis@aetna.com
Telephone Number:	954-858-3139		

Assumptions

Contract State:	FL	Lives:	375
Medical Pooling Level:	$175,000	Sic Code:	9111
Commissions:	0.00%	Mem/EE Ratio:	1.92
Health Insurance Provider Fee%*:	0.65%	Rx Formulary:	Included

Proposed Rates

Effective Date: October 1, 2020 **End Date:** September 30, 2021

OA HMO (Health Network Only)				
OA HNO				
EE	213	$667.96	$708.03	6.00%
EE + 1	65	$1,269.13	$1,345.26	6.00%
Family	97	$1,903.69	$2,017.88	6.00%
Total	375	$409,426.86	$433,986.65	6.00%

Total Medical Lives	**375**
Current Monthly Total Amount Due	**$409,426.86**
Proposed Monthly Total Amount Due	**$433,986.65**
Total % Change	**6.00%**
Proposed Annual Total Amount Due	**$5,207,839.80**

Clarifications

*The Affordable Care Act imposed the health insurance provider fee effective January 1 2014. This rate quote includes, where permitted, an estimate proportionate allocation of expenses associated with these fees.

City Of Hallandale Beach

Experience Exhibit — Effective Date: October 01, 2020

Control Number 00143062, 00143729, 00487581

- This exhibit displays the historical experience used in the development of the rates.
- Claims displayed are incurred claims and have been completed.
- Claims experience includes National Advantage Program access fees (for savings achieved on covered claims with
- non-network providers and on high dollar, in-network facility claims).
- This exhibit may include information from other carriers.

Current Year's Experience

Month	Members	Premium	Total Medical FFS/Caps	Rx Claims	
201903	911	$501,626	$311,252	$169,453	
201904	905	$499,142	$749,375	$78,759	
201905	903	$499,868	$448,239	$100,990	
201906	903	$498,629	$391,703	$110,500	
201907	898	$494,056	$517,915	$124,387	
201908	903	$497,224	$294,229	$95,258	
201909	898	$492,713	$366,367	$108,127	
201910	888	$493,630	$195,779	$61,211	
201911	879	$487,780	$88,817	$94,775	
201912	873	$487,087	$301,061	$110,314	
202001	873	$486,526	$320,517	$105,137	
202002	735	$412,856	$167,180	$100,270	
					Loss Ratio
TOTALS	**10,569**	**$5,851,137**	**$4,152,435**	**$1,259,180**	**92.5%**
	Current Year Incurred Claims PMPM		**$392.89**	**$119.14**	

Prior Year's Experience

Month	Members	Premium	Total Medical FFS/Caps	Rx Claims	
201803	936	$382,915	$257,841	$108,983	
201804	932	$381,437	$222,950	$121,884	
201805	941	$384,751	$321,857	$111,358	
201806	951	$386,711	$340,511	$167,138	
201807	951	$386,670	$386,270	$80,461	
201808	952	$387,183	$165,502	$164,959	
201809	944	$383,376	$327,694	$118,079	
201810	939	$515,119	$73,548	$19,569	
201811	931	$511,888	$272,750	$102,755	
201812	922	$509,440	$189,616	$74,446	
201901	913	$504,291	$140,327	$151,099	
201902	916	$504,165	$297,864	$110,644	
					Loss Ratio
TOTALS	**11,228**	**$5,237,946**	**$2,996,730**	**$1,331,375**	**82.6%**
	Prior Year Incurred Claims PMPM		**$266.90**	**$118.58**	

Premium Development

Current Monthly Amount Due	$409,427
Current Subscribers	375
Current Members	721
Current Premium PMPM	**$567.86**

City Of Hallandale Beach

Rate Change Development — Effective Date: October 01, 2020

- The components of your renewal rate change are detailed below.
- The current Net Adjusted Incurred Claims Per Member Per Month (PMPM) are trended forward to the Renewal Rate Period.
- Based on customer size by experience rating group, claims over a certain threshold are removed to normalize the claims experience in order to minimize large yearly fluctuations.
- A large claim adjustment is added to the Incurred Claims PMPM, and blended with Manual Claims PMPM, if applicable, to develop a blended expected claim PMPM. An adjustment for renewal benefit change is added if applicable.
- State taxes, commissions, and other adjustments are then added resulting in the final required premium PMPM.
- This exhibit may include information from other carriers.

			Current Year Experience	Prior Year Experience
Experience Grouping:	Experience Group 1	Claim Basis:	Incurred	Incurred
Current Subscribers:	375	Year Experience Period:	3/1/2019 - 2/29/2020	3/1/2018 - 2/28/2019
Current Members:	721	Paid Through:	4/29/2020	4/29/2020
		Subscriber Months:	5,228	5,540
		Member Months:	10,569	11,228
		Experience Period Average Members:	881	936

	Current Year Experience				Prior Year Experience		
	Medical	Rx	HRA Fund	Total	Medical	Rx	Total
	PMPM	PMPM	PMPM	PMPM	PMPM	PMPM	PMPM
1 Incurred Claims	$392.89	$119.14	$0.00	$512.03	$266.90	$118.58	$385.48
2 Deductible Supression	0.9995		1.0000		0.9996		
3 Incurred Claims x Deductible Suppression Factor	$392.68	$119.14	$0.00	$511.82	$266.80	$118.58	$385.38
4 Pooled Claims	$25.57			$25.57	$8.56		$8.56
5 Pooling Charge							
a. Pooling Point	$175,000			$175,000	$175,000		$175,000
b. Pooling Factor (medical claims only)	12.27%				12.27%		
c. Pooling Charge	$44.95			$44.95	$31.63		$31.63
6 Incurred Claims w/ Pooling (3 - 4 + 5c)	$412.06	$119.14	$0.00	$531.20	$289.88	$118.58	$408.45
7 Adjustment for Change in Network	1.0000	1.0000	1.0000		1.0000	1.0000	
8 Adjustment for Change in Plan	1.0006	1.0000	1.0000		1.0010	1.0000	
9 Adjustment for Change in Demographics	1.0221	1.0422	1.0000		1.0221	1.0422	
10 Underwriting Adjustment	1.0000	1.0000	1.0000		1.0000	1.0000	
11 Adjusted Incurred Claims (6 x 7 x 8 x 9 x 10)	$421.38	$124.16	$0.00	$545.54	$296.57	$123.58	$420.15
12 Trend							
a. Annual Trend Factor	10.84%	11.04%	100.00%		10.84%	11.04%	
b. # of Months of Trend	19.0	19.0	0.0		31.0	31.0	
c. Projection Factor	1.1769	1.1804	1.0000		1.3046	1.3108	
13 Exp. Based Projected Claims (11 x 12c)	$495.94	$146.56	$0.00	$642.50	$386.92	$161.98	$548.90
14 Experience Weighting	70%	70%	70%	70%	30%	30%	30%

	Blended Results			
	Medical	Rx	HRA Fund	Total
15 Experience Blended Projected Claims	$463.23	$151.18	$0.00	$614.42
16 Experience Credibility	89.9%	89.9%	89.9%	89.9%
17 Manual (CRC) Projected Claims	$348.65	$91.38	$0.00	$440.03
18 Blended Projected Claims	$451.66	$145.14	$0.00	$596.80
19 Large Claim Adjustment				($11.09)
20 Retention Charges		**Total**		**Total**
a. Administrative Component		14.25%		$99.21
b. Broker Commission Component		0.00%		$0.00
c. Premium Tax Component		0.97%		$6.78
d. Health Insurance Providers Fee		0.65%		$4.53
e. Total Retention Charges (a + b + c + d)		15.87%		$110.52
21 Projected Premium				$696.23
22 Multi Product Discount				$0.00
23 Rate Adjustment				($94.31)
24 Proposed Premium				*$601.92*
26 Estimated Current Total Amount Due				$567.86
27 Required Rate Change (excludes 22 & 23)				*22.61%*
28 Proposed Rate Change (26 / 27 - 1)				*6.00%*

City Of Hallandale Beach

Programs and Services - Fully Insured Funding		Effective Date: October 01, 2020
Program Summary	OA EC	OA HNO
Implementation/Account Management		
Designated Account Management Team	Included	Included
Designated Service Center	Included	Included
Open Enrollment Marketing Material (Standard) and Onsite Meeting Preparation	Included	Included
Standard ID Cards	Included	Included
Network Services		
Nap Flex	Included	Included
Teladoc®	Included	Included
National Medical Excellence Program® - Transplant Coordination	Included	Included
Care Management		
MedQuery® with Member Messaging	Included	Included
Aetna Maternity Program	Included	Included
Enhanced Clinical Review	Included	Included
Aetna's CareEngine-Powered PHR	Included	Included
Utilization Management	Included	Included
Aetna In Touch Care℠ - Premier	Included	Included
Member Resources		
Member Website and Mobile Experience	Included	Included
Aetna Concierge	Included	Included
Attain by Aetna℠ (Apple Watch Program)	Included	Included
Allowances		
Enrollment Support- $20,000	Included	Included
Annual Wellness Allowance - $85,000	Included	Included
Pharmacy Programs		
Choose Generics	Included	Included
Step Therapy	Included	Included
Reporting		
Utilization Management Reporting	Included	Included
Behavioral Health		
Managed Behavioral Health	Included	Included
Applied Behavioral Analysis (ABA)	Included	Included
AbleTo Network - subject to member cost share	Included	Included

Allowances

Annual Wellness Allowance	Cost
We are including a wellness allowance of up to $85,000 that may be used towards reasonable wellness services procured by the Plan Sponsor from third party vendors to pay for wellness-related expense such as wellness fairs, biometric screenings and on-site flu vaccinations incurred during the October 01, 2020 to September 30, 2021 plan year. These funds will be available as of the effective date of the period. Our preferred method of payment of wellness-related expenses is directly to the vendor. Payment will be made once the expenses are incurred and invoice(s) are provided. Invoices must be submitted to us within 60 days following the close of the plan year. Expenses must be for wellness related programs or activities that are designed to promote the health and well being of plan participants, or to educate the participants about healthy lifestyles and choices. Any expenses beyond the Wellness Allowance are the responsibility of the customer. Any balance of this allowance fund remaining at the end of the policy year will be forfeited. Any amounts ("Wellness allowance") paid by Aetna to a plan sponsor to offset or reimburse such plan sponsor for any expense or costs incurred as a result of contracting with Aetna for benefits plan administration services, shall be paid in accordance with applicable law. Plan sponsors are advised to determine appropriate accounting for these payments with their own counsel or accountant. Any plan sponsor receiving a wellness 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, and for additional counsel regarding the accounting for reporting of such payments. We assume the funding of any wellness 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.	Included

City Of Hallandale Beach

Caveats - Fully Insured Funding — Effective Date: October 01, 2020

We are relying on information from the Plan Sponsor and its representatives in establishing the rates and terms of this proposal. 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. For example, but without limitation, Aetna may change rates if there is a material deviation from the rate quotation assumptions, manufacturer Rebate contracts, or if the Plan Sponsor is unable to provide us with the requested information. As another example, if additional information related to this quotation is made available to us at a later date, we reserve the right to reassess, and potentially revise, this quotation based upon analysis of that information. For states that require approval of rate filings, your final rate may be different if the quoted rates are not approved by the effective date of coverage.

Documentation
Summary of Renewal Rates, Experience and Rate Change Development The attached Summary of Renewal Rates exhibit outlines your premium rates for the upcoming policy period. The Experience exhibit(s) displays your experience for the most recent 12 months and adjusts for any plan change (if applicable). The Rate Change Development takes the current experience, and adds on trend, a large claim adjustment factor, expenses, taxes and/ or producer service fees/commissions to develop the required premium.
Assumptions
Prospective Quoting The quoted insured medical rates are offered on a prospectively rated basis. No policy year accounting balance will be calculated for these coverages.
Billing and Payment of Premium Amount due is payable on the first day of the month covered by the invoice. If the amount due is not paid in full within 30 days, we reserve the right to terminate the contract and/or assess late premium payment charges.
Claim Fiduciary Aetna will be the claim fiduciary for medical coverages. As claim fiduciary, Aetna will be responsible for final claim determination and the legal defense of disputed benefit payments for medical.
Domestic Partner This proposal assumes that coverage is extended to Domestic Partners. Eligible dependents include an employee's spouse and children up to the limiting age of the plan. Individuals cannot be covered as an employee and dependent under the same plan, nor may both under the same plan cover children eligible for coverage through both parents. Dependents must enroll in same benefit option as the employee.
Large Claim Adjustment Standalone, non-medical pharmacy claims are excluded and do not accumulate towards the large claim threshold.
Producer Compensation We are not serving as billing and collection agent for producer service fee, therefore such fee is not included in this renewal and commissions have also been excluded from our quoted rates.
Contributions Our rates assume compliance with our standard guidelines on employer contribution strategy. We standardly require that the employer contribute 75% of the employee cost, or 50% of the total employee and dependent cost. Employer contributions may not favor other medical plans over that of the Aetna plans. Our plan will have neutral to favorable employer contributions after adjusting for plan design, compared to other medical plans, including consumer directed plans (HRA and/or HSA models). In option situations, employer contributions must not disadvantage our offering.
Group Policy/Group Agreement ("Contract") Period The policy period begins on the effective date of October 01, 2020.
Mandates Benefit provisions are subject to state, local, and federal mandates. Future mandates will be incorporated in the plan(s) as of the date required by law and may require rate adjustments.
Medical Pooling The enclosed insured medical rates month pooling point threshold of $175,000
Mental Health/Substance Abuse Benefits Mental health/chemical dependency benefits are included.

City Of Hallandale Beach

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Plan Design

All competing offerings (HMO, POS, PPO, ACO, EPO Plus, Open Access EPO, Managed Plus, Open Access Managed Plus, Network Only Plus, Open Access Network Only Plus, and Indemnity) must include similar coverage for the specific benefit provisions outlined below that may cause adverse plan selections. This could include specific provisions such as DME, Infertility/Advanced Reproductive Technology (ART), self injectables, pharmacy, bariatric surgery, diabetic supplies, domestic partners, lens/vision hardware, chiropractic coverage , emergency room coverage, etc. It could include exclusions/limitations or benefits furnished under a self-insured plan PPO, POS or consumer directed alternative. Similar maximums must also exist for mental health and substance abuse, skilled nursing facility days of care , and home health care coverage. The provision also allows for adjustments required because of regulatory or legislative action. Employees eligible for these benefits will not be eligible for Limited Benefits style plans (i.e. insurance plans that offer only basic coverage for accident and sickness related medical expenses or plans that provide limited benefits and not coverage for catastrophic medical or chronic medical conditions).

Plan Design

For our fully insured products, all applicable government regulations and state mandates will apply.

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.

Rate Mutualization

The enclosed rates are mutualized and assume that either our medical plans are offered on a sole replacement basis with-out competitor plan offerings, or that competitors' rates are mutualized over exactly the same service areas. Rate mutualization is also offered under the condition that the site specific contribution strategy does not financially disfavor us from any competitor plan offerings. The mutualized rates assume that the plan will be offered in all sites included in the mutualized rates. If actual site-specific enrollment differs significantly from that assumed during the mutualized rate calculation, we reserve the right to recalculate the mutualized rates based upon actual site-by-site enrollment.

Run-In Claim Processing

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

Network Re-Contracting

In addition to standard fee-for-services rates, contracted rates with network providers may also be based on case and/or per diem rates and in some circumstances, include risk-adjustment calculations, quality incentives, pay-for-performance and other incentive and adjustment mechanisms. These mechanisms may include payments to organizations that may refer to themselves as accountable care organizations (“ACOs”) and patient-centered medical homes (“PCMHs”), in the form of accountable care payments (ACP) and incentive arrangements based on clinical performance and cost-effectiveness. The ACP amount is based upon an assessment for each member who is already accessing providers in an ACO, and is assessed retrospectively on a quarterly basis and collected through established claim wire. Each ACO will have a different ACP based on the clinical efficiencies targeted and network negotiations. The ACP assists the ACO in funding transformation of the health care system to improve quality, reduce costs and enhance the patient experience by:

- Identifying and engaging patients at risk for health crises sooner through more data-sharing
- Increasing patient engagement in best-in-class care management programs through doctor-driven outreach
- Delivering better health outcomes through increased collaboration between the health plan and ACO providers

City Of Hallandale Beach

Caveats - Fully Insured Funding — Effective Date: October 01, 2020

We are relying on information from the Plan Sponsor and its representatives in establishing the rates and terms of this proposal. 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. For example, but without limitation, Aetna may change rates if there is a material deviation from the rate quotation assumptions, manufacturer Rebate contracts, or if the Plan Sponsor is unable to provide us with the requested information. As another example, if additional information related to this quotation is made available to us at a later date, we reserve the right to reassess, and potentially revise, this quotation based upon analysis of that information. For states that require approval of rate filings, your final rate may be different if the quoted rates are not approved by the effective date of coverage.

We reserve the right to revise the premium, modify the terms of the offer, or terminate if:
Member/Subscriber Ratio The enrolled member to subscriber ratio increases or decreases by more than 10% from the 1.92 ratio assumed in this quote.
Enrollment The actual enrollment in total or by plan changes by more than 10% compared with what was proposed. The plan sponsor offers coverage to employee previously not covered under the plan without prior notification. (Change in census is based on additions and subtractions - a 60 life group who adds 3 people and takes away 3 others has a 6 person change in census even though they stay at 60 lives.)
Participation and Contribution Rules Under Affordable Care Act (ACA) and state insurance regulations, a group health insurance policy may be non-renewed for certain reasons. We reserve the right to non-renew for failure to comply with certain requirements such as participation and/or contribution rules.
Contract Provisions The final benefit provisions, account structure, claim payment requirements or services change from those proposed.
Covered Lives, Demographics A 5.0% percent change in the demographics and/or geographic mix of the enrolled group in aggregate or in any site with at least 100 enrolled subscribers. A 10 percent change in the total number of subscribers enrolled in each individual product or in aggregate, including the impact of new or terminating locations and/or groups.
Retiree & COBRA Members The premium rates assume that the pre-65 retirees, COBRA and non-Medicare disabled participants combined comprise less than five percent of the total Aetna covered group and that this group doesn't vary in size by more than two percent from the previous year. For option (slice) offerings, pre-65, COBRA and non-Medicare disabled participants must be eligible for the same benefits as the active population. Retirees are not included among the eligible population. We expect Medicare primary individuals to pursue such coverage. The premium rates assume that COBRA participants comprise less than ten percent of the total Aetna covered group. Include if customer covers Medicare eligible retirees which is non-standard - Medicare eligibles must participate in both Medicare Part A and Medicare Part B.
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 Products and Services Costs for special services, that are not included or assumed in the rate guarantee will be direct-billed after such services have been rendered. For example, the Plan Sponsor will be subject to additional charges for customized communication materials. 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.

Additional
Please review the additional important information found at the following URL: http://www.aetna.com/legal-notices/documents/2020-middle-market-public-labor-insured-medical-uw-disclosures-03.15.20.pdf http://www.aetna.com/legal-notices/documents/2021-national-accounts-insured-medical-uw-disclosures.pdf This information is incorporated in and is a part of this proposal. This quote is subject to all the terms and conditions set forth in this URL. In the event that any information contained herein conflicts or is inconsistent with the information in the Underwriter Disclosure document, the information in your Package shall prevail.
Point of Service Rebates This proposal may include point of service rebates ("POS Rebates") favorable to, and shared with, eligible subscribers and dependents. However, Aetna reserves the right to make appropriate changes to the premium offered hereunder in the event POS Rebates are discontinued, in whole or in part, on account of any material changes made to (i) the laws, rules and/or regulations applicable to POS Rebates or (ii) any material drug manufacturer rebate contracts providing the source for POS Rebates.

City Of Hallandale Beach

Caveats - Fully Insured Funding — Effective Date: October 01, 2020

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Medical Disclosure Information

At the time of annual enrollment, your plan participants should be provided with the Medical Disclosure information related to their plan of benefits. Go to our corporate website and enter the state followed by the word 'Disclosure' in the search field Please provide the applicable Medical Disclosure document and any required Addendum to your plan participants. If you have any questions, please contact your broker or account management team.

Health Care Reform Caveats

This renewal offer assumes your plan is not grandfathered.

As a non-grandfathered plan, the plan will include Preventive care as defined by regulation without cost sharing on In Network services.
This renewal includes the women's preventive care coverage requirements, e.g., coverage for contraceptive methods and counseling, breastfeeding support and equipment, and prenatal care.
Certain employers and organizations may be exempt from contraceptive services coverage requirements, and choose an optional accommodation. If you qualify and want to be exempt from including ACA contraceptive services benefits in your policy, please work with your Account Manager/Account Executive to provide the required documentation to us so that we can administer accordingly. We have the right to treat insured plans as subject to the ACA contraceptive services coverage requirements without an executed certification document. Applicable state laws requiring coverage of or related to contraceptive services benefits still may apply.

Affordable Care Act – fees and assessments

The Affordable Care Act (ACA) imposed several fees/assessments, including the Health Insurance Providers Fee (HIF). HIF is a recurring, annual, industry fee assessed based on each insurer's share of the fully insured market, as determined by the IRS. This rate quote includes, as applicable, an estimated proportionate allocation of expense associated with the HIF. We reserve 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.

Waiting Period Requirement

When renewing your plan(s) with us, you represent that:

- You will give us effective dates for your employees and their dependents that take into account all state and federal eligibility conditions and waiting period requirements, including a reasonable and bona fide orientation period.
- If this information changes, you will inform us immediately.

Summaries of Benefits and Coverage (SBC)

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

Under the Affordable Care Act (ACA), minimum value and minimum essential coverage determinations are associated with the employer shared responsibility provisions. We will review the minimum value standard for each plan based on the MV calculator criteria provided by the Department of Health and Human Services (HHS) and will indicate within the SBC whether the plan meets or does not meet the MV standard based on this review. We do not provide legal or tax advice, and recommend that plan sponsors consult with their own legal and tax counselors when reviewing MEC and MV determinations. We have no responsibility or liability regarding the minimum value or minimum essential coverage evaluation, regardless of the role we may have played in reviewing/producing the SBC documents. To the extent you disagree with our evaluation, we will make changes to reflect your determination, as you are responsible for the final determination of these SBC elements.

City Of Hallandale Beach

Caveats - Fully Insured Funding — Effective Date: October 01, 2020

We are relying on information from the Plan Sponsor and its representatives in establishing the rates and terms of this proposal. 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. For example, but without limitation, Aetna may change rates if there is a material deviation from the rate quotation assumptions, manufacturer Rebate contracts, or if the Plan Sponsor is unable to provide us with the requested information. As another example, if additional information related to this quotation is made available to us at a later date, we reserve the right to reassess, and potentially revise, this quotation based upon analysis of that information. For states that require approval of rate filings, your final rate may be different if the quoted rates are not approved by the effective date of coverage.

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 insured group health plans, the reporting obligation under Section 6055 is our responsibility. We will report the required information to the IRS about the type and period of coverage provided to each individual member enrolled in our insured plans, and will furnish the required statements to subscribers.

We must report the entire Social Security numbers (SSN) to the IRS for each subscriber and dependent in order to complete our required reporting. However, the final rules allow the use of truncated social security numbers on statements furnished to individuals (for example, give only the last four digits of the SSN). If we don't receive the SSN through the employer, the law requires we reach out to each subscriber up to three separate times to request the information.

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

To satisfy the 6056 employer reporting requirements, an applicable large employer 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.

City Of Hallandale Beach

The Federal Mental Health Parity and Addiction Equity Act **Effective Date: October 01, 2020**

The Federal Mental Health Parity and Addiction Equity Act (MHPAEA) requires parity in coverage for mental health and substance abuse services compared to medical and surgical services. The law allows outpatient benefits to be sub-classified between "office visits" and "all other" outpatient services. Beginning on 1/1/18, or your next renewal date, we are changing your benefits separating Outpatient Mental health/Substance Abuse into two new benefit categories: BH Office Visit and BH All Other.

- "BH Office Visit " includes services where members will interact with a provider in an office setting for treatment
- "BH All other" includes services where members will have some other interaction with providers in obtaining care – such as technological intervention or where the service is traditionally delivered outside an office setting, like in the home

Beginning January 1, 2018, the following Behavioral Health services will be classified as behavioral health outpatient "all other" for purposes of Federal Mental Health Parity law:

- Partial hospitalization programs (PHP)
- Intensive outpatient programs (IOP)
- Applied behavior analysis (ABA) for the treatment of autism spectrum disorder
- Home health care
- Transcranial magnetic stimulation
- Electroconvulsive therapy (ECT)
- Vagus nerve stimulation (normally an excluded benefit)
- Outpatient monitoring of injectable therapy
- Psychological testing
- Neuropsychological testing
- Medical treatment for withdrawal symptoms
- Outpatient detoxification
- Ambulatory detoxification
- 23-hour observation

In an effort to comply with the new law, we are also revising several medical, mental health and substance use disorder benefits cost share. In order for your plan to pass the 'substantially all" and "predominate" cost share testing required by MHPAEA, the following medical benefits cost share may change with your renewal:

- Lab
- X-ray noncomplex and X-ray complex
- Outpatient Surgery Freestanding
- Outpatient Surgery Hospital
- Medical Injection in an Office Visit
- Home Health
- Outpatient Hospice

In addition, the behavioral Health All Other benefit will have a cost share that is equal to or better than the above medical benefits.