**Active**

**EUTF – 90/10 PPO Plan**

**Table and Proposal Sheets #1**

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| **ACTIVE** |  |  |  |
| **EUTF – 90/10 PPO PLAN** |  |  |  |
| **TABLE AND PROPOSAL SHEETS #1** | | | |
|  |  |  |  |
| Detailed benefits information is provided in Exhibit E. Please note any deviation in proposed benefits in the charts below. Unless noted it will be assumed that proposed benefits match the requested benefits exactly. You must agree to a “no loss, no gain” provision with the current benefit plan. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis. | | | |

| **TABLE 1 - ACTIVE** | | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| **Plan Design** | | **EUTF 90/10 PPO PLAN** | | | **NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS** | |
| **MEDICAL** | | **Provided by HMSA** | | |  | |
| **General** | | **In-Network** | **Out-of-Network\*** | |  | |
| Calendar Year Deductible | | None | $100 per person  $300 per family | |  | |
| Calendar Year Maximum  Out-of-Pocket | | $2,000 per person  $4,000 per family | | |  | |
| Lifetime Benefit Maximum | | None | | |  | |
| Plan Year Benefit Maximum | | None | | |  | |
| **PHYSICIAN SERVICES** | | **MEMBER PAYS** | | |  | |
| Physician Office Visit (including primary care and specialist office visits) | | 10% | 30% | |  | |
| Annual Health Exam | | No Charge | No Charge\*\* | |  | |
| Diabetes Prevention Program | | No Charge  (one program/  lifetime) | Not Covered | |  | |
| Immunizations | | No Charge | No Charge\*\* | |  | |
| Well Child Care Visits | | No Charge | 30%\*\* | |  | |
| Maternity | | 10% | 30% | |  | |
| Screening Mammography | | No Charge | 30%\*\* | |  | |
| Advance Care Planning | | No Charge | 30% | |  | |
| **EMERGENCY SERVICES** | | | | | | |
| Emergency Room | | 10% | 10%\*\* | |  | |
| Ambulance | | 10% | 30% | |  | |
| **INPATIENT CARE** | | | | | | |
| Room and Board | | 10% | 30% | |  | |
| Ancillary Services | | 10% | 30% | |  | |
| Physician Services | | 10% | 30% | |  | |
| Surgery | | 10% | 30% | |  | |
| Anesthesia | | 10% | 30% | |  | |
| Mental Health Services | | 10% | 30% | |  | |
| **OUTPATIENT CARE** | | | | | | |
| Chemotherapy | | 10% | 30% | |  | |
| Radiation Therapy | | 10% | 30% | |  | |
| Lab and Pathology | | 10% | 30% | |  | |
| Diagnostic Testing and X-ray (including genetic testing and counseling) | | 10% | 30% | |  | |
| Allergy Testing | | 10% | 30% | |  | |
| Surgery | | 10% | 30% | |  | |
| Anesthesia | | 10% | 30% | |  | |
| Mental Health Services | | 10% | 30% | |  | |
| **TABLE 1 - ACTIVE** | | | | | | |
| **Plan Design** | **EUTF 90/10 PPO PLAN** | | | | | **NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS** |
| **OTHER SERVICES** | | | | | | |
| Durable Medical Equipment | 10% | | | 30% | |  |
| Hearing Aids | 10%  (one device per ear every 60 months) | | | 30%  (one device per ear every 60 months) | |  |
| Home Health Care | No Charge  (150 visits/CY) | | | 30%  (150 visits/CY) | |  |
| Hospice Care | No Charge | | | Not Covered | |  |
| Supportive Care | No Charge  (90 days/  12-month period) | | | Not Covered | |  |
| Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities) | 10%  (120 days/CY) | | | 30%  (120 days/CY) | |  |
| Physical and Occupational Therapy | 10% | | | 30% | |  |
| Reversing Heart Disease Program | $20 per session  (one program/  lifetime) | | | Not Covered | |  |
| Chiropractic Services | $15  (20 visits/CY)  through American Specialty Health Group, Inc. | | | Not Covered | |  |
| **PRESCRIPTION DRUGS** | **Provided by CVS/caremark** | | | | |  |
|  | **Participating Pharmacy** | | | **Non-Participating Pharmacy\*** | |  |
| Calendar Year Maximum  Out-of-Pocket\*\*\* | $4,350 per person  $8,700 per family | | | | |  |
| **Retail** |  | | |  | |  |
| Day Supply | 30/60/90 | | | 30/60/90 | |  |
| Generic | $5/$10/$15 | | | $5/$10/$15 + 20% of eligible charges | |  |
| Preferred Brand | $25/$50/$75 | | | $25/$50/$75 + 20% of eligible charges | |  |
| Non-Preferred Brand | $50/$100/$150 | | | $50/$100/$150 + 20% of eligible charges | |  |
| Preferred Insulin | $5/$10/$15 | | | $5/$10/$15 + 20% of eligible charges | |  |
| Other Insulin | $25/$50/$75 | | | $25/$50/$75 + 20% of eligible charges | |  |
| Preferred Diabetic Supplies | No Charge | | | 20% of eligible charges | |  |
| Other Diabetic Supplies | $25/$50/$75 | | | $25/$50/$75 + 20% of eligible charges | |  |
| Oral Contraceptives | No Charge | | | 20% of eligible charges | |  |
| **Injectables & Specialty Drug** | **30-day supply only** | | | | |  |
| Specialty Calendar Year Maximum Out-of-Pocket | $2,500 per person | | | | |  |
| Specialty Generic | 10% of eligible charges (up to $200 per fill) | | | | |  |
| Specialty Preferred Brand | 20% of eligible charges (up to $300 per fill) | | | | |  |
| Specialty Non-Preferred Brand | 30% of eligible charges (up to $400 per fill) | | | | |  |
| Oral Oncology | $30 | | | | |  |
| **Retail 90 and Mail Order** | **Retail 90 or Mail Pharmacy** | | | **Non-Retail 90 Pharmacy** | |  |
| Day Supply | 30/60/90 | | | 30/60/90 | |  |
| Generic | $5/$10/$10 | | | $5/$10/$15 | |  |
| Preferred Brand | $25/$50/$50 | | | $25/$50/$75 | |  |
| Non-Preferred Brand | $50/$100/$100 | | | $50/$100/$150 | |  |
| Preferred Insulin | $5/$10/$10 | | | $5/$10/$15 | |  |
| Other Insulin | $25/$50/$50 | | | $25/$50/$75 | |  |
| Preferred Diabetic Supplies | No Charge | | | No Charge | |  |
| Other Diabetic Supplies | $25/$50/$50 | | | $25/$50/$75 | |  |
| Oral Contraceptives | No Charge | | | No Charge | |  |
| Injectables & Specialty Drug | Not Covered | | | See benefit described above | |  |

**NOTE: Prescription drug benefits are currently provided under a separate contract.**

Footnotes applicable to Medical and Prescription Drug benefits:

*\* Out-of-Network benefits are limited to usual customary and reasonable charges. Out-of-pocket expenses for out-of-network benefits apply towards the total annual maximum out-of-pocket (MOOP) but may exceed the MOOP once the MOOP is reached.*

*\*\* Deductible does not apply.*

*\*\*\* Applicable copayments and caps for specialty medications apply towards the total annual maximum out-of-pocket.*

*✝ Maintenance medications must be filled in a 90-day supply after the first three 30-day initial fills; can be filled at any retail network or mail pharmacy.*

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| **INSURED, RISK SHARING** |  |  |  |
| **Proposal Sheet 1A** | | | |
| **90/10 PPO Plan – EUTF Active – All Bargaining Units** | | | |
| **Premium Rate Table (Insured with Risk Sharing-Surplus Refund)** | | | |
| ***Complete the following table on a monthly, per capita tiered basis ONLY*** | | | |
|  |  |  |  |
| The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. If the total benefit paid at the end of the runout period is less than the proposed benefit cost, the excess amount will be refunded to the EUTF. The EUTF reserves the right to carve-out the prescription drugs from this proposal. | | | |

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| **EUTF 90/10 PPO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL*** | | | | |
| **Monthly Medical (Excluding DM/IHM and Chiropractic) Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly Chiropractic Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Monthly Administration and Retention:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Total Medical Premium (Including DM/IHM, Chiropractic, and Administration and Retention):** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly ACA Fees to be Added to the Above Total Medical Premium** | | | | |
| **Insurer Fee:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

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| **EUTF 90/10 PPO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***PRESCRIPTION DRUG*** | | | | |
| **Monthly Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Monthly Administration and Retention:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Total Prescription Drug Premium (Including Administration and Retention):** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly ACA Fees to be Added to the Above Total Prescription Drug Premium** | | | | |
| **Insurer Fee:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

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| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
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| **Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): \_\_\_\_\_%** | | | | |
| NOTES:  (1) The EUTF reserves the right to offer multiple carrier options.  (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable. | | | | |
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| **Authorized Signature** |  |  |  |  |
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| **Title** |  |  |  |  |
|  |  |  |  |  |
| **Name of Company** |  |  | **Date** |  |

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| **SELF-INSURED** |  |  |  |
| **Proposal Sheet 1B** | | | |
| **90/10 PPO Plan – EUTF Active – All Bargaining Units** | | | |
| **Target Claims, Retention and Fees Tables (Self-Insured ASO)** | | | |
| ***Complete the following table based upon enrollment census and claims assumptions provided.*** | | | |

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| **EUTF 90/10 PPO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL*** | | | | |
| **Monthly Medical ASO Fees (PEPM):** | | | | |
| PPO Leasing/Network Access Fees |  |  |  |  |
| Claims Adjudication Fee |  |  |  |  |
| Utilization Management Fees |  |  |  |  |
| Disease Management (DM) |  |  |  |  |
| Integrated Health Management (IHM) |  |  |  |  |
| Other\* |  |  |  |  |
| **Total Medical ASO Fees (PEPM):** |  |  |  |  |
| **Total Medical ASO Fees by Tier:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Estimated Medical Claims Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

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| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
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| \* ID Cards, Wellness, Provider Directory, Booklets/SPDs, Data Reporting, Medical Info Line, Banking, Any Start-up Cost, etc. | | | | |
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| **Authorized Signature** |  |  |  |  |
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| **Title** |  |  |  |  |
|  |  |  |  |  |
| **Name of Company** |  |  | **Date** |  |

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| **MINIMUM PREMIUM** |  |  |  |
| **Proposal Sheet 1C** | | | |
| **90/10 PPO Plan – EUTF Active – All Bargaining Units** | | | |
| **Premium Rate Table (Insured with Limited Risk Sharing)** | | | |
| ***Complete the following table on a monthly, per capita tiered basis ONLY*** | | | |
|  | | | |
| The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. The EUTF will pay the Medical ASO Fees, and actual medical claims up to the Maximum Medical Claims Cost indicated below. If the total claims paid at the end of the runout period is greater than the Maximum Medical Claims Cost indicated below, the excess amount will not be collected from the EUTF. Only actual claims and fees up to the targeted claim maximum will be charged. The EUTF reserves the right to carve-out the prescription drugs from this proposal. | | | |

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| **EUTF 90/10 PPO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL*** | | | | |
| **Monthly Medical ASO Fees (PEPM):** | | | | |
| PPO Leasing/Network Access Fees |  |  |  |  |
| Claims Adjudication Fee |  |  |  |  |
| Utilization Management Fees |  |  |  |  |
| Disease Management (DM) |  |  |  |  |
| Integrated Health Management (IHM) |  |  |  |  |
| Other\* |  |  |  |  |
| **Total Medical ASO Fees (PEPM):** |  |  |  |  |
| **Total Medical ASO Fees by Tier:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Maximum Medical Claims Cost (paid by EUTF):** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

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| --- | --- | --- | --- | --- |
| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
|  |  |  |  |  |
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|  |  |  |  |  |
|  |  |  |  |  |
| \* ID Cards, Wellness, Provider Directory, Booklets/SPDs, Data Reporting, Medical Info Line, Banking, Any Start-up Cost, etc. | | | | |
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|  |  |  |  |  |
| **Authorized Signature** |  |  |  |  |
|  |  |  |  |  |
| **Title** |  |  |  |  |
|  |  |  |  |  |
| **Name of Company** |  |  | **Date** |  |

**Active**

**EUTF – 80/20 PPO Plan**

**Table and Proposal Sheets #2**

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| **ACTIVE** |  |  |  |
| **EUTF – 80/20 PPO PLAN** |  |  |  |
| **TABLE AND PROPOSAL SHEETS #2** | | | |
|  |  |  |  |
| Detailed benefits information is provided in Exhibit E. Please note any deviation in proposed benefits in the charts below. Unless noted it will be assumed that proposed benefits match the requested benefits exactly. You must agree to a “no loss, no gain” provision with the current benefit plan. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis. | | | |

| **TABLE 2 - ACTIVE** | | | |
| --- | --- | --- | --- |
| **Plan Design** | **EUTF 80/20 PPO PLAN** | | **NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS** |
| **MEDICAL** | **Provided by HMSA** | |  |
| **General** | **In-Network** | **Out-of-Network\*** |  |
| Calendar Year Deductible | None | $250 per person  $750 per family |  |
| Calendar Year Maximum  Out-of-Pocket | $2,500 per person  $5,000 per family | |  |
| Lifetime Benefit Maximum | None | |  |
| Plan Year Benefit Maximum | None | |  |
| **PHYSICIAN SERVICES** | **MEMBER PAYS** | |  |
| Physician Office Visit (including primary care and specialist office visits) | 20% | 40% |  |
| Annual Health Exam | No Charge | No Charge\*\* |  |
| Diabetes Prevention Program | No Charge  (one program/  lifetime) | Not Covered |  |
| Immunizations | No Charge | No Charge\*\* |  |
| Well Child Care Visits | No Charge | 40%\*\* |  |
| Maternity | 20% | 40% |  |
| Screening Mammography | No Charge | 40%\*\* |  |
| Advance Care Planning | No Charge | 40% |  |
| **EMERGENCY SERVICES** | | | |
| Emergency Room | 20% | 20%\*\* |  |
| Ambulance | 20% | 40% |  |
| **INPATIENT CARE** | | | |
| Room and Board | 20% | 40% |  |
| Ancillary Services | 20% | 40% |  |
| Physician Services | 20% | 40% |  |
| Surgery | 20% | 40% |  |
| Anesthesia | 20% | 40% |  |
| Mental Health Services | 20% | 40% |  |
| **OUTPATIENT CARE** | | | |
| Chemotherapy | 20% | 40% |  |
| Radiation Therapy | 20% | 40% |  |
| Lab and Pathology | 20% | 40% |  |
| Diagnostic Testing and X-ray (including genetic testing and counseling) | 20% | 40% |  |
| Allergy Testing | 20% | 40% |  |
| Surgery | 20% | 40% |  |
| Anesthesia | 20% | 40% |  |
| Mental Health Services | 20% | 40% |  |

| **TABLE 2 - ACTIVE** | | | |
| --- | --- | --- | --- |
| **Plan Design** | **EUTF 80/20 PPO PLAN** | | **NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS** |
| **OTHER SERVICES** | | | |
| Durable Medical Equipment | 20% | 40% |  |
| Hearing Aids | 20%  (one device per ear every 60 months) | 40%  (one device per ear every 60 months) |  |
| Home Health Care | 20%  (150 visits/CY) | 40%  (150 visits/CY) |  |
| Hospice Care | No Charge | Not Covered |  |
| Supportive Care | No Charge  (90 days/  12-month period) | Not Covered |  |
| Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities) | 20%  (120 days/CY) | 40%  (120 days/CY) |  |
| Physical and Occupational Therapy | 20% | 40% |  |
| Reversing Heart Disease Program | $20 per session  (one program/  lifetime) | Not Covered |  |
| Chiropractic Services | $15  (20 visits/CY)  through American Specialty Health Group, Inc. | Not Covered |  |
| **PRESCRIPTION DRUGS** | **Provided by CVS/caremark** | |  |
|  | **Participating Pharmacy** | **Non-Participating Pharmacy\*** |  |
| Calendar Year Maximum  Out-of-Pocket\*\*\* | $4,350 per person  $8,700 per family | |  |
| **Retail** |  |  |  |
| Day Supply | 30/60/90 | 30/60/90 |  |
| Generic | $5/$10/$15 | $5/$10/$15 + 20% of eligible charges |  |
| Preferred Brand | $25/$50/$75 | $25/$50/$75 + 20% of eligible charges |  |
| Non-Preferred Brand | $50/$100/$150 | $50/$100/$150 + 20% of eligible charges |  |
| Preferred Insulin | $5/$10/$15 | $5/$10/$15 + 20% of eligible charges |  |
| Other Insulin | $25/$50/$75 | $25/$50/$75 + 20% of eligible charges |  |
| Preferred Diabetic Supplies | No Charge | 20% of eligible charges |  |
| Other Diabetic Supplies | $25/$50/$75 | $25/$50/$75 + 20% of eligible charges |  |
| Oral Contraceptives | No Charge | 20% of eligible charges |  |
| **Injectables & Specialty Drug** | **30-day supply only** | |  |
| Specialty Calendar Year Maximum Out-of-Pocket | $2,500 per person | |  |
| Specialty Generic | 10% of eligible charges (up to $200 per fill) | |  |
| Specialty Preferred Brand | 20% of eligible charges (up to $300 per fill) | |  |
| Specialty Non-Preferred Brand | 30% of eligible charges (up to $400 per fill) | |  |
| Oral Oncology | $30 | |  |
| **Retail 90 and Mail Order** | **Retail 90 or Mail Pharmacy** | **Non-Retail 90 Pharmacy** |  |
| Day Supply | 30/60/90 | 30/60/90 |  |
| Generic | $5/$10/$10 | $5/$10/$15 |  |
| Preferred Brand | $25/$50/$50 | $25/$50/$75 |  |
| Non-Preferred Brand | $50/$100/$100 | $50/$100/$150 |  |
| Preferred Insulin | $5/$10/$10 | $5/$10/$15 |  |
| Other Insulin | $25/$50/$50 | $25/$50/$75 |  |
| Preferred Diabetic Supplies | No Charge | No Charge |  |
| Other Diabetic Supplies | $25/$50/$50 | $25/$50/$75 |  |
| Oral Contraceptives | No Charge | No Charge |  |
| Injectables & Specialty Drug | Not Covered | See benefit described above |  |

**NOTE: Prescription drug benefits are currently provided under a separate contract.**

Footnotes applicable to Medical and Prescription Drug benefits:

*\* Out-of-Network benefits are limited to usual customary and reasonable charges. Out-of-pocket expenses for out-of-network benefits apply towards the total annual maximum out-of-pocket (MOOP) but may exceed the MOOP once the MOOP is reached.*

*\*\* Deductible does not apply.*

*\*\*\* Applicable copayments and caps for specialty medications apply towards the total annual maximum out-of-pocket.*

*✝ Maintenance medications must be filled in a 90-day supply after the first three 30-day initial fills; can be filled at any retail network or mail pharmacy.*

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| **INSURED, RISK SHARING** |  |  |  |
| **Proposal Sheet 2A** | | | |
| **80/20 PPO Plan – EUTF Active – All Bargaining Units** | | | |
| **Premium Rate Table (Insured with Risk Sharing-Surplus Refund)** | | | |
| ***Complete the following table on a monthly, per capita tiered basis ONLY*** | | | |
|  |  |  |  |
| The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. If the total benefit paid at the end of the runout period is less than the proposed benefit cost, the excess amount will be refunded to the EUTF. The EUTF reserves the right to carve-out the prescription drugs from this proposal. | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **EUTF 80/20 PPO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL*** | | | | |
| **Monthly Medical (Excluding DM/IHM and Chiropractic) Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly Chiropractic Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Monthly Administration and Retention:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Total Medical Premium (Including DM/IHM, Chiropractic, and Administration and Retention):** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly ACA Fees to be Added to the Above Total Medical Premium** | | | | |
| **Insurer Fee:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

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| **EUTF 80/20 PPO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***PRESCRIPTION DRUG*** | | | | |
| **Monthly Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Monthly Administration and Retention:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Total Prescription Drug Premium (Including Administration and Retention):** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly ACA Fees to be Added to the Above Total Prescription Drug Premium** | | | | |
| **Insurer Fee:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

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| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
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| **Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): \_\_\_\_\_%** | | | | |
| NOTES:  (1) The EUTF reserves the right to offer multiple carrier options.  (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable. | | | | |
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| **Authorized Signature** |  |  |  |  |
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| **SELF-INSURED** |  |  |  |
| **Proposal Sheet 2B** | | | |
| **80/20 PPO Plan – EUTF Active – All Bargaining Units** | | | |
| **Target Claims, Retention and Fees Tables (Self-Insured ASO)** | | | |
| ***Complete the following table based upon enrollment census and claims assumptions provided.*** | | | |

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| **EUTF 80/20 PPO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL*** | | | | |
| **Monthly Medical ASO Fees (PEPM):** | | | | |
| PPO Leasing/Network Access Fees |  |  |  |  |
| Claims Adjudication Fee |  |  |  |  |
| Utilization Management Fees |  |  |  |  |
| Disease Management (DM) |  |  |  |  |
| Integrated Health Management (IHM) |  |  |  |  |
| Other\* |  |  |  |  |
| **Total Medical ASO Fees (PEPM):** |  |  |  |  |
| **Total Medical ASO Fees by Tier:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Estimated Medical Claims Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

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| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
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|  |  |  |  |  |
| \* ID Cards, Wellness, Provider Directory, Booklets/SPDs, Data Reporting, Medical Info Line, Banking, Any Start-up Cost, etc. | | | | |
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| **Authorized Signature** |  |  |  |  |
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| **Name of Company** |  |  | **Date** |  |

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| **MINIMUM PREMIUM** |  |  |  |
| **Proposal Sheet 2C** | | | |
| **80/20 PPO Plan – EUTF Active – All Bargaining Units** | | | |
| **Premium Rate Table (Insured with Limited Risk Sharing)** | | | |
| ***Complete the following table on a monthly, per capita tiered basis ONLY*** | | | |
|  | | | |
| The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. The EUTF will pay the Medical ASO Fees, and actual medical claims up to the Maximum Medical Claims Cost indicated below. If the total claims paid at the end of the runout period is greater than the Maximum Medical Claims Cost indicated below, the excess amount will not be collected from the EUTF. Only actual claims and fees up to the targeted claim maximum will be charged. The EUTF reserves the right to carve-out the prescription drugs from this proposal. | | | |

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| **EUTF 80/20 PPO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL*** | | | | |
| **Monthly Medical ASO Fees (PEPM):** | | | | |
| PPO Leasing/Network Access Fees |  |  |  |  |
| Claims Adjudication Fee |  |  |  |  |
| Utilization Management Fees |  |  |  |  |
| Disease Management (DM) |  |  |  |  |
| Integrated Health Management (IHM) |  |  |  |  |
| Other\* |  |  |  |  |
| **Total Medical ASO Fees (PEPM):** |  |  |  |  |
| **Total Medical ASO Fees by Tier:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Maximum Medical Claims Cost (paid by EUTF):** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

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| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
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| \* ID Cards, Wellness, Provider Directory, Booklets/SPDs, Data Reporting, Medical Info Line, Banking, Any Start-up Cost, etc. | | | | |
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| **Name of Company** |  |  | **Date** |  |

**Active**

**EUTF – 75/25 PPO Plan**

**Table and Proposal Sheets #3**

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| **ACTIVE** |  |  |  |
| **EUTF – 75/25 PPO PLAN** |  |  |  |
| **TABLE AND PROPOSAL SHEETS #3** | | | |
|  |  |  |  |
| Detailed benefits information is provided in Exhibit E. Please note any deviation in proposed benefits in the charts below. Unless noted it will be assumed that proposed benefits match the requested benefits exactly. You must agree to a “no loss, no gain” provision with the current benefit plan. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis. | | | |

| **TABLE 3 - ACTIVE** | | | |
| --- | --- | --- | --- |
| **Plan Design** | **EUTF 75/25 PPO PLAN** | | **NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS** |
| **MEDICAL** | **Provided by HMSA** | |  |
| **General** | **In-Network** | **Out-of-Network\*** |  |
| Calendar Year Deductible | $300 per person  $900 per family | |  |
| Calendar Year Maximum  Out-of-Pocket | $5,000 per person  $10,000 per family | |  |
| Lifetime Benefit Maximum | None | |  |
| Plan Year Benefit Maximum | None | |  |
| **PHYSICIAN SERVICES** | **MEMBER PAYS** | |  |
| Physician Office Visit (including primary care and specialist office visits) | 25%\*\* | 40% |  |
| Annual Health Exam | No Charge\*\* | No Charge\*\* |  |
| Diabetes Prevention Program | No Charge\*\*  (one program/  lifetime) | Not Covered |  |
| Immunizations | No Charge\*\* | No Charge\*\* |  |
| Well Child Care Visits | No Charge\*\* | 40%\*\* |  |
| Maternity | 25% | 40% |  |
| Screening Mammography | No Charge\*\* | 40%\*\* |  |
| Advance Care Planning | No Charge\*\* | 40% |  |
| **EMERGENCY SERVICES** | | | |
| Emergency Room | 25% | 25% |  |
| Ambulance | 25% | 40% |  |
| **INPATIENT CARE** | | | |
| Room and Board | 25% | 40% |  |
| Ancillary Services | 25% | 40% |  |
| Physician Services | 25%\*\* | 40% |  |
| Surgery | 25% | 40% |  |
| Anesthesia | 25% | 40% |  |
| Mental Health Services – Facility Services | 25% | 40% |  |
| **OUTPATIENT CARE** | | | |
| Chemotherapy | 25% | 40% |  |
| Radiation Therapy | 25% | 40% |  |
| Lab and Pathology | 25%\*\* | 40% |  |
| Diagnostic Testing and X-ray (including genetic testing and counseling) | 25% | 40% |  |
| Allergy Testing | 25% | 40% |  |
| Surgery | 25% | 40% |  |
| Anesthesia | 25% | 40% |  |
| Mental Health Services – Facility Services | 25% | 40% |  |

| **TABLE 3 - ACTIVE** | | | |
| --- | --- | --- | --- |
| **Plan Design** | **EUTF 75/25 PPO PLAN** | | **NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS** |
| **OTHER SERVICES** | | | |
| Durable Medical Equipment | 25% | 40% |  |
| Hearing Aids | 25%  (one device per ear every 60 months) | 40%  (one device per ear every 60 months) |  |
| Home Health Care | 25%  (150 visits/CY) | 40%  (150 visits/CY) |  |
| Hospice Care | No Charge | Not Covered |  |
| Supportive Care | No Charge  (90 days/  12-month period) | Not Covered |  |
| Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities) | 25%  (120 days/CY) | 40%  (120 days/CY) |  |
| Physical and Occupational Therapy | 25% | 40% |  |
| Reversing Heart Disease Program | $20 per session\*\*  (one program/  lifetime) | Not Covered |  |
| Chiropractic Services | $15  (20 visits/CY)  through American Specialty Health Group, Inc. | Not Covered |  |
| **PRESCRIPTION DRUGS** | **Provided by CVS/caremark** | |  |
|  | **Participating Pharmacy** | **Non-Participating Pharmacy\*** |  |
| Calendar Year Maximum  Out-of-Pocket\*\*\* | $3,150 per person  $6,300 per family | |  |
| **Retail** |  |  |  |
| Day Supply | 30/60/90 | 30/60/90 |  |
| Generic | $5/$10/$15 | $5/$10/$15 + 20% of eligible charges |  |
| Preferred Brand | $25/$50/$75 | $25/$50/$75 + 20% of eligible charges |  |
| Non-Preferred Brand | $50/$100/$150 | $50/$100/$150 + 20% of eligible charges |  |
| Preferred Insulin | $5/$10/$15 | $5/$10/$15 + 20% of eligible charges |  |
| Other Insulin | $25/$50/$75 | $25/$50/$75 + 20% of eligible charges |  |
| Preferred Diabetic Supplies | No Charge | 20% of eligible charges |  |
| Other Diabetic Supplies | $25/$50/$75 | $25/$50/$75 + 20% of eligible charges |  |
| Oral Contraceptives | No Charge | 20% of eligible charges |  |
| **Injectables & Specialty Drug** | **30-day supply only** | |  |
| Specialty Calendar Year Maximum Out-of-Pocket | $2,500 per person | |  |
| Specialty Generic | 10% of eligible charges (up to $200 per fill) | |  |
| Specialty Preferred Brand | 20% of eligible charges (up to $300 per fill) | |  |
| Specialty Non-Preferred Brand | 30% of eligible charges (up to $400 per fill) | |  |
| Oral Oncology | $30 | |  |
| **Retail 90 and Mail Order** | **Retail 90 or Mail Pharmacy** | **Non-Retail 90 Pharmacy** |  |
| Day Supply | 30/60/90 | 30/60/90 |  |
| Generic | $5/$10/$10 | $5/$10/$15 |  |
| Preferred Brand | $25/$50/$50 | $25/$50/$75 |  |
| Non-Preferred Brand | $50/$100/$100 | $50/$100/$150 |  |
| Preferred Insulin | $5/$10/$10 | $5/$10/$15 |  |
| Other Insulin | $25/$50/$50 | $25/$50/$75 |  |
| Preferred Diabetic Supplies | No Charge | No Charge |  |
| Other Diabetic Supplies | $25/$50/$50 | $25/$50/$75 |  |
| Oral Contraceptives | No Charge | No Charge |  |
| Injectables & Specialty Drug | Not Covered | See benefit described above |  |

**NOTE: Prescription drug benefits are currently provided under a separate contract.**

Footnotes applicable to Medical and Prescription Drug benefits:

*\* Out-of-Network benefits are limited to usual customary and reasonable charges. Out-of-pocket expenses for out-of-network benefits apply towards the total annual maximum out-of-pocket (MOOP) but may exceed the MOOP once the MOOP is reached.*

*\*\* Deductible does not apply.*

*\*\*\* Applicable copayments and caps for specialty medications apply towards the total annual maximum out-of-pocket.*

*✝ Maintenance medications must be filled in a 90-day supply after the first three 30-day initial fills; can be filled at any retail network or mail pharmacy.*

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| **INSURED, RISK SHARING** |  |  |  |
| **Proposal Sheet 3A** | | | |
| **75/25 PPO Plan – EUTF Active – All Bargaining Units** | | | |
| **Premium Rate Table (Insured with Risk Sharing-Surplus Refund)** | | | |
| ***Complete the following table on a monthly, per capita tiered basis ONLY*** | | | |
|  |  |  |  |
| The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. If the total benefit paid at the end of the runout period is less than the proposed benefit cost, the excess amount will be refunded to the EUTF. The EUTF reserves the right to carve-out the prescription drugs from this proposal. | | | |

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| **EUTF 75/25 PPO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL*** | | | | |
| **Monthly Medical (Excluding DM/IHM and Chiropractic) Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly Chiropractic Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Monthly Administration and Retention:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Total Medical Premium (Including DM/IHM, Chiropractic, and Administration and Retention):** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly ACA Fees to be Added to the Above Total Medical Premium** | | | | |
| **Insurer Fee:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

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| **EUTF 75/25 PPO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***PRESCRIPTION DRUG*** | | | | |
| **Monthly Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Monthly Administration and Retention:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Total Prescription Drug Premium (Including Administration and Retention):** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly ACA Fees to be Added to the Above Total Prescription Drug Premium** | | | | |
| **Insurer Fee:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

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| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
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|  |  |  |  |  |
| **Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): \_\_\_\_\_%** | | | | |
| NOTES:  (1) The EUTF reserves the right to offer multiple carrier options.  (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable. | | | | |
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| **Authorized Signature** |  |  |  |  |
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| **SELF-INSURED** |  |  |  |
| **Proposal Sheet 3B** | | | |
| **75/25 PPO Plan – EUTF Active – All Bargaining Units** | | | |
| **Target Claims, Retention and Fees Tables (Self-Insured ASO)** | | | |
| ***Complete the following table based upon enrollment census and claims assumptions provided.*** | | | |

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| --- | --- | --- | --- | --- |
| **EUTF 75/25 PPO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL*** | | | | |
| **Monthly Medical ASO Fees (PEPM):** | | | | |
| PPO Leasing/Network Access Fees |  |  |  |  |
| Claims Adjudication Fee |  |  |  |  |
| Utilization Management Fees |  |  |  |  |
| Disease Management (DM) |  |  |  |  |
| Integrated Health Management (IHM) |  |  |  |  |
| Other\* |  |  |  |  |
| **Total Medical ASO Fees (PEPM):** |  |  |  |  |
| **Total Medical ASO Fees by Tier:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Estimated Medical Claims Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

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| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
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|  |  |  |  |  |
| \* ID Cards, Wellness, Provider Directory, Booklets/SPDs, Data Reporting, Medical Info Line, Banking, Any Start-up Cost, etc. | | | | |
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| **Authorized Signature** |  |  |  |  |
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| **Name of Company** |  |  | **Date** |  |

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| **MINIMUM PREMIUM** |  |  |  |
| **Proposal Sheet 3C** | | | |
| **75/25 PPO Plan – EUTF Active – All Bargaining Units** | | | |
| **Premium Rate Table (Insured with Limited Risk Sharing)** | | | |
| ***Complete the following table on a monthly, per capita tiered basis ONLY*** | | | |
|  | | | |
| The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. The EUTF will pay the Medical ASO Fees, and actual medical claims up to the Maximum Medical Claims Cost indicated below. If the total claims paid at the end of the runout period is greater than the Maximum Medical Claims Cost indicated below, the excess amount will not be collected from the EUTF. Only actual claims and fees up to the targeted claim maximum will be charged. The EUTF reserves the right to carve-out the prescription drugs from this proposal. | | | |

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| **EUTF 75/25 PPO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL*** | | | | |
| **Monthly Medical ASO Fees (PEPM):** | | | | |
| PPO Leasing/Network Access Fees |  |  |  |  |
| Claims Adjudication Fee |  |  |  |  |
| Utilization Management Fees |  |  |  |  |
| Disease Management (DM) |  |  |  |  |
| Integrated Health Management (IHM) |  |  |  |  |
| Other\* |  |  |  |  |
| **Total Medical ASO Fees (PEPM):** |  |  |  |  |
| **Total Medical ASO Fees by Tier:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Maximum Medical Claims Cost (paid by EUTF):** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

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| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
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|  |  |  |  |  |
| \* ID Cards, Wellness, Provider Directory, Booklets/SPDs, Data Reporting, Medical Info Line, Banking, Any Start-up Cost, etc. | | | | |
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| **Authorized Signature** |  |  |  |  |
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| **Title** |  |  |  |  |
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| **Name of Company** |  |  | **Date** |  |

**Active**

**EUTF – 75/25 PPO Plan**

**(Part-Time and Temporary Employees)**

**Table and Proposal Sheets #4**

|  |  |  |  |
| --- | --- | --- | --- |
| **ACTIVE** |  |  |  |
| **EUTF – 75/25 PPO PLAN (PART-TIME AND TEMPORARY EMPLOYEES)** | | | |
| **TABLE AND PROPOSAL SHEETS #4** | | | |
|  |  |  |  |
| Detailed benefits information is provided in Exhibit E. Please note any deviation in proposed benefits in the charts below. Unless noted it will be assumed that proposed benefits match the requested benefits exactly. You must agree to a “no loss, no gain” provision with the current benefit plan. Please note that the benefit plan design shall not change throughout the duration of the contract unless required otherwise by law. | | | |

| **TABLE 4 - ACTIVE** | | | |
| --- | --- | --- | --- |
| **Plan Design** | **EUTF 75/25 PPO PLAN** | | **NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS** |
| **MEDICAL** | **Provided by HMSA** | |  |
| **General** | **In-Network** | **Out-of-Network\*** |  |
| Calendar Year Deductible | $300 per person  $900 per family | |  |
| Calendar Year Maximum  Out-of-Pocket | $5,000 per person  $10,000 per family | |  |
| Lifetime Benefit Maximum | None | |  |
| Plan Year Benefit Maximum | None | |  |
| **PHYSICIAN SERVICES** | **MEMBER PAYS** | |  |
| Physician Office Visit (including primary care and specialist office visits) | 25%\*\* | 40% |  |
| Annual Health Exam | No Charge\*\* | No Charge\*\* |  |
| Diabetes Prevention Program | No Charge\*\*  (one program/  lifetime) | Not Covered |  |
| Immunizations | No Charge\*\* | No Charge\*\* |  |
| Well Child Care Visits | No Charge\*\* | 40%\*\* |  |
| Maternity | 25% | 40% |  |
| Screening Mammography | No Charge\*\* | 40%\*\* |  |
| Advance Care Planning | No Charge\*\* | 40% |  |
| **EMERGENCY SERVICES** | | | |
| Emergency Room | 25% | 25% |  |
| Ambulance | 25% | 40% |  |
| **INPATIENT CARE** | | | |
| Room and Board | 25% | 40% |  |
| Ancillary Services | 25% | 40% |  |
| Physician Services | 25%\*\* | 40% |  |
| Surgery | 25% | 40% |  |
| Anesthesia | 25% | 40% |  |
| Mental Health Services – Facility Services | 25% | 40% |  |
| **OUTPATIENT CARE** | | | |
| Chemotherapy | 25% | 40% |  |
| Radiation Therapy | 25% | 40% |  |
| Lab and Pathology | 25%\*\* | 40% |  |
| Diagnostic Testing and X-ray (including genetic testing and counseling) | 25% | 40% |  |
| Allergy Testing | 25% | 40% |  |
| Surgery | 25% | 40% |  |
| Anesthesia | 25% | 40% |  |
| Mental Health Services – Facility Services | 25% | 40% |  |
| **OTHER SERVICES** | | | |
| Durable Medical Equipment | 25% | 40% |  |
| Hearing Aids | 25%  (one device per ear every 60 months) | 40%  (one device per ear every 60 months) |  |
| Home Health Care | 25%  (150 visits/CY) | 40%  (150 visits/CY) |  |
| Hospice Care | No Charge | Not Covered |  |
| Supportive Care | No Charge  (90 days/  12-month period) | Not Covered |  |
| Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities) | 25%  (120 days/CY) | 40%  (120 days/CY) |  |
| Physical and Occupational Therapy | 25% | 40% |  |
| Reversing Heart Disease Program | $20 per session\*\*  (one program/  lifetime) | Not Covered |  |
| **PRESCRIPTION DRUGS**  **Provided by HMSA** | **Participating Pharmacy** | **Non-Participating Pharmacy\*** |  |
| Calendar Year Maximum  Out-of-Pocket\*\*\* | $3,150 per person  $6,300 per family | |  |
| **Retail** |  |  |  |
| Day Supply | 30/60/90 | 30/60/90 |  |
| Generic | $5/$10/$15 | $5/$10/$15 + 20% of eligible charges |  |
| Preferred Brand | $25/$50/$75 | $25/$50/$75 + 20% of eligible charges |  |
| Non-Preferred Brand | $50/$100/$150 | $50/$100/$150 + 20% of eligible charges |  |
| Preferred Insulin | $5/$10/$15 | $5/$10/$15 + 20% of eligible charges |  |
| Other Insulin | $25/$50/$75 | $25/$50/$75 + 20% of eligible charges |  |
| Preferred Diabetic Supplies | No Charge | 20% of eligible charges |  |
| Other Diabetic Supplies | $25/$50/$75 | $25/$50/$75 + 20% of eligible charges |  |
| Oral Contraceptives | No Charge | 20% of eligible charges |  |
| **Injectables & Specialty Drug** | **30-day supply only** | |  |
| Specialty Calendar Year Maximum Out-of-Pocket | $2,500 per person | |  |
| Specialty Generic | 10% of eligible charges (up to $200 per fill) | |  |
| Specialty Preferred Brand | 20% of eligible charges (up to $300 per fill) | |  |
| Specialty Non-Preferred Brand | 30% of eligible charges (up to $400 per fill) | |  |
| Oral Oncology | $30 | |  |
| **Retail 90 and Mail Order** | **Retail 90 or Mail Pharmacy** | **Non-Retail 90 Pharmacy** |  |
| Day Supply | 30/60/90 | 30/60/90 |  |
| Generic | $5/$10/$10 | $5/$10/$15 |  |
| Preferred Brand | $25/$50/$50 | $25/$50/$75 |  |
| Non-Preferred Brand | $50/$100/$100 | $50/$100/$150 |  |
| Preferred Insulin | $5/$10/$10 | $5/$10/$15 |  |
| Other Insulin | $25/$50/$50 | $25/$50/$75 |  |
| Preferred Diabetic Supplies | No Charge | No Charge |  |
| Other Diabetic Supplies | $25/$50/$50 | $25/$50/$75 |  |
| Oral Contraceptives | No Charge | No Charge |  |
| Injectables & Specialty Drug | Not Covered | See benefit described above |  |

Footnotes applicable to Medical and Prescription Drug benefits:

*\* Out-of-Network benefits are limited to usual customary and reasonable charges. Out-of-pocket expenses for out-of-network benefits apply towards the total annual maximum out-of-pocket (MOOP) but may exceed the MOOP once the MOOP is reached.*

*\*\* Deductible does not apply.*

*\*\*\* Applicable copayments and caps for specialty medications apply towards the total annual maximum out-of-pocket.*

*✝ Maintenance medications must be filled in a 90-day supply after the first three 30-day initial fills; can be filled at any retail network or mail pharmacy.*

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| **INSURED** |  |  |  |
| **Proposal Sheet 4** | | | |
| **75/25 PPO Plan – EUTF Active – Part-Time and Temporary Employees** | | | |
| **Premium Rate Table (Fully Insured)** | | | |
| ***Complete the following table on a monthly, per capita tiered basis ONLY*** | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **EUTF 75/25 PPO Plan**  **(Part-Time and Temporary Employees)** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL AND PRESCRIPTION DRUG*** | | | | |
| **Monthly Medical Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly Prescription Drug Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Monthly Administration and Retention:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Total Medical and Prescription Drug Premium (Including Administration and Retention):** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly ACA Fees to be Added to the Above Total Medical and Prescription Drug Premium** | | | | |
| **Insurer Fee:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| NOTES:  (1) The EUTF reserves the right to offer multiple carrier options.  (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable. | | | | |
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| **Authorized Signature** |  |  |  |  |
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| **Title** |  |  |  |  |
|  |  |  |  |  |
| **Name of Company** |  |  | **Date** |  |

**Active**

**EUTF – HMO Plan**

**Table and Proposal Sheets #5**

|  |  |  |  |
| --- | --- | --- | --- |
| **ACTIVE** |  |  |  |
| **EUTF – HMO PLAN** |  |  |  |
| **TABLE AND PROPOSAL SHEETS #5** | | | |
|  |  |  |  |
| Detailed benefits information is provided in Exhibit E. Please note any deviation in proposed benefits in the charts below. Unless noted it will be assumed that proposed benefits match the requested benefits exactly. You must agree to a “no loss, no gain” provision with the current benefit plan. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis. | | | |

| **TABLE 5 - ACTIVE** | | | |
| --- | --- | --- | --- |
| **Plan Design** | **EUTF HMO PLAN** | | **NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS** |
| **MEDICAL** | **Provided by HMSA** | |  |
| **General** | **HMO Network** | |  |
| Calendar Year Deductible | None | |  |
| Calendar Year Maximum  Out-of-Pocket | $1,500 per person  $3,000 per family | |  |
| Lifetime Benefit Maximum | None | |  |
| Plan Year Benefit Maximum | None | |  |
| **PHYSICIAN SERVICES** | **MEMBER PAYS** | |  |
| Physician Office Visit (including primary care and specialist office visits) | $15 | |  |
| Annual Health Exam | No Charge | |  |
| Diabetes Prevention Program | No Charge  (one program/lifetime) | |  |
| Immunizations | No Charge | |  |
| Well Child Care Visits | No Charge | |  |
| Maternity | No Charge for routine prenatal visits, delivery, and one postpartum visit | |  |
| Screening Mammography | No Charge | |  |
| Advance Care Planning | No Charge | |  |
| **EMERGENCY SERVICES** | | | |
| Emergency Room | $100 | |  |
| Ambulance | 20% | |  |
| **INPATIENT CARE** | | | |
| Room and Board | No Charge | |  |
| Ancillary Services | No Charge | |  |
| Physician Services | No Charge | |  |
| Surgery | No Charge | |  |
| Anesthesia | No Charge | |  |
| Mental Health Services – Facility Services | No Charge | |  |
| **OUTPATIENT CARE** | | | |
| Chemotherapy | $15 | |  |
| Radiation Therapy | $15 | |  |
| Lab and Pathology | No Charge | |  |
| Diagnostic Testing and X-ray (including genetic testing and counseling) | No Charge for diagnostic testing  $15 per X-ray | |  |
| Allergy Testing | $15 | |  |
| Surgery | No Charge for outpatient surgery center  $15 for outpatient professional charges | |  |
| Anesthesia | $15 | |  |
| Mental Health Services – Facility Services | No Charge | |  |
| **OTHER SERVICES** | | | |
| Durable Medical Equipment | 20% | |  |
| Hearing Aids | 20%  (one device per ear every 60 months) | |  |
| Home Health Care | No Charge  (365 visits/illness or injury) | |  |
| Hospice Care | No Charge | |  |
| Supportive Care | No Charge  (90 days/12-month period) | |  |
| Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities) | No Charge  (100 days/CY) | |  |
| Physical and Occupational Therapy | $15 (Outpatient) | |  |
| Reversing Heart Disease Program | $20 per session  (one program/lifetime) | |  |
| Chiropractic Services | $15 (20 visits/CY)  through American Specialty Health Group, Inc. | |  |
| **PRESCRIPTION DRUGS** | **Provided by CVS/caremark** | |  |
|  | **Participating Pharmacy** | **Non-Participating Pharmacy\*** |  |
| Calendar Year Maximum  Out-of-Pocket\*\* | $4,350 per person  $8,700 per family | |  |
| **Retail** |  |  |  |
| Day Supply | 30/60/90 | 30/60/90 |  |
| Generic | $5/$10/$15 | $5/$10/$15 + 20% of eligible charges |  |
| Preferred Brand | $25/$50/$75 | $25/$50/$75 + 20% of eligible charges |  |
| Non-Preferred Brand | $50/$100/$150 | $50/$100/$150 + 20% of eligible charges |  |
| Preferred Insulin | $5/$10/$15 | $5/$10/$15 + 20% of eligible charges |  |
| Other Insulin | $25/$50/$75 | $25/$50/$75 + 20% of eligible charges |  |
| Preferred Diabetic Supplies | No Charge | 20% of eligible charges |  |
| Other Diabetic Supplies | $25/$50/$75 | $25/$50/$75 + 20% of eligible charges |  |
| Oral Contraceptives | No Charge | 20% of eligible charges |  |
| **Injectables & Specialty Drug** | **30-day supply only** | |  |
| Specialty Calendar Year Maximum Out-of-Pocket | $2,500 per person | |  |
| Specialty Generic | 10% of eligible charges (up to $200 per fill) | |  |
| Specialty Preferred Brand | 20% of eligible charges (up to $300 per fill) | |  |
| Specialty Non-Preferred Brand | 30% of eligible charges (up to $400 per fill) | |  |
| Oral Oncology | $30 | |  |
| **Retail 90 and Mail Order** | **Retail 90 or Mail Pharmacy** | **Non-Retail 90 Pharmacy** |  |
| Day Supply | 30/60/90 | 30/60/90 |  |
| Generic | $5/$10/$10 | $5/$10/$15 |  |
| Preferred Brand | $25/$50/$50 | $25/$50/$75 |  |
| Non-Preferred Brand | $50/$100/$100 | $50/$100/$150 |  |
| Preferred Insulin | $5/$10/$10 | $5/$10$/15 |  |
| Other Insulin | $25/$50/$50 | $25/$50/$75 |  |
| Preferred Diabetic Supplies | No Charge | No Charge |  |
| Other Diabetic Supplies | $25/$50/$50 | $25/$50/$75 |  |
| Oral Contraceptives | No Charge | No Charge |  |
| Injectables & Specialty Drug | Not Covered | See benefit described above |  |

**NOTE: Prescription drug benefits are currently provided under a separate contract.**

Footnotes applicable to Prescription Drug benefits:

*\* Out-of-Network benefits are limited to usual customary and reasonable charges. Out-of-pocket expenses for out-of-network benefits apply towards the total annual maximum out-of-pocket (MOOP) but may exceed the MOOP once the MOOP is reached.*

*\*\* Applicable copayments and caps for specialty medications apply towards the total annual maximum out-of-pocket.*

*\*\*\* Maintenance medications must be filled in a 90-day supply after the first three 30-day initial fills; can be filled at any retail network or mail pharmacy.*

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| **INSURED, RISK SHARING** |  |  |  |
| **Proposal Sheet 5A** | | | |
| **HMO Plan – EUTF Active – All Bargaining Units** | | | |
| **Premium Rate Table (Insured with Risk Sharing-Surplus Refund)** | | | |
| ***Complete the following table on a monthly, per capita tiered basis ONLY*** | | | |
|  |  |  |  |
| The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. If the total benefit paid at the end of the runout period is less than the proposed benefit cost, the excess amount will be refunded to the EUTF. The EUTF reserves the right to carve-out the prescription drugs from this proposal. | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **EUTF HMO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL*** | | | | |
| **Monthly Medical (Excluding DM/IHM and Chiropractic) Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly Chiropractic Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Monthly Administration and Retention:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Total Medical Premium (Including DM/IHM, Chiropractic, and Administration and Retention):** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly ACA Fees to be Added to the Above Total Medical Premium** | | | | |
| **Insurer Fee:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **EUTF HMO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***PRESCRIPTION DRUG*** | | | | |
| **Monthly Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Monthly Administration and Retention:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Total Prescription Drug Premium (Including Administration and Retention):** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly ACA Fees to be Added to the Above Total Prescription Drug Premium** | | | | |
| **Insurer Fee:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): \_\_\_\_\_%** | | | | |
| NOTES:  (1) The EUTF reserves the right to offer multiple carrier options.  (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable. | | | | |
|  |  |  |  |  |
|  |  |  |  |  |
| **Authorized Signature** |  |  |  |  |
|  |  |  |  |  |
| **Title** |  |  |  |  |
|  |  |  |  |  |
| **Name of Company** |  |  | **Date** |  |

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| **SELF-INSURED** |  |  |  |
| **Proposal Sheet 5B** | | | |
| **HMO Plan – EUTF Active – All Bargaining Units** | | | |
| **Target Claims, Retention and Fees Tables (Self-Insured ASO)** | | | |
| ***Complete the following table based upon enrollment census and claims assumptions provided.*** | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **EUTF HMO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL*** | | | | |
| **Monthly Medical ASO Fees (PEPM):** | | | | |
| HMO Leasing/Network Access Fees |  |  |  |  |
| Capitation Fee |  |  |  |  |
| Claims Adjudication Fee |  |  |  |  |
| Utilization Management Fees |  |  |  |  |
| Disease Management (DM) |  |  |  |  |
| Integrated Health Management (IHM) |  |  |  |  |
| Other\* |  |  |  |  |
| **Total Medical ASO Fees (PEPM):** |  |  |  |  |
| **Total Medical ASO Fees by Tier:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Estimated Medical Claims Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| \* ID Cards, Wellness, Provider Directory, Booklets/SPDs, Data Reporting, Medical Info Line, Banking, Any Start-up Cost, etc. | | | | |
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|  |  |  |  |  |
| **Authorized Signature** |  |  |  |  |
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| **Title** |  |  |  |  |
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| **Name of Company** |  |  | **Date** |  |

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| **MINIMUM PREMIUM** |  |  |  |
| **Proposal Sheet 5C** | | | |
| **HMO Plan – EUTF Active – All Bargaining Units** | | | |
| **Premium Rate Table (Insured with Limited Risk Sharing)** | | | |
| ***Complete the following table on a monthly, per capita tiered basis ONLY*** | | | |
|  | | | |
| The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. The EUTF will pay the Medical ASO Fees, and actual medical claims up to the Maximum Medical Claims Cost indicated below. If the total claims paid at the end of the runout period is greater than the Maximum Medical Claims Cost indicated below, the excess amount will not be collected from the EUTF. Only actual claims and fees up to the targeted claim maximum will be charged. The EUTF reserves the right to carve-out the prescription drugs from this proposal. | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **EUTF HMO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL*** | | | | |
| **Monthly Medical ASO Fees (PEPM):** | | | | |
| HMO Leasing/Network Access Fees |  |  |  |  |
| Capitation Fee |  |  |  |  |
| Claims Adjudication Fee |  |  |  |  |
| Utilization Management Fees |  |  |  |  |
| Disease Management (DM) |  |  |  |  |
| Integrated Health Management (IHM) |  |  |  |  |
| Other\* |  |  |  |  |
| **Total Medical ASO Fees (PEPM):** |  |  |  |  |
| **Total Medical ASO Fees by Tier:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Maximum Medical Claims Cost (paid by EUTF):** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| \* ID Cards, Wellness, Provider Directory, Booklets/SPDs, Data Reporting, Medical Info Line, Banking, Any Start-up Cost, etc. | | | | |
|  |  |  |  |  |
| **Authorized Signature** |  |  |  |  |
|  |  |  |  |  |
| **Title** |  |  |  |  |
|  |  |  |  |  |
| **Name of Company** |  |  | **Date** |  |

**Active**

**EUTF – Closed Panel Comprehensive HMO Plan**

**Table and Proposal Sheets #6**

|  |  |  |  |
| --- | --- | --- | --- |
| **ACTIVE** |  |  |  |
| **EUTF – CLOSED PANEL COMPREHENSIVE HMO PLAN** | | | |
| **TABLE AND PROPOSAL SHEETS #6** | | | |
|  |  |  |  |
| Detailed benefits information is provided in Exhibit E. Please note any deviation in proposed benefits in the charts below. Unless noted it will be assumed that proposed benefits match the requested benefits exactly. You must agree to a “no loss, no gain” provision with the current benefit plan. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis. | | | |

| **TABLE 6 - ACTIVE** | | |
| --- | --- | --- |
| **Plan Design** | **EUTF CLOSED PANEL**  **COMPREHENSIVE HMO PLAN** | **NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS** |
| **MEDICAL** | **Provided by Kaiser** |  |
| **General** | **HMO Network** |  |
| Calendar Year Deductible | None |  |
| Calendar Year Maximum  Out-of-Pocket | $2,000 per person  $6,000 per family |  |
| Lifetime Benefit Maximum | None |  |
| Plan Year Benefit Maximum | None |  |
| **PHYSICIAN SERVICES** | **MEMBER PAYS** |  |
| Physician Office Visit (including primary care and specialist office visits) | $15 |  |
| Annual Health Exam | No Charge |  |
| Diabetes Prevention Program | No Charge |  |
| Immunizations | No Charge |  |
| Well Child Care Visits | No Charge |  |
| Maternity | No Charge for routine prenatal visits, delivery, and one postpartum visit |  |
| Screening Mammography | No Charge |  |
| Advance Care Planning | No Charge (Continuing Care) |  |
| **EMERGENCY SERVICES** | | |
| Emergency Room | $50 |  |
| Ambulance | 20% |  |
| **INPATIENT CARE** | | |
| Room and Board | No Charge |  |
| Ancillary Services | No Charge |  |
| Physician Services | No Charge |  |
| Surgery | No Charge |  |
| Anesthesia | No Charge |  |
| Mental Health Services | No Charge |  |
| **OUTPATIENT CARE** | | |
| Chemotherapy | $15 |  |
| Radiation Therapy | $15 |  |
| Lab and Pathology | $15 per day |  |
| Diagnostic Testing and X-ray | $15 per day |  |
| Allergy Testing | $15 |  |
| Surgery | $15 |  |
| Anesthesia | $15 |  |
| Mental Health Services | $15 |  |
| **OTHER SERVICES** | | |
| Durable Medical Equipment | 20% |  |
| Hearing Aids | 60%  (one device per ear every 36 months) |  |
| Home Health Care | No Charge |  |
| Hospice Care | No Charge |  |
| Skilled Nursing Facility Care | No Charge  (100 days/benefit period) |  |
| Physical and Occupational Therapy | $15 (Outpatient) |  |
| Chiropractic Services | $15 (20 visits/CY)  through American Specialty Health Group, Inc. |  |
| **PRESCRIPTION DRUGS** | **Provided by Kaiser** |  |
| Calendar Year Maximum  Out-of-Pocket | Applies towards the medical maximum  out-of-pocket |  |
| **Retail** |  |  |
| Day Supply | 30/60/90 |  |
| Generic | $5/$10/$15 – tier 1  $10/$20/$30 – tier 2 |  |
| Preferred Brand | $35/$70/$105 |  |
| Non-Preferred Brand | $35/$70/$105 |  |
| Preferred Insulin | $35/$70/$105 |  |
| Other Insulin | $10/$20/$30 (Generic) |  |
| Preferred Diabetic Supplies | $35/$70/$105 |  |
| Other Diabetic Supplies | $35/$70/$105 |  |
| Oral Contraceptives | No Charge |  |
| Injectables & Specialty Drug | $75/$150/$225 |  |
| Oral Oncology | No Charge |  |
| **Mail Order** |  |  |
| Day Supply | 30/60/90 |  |
| Generic | $5/$10/$10 – tier 1  $10/$20/$20 – tier 2 |  |
| Preferred Brand | $35/$70/$70 |  |
| Non-Preferred Brand | $35/$70/$70 |  |
| Preferred Insulin | Not available through Mail Order |  |
| Other Insulin | Not available through Mail Order |  |
| Preferred Diabetic Supplies | $35/$70/$70 |  |
| Other Diabetic Supplies | $35/$70/$70 |  |
| Oral Contraceptives | No Charge |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **INSURED** |  |  |  |
| **Proposal Sheet 6** | | | |
| **Closed Panel Comprehensive HMO Plan – EUTF Active – All Bargaining Units** | | | |
| **Premium Rate Table (Fully Insured)** | | | |
| ***Complete the following table on a monthly, per capita tiered basis ONLY*** | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **EUTF Closed Panel Comprehensive HMO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL AND PRESCRIPTION DRUG*** | | | | |
| **Monthly Medical and Prescription Drug (Excluding DM/IHM and Chiropractic) Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly Chiropractic Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Monthly Administration and Retention:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Total Medical and Prescription Drug Premium (Including DM/IHM, Chiropractic, and Administration and Retention):** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly ACA Fees to be Added to the Above Total Medical and Prescription Drug Premium** | | | | |
| **Insurer Fee:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| NOTES:  (1) The EUTF reserves the right to offer multiple carrier options.  (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable. | | | | |
|  |  |  |  |  |
|  |  |  |  |  |
| **Authorized Signature** |  |  |  |  |
|  |  |  |  |  |
| **Title** |  |  |  |  |
|  |  |  |  |  |
| **Name of Company** |  |  | **Date** |  |

**Active**

**EUTF – Closed Panel Standard HMO Plan**

**Table and Proposal Sheets #7**

|  |  |  |  |
| --- | --- | --- | --- |
| **ACTIVE** |  |  |  |
| **EUTF – CLOSED PANEL STANDARD HMO PLAN** | | | |
| **TABLE AND PROPOSAL SHEETS #7** | | | |
|  |  |  |  |
| Detailed benefits information is provided in Exhibit E. Please note any deviation in proposed benefits in the charts below. Unless noted it will be assumed that proposed benefits match the requested benefits exactly. You must agree to a “no loss, no gain” provision with the current benefit plan. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis. | | | |

| **TABLE 7 - ACTIVE** | | |
| --- | --- | --- |
| **Plan Design** | **EUTF CLOSED PANEL**  **STANDARD HMO PLAN** | **NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS** |
| **MEDICAL** | **Provided by Kaiser** |  |
| **General** | **HMO Network** |  |
| Calendar Year Deductible | None |  |
| Calendar Year Maximum  Out-of-Pocket | $2,500 per person  $7,500 per family |  |
| Lifetime Benefit Maximum | None |  |
| Plan Year Benefit Maximum | None |  |
| **PHYSICIAN SERVICES** | **MEMBER PAYS** |  |
| Physician Office Visit (including primary care and specialist office visits) | $20 |  |
| Annual Health Exam | No Charge |  |
| Diabetes Prevention Program | No Charge |  |
| Immunizations | No Charge |  |
| Well Child Care Visits | No Charge |  |
| Maternity | No Charge for routine prenatal visits and one postpartum visit  15% for delivery |  |
| Screening Mammography | No Charge |  |
| Advance Care Planning | No Charge (Continuing Care) |  |
| **EMERGENCY SERVICES** | | |
| Emergency Room | $100 |  |
| Ambulance | 20% |  |
| **INPATIENT CARE** | | |
| Room and Board | 15% |  |
| Ancillary Services | 15% |  |
| Physician Services | 15% |  |
| Surgery | 15% |  |
| Anesthesia | 15% |  |
| Mental Health Services | 15% |  |
| **OUTPATIENT CARE** | | |
| Chemotherapy | $20 |  |
| Radiation Therapy | 20% |  |
| Lab and Pathology | $10 per day for basic  20% for specialty |  |
| Diagnostic Testing and X-ray | 20% for testing services  $10 per day for general imaging services  20% for specialty imaging services |  |
| Allergy Testing | $20 |  |
| Surgery | 15% for outpatient surgery center  $20 for outpatient professional charges |  |
| Anesthesia | $20 |  |
| Mental Health Services | $20 |  |

| **TABLE 7 - ACTIVE** | | |
| --- | --- | --- |
| **Plan Design** | **EUTF CLOSED PANEL**  **STANDARD HMO PLAN** | **NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS** |
| **OTHER SERVICES** | | |
| Durable Medical Equipment | 50% |  |
| Hearing Aids | 60%  (one device per ear every 36 months) |  |
| Home Health Care | No Charge |  |
| Hospice Care | No Charge |  |
| Skilled Nursing Facility Care | 15%  (60 days/benefit period) |  |
| Physical and Occupational Therapy | $20 (Outpatient) |  |
| Chiropractic Services | $15 (20 visits/CY)  through American Specialty Health Group, Inc. |  |
| **PRESCRIPTION DRUGS** | **Provided by Kaiser** |  |
| Calendar Year Maximum  Out-of-Pocket | Applies towards the medical maximum  out-of-pocket |  |
| **Retail** |  |  |
| Day Supply | 30/60/90 |  |
| Generic | $5/$10/$15 – tier 1  $15/$30/$45 – tier 2 |  |
| Preferred Brand | $50/$100/$150 |  |
| Non-Preferred Brand | $50/$100/$150 |  |
| Preferred Insulin | $50/$100/$150 |  |
| Other Insulin | $15/$30/$45 (Generic) |  |
| Preferred Diabetic Supplies | 50% of applicable charges |  |
| Other Diabetic Supplies | 50% of applicable charges |  |
| Oral Contraceptives | No Charge |  |
| Injectables & Specialty Drug | $75/$150/$225 |  |
| Oral Oncology | Subject to applicable generic/brand/specialty copayments |  |
| **Mail Order** |  |  |
| Day Supply | 30/60/90 |  |
| Generic | $5/$10/$10 – tier 1  $15/$30/$30 – tier 2 |  |
| Preferred Brand | $50/$100/$100 |  |
| Non-Preferred Brand | $50/$100/$100 |  |
| Preferred Insulin | Not available through Mail Order |  |
| Other Insulin | Not available through Mail Order |  |
| Preferred Diabetic Supplies | 50% of applicable charges |  |
| Other Diabetic Supplies | 50% of applicable charges |  |
| Oral Contraceptives | No Charge |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **INSURED** |  |  |  |
| **Proposal Sheet 7** | | | |
| **Closed Panel Standard HMO Plan – EUTF Active – All Bargaining Units** | | | |
| **Premium Rate Table (Fully Insured)** | | | |
| ***Complete the following table on a monthly, per capita tiered basis ONLY*** | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **EUTF Closed Panel Standard HMO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL AND PRESCRIPTION DRUG*** | | | | |
| **Monthly Medical and Prescription Drug (Excluding DM/IHM and Chiropractic) Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly Chiropractic Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Monthly Administration and Retention:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Total Medical and Prescription Drug Premium (Including DM/IHM, Chiropractic, and Administration and Retention):** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly ACA Fees to be Added to the Above Total Medical and Prescription Drug Premium** | | | | |
| **Insurer Fee:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| NOTES:  (1) The EUTF reserves the right to offer multiple carrier options.  (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable. | | | | |
|  |  |  |  |  |
|  |  |  |  |  |
| **Authorized Signature** |  |  |  |  |
|  |  |  |  |  |
| **Title** |  |  |  |  |
|  |  |  |  |  |
| **Name of Company** |  |  | **Date** |  |

**Active**

**EUTF – Closed Panel Standard HMO Plan**

**(Part-Time and Temporary Employees)**

**Table and Proposal Sheets #8**

|  |  |  |  |
| --- | --- | --- | --- |
| **ACTIVE** | | | |
| **EUTF – CLOSED PANEL STANDARD HMO PLAN (PART-TIME AND TEMPORARY EMPLOYEES)** | | | |
| **TABLE AND PROPOSAL SHEETS #8** | | | |
|  |  |  |  |
| Detailed benefits information is provided in Exhibit E. Please note any deviation in proposed benefits in the charts below. Unless noted it will be assumed that proposed benefits match the requested benefits exactly. You must agree to a “no loss, no gain” provision with the current benefit plan. Please note that the benefit plan design shall not change throughout the duration of the contract unless required otherwise by law. | | | |

| **TABLE 8 – ACTIVE** | | |
| --- | --- | --- |
| **Plan Design** | **EUTF CLOSED PANEL**  **STANDARD HMO PLAN** | **NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS** |
| **MEDICAL** | **Provided by Kaiser** |  |
| **General** | **HMO Network** |  |
| Calendar Year Deductible | None |  |
| Calendar Year Maximum  Out-of-Pocket | $2,500 per person  $7,500 per family |  |
| Lifetime Benefit Maximum | None |  |
| Plan Year Benefit Maximum | None |  |
| **PHYSICIAN SERVICES** | **MEMBER PAYS** |  |
| Physician Office Visit (including primary care and specialist office visits) | $20 |  |
| Annual Health Exam | No Charge |  |
| Diabetes Prevention Program | No Charge |  |
| Immunizations | No Charge |  |
| Well Child Care Visits | No Charge |  |
| Maternity | No Charge for routine prenatal visits and one postpartum visit  15% for delivery |  |
| Screening Mammography | No Charge |  |
| Advance Care Planning | No Charge (Continuing Care) |  |
| **EMERGENCY SERVICES** | | |
| Emergency Room | $100 |  |
| Ambulance | 20% |  |
| **INPATIENT CARE** | | |
| Room and Board | 15% |  |
| Ancillary Services | 15% |  |
| Physician Services | 15% |  |
| Surgery | 15% |  |
| Anesthesia | 15% |  |
| Mental Health Services | 15% |  |
| **OUTPATIENT CARE** | | |
| Chemotherapy | $20 |  |
| Radiation Therapy | 20% |  |
| Lab and Pathology | $10 per day for basic  20% for specialty |  |
| Diagnostic Testing and X-ray | 20% for testing services  $10 per day for general imaging services  20% for specialty imaging services |  |
| Allergy Testing | $20 |  |
| Surgery | 15% for outpatient surgery center  $20 for outpatient professional charges |  |
| Anesthesia | $20 |  |
| Mental Health Services | $20 |  |
| **OTHER SERVICES** | | |
| Durable Medical Equipment | 50% |  |
| Home Health Care | No Charge |  |
| Hospice Care | No Charge |  |
| Skilled Nursing Facility Care | 15%  (60 days/benefit period) |  |
| Physical and Occupational Therapy | $20 (Outpatient) |  |
| **PRESCRIPTION DRUGS** | **Provided by Kaiser** |  |
| Calendar Year Maximum  Out-of-Pocket | Applies towards the medical maximum  out-of-pocket |  |
| **Retail** |  |  |
| Day Supply | 30/60/90 |  |
| Generic | $5/$10/$15 – tier 1  $15/$30/$45 – tier 2 |  |
| Preferred Brand | $50/$100/$150 |  |
| Non-Preferred Brand | $50/$100/$150 |  |
| Preferred Insulin | $50/$100/$150 |  |
| Other Insulin | $15/$30/$45 (Generic) |  |
| Preferred Diabetic Supplies | 50% of applicable charges |  |
| Other Diabetic Supplies | 50% of applicable charges |  |
| Oral Contraceptives | No Charge |  |
| Injectables & Specialty Drug | $75/$150/$225 |  |
| Oral Oncology | Subject to applicable generic/brand/specialty copayments |  |
| **Mail Order** |  |  |
| Day Supply | 30/60/90 |  |
| Generic | $5/$10/$10 – tier 1  $15/$30/$30 – tier 2 |  |
| Preferred Brand | $50/$100/$100 |  |
| Non-Preferred Brand | $50/$100/$100 |  |
| Preferred Insulin | Not available through Mail Order |  |
| Other Insulin | Not available through Mail Order |  |
| Preferred Diabetic Supplies | 50% of applicable charges |  |
| Other Diabetic Supplies | 50% of applicable charges |  |
| Oral Contraceptives | No Charge |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **INSURED** |  |  |  |
| **Proposal Sheet 8** | | | |
| **Closed Panel Standard HMO Plan – EUTF Active – Part-Time and Temporary Employees** | | | |
| **Premium Rate Table (Fully Insured)** | | | |
| ***Complete the following table on a monthly, per capita tiered basis ONLY*** | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **EUTF Closed Panel Standard HMO Plan**  **(Part-Time and Temporary Employees)** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL AND PRESCRIPTION DRUG*** | | | | |
| **Monthly Medical and Prescription Drug Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Monthly Administration and Retention:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Total Medical and Prescription Drug Premium (Including Administration and Retention):** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly ACA Fees to be Added to the Above Total Medical and Prescription Drug Premium** | | | | |
| **Insurer Fee:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| NOTES:  (1) The EUTF reserves the right to offer multiple carrier options.  (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable. | | | | |
|  |  |  |  |  |
|  |  |  |  |  |
| **Authorized Signature** |  |  |  |  |
|  |  |  |  |  |
| **Title** |  |  |  |  |
|  |  |  |  |  |
| **Name of Company** |  |  | **Date** |  |

**Active**

**EUTF – Supplemental Copay Plan**

**Table and Proposal Sheets #9**

|  |  |  |  |
| --- | --- | --- | --- |
| **ACTIVE** |  |  |  |
| **EUTF – SUPPLEMENTAL COPAY PLAN** | | | |
| **TABLE AND PROPOSAL SHEETS #9** | | | |
|  |  |  |  |
| Detailed benefits information is provided in Exhibit E. Please note any deviation in proposed benefits in the charts below. Unless noted it will be assumed that proposed benefits match the requested benefits exactly. You must agree to a “no loss, no gain” provision with the current benefit plan. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed fees on a tiered basis. | | | |

| **TABLE 9 – ACTIVE** | | |
| --- | --- | --- |
| **Plan Design** | **EUTF SUPPLEMENTAL COPAY PLAN** | **NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS** |
| **MEDICAL** | **Provided by HMA** |  |
| **General** |  |  |
| Calendar Year Deductible | None |  |
| Calendar Year Out-of-Pocket Limit | None |  |
| Lifetime Benefit Maximum | None |  |
| Plan Year Benefit Maximum | All Services: $2,750 per person, including the Rx Sublimit listed below |  |
| **PHYSICIAN SERVICES** | **MEMBER PAYS** |  |
| Physician Office Visit (including primary care and specialist office visits) | Copay/Coinsurance covered |  |
| Annual Health Exam | Copay/Coinsurance covered |  |
| Immunizations | Copay/Coinsurance covered |  |
| Well Baby Care Visits | Copay/Coinsurance covered |  |
| Maternity | Copay/Coinsurance covered |  |
| Screening Mammography | Copay/Coinsurance covered |  |
| **EMERGENCY SERVICES** | | |
| Emergency Room | Copay/Coinsurance covered |  |
| Ambulance | Copay/Coinsurance covered |  |
| **INPATIENT HOSPITAL SERVICES** | | |
| Room and Board | Copay/Coinsurance covered |  |
| Ancillary Services | Copay/Coinsurance covered |  |
| Physician Services | Copay/Coinsurance covered |  |
| Surgery | Copay/Coinsurance covered |  |
| Anesthesia | Copay/Coinsurance covered |  |
| Mental Health Services | Copay/Coinsurance covered |  |
| **OUTPATIENT SERVICES** | | |
| Chemotherapy | Copay/Coinsurance covered |  |
| Radiation Therapy | Copay/Coinsurance covered |  |
| Lab and Pathology | Copay/Coinsurance covered |  |
| Diagnostic Testing and X-ray | Copay/Coinsurance covered |  |
| Allergy Testing | Copay/Coinsurance covered |  |
| Surgery | Copay/Coinsurance covered |  |
| Anesthesia | Copay/Coinsurance covered |  |
| Mental Health Services | Copay/Coinsurance covered |  |
| **OTHER SERVICES** | | |
| Durable Medical Equipment | Copay/Coinsurance covered |  |
| Home Health Care | Copay/Coinsurance covered |  |
| Hospice Care | Copay/Coinsurance covered |  |
| Skilled Nursing Facility Care | Copay/Coinsurance covered |  |
| Physical and Occupational Therapy | Copay/Coinsurance covered |  |
| **PRESCRIPTION DRUGS** | Reimbursement for prescription drug copays charges shall not exceed $20 per 30-day supply, $40 per 60-day supply, and $60 per 90-day supply. Reimbursement for prescription drugs copay counts towards the Plan Year Benefit Maximum. |  |
| Plan Year Benefit Maximum Rx Sublimit | $250 per person |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **SELF-INSURED** |  |  |  |
| **Proposal Sheet 9A** | | | |
| **Supplemental Copay Plan – EUTF Active – All Bargaining Units** | | | |
| **Target Claims, Retention and Fees Tables (Self-Insured ASO)** | | | |
| ***Complete the following table based upon enrollment census and claims assumptions provided.*** | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **EUTF Supplemental Copay Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL AND PRESCRIPTION DRUG*** | | | | |
| **Monthly ASO Fees (PEPM):** | | | | |
| Claims Adjudication Fee |  |  |  |  |
| Other\* |  |  |  |  |
| **Total ASO Fees (PEPM):** |  |  |  |  |
| **Total ASO Fees by Tier:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total ASO fees indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| \* ID Cards, Wellness, Provider Directory, Booklets/SPDs, Data Reporting, Medical Info Line, Banking, Any Start-up Cost, etc. | | | | |
|  |  |  |  |  |
|  |  |  |  |  |
| **Authorized Signature** |  |  |  |  |
|  |  |  |  |  |
| **Title** |  |  |  |  |
|  |  |  |  |  |
| **Name of Company** |  |  | **Date** |  |

**Active**

**HSTA VB – 90/10 PPO Plan**

**Table and Proposal Sheets #10**

|  |  |  |  |
| --- | --- | --- | --- |
| **ACTIVE** |  |  |  |
| **HSTA VB – 90/10 PPO PLAN** |  |  |  |
| **TABLE AND PROPOSAL SHEETS #10** | | | |
|  |  |  |  |
| Detailed benefits information is provided in Exhibit E. Please note any deviation in proposed benefits in the charts below. Unless noted it will be assumed that proposed benefits match the requested benefits exactly. You must agree to a “no loss, no gain” provision with the current benefit plan. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis. | | | |

| **TABLE 10 – ACTIVE** | | | |
| --- | --- | --- | --- |
| **Plan Design** | **HSTA VB 90/10 PPO PLAN** | | **NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS** |
| **MEDICAL** | **Provided by HMSA** | |  |
| **General** | **In-Network** | **Out-of-Network\*** |  |
| Calendar Year Deductible | None | $100 per person  $300 per family |  |
| Calendar Year Maximum  Out-of-Pocket | $2,000 per person  $4,000 per family | |  |
| Lifetime Benefit Maximum | None | |  |
| Plan Year Benefit Maximum | None | |  |
| **PHYSICIAN SERVICES** | **MEMBER PAYS** | |  |
| Physician Office Visit (including primary care and specialist office visits) | 10% | 30% |  |
| Annual Health Exam | No Charge | No Charge\*\* |  |
| Diabetes Prevention Program | No Charge  (one program/  lifetime) | Not Covered |  |
| Immunizations | No Charge | 30% |  |
| Well Child Care Visits | No Charge | 30%\*\* |  |
| Maternity | 10% | 30% |  |
| Screening Mammography | No Charge | 30% |  |
| Advance Care Planning | No Charge | 30% |  |
| **EMERGENCY SERVICES** | | | |
| Emergency Room | 10% | 10%\*\* |  |
| Ambulance | 10% | 30% |  |
| **INPATIENT CARE** | | | |
| Room and Board | 10% | 30% |  |
| Ancillary Services | 10% | 30% |  |
| Physician Services | 10% | 30% |  |
| Surgery | 10% | 30% |  |
| Anesthesia | 10% | 30% |  |
| Mental Health Services | 10% | 30% |  |
| **OUTPATIENT CARE** | | | |
| Chemotherapy | 10% | 30% |  |
| Radiation Therapy | 10% | 30% |  |
| Lab and Pathology | 10% | 30% |  |
| Diagnostic Testing and X-ray (including genetic testing and counseling) | 10% | 30% |  |
| Allergy Testing | 10% | 30% |  |
| Surgery | 10% | 30% |  |
| Anesthesia | 10% | 30% |  |
| Mental Health Services | 10% | 30% |  |
| **OTHER SERVICES** | | | |
| Durable Medical Equipment | 10% | 30% |  |
| Hearing Aids | 10%  (one device per ear every 60 months) | 30%  (one device per ear every 60 months) |  |
| Home Health Care | No Charge  (150 visits/CY) | 30%  (150 visits/CY) |  |
| Hospice Care | No Charge | Not Covered |  |
| Supportive Care | No Charge  (90 days/  12-month period) | Not Covered |  |
| Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities) | 10%  (120 days/CY) | 30%  (120 days/CY) |  |
| Physical and Occupational Therapy | 10% | 30% |  |
| Reversing Heart Disease Program | $20 per session  (one program/ lifetime) | Not Covered |  |
| Chiropractic Services | $12  (20 visits/CY)  through American Specialty Health Group, Inc. | Not Covered |  |
| **PRESCRIPTION DRUGS** | **Provided by CVS/caremark** | |  |
|  | **Participating Pharmacy** | **Non-Participating Pharmacy\*** |  |
| Calendar Year Maximum  Out-of-Pocket | $4,350 per person  $8,700 per family | |  |
| **Retail** |  |  |  |
| Day Supply | 30/60/90 | 30/60/90 |  |
| Generic | $5/$9/$9 | $5/$9/$9 + 30% of eligible charges |  |
| Brand | $15/$27/$27 | $15/$27/$27 + 30% of eligible charges |  |
| Insulin | $5/$9/$9 | $5/$9/$9 + 30% of eligible charges |  |
| Diabetic Supplies | No Charge | 30% of eligible charges |  |
| Oral Contraceptives | No Charge | 30% of eligible charges |  |
| Injectables & Specialty Drug | Subject to applicable generic/brand copayments | |  |
| Oral Oncology | No Charge | 30% of eligible charges |  |
| **Mail Order** | **Participating Mail Pharmacy** | **Non-Participating Mail Pharmacy** |  |
| Day Supply | 30/60/90 | Not Covered |  |
| Generic | $5/$9/$9 | Not Covered |  |
| Brand | $15/$27/$27 | Not Covered |  |
| Insulin | $5/$9/$9 | Not Covered |  |
| Diabetic Supplies | No Charge | Not Covered |  |
| Oral Contraceptives | No Charge | Not Covered |  |

**NOTE: Prescription drug benefits are currently provided under a separate contract.**

Footnotes applicable to Medical and Prescription Drugs:

*\* Out-of-Network benefits are limited to usual customary and reasonable charges. Out-of-pocket expenses for out-of-network benefits apply towards the total annual maximum out-of-pocket (MOOP) but may exceed the MOOP once the MOOP is reached.*

*\*\* Deductible does not apply.*

|  |  |  |  |
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| **INSURED, RISK SHARING** |  |  |  |
| **Proposal Sheet 10A** | | | |
| **90/10 PPO Plan – HSTA VB Active – HSTA Bargaining Unit Only** | | | |
| **Premium Rate Table (Insured With Risk Sharing-Surplus Refund)** | | | |
| ***Complete the following table on a monthly, per capita tiered basis ONLY*** | | | |
|  |  |  |  |
| The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. If the total benefit paid at the end of the runout period is less than the proposed benefit cost, the excess amount will be refunded to the EUTF. The EUTF reserves the right to carve-out the prescription drugs from this proposal. | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **HSTA VB 90/10 PPO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL*** | | | | |
| **Monthly Medical (Excluding DM/IHM and Chiropractic) Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly Chiropractic Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Monthly Administration and Retention:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Total Medical Premium (Including DM/IHM, Chiropractic, and Administration and Retention):** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly ACA Fees to be Added to the Above Total Medical Premium** | | | | |
| **Insurer Fee:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **HSTA VB 90/10 PPO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***PRESCRIPTION DRUG*** | | | | |
| **Monthly Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Monthly Administration and Retention:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Total Prescription Drug Premium (Including Administration and Retention):** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly ACA Fees to be Added to the Above Total Prescription Drug Premium** | | | | |
| **Insurer Fee:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

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| --- | --- | --- | --- | --- |
| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): \_\_\_\_\_%** | | | | |
| NOTES:  (1) The EUTF reserves the right to offer multiple carrier options.  (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable. | | | | |
|  |  |  |  |  |
|  |  |  |  |  |
| **Authorized Signature** |  |  |  |  |
|  |  |  |  |  |
| **Title** |  |  |  |  |
|  |  |  |  |  |
| **Name of Company** |  |  | **Date** |  |

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| --- | --- | --- | --- |
| **SELF-INSURED** |  |  |  |
| **Proposal Sheet 10B** | | | |
| **90/10 PPO Plan – HSTA VB Active – HSTA Bargaining Unit Only** | | | |
| **Target Claims, Retention and Fees Tables (Self-Insured ASO)** | | | |
| ***Complete the following table based upon enrollment census and claims assumptions provided.*** | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **HSTA VB 90/10 PPO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL*** | | | | |
| **Monthly Medical ASO Fees (PEPM):** | | | | |
| PPO Leasing/Network Access Fees |  |  |  |  |
| Claims Adjudication Fee |  |  |  |  |
| Utilization Management Fees |  |  |  |  |
| Disease Management (DM) |  |  |  |  |
| Integrated Health Management (IHM) |  |  |  |  |
| Other\* |  |  |  |  |
| **Total Medical ASO Fees (PEPM):** |  |  |  |  |
| **Total Medical ASO Fees by Tier:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Estimated Medical Claims Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| \* ID Cards, Wellness, Provider Directory, Booklets/SPDs, Data Reporting, Medical Info Line, Banking, Any Start-up Cost, etc. | | | | |
|  |  |  |  |  |
|  |  |  |  |  |
| **Authorized Signature** |  |  |  |  |
|  |  |  |  |  |
| **Title** |  |  |  |  |
|  |  |  |  |  |
| **Name of Company** |  |  | **Date** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **MINIMUM PREMIUM** |  |  |  |
| **Proposal Sheet 10C** | | | |
| **90/10 PPO Plan – HSTA VB Active – HSTA Bargaining Unit Only** | | | |
| **Premium Rate Table (Insured with Limited Risk Sharing)** | | | |
| ***Complete the following table on a monthly, per capita tiered basis ONLY*** | | | |
|  | | | |
| The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. The EUTF will pay the Medical ASO Fees, and actual medical claims up to the Maximum Medical Claims Cost indicated below. If the total claims paid at the end of the runout period is greater than the Maximum Medical Claims Cost indicated below, the excess amount will not be collected from the EUTF. Only actual claims and fees up to the targeted claim maximum will be charged. The EUTF reserves the right to carve-out the prescription drugs from this proposal. | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **HSTA VB 90/10 PPO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL*** | | | | |
| **Monthly Medical ASO Fees (PEPM):** | | | | |
| PPO Leasing/Network Access Fees |  |  |  |  |
| Claims Adjudication Fee |  |  |  |  |
| Utilization Management Fees |  |  |  |  |
| Disease Management (DM) |  |  |  |  |
| Integrated Health Management (IHM) |  |  |  |  |
| Other\* |  |  |  |  |
| **Total Medical ASO Fees (PEPM):** |  |  |  |  |
| **Total Medical ASO Fees by Tier:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Maximum Medical Claims Cost (paid by EUTF):** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| \* ID Cards, Wellness, Provider Directory, Booklets/SPDs, Data Reporting, Medical Info Line, Banking, Any Start-up Cost, etc. | | | | |
|  |  |  |  |  |
|  |  |  |  |  |
| **Authorized Signature** |  |  |  |  |
|  |  |  |  |  |
| **Title** |  |  |  |  |
|  |  |  |  |  |
| **Name of Company** |  |  | **Date** |  |

**Active**

**HSTA VB – 80/20 PPO Plan**

**Table and Proposal Sheets #11**

|  |  |  |  |
| --- | --- | --- | --- |
| **ACTIVE** |  |  |  |
| **HSTA VB – 80/20 PPO PLAN** |  |  |  |
| **TABLE AND PROPOSAL SHEETS #11** | | | |
|  |  |  |  |
| Detailed benefits information is provided in Exhibit E. Please note any deviation in proposed benefits in the charts below. Unless noted it will be assumed that proposed benefits match the requested benefits exactly. You must agree to a “no loss, no gain” provision with the current benefit plan. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis. | | | |

| **TABLE 11 – ACTIVE** | | | |
| --- | --- | --- | --- |
| **Plan Design** | **HSTA VB 80/20 PPO PLAN** | | **NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS** |
| **MEDICAL** | **Provided by HMSA** | |  |
| **General** | **In-Network** | **Out-of-Network\*** |  |
| Calendar Year Deductible | None | |  |
| Calendar Year Maximum  Out-of-Pocket | $2,500 per person  $5,000 per family | |  |
| Lifetime Benefit Maximum | None | |  |
| Plan Year Benefit Maximum | None | |  |
| **PHYSICIAN SERVICES** | **MEMBER PAYS** | |  |
| Physician Office Visit (including primary care and specialist office visits) | 20% | 20% |  |
| Annual Health Exam | No Charge | No Charge |  |
| Diabetes Prevention Program | No Charge  (one program/  lifetime) | Not Covered |  |
| Immunizations | No Charge | No Charge |  |
| Well Child Care Visits | No Charge | No Charge |  |
| Maternity | 20% | 20% |  |
| Screening Mammography | No Charge | No Charge |  |
| Advance Care Planning | No Charge | 20% |  |
| **EMERGENCY SERVICES** | | | |
| Emergency Room | 20% | 20% |  |
| Ambulance | 20% | 20% |  |
| **INPATIENT CARE** | | | |
| Room and Board | 20% | 20% |  |
| Ancillary Services | 20% | 20% |  |
| Physician Services | 20% | 20% |  |
| Surgery | 20% | 20% |  |
| Anesthesia | 20% | 20% |  |
| Mental Health Services | 20% | 20% |  |
| **OUTPATIENT CARE** | | | |
| Chemotherapy | 20% | 20% |  |
| Radiation Therapy | 20% | 20% |  |
| Lab and Pathology | No Charge | No Charge |  |
| Diagnostic Testing and X-ray (including genetic testing and counseling) | 20% | 20% |  |
| Allergy Testing | 20% | 20% |  |
| Surgery | 20% | 20% |  |
| Anesthesia | 20% | 20% |  |
| Mental Health Services | 20% | 20% |  |
| **OTHER SERVICES** | | | |
| Durable Medical Equipment | 20% | 20% |  |
| Hearing Aids | 20%  (one device per ear every 60 months) | 20%  (one device per ear every 60 months) |  |
| Home Health Care | No Charge  (150 visits/CY) | No Charge  (150 visits/CY) |  |
| Hospice Care | No Charge | No Charge |  |
| Supportive Care | No Charge  (90 days/  12-month period) | Not Covered |  |
| Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities) | 20%  (120 days/CY) | 20%  (120 days/CY) |  |
| Physical and Occupational Therapy | 20% | 20% |  |
| Reversing Heart Disease Program | $20 per session  (one program/  lifetime) | Not Covered |  |
| Chiropractic Services | $12  (20 visits/CY)  through American Specialty Health Group, Inc. | Not Covered |  |
| **PRESCRIPTION DRUGS** | **Provided by CVS/caremark** | |  |
|  | **Participating Pharmacy** | **Non-Participating Pharmacy\*** |  |
| Calendar Year Maximum  Out-of-Pocket | $4,350 per person  $8,700 per family | |  |
| **Retail** |  |  |  |
| Day Supply | 30/60/90 | 30/60/90 |  |
| Generic | $5/$9/$9 | $5/$9/$9 + 30% of eligible charges |  |
| Brand | $15/$27/$27 | $15/$27/$27 + 30% of eligible charges |  |
| Insulin | $5/$9/$9 | $5/$9/$9 + 30% of eligible charges |  |
| Diabetic Supplies | No Charge | 30% of eligible charges |  |
| Oral Contraceptives | No Charge | 30% of eligible charges |  |
| Injectables & Specialty Drug | Subject to applicable generic/brand copayments | |  |
| Oral Oncology | No Charge | 30% of eligible charges |  |
| **Mail Order** | **Participating Mail Pharmacy** | **Non-Participating Mail Pharmacy** |  |
| Day Supply | 30/60/90 | Not Covered |  |
| Generic | $5/$9/$9 | Not Covered |  |
| Brand | $15/$27/$27 | Not Covered |  |
| Insulin | $5/$9/$9 | Not Covered |  |
| Diabetic Supplies | No Charge | Not Covered |  |
| Oral Contraceptives | No Charge | Not Covered |  |

**NOTE: Prescription drug benefits are currently provided under a separate contract.**

Footnotes applicable to Medical and Prescription Drugs:

*\* Out-of-Network benefits are limited to usual customary and reasonable charges. Out-of-pocket expenses for out-of-network benefits apply towards the total annual maximum out-of-pocket (MOOP) but may exceed the MOOP once the MOOP is reached.*

|  |  |  |  |
| --- | --- | --- | --- |
| **INSURED, RISK SHARING** |  |  |  |
| **Proposal Sheet 11A** | | | |
| **80/20 PPO Plan – HSTA VB Active – HSTA Bargaining Unit Only** | | | |
| **Premium Rate Table (Insured with Risk Sharing-Surplus Refund)** | | | |
| ***Complete the following table on a monthly, per capita tiered basis ONLY*** | | | |
|  |  |  |  |
| The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. If the total benefit paid at the end of the runout period is less than the proposed benefit cost, the excess amount will be refunded to the EUTF. The EUTF reserves the right to carve-out the prescription drugs from this proposal. | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **HSTA VB 80/20 PPO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL*** | | | | |
| **Monthly Medical (Excluding DM/IHM and Chiropractic) Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly Chiropractic Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Monthly Administration and Retention:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Total Medical Premium (Including DM/IHM, Chiropractic, and Administration and Retention):** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly ACA Fees to be Added to the Above Total Medical Premium** | | | | |
| **Insurer Fee:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **HSTA VB 80/20 PPO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***PRESCRIPTION DRUG*** | | | | |
| **Monthly Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Monthly Administration and Retention:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Total Prescription Drug Premium (Including Administration and Retention):** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly ACA Fees to be Added to the Above Total Prescription Drug Premium** | | | | |
| **Insurer Fee:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): \_\_\_\_\_%** | | | | |
| NOTES:  (1) The EUTF reserves the right to offer multiple carrier options.  (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable. | | | | |
|  |  |  |  |  |
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| **Authorized Signature** |  |  |  |  |
|  |  |  |  |  |
| **Title** |  |  |  |  |
|  |  |  |  |  |
| **Name of Company** |  |  | **Date** |  |

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| **SELF-INSURED** |  |  |  |
| **Proposal Sheet 11B** | | | |
| **80/20 PPO Plan – HSTA VB Active – HSTA Bargaining Unit Only** | | | |
| **Target Claims, Retention and Fees Tables (Self-Insured ASO)** | | | |
| ***Complete the following table based upon enrollment census and claims assumptions provided.*** | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **HSTA VB 80/20 PPO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL*** | | | | |
| **Monthly Medical ASO Fees (PEPM):** | | | | |
| PPO Leasing/Network Access Fees |  |  |  |  |
| Claims Adjudication Fee |  |  |  |  |
| Utilization Management Fees |  |  |  |  |
| Disease Management (DM) |  |  |  |  |
| Integrated Health Management (IHM) |  |  |  |  |
| Other\* |  |  |  |  |
| **Total Medical ASO Fees (PEPM):** |  |  |  |  |
| **Total Medical ASO Fees by Tier:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Estimated Medical Claims Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
|  |  |  |  |  |
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|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| \* ID Cards, Wellness, Provider Directory, Booklets/SPDs, Data Reporting, Medical Info Line, Banking, Any Start-up Cost, etc. | | | | |
|  |  |  |  |  |
|  |  |  |  |  |
| **Authorized Signature** |  |  |  |  |
|  |  |  |  |  |
| **Title** |  |  |  |  |
|  |  |  |  |  |
| **Name of Company** |  |  | **Date** |  |

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| --- | --- | --- | --- |
| **MINIMUM PREMIUM** |  |  |  |
| **Proposal Sheet 11C** | | | |
| **80/20 PPO Plan – HSTA VB Active –HSTA VB Bargaining Unit Only** | | | |
| **Premium Rate Table (Insured with Limited Risk Sharing)** | | | |
| ***Complete the following table on a monthly, per capita tiered basis ONLY*** | | | |
|  | | | |
| The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. The EUTF will pay the Medical ASO Fees, and actual medical claims up to the Maximum Medical Claims Cost indicated below. If the total claims paid at the end of the runout period is greater than the Maximum Medical Claims Cost indicated below, the excess amount will not be collected from the EUTF. Only actual claims and fees up to the targeted claim maximum will be charged. The EUTF reserves the right to carve-out the prescription drugs from this proposal. | | | |

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| **HSTA VB 80/20 PPO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL*** | | | | |
| **Monthly Medical ASO Fees (PEPM):** | | | | |
| PPO Leasing/Network Access Fees |  |  |  |  |
| Claims Adjudication Fee |  |  |  |  |
| Utilization Management Fees |  |  |  |  |
| Disease Management (DM) |  |  |  |  |
| Integrated Health Management (IHM) |  |  |  |  |
| Other\* |  |  |  |  |
| **Total Medical ASO Fees (PEPM):** |  |  |  |  |
| **Total Medical ASO Fees by Tier:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Maximum Medical Claims Cost (paid by EUTF):** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| \* ID Cards, Wellness, Provider Directory, Booklets/SPDs, Data Reporting, Medical Info Line, Banking, Any Start-up Cost, etc. | | | | |
|  |  |  |  |  |
|  |  |  |  |  |
| **Authorized Signature** |  |  |  |  |
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|  |  |  |  |  |
| **Name of Company** |  |  | **Date** |  |

**Active**

**HSTA VB – Closed Panel Comprehensive HMO Plan**

**Table and Proposal Sheets #12**

|  |  |  |  |
| --- | --- | --- | --- |
| **ACTIVE** |  |  |  |
| **HSTA VB – CLOSED PANEL COMPREHENSIVE HMO PLAN** | | | |
| **TABLE AND PROPOSAL SHEETS #12** | | | |
|  |  |  |  |
| Detailed benefits information is provided in Exhibit E. Please note any deviation in proposed benefits in the charts below. Unless noted it will be assumed that proposed benefits match the requested benefits exactly. You must agree to a “no loss, no gain” provision with the current benefit plan. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis. | | | |

| **TABLE 12 - ACTIVE** | | |
| --- | --- | --- |
| **Plan Design** | **HSTA VB CLOSED PANEL**  **COMPREHENSIVE HMO PLAN** | **NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS** |
| **MEDICAL** | **Provided by Kaiser** |  |
| **General** | **HMO Network** |  |
| Calendar Year Deductible | None |  |
| Calendar Year Out-of-Pocket Limit | $2,000 per person  $6,000 per family |  |
| Lifetime Benefit Maximum | None |  |
| Plan Year Benefit Maximum | None |  |
| **PHYSICIAN SERVICES** | **MEMBER PAYS** |  |
| Physician Office Visit (including primary care and specialist office visits) | $15 |  |
| Annual Health Exam | No Charge |  |
| Diabetes Prevention Program | No Charge |  |
| Immunizations | No Charge |  |
| Well Child Care Visits | No Charge |  |
| Maternity | No Charge for routine prenatal visits, delivery, and one postpartum visit |  |
| Screening Mammography | No Charge |  |
| Advance Care Planning | No Charge (Continuing Care) |  |
| **EMERGENCY SERVICES** | | |
| Emergency Room | $50 |  |
| Ambulance | 20% |  |
| **INPATIENT HOSPITAL SERVICES** | | |
| Room and Board | No Charge |  |
| Ancillary Services | No Charge |  |
| Physician Services | No Charge |  |
| Surgery | No Charge |  |
| Anesthesia | No Charge |  |
| Mental Health Services | No Charge |  |
| **OUTPATIENT SERVICES** | | |
| Chemotherapy | $15 |  |
| Radiation Therapy | $15 |  |
| Lab and Pathology | $15 per day |  |
| Diagnostic Testing and X-ray | $15 per day |  |
| Allergy Testing | $15 |  |
| Surgery | $15 |  |
| Anesthesia | $15 |  |
| Mental Health Services | $15 |  |
| **OTHER SERVICES** | | |
| Durable Medical Equipment | 20% |  |
| Hearing Aids | 60%  (one device per ear every 36 months) |  |
| Home Health Care | No Charge |  |
| Hospice Care | No Charge |  |
| Skilled Nursing Facility Care | No Charge  (100 days/benefit period) |  |
| Physical and Occupational Therapy | $15 (Outpatient) |  |
| Chiropractic Services | $12 (20 visits/CY)  through American Specialty Health Group, Inc. |  |
| **PRESCRIPTION DRUGS** | **Provided by Kaiser** |  |
| Calendar Year Maximum  Out-of-Pocket | Applies towards the medical maximum  out-of-pocket |  |
| **Retail** |  |  |
| Day Supply | 30/60/90 |  |
| Generic | $10/$20/$30 |  |
| Brand | $10/$20/$30 |  |
| Insulin | $10/$20/$30 |  |
| Diabetic Supplies | 50% of applicable charges |  |
| Oral Contraceptives | No Charge |  |
| Injectables & Specialty Drug | $10/$20/$30 |  |
| Oral Oncology | No Charge |  |
| **Mail Order** |  |  |
| Day Supply | 30/60/90 |  |
| Generic | $10/$20/$20 |  |
| Brand | $10/$20/$20 |  |
| Insulin | Not available through Mail Order |  |
| Diabetic Supplies | 50% of applicable charges |  |
| Oral Contraceptives | No Charge |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **INSURED** |  |  |  |
| **Proposal Sheet 12** | | | |
| **Closed Panel Comprehensive HMO Plan – HSTA VB Active – HSTA Bargaining Unit Only** | | | |
| **Premium Rate Table (Fully Insured)** | | | |
| ***Complete the following table on a monthly, per capita tiered basis ONLY*** | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **HSTA VB Closed Panel Comprehensive HMO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL AND PRESCRIPTION DRUG*** | | | | |
| **Monthly Medical and Prescription Drug (Excluding DM/IHM and Chiropractic) Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly Chiropractic Benefit Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Monthly Administration and Retention:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Total Medical and Prescription Drug Premium (Including DM/IHM, Chiropractic, and Administration and Retention):** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Monthly ACA Fees to be Added to the Above Total Medical and Prescription Drug Premium** | | | | |
| **Insurer Fee:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| NOTES:  (1) The EUTF reserves the right to offer multiple carrier options.  (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable. | | | | |
|  |  |  |  |  |
|  |  |  |  |  |
| **Authorized Signature** |  |  |  |  |
|  |  |  |  |  |
| **Title** |  |  |  |  |
|  |  |  |  |  |
| **Name of Company** |  |  | **Date** |  |

**Retiree**

**EUTF – 90/10 PPO Plan**

**Table and Proposal Sheets #13**

|  |  |  |  |
| --- | --- | --- | --- |
| **NON-MEDICARE RETIREE** |  |  |  |
| **EUTF – 90/10 PPO PLAN** |  |  |  |
| **TABLE AND PROPOSAL SHEETS #13** | | | |
|  |  |  |  |
| Detailed benefits information is provided in Exhibit E. Please note any deviation in proposed benefits in the charts below. Unless noted it will be assumed that proposed benefits match the requested benefits exactly. You must agree to a “no loss, no gain” provision with the current benefit plan. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis. | | | |

| **TABLE 13 – NON-MEDICARE RETIREE** | | | |
| --- | --- | --- | --- |
| **Plan Design** | **EUTF 90/10 PPO PLAN** | | **NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS** |
| **MEDICAL** | **Provided by HMSA** | |  |
| **General** | **In-Network** | **Out-of-Network\*** |  |
| Calendar Year Deductible | $100 per person  $300 per family | |  |
| Calendar Year Maximum  Out-of-Pocket | $2,500 per person  $7,500 per family | |  |
| Lifetime Benefit Maximum | None | |  |
| Plan Year Benefit Maximum | None | |  |
| **PHYSICIAN SERVICES** | **MEMBER PAYS** | |  |
| Physician Office Visit  (including primary care and specialist office visits) | 10%\*\* | 30% |  |
| Annual Health Exam | No Charge\*\* | 30%\*\* |  |
| Diabetes Prevention Program\*\*\* | No Charge\*\*  (one program/  lifetime) | Not Covered |  |
| Immunizations | No Charge\*\* | No Charge |  |
| Well Child Care Visits | No Charge\*\* | 30%\*\* |  |
| Maternity | 10%\*\* | 30% |  |
| Screening Mammography | 20%\*\* | 30%\*\* |  |
| Advance Care Planning | No Charge\*\* | 10%\*\* |  |
| **EMERGENCY SERVICES** | | | |
| Emergency Room | 10%\*\* | 10%\*\* |  |
| Ambulance | 20% | 30% |  |
| **INPATIENT HOSPITAL SERVICES** | | | |
| Room and Board | 10%\*\* | 30% |  |
| Ancillary Services | 10%\*\* | 30% |  |
| Physician Services | 10%\*\* | 30% |  |
| Surgery | 10%\*\* (Cutting) | 30% |  |
| Anesthesia | 10%\*\* | 30% |  |
| Mental Health Services | 10%\*\* | 30% |  |
| **OUTPATIENT SERVICES** | | | |
| Chemotherapy | 20% | 30% |  |
| Radiation Therapy | 20%\*\* | 30% |  |
| Lab and Pathology | 20%\*\* | 30% |  |
| Diagnostic Testing and X-ray  (including genetic testing and counseling) | 20%\*\* | 30% |  |
| Allergy Testing | 20% | 30% |  |
| Surgery | 10%\*\* (Cutting) | 30% |  |
| Anesthesia | 10%\*\* | 30% |  |
| Mental Health Services | 10%\*\*  20%\*\* (Psych Testing) | 30% |  |

| **TABLE 13 – NON-MEDICARE RETIREE** | | | | |
| --- | --- | --- | --- | --- |
| **Plan Design** | **EUTF 90/10 PPO PLAN** | | | **NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS** |
| **OTHER SERVICES** | | | | |
| Durable Medical Equipment | 20% | 30% | |  |
| Hearing Aids | 20%  (one device per ear every 60 months) | 30%  (one device per ear every 60 months) | |  |
| Home Health Care | No Charge\*\*  (150 visits/CY) | 30%  (150 visits/CY) | |  |
| Hospice Care | No Charge\*\* | Not Covered | |  |
| Supportive Care\*\*\* | No Charge\*\*  (90 days/  12-month period) | Not Covered | |  |
| Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities) | 10%\*\*  (120 days/CY) | 30%  (120 days/CY) | |  |
| Physical and Occupational Therapy | 20%  (Outpatient) | 30% | |  |
| Reversing Heart Disease Program\*\*\* | $20 per session\*\*  (one program/  lifetime) | Not Covered | |  |
| Chiropractic Services\*\*\* | Not Covered | Not Covered | |  |
| **PRESCRIPTION DRUGS** | **Provided by CVS/caremark** | | |  |
|  | **Participating Pharmacy** | **Non-Participating Pharmacy\*** | |  |
| Calendar Year Maximum  Out-of-Pocket | None | | |  |
| **Retail** |  |  | |  |
| Day Supply | 30/60/90 | 30/60/90 | |  |
| Generic | $5/$10/$15 | $5/$10/$15 + 20% of eligible charges | |  |
| Preferred Brand | $15/$30/$45 | $15/$30/$45 + 20% of eligible charges | |  |
| Non-Preferred Brand | $30/$60/$90 | $30/$60/$90 + 20% of eligible charges | |  |
| Preferred Insulin | $5/$10/$15 | $5/$10/$15 + 20% of eligible charges | |  |
| Other Insulin | $15/$30/$45 | $15/$30/$45 + 20% of eligible charges | |  |
| Preferred Diabetic Supplies | No Charge | 20% of eligible charges | |  |
| Other Diabetic Supplies | $15/$30/$45 | $15/$30/$45 + 20% of eligible charges | |  |
| Oral Contraceptives | Subject to applicable generic/brand copayments | | 20% of eligible charges |  |
| Injectables & Specialty Drug | 20% of eligible charges; Up to $250 maximum per fill; $2,000 maximum out-of-pocket per calendar year. Specialty drugs are not available through mail order and only dispensed up to a 30-day supply. | | |  |
| Oral Oncology | $30 | | |  |
| **Retail 90 and Mail Order** | **Retail 90 or Mail Pharmacy** | **Non-Retail 90 Pharmacy** | |  |
| Day Supply | 30/60/90 | 30/60/90 | |  |
| Generic | $5/$10/$10 | $5/$10/$15 | |  |
| Preferred Brand | $15/$30/$30 | $15/$30/$45 | |  |
| Non-Preferred Brand | $30/$60/$60 | $30/$60/$90 | |  |
| Preferred Insulin | $5/$10/$10 | $5/$10/$15 | |  |
| Other Insulin | $15/$30/$30 | $15/$30/$45 | |  |
| Preferred Diabetic Supplies | No Charge | No Charge | |  |
| Other Diabetic Supplies | $15/$30/$30 | $15/$30/$45 | |  |
| Oral Contraceptives | Subject to applicable generic/brand copayments | | 20% of eligible charges |  |
| Injectables & Specialty Drug | Not Covered | | See benefit described above |  |

**NOTE: Prescription drug benefits are currently provided under a separate contract.**

Footnotes applicable to Medical and Prescription Drugs:

*\* Out-of-Network benefits are limited to usual customary and reasonable charges. Out-of-pocket expenses for out-of-network benefits apply towards the total annual maximum out-of-pocket (MOOP) but may exceed the MOOP once the MOOP is reached.*

*\*\* Deductible does not apply.*

*\*\*\* The Diabetes Prevention, Reversing Heart Disease, and Supportive Care programs are currently pilot programs approved through December 31, 2020. In a separate attachment, please include the proposed rate on a tiered basis to continue these programs into the term of the new contract. Chiropractic services are currently not covered under this plan. In the same attachment, please also include the proposed rate on a tiered basis for a fully insured in-network chiropractic benefit (in-network $15 per visit limited to 20 visits per calendar year and not covered out-of-network).*

*✝ Maintenance medications must be filled in a 90-day supply after the first three 30-day initial fills; can be filled at any retail network or mail pharmacy.*

|  |  |  |  |
| --- | --- | --- | --- |
| **MEDICARE RETIREE** |  |  |  |
| **EUTF – 90/10 PPO PLAN** |  |  |  |
| **TABLE AND PROPOSAL SHEETS #13 Continued** | | | |
|  |  |  |  |
| Detailed benefits information is provided in Exhibit E. Please note any deviation in proposed benefits in the charts below. Unless noted it will be assumed that proposed benefits match the requested benefits exactly. You must agree to a “no loss, no gain” provision with the current benefit plan. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis. | | | |

| **TABLE 13 Continued – MEDICARE RETIREE** | | | |
| --- | --- | --- | --- |
| **Plan Design** | **EUTF 90/10 PPO PLAN** | | **NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS** |
| **MEDICAL** | **Provided by HMSA** | |  |
| **General** | **In-Network** | **Out-of-Network\*** |  |
| Calendar Year Deductible | $100 per person  $300 per family | |  |
| Calendar Year Maximum  Out-of-Pocket | $2,500 per person  $7,500 per family | |  |
| Lifetime Benefit Maximum | None | |  |
| Plan Year Benefit Maximum | None | |  |
| **PHYSICIAN SERVICES** | **MEMBER PAYS** | |  |
| Physician Office Visit  (including primary care and specialist office visits) | 10%\*\* | 30% |  |
| Annual Wellness Visit  (Covered under Medicare) | No Charge\*\* | No Charge\*\* |  |
| Annual Health Exam | No Charge\*\* | 30%\*\* |  | |
| Diabetes Prevention Program\*\*\* | No Charge\*\*  (one program/  lifetime) | Not Covered |  |
| Immunizations | No Charge\*\* | No Charge |  |
| Well Child Care Visits | No Charge\*\* | 30%\*\* |  |
| Maternity | 10%\*\* | 30% |  |
| Screening Mammography | 20%\*\* | 30%\*\* |  |
| Advance Care Planning | No Charge\*\* | 10%\*\* |  |
| **EMERGENCY SERVICES** | | | |
| Emergency Room | 10%\*\* | 10%\*\* |  |
| Ambulance | 20% | 30% |  |
| **INPATIENT HOSPITAL SERVICES** | | | |
| Room and Board | 10%\*\* | 30% |  |
| Ancillary Services | 10%\*\* | 30% |  |
| Physician Services | 10%\*\* | 30% |  |
| Surgery | 10%\*\* (Cutting) | 30% |  |
| Anesthesia | 10%\*\* | 30% |  |
| Mental Health Services | 10%\*\* | 30% |  |
| **OUTPATIENT SERVICES** | | | |
| Chemotherapy | 20% | 30% |  |
| Radiation Therapy | 20%\*\* | 30% |  |
| Lab and Pathology | 20%\*\* | 30% |  |
| Diagnostic Testing and X-ray  (including genetic testing and counseling) | 20%\*\* | 30% |  |
| Allergy Testing | 20% | 30% |  |
| Surgery | 10%\*\* (Cutting) | 30% |  |
| Anesthesia | 10%\*\* | 30% |  |
| Mental Health Services | 10%\*\*  20%\*\* (Psych Testing) | 30% |  |
| **OTHER SERVICES** | | | |
| Durable Medical Equipment | 20% | 30% |  |
| Hearing Aids | 20%  (one device per ear every 60 months) | 30%  (one device per ear every 60 months) |  |
| Home Health Care | No Charge\*\*  (150 visits/CY) | 30%  (150 visits/CY) |  |
| Hospice Care | No Charge\*\* | Not Covered |  |
| Supportive Care\*\*\* | No Charge\*\*  (90 days/  12-month period) | Not Covered |  |
| Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities) | 10%\*\*  (120 days/CY) | 30%  (120 days/CY) |  |
| Physical and Occupational Therapy | 20%  (Outpatient) | 30% |  |
| Reversing Heart Disease Program\*\*\* | $20 per session\*\*  (one program/  lifetime) | Not Covered |  |
| Chiropractic Services\*\*\* | Not Covered | Not Covered |  |
| **MEDICARE PART D PRESCRIPTION DRUGS** | **Provided by SilverScript** | |  |
|  | **Participating Pharmacy** | **Non-Participating Pharmacy** |  |
| Calendar Year Maximum  Out-of-Pocket | None | |  |
| **Retail** |  |  |  |
| Day Supply | 30/60/90 | 30/60/90 |  |
| Generic | $5/$10/$10 | $5/$10/$10 + 20% of eligible charges |  |
| Preferred Brand | $15/$30/$30 | $15/$30/$30 + 20% of eligible charges |  |
| Non-Preferred Brand | $30/$60/$60 | $30/$60/$60 + 20% of eligible charges |  |
| Insulin | $5/$10/$10 | $5/$10/$10 + 20% of eligible charges |  |
| Diabetic Supplies | No Charge  Meters: Covered by Medicare Part B and the EUTF 90/10 PPO medical plan. | 20% of eligible charges  Meters: Covered by Medicare Part B and the EUTF 90/10 PPO medical plan. |  |
| Injectables & Specialty Drug | 20% of eligible charges; Up to $250 maximum per fill; $2,000 maximum out-of-pocket per calendar year. Specialty drugs are not available through mail order and only dispensed up to a 30-day supply. | 50% of eligible charges |  |
| Oral Oncology | $30/$60/$60 | $30/$60/$60 + 20% of eligible charges |  |
| **Mail Order** | **Participating Mail Pharmacy** | **Non-Participating Mail Pharmacy** |  |
| Day Supply | 30/60/90 | Not Covered |  |
| Generic | $5/$10/$10 | Not Covered |  |
| Preferred Brand | $15/$30/$30 | Not Covered |  |
| Non-Preferred Brand | $30/$60/$60 | Not Covered |  |
| Insulin | $5/$10/$10 | Not Covered |  |
| Diabetic Supplies | No Charge | Not Covered |  |

**NOTE: Prescription drug benefits are currently provided under a separate contract.**

Footnotes applicable to Medical:

*\* Out-of-Network benefits are limited to usual customary and reasonable charges.*

*\*\* Deductible does not apply.*

*\*\*\* The Diabetes Prevention, Reversing Heart Disease, and Supportive Care programs are currently pilot programs approved through December 31, 2020. In a separate attachment, please include the proposed rate on a tiered basis to continue these programs into the term of the new contract. Chiropractic services are currently not covered under this plan. In the same attachment, please also include the proposed rate on a tiered basis for a fully insured in-network chiropractic benefit (in-network $15 per visit limited to 20 visits per calendar year and not covered out-of-network).*

|  |  |  |  |
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| **INSURED, RISK SHARING** |  |  |  |
| **Proposal Sheet 13A** | | | |
| **90/10 PPO Plan – EUTF Retiree** | | | |
| **Premium Rate Table (Insured with Risk Sharing-Surplus Refund)** | | | |
| ***Complete the following table on a monthly, per capita tiered basis ONLY*** | | | |
|  |  |  |  |
| The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. If the total benefit paid at the end of the runout period is less than the proposed benefit cost, the excess amount will be refunded to the EUTF. The EUTF reserves the right to carve-out the prescription drugs from this proposal. | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **EUTF 90/10 PPO Plan** | **Contract**  **Period 1** | | **Contract**  **Period 2** | | **Contract**  **Period 3** | | **Contract**  **Period 4** | |
| **Non-Medicare** | **Medicare** | **Non-Medicare** | **Medicare** | **Non-Medicare** | **Medicare** | **Non-Medicare** | **Medicare** |
| ***MEDICAL*** | | | | | | | | |
| **Monthly Medical (Excluding DM/IHM) Benefit Cost:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):** | N/A | | \_\_\_\_\_% | | \_\_\_\_\_% | | \_\_\_\_\_% | |
| **Monthly Administration and Retention:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Total Medical Premium (Including DM/IHM and Administration and Retention):** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Monthly ACA Fees to be Added to the Above Total Medical Premium** | | | | | | | | |
| **Insurer Fee:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **EUTF 90/10 PPO Plan** | **Contract**  **Period 1** | | **Contract**  **Period 2** | | **Contract**  **Period 3** | | **Contract**  **Period 4** | |
| **Non-Medicare** | **Medicare** | **Non-Medicare** | **Medicare** | **Non-Medicare** | **Medicare** | **Non-Medicare** | **Medicare** |
| ***PRESCRIPTION DRUG*** | | | | | | | | |
| **Monthly Benefit Cost:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):** | N/A | | \_\_\_\_\_% | | \_\_\_\_\_% | | \_\_\_\_\_% | |
| **Monthly Administration and Retention:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Total Prescription Drug Premium (Including Administration and Retention):** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Monthly ACA Fees to be Added to the Above Total Prescription Drug Premium** | | | | | | | | |
| **Insurer Fee:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- |
| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
|  |  |  |  |  |
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|  |  |  |  |  |
| **Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): \_\_\_\_\_%** | | | | |
| NOTES:  (1) The EUTF reserves the right to offer multiple carrier options.  (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable. | | | | |
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| **Authorized Signature** |  |  |  |  |
|  |  |  |  |  |
| **Title** |  |  |  |  |
|  |  |  |  |  |
| **Name of Company** |  |  | **Date** |  |
| **SELF-INSURED** | |  |  |  |
| **Proposal Sheet 13B** | | | | |
| **90/10 PPO Plan – EUTF Retiree** | | | | |
| **Target Claims, Retention and Fees Tables (Self-Insured ASO)** | | | | |
| ***Complete the following table based upon enrollment census and claims assumptions provided.*** | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **EUTF 90/10 PPO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL*** | | | | |
| **Monthly Medical ASO Fees (PEPM):** | | | | |
| PPO Leasing/Network Access Fees |  |  |  |  |
| Claims Adjudication Fee |  |  |  |  |
| Utilization Management Fees |  |  |  |  |
| Disease Management (DM) |  |  |  |  |
| Integrated Health Management (IHM) |  |  |  |  |
| Other\* |  |  |  |  |
| **Total Medical ASO Fees (PEPM):** |  |  |  |  |
| **Total Medical ASO Fees by Tier:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Estimated Medical Claims Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** |  |  |  |  |
| **DM/IHM Services (PEPM):** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| \* ID Cards, Wellness, Provider Directory, Booklets/SPDs, Data Reporting, Medical Info Line, Banking, Any Start-up Cost, etc. | | | | |
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|  |  |  |  |  |
| **Authorized Signature** |  |  |  |  |
|  |  |  |  |  |
| **Title** |  |  |  |  |
|  |  |  |  |  |
| **Name of Company** |  |  | **Date** |  |

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| --- | --- | --- | --- |
| **MINIMUM PREMIUM** |  |  |  |
| **Proposal Sheet 13C** | | | |
| **90/10 PPO Plan – EUTF Retiree** | | | |
| **Premium Rate Table (Insured with Limited Risk Sharing)** | | | |
| ***Complete the following table on a monthly, per capita tiered basis ONLY*** | | | |
|  | | | |
| The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. The EUTF will pay the Medical ASO Fees, and actual medical claims up to the Maximum Medical Claims Cost indicated below. If the total claims paid at the end of the runout period is greater than the Maximum Medical Claims Cost indicated below, the excess amount will not be collected from the EUTF. Only actual claims and fees up to the targeted claim maximum will be charged. The EUTF reserves the right to carve-out the prescription drugs from this proposal. | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **EUTF 90/10 PPO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL*** | | | | |
| **Monthly Medical ASO Fees (PEPM):** | | | | |
| PPO Leasing/Network Access Fees |  |  |  |  |
| Claims Adjudication Fee |  |  |  |  |
| Utilization Management Fees |  |  |  |  |
| Disease Management (DM) |  |  |  |  |
| Integrated Health Management (IHM) |  |  |  |  |
| Other\* |  |  |  |  |
| **Total Medical ASO Fees (PEPM):** |  |  |  |  |
| **Total Medical ASO Fees by Tier:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Maximum Medical Claims Cost (paid by EUTF):** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| \* ID Cards, Wellness, Provider Directory, Booklets/SPDs, Data Reporting, Medical Info Line, Banking, Any Start-up Cost, etc. | | | | |
|  |  |  |  |  |
|  |  |  |  |  |
| **Authorized Signature** |  |  |  |  |
|  |  |  |  |  |
| **Title** |  |  |  |  |
|  |  |  |  |  |
| **Name of Company** |  |  | **Date** |  |

**Retiree**

**EUTF – Closed Panel HMO Plan**

**Table and Proposal Sheets #14**

|  |  |  |  |
| --- | --- | --- | --- |
| **NON-MEDICARE RETIREE** |  |  |  |
| **EUTF – CLOSED PANEL HMO PLAN** | | | |
| **TABLE AND PROPOSAL SHEETS #14** | | | |
|  |  |  |  |
| Detailed benefits information is provided in Exhibit E. Please note any deviation in proposed benefits in the charts below. Unless noted it will be assumed that proposed benefits match the requested benefits exactly. You must agree to a “no loss, no gain” provision with the current benefit plan. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis. | | | |

| **TABLE 14 – NON-MEDICARE RETIREE** | | |
| --- | --- | --- |
| **Plan Design** | **EUTF CLOSED PANEL HMO PLAN** | **NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS** |
| **MEDICAL** | **Provided by Kaiser** |  |
| **General** | **HMO Network** |  |
| Calendar Year Deductible | None |  |
| Calendar Year Maximum  Out-of-Pocket | $2,000 per person  $6,000 per family |  |
| Lifetime Benefit Maximum | None |  |
| Plan Year Benefit Maximum | None |  |
| **PHYSICIAN SERVICES** | **MEMBER PAYS** |  |
| Physician Office Visit  (including primary care and specialist office visits) | $15 |  |
| Annual Health Exam | No Charge |  |
| Diabetes Prevention Program | No Charge |  |
| Immunizations | No Charge |  |
| Well Child Care Visits | No Charge |  |
| Maternity | No Charge for routine prenatal visits, delivery, and one postpartum visit |  |
| Screening Mammography | No Charge |  |
| Advance Care Planning | No Charge (Continuing Care) |  |
| **EMERGENCY SERVICES** | | |
| Emergency Room | $50 in area / 20% out |  |
| Ambulance | 20% |  |
| **INPATIENT HOSPITAL SERVICES** | | |
| Room and Board | No Charge |  |
| Ancillary Services | No Charge |  |
| Physician Services | No Charge |  |
| Surgery | No Charge |  |
| Anesthesia | No Charge |  |
| Mental Health Services | No Charge |  |
| **OUTPATIENT SERVICES** | | |
| Chemotherapy | $15 |  |
| Radiation Therapy | $15 |  |
| Lab and Pathology | $15 |  |
| Diagnostic Testing and X-ray | $15 |  |
| Allergy Testing | $15 |  |
| Surgery | $15 |  |
| Anesthesia | $15 |  |
| Mental Health Services | $15 |  |
| **OTHER SERVICES** | | |
| Durable Medical Equipment | 20% (including Diabetes Equipment) |  |
| Hearing Aids\* | Not Covered |  |
| Home Health Care | No Charge |  |
| Hospice Care | No Charge |  |
| Skilled Nursing Facility Care | No Charge  (100 days/benefit period) |  |
| Physical and Occupational Therapy | $15 (Outpatient) |  |
| Chiropractic Services\* | Not Covered |  |
| **PRESCRIPTION DRUGS** | **Provided by Kaiser** |  |
| Calendar Year Maximum  Out-of-Pocket | Applies towards the medical maximum  out-of-pocket |  |
| **Retail** |  |  |
| Day Supply | 30/60/90 |  |
| Generic | $15/$30/$45 |  |
| Preferred Brand | $15/$30/$45 |  |
| Non-Preferred Brand | $15/$30/$45 |  |
| Preferred Insulin | $15/$30/$45 |  |
| Other Insulin | $15/$30/$45 |  |
| Preferred Diabetic Supplies | $15/$30/$45 |  |
| Other Diabetic Supplies | $15/$30/$45 |  |
| Oral Contraceptives | 50% of applicable charges |  |
| Injectables & Specialty Drug | $15 up to a 30-day supply  Not all drugs can be mailed; restrictions and limitations apply |  |
| Oral Oncology | No Charge |  |
| **Mail Order** |  |  |
| Day Supply | 30/60/90 |  |
| Generic | $15/$30/$30 |  |
| Preferred Brand | $15/$30/$30 |  |
| Non-Preferred Brand | $15/$30/$30 |  |
| Preferred Insulin | Not available through Mail Order |  |
| Other Insulin | Not available through Mail Order |  |
| Preferred Diabetic Supplies | $15/$30/$30 |  |
| Other Diabetic Supplies | $15/$30/$30 |  |
| Oral Contraceptives | 50% of applicable charges |  |

Footnotes applicable to Medical:

*\* Hearing aids and chiropractic services are currently not covered under this plan. In a separate attachment, please include the proposed rates on a tiered basis for fully insured hearing aid (in-network 40% benefit per ear every 36 months) and chiropractic benefits (in-network $15 per visit limited to 20 visits per calendar year and not covered out-of-network).*

|  |  |  |  |
| --- | --- | --- | --- |
| **MEDICARE RETIREE** |  |  |  |
| **EUTF – CLOSED PANEL HMO PLAN** | | | |
| **TABLE AND PROPOSAL SHEETS #14 Continued** | | | |
|  |  |  |  |
| Detailed benefits information is provided in Exhibit E. Please note any deviation in proposed benefits in the charts below. Unless noted it will be assumed that proposed benefits match the requested benefits exactly. You must agree to a “no loss, no gain” provision with the current benefit plan. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis. | | | |

| **TABLE 14 Continued – MEDICARE RETIREE** | | |
| --- | --- | --- |
| **Plan Design** | **EUTF CLOSED PANEL HMO PLAN** | **NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS** |
| **MEDICAL** | **Provided by Kaiser** |  |
| **General** | **HMO Network** |  |
| Calendar Year Deductible | None |  |
| Calendar Year Maximum  Out-of-Pocket | $2,000 per person  $6,000 per family |  |
| Lifetime Benefit Maximum | None |  |
| Plan Year Benefit Maximum | None |  |
| **PHYSICIAN SERVICES** | **MEMBER PAYS** |  |
| Physician Office Visit  (including primary care and specialist office visits) | $15 |  |
| Annual Wellness Visit | No Charge |  |
| Annual Health Exam | No Charge |  |
| Medicare Diabetes Prevention Program | No Charge |  |
| Immunizations | No Charge |  |
| Screening Mammography | No Charge |  |
| Advance Care Planning | No Charge (Continuing Care) |  |
| **EMERGENCY SERVICES** | | |
| Emergency Room | $50 |  |
| Ambulance | 20% |  |
| **INPATIENT HOSPITAL SERVICES** | | |
| Room and Board | No Charge |  |
| Ancillary Services | No Charge |  |
| Physician Services | No Charge |  |
| Surgery | No Charge |  |
| Anesthesia | No Charge |  |
| Mental Health Services | No Charge |  |
| **OUTPATIENT SERVICES** | | |
| Chemotherapy | $15 |  |
| Radiation Therapy | $15 |  |
| Lab and Pathology | No Charge |  |
| Diagnostic Testing and X-ray | No Charge |  |
| Allergy Testing | $15 |  |
| Surgery | $15 |  |
| Anesthesia | $15 |  |
| Mental Health Services | $15 |  |
| **OTHER SERVICES** | | |
| Durable Medical Equipment | 20% (including Diabetes Equipment) |  |
| Hearing Aids\* | Not Covered |  |
| Home Health Care | No Charge |  |
| Hospice Care | No Charge |  |
| Skilled Nursing Facility Care | No Charge  (100 days/benefit period) |  |
| Physical and Occupational Therapy | $15 (Outpatient) |  |
| Chiropractic Services\* | Not Covered |  |
| **PRESCRIPTION DRUGS** | **Provided by Kaiser** |  |
| Calendar Year Maximum  Out-of-Pocket | Applies towards the medical maximum  out-of-pocket |  |
| **Retail** |  |  |
| Day Supply | 30/60/90 |  |
| Generic | $15/$30/$45 |  |
| Preferred Brand | $15/$30/$45 |  |
| Non-Preferred Brand | $15/$30/$45 |  |
| Insulin | $15/$30/$45 |  |
| Diabetic Supplies | Lancets, Strips & Meters: 20%  Syringes/Needles: $15/$30/$45 |  |
| Injectables & Specialty Drug | $15 up to a 30-day supply  Not all drugs can be mailed; restrictions and limitations apply |  |
| Oral Oncology | $15/$30/$45 |  |
| **Mail Order** |  |  |
| Day Supply | 30/60/90 |  |
| Generic | $15/$30/$30 |  |
| Preferred Brand | $15/$30/$30 |  |
| Non-Preferred Brand | $15/$30/$30 |  |
| Insulin | Not available through Mail Order |  |
| Diabetic Supplies | Lancets, Strips & Meters: 20%  Syringes/Needles: $15/$30/$30 |  |

Footnotes applicable to Medical:

*\* Hearing aids and chiropractic services are currently not covered under this plan. In a separate attachment, please include the proposed rates on a tiered basis for fully insured hearing aid (in-network 40% benefit per ear every 36 months) and chiropractic benefits (in-network $15 per visit limited to 20 visits per calendar year and not covered out-of-network).*

|  |  |  |  |
| --- | --- | --- | --- |
| **INSURED** |  |  |  |
| **Proposal Sheet 14** | | | |
| **Closed Panel HMO Plan – EUTF Retiree** | | | |
| **Premium Rate Table (Fully Insured)** | | | |
| ***Complete the following table on a monthly, per capita tiered basis ONLY*** | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **EUTF Closed Panel HMO Plan** | **Contract**  **Period 1** | | **Contract**  **Period 2** | | **Contract**  **Period 3** | | **Contract**  **Period 4** | |
| **Non-Medicare** | **Medicare** | **Non-Medicare** | **Medicare** | **Non-Medicare** | **Medicare** | **Non-Medicare** | **Medicare** |
| ***MEDICAL AND PRESCRIPTION DRUG*** | | | | | | | | |
| **Monthly Medical and Prescription Drug (Excluding DM/IHM) Benefit Cost:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):** | N/A | | \_\_\_\_\_% | | \_\_\_\_\_% | | \_\_\_\_\_% | |
| **Monthly Administration and Retention:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Total Medical and Prescription Drug Premium (Including DM/IHM and Administration and Retention):** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Monthly ACA Fees to be Added to the Above Total Medical and Prescription Drug Premium** | | | | | | | | |
| **Insurer Fee:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- |
| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
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| NOTES:  (1) The EUTF reserves the right to offer multiple carrier options.  (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable. | | | | |
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| **Authorized Signature** |  |  |  |  |
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| **Title** |  |  |  |  |
|  |  |  |  |  |
| **Name of Company** |  |  | **Date** |  |

**Medicare Retiree**

**EUTF – Medicare Advantage LPPO Plan**

**Table and Proposal Sheets #15**

|  |  |  |  |
| --- | --- | --- | --- |
| **MEDICARE RETIREE** |  |  |  |
| **EUTF – MEDICARE ADVANTAGE LPPO PLAN** | | | |
| **TABLE AND PROPOSAL SHEETS #15** | | | |
|  |  |  |  |
| Please note any deviation in proposed benefits in the charts below. Unless noted it will be assumed that proposed benefits match the requested benefits exactly. You must agree to a “no loss, no gain” provision with the requested benefit plan. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on tiered basis. | | | |

| **TABLE 15 – MEDICARE (AND NON-MEDICARE, IF OFFERED) RETIREE** | | | |
| --- | --- | --- | --- |
| **Plan Design** | **EUTF MEDICARE ADVANTAGE LPPO PLAN (AND NON-MEDICARE IF OFFERED)** | | **NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS** |
| **MEDICAL** | **Requested** | |  |
| **General** | **In-Network** | **Out-of-Network** |  |
| Calendar Year Deductible | $100 per person | |  |
| Calendar Year Maximum Out-of-Pocket | $2,500 per person | |  |
| Lifetime Benefit Maximum | None | |  |
| Plan Year Benefit Maximum | None | |  |
| **PHYSICIAN SERVICES** | **MEMBER PAYS** | |  |
| Physician Office Visit  (including primary care and specialist office visits) | 10%\* | 10% |  |
| Annual Wellness Visit | No Charge\* | No Charge\* |  |
| Annual Health Exam | No Charge\* | No Charge\* |  |
| Diabetes Prevention Program\*\* | No Charge\*  (one program for non-Medicare and Medicare/  lifetime) | Not Covered |  |
| Immunizations | No Charge\* | No Charge\* |  |
| Screening Mammography | 10%\* | 10%\* |  |
| Advance Care Planning | No Charge\* | 10% |  |
| **EMERGENCY SERVICES** | | | |
| Emergency Room | 10% | 10% |  |
| Ambulance | 10% | 10% |  |
| **INPATIENT HOSPITAL SERVICES** | | | |
| Room and Board | 10% | 10% |  |
| Ancillary Services | 10% | 10% |  |
| Physician Services | 10% | 10% |  |
| Surgery | 10% | 10% |  |
| Anesthesia | 10% | 10% |  |
| Mental Health Services | 10% | 10% |  |
| **OUTPATIENT SERVICES** | | | |
| Chemotherapy | 10% | 10% |  |
| Radiation Therapy | 10% | 10% |  |
| Lab and Pathology | 10% | 10% |  |
| Diagnostic Testing | 10% | 10% |  |
| Allergy Testing | 10% | 10% |  |
| Surgery | 10% | 10% |  |
| Anesthesia | 10% | 10% |  |
| Mental Health Services | 10% | 10% |  |
| **OTHER SERVICES** | | | |
| Medicare Part B Covered Diabetic Supplies | 10%\* | 10% |  |
| Durable Medical Equipment | 10% | 10% |  |
| Hearing Aids | 20%  (one device per ear every 60 months) | 30%  (one device per ear every 60 months) |  |
| Home Health Care | No Charge\*  (150 visits/CY) | 10%  (150 visits/CY) |  |
| Hospice Care | No Charge\* | Not Covered |  |
| Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities) | 10%  (120 days/CY) | 10%  (120 days/CY) |  |
| Physical and Occupational Therapy | 10% | 10% |  |
| Fitness Program | No Charge | Not Covered |  |
| **MEDICARE PART D PRESCRIPTION DRUGS✝** | **Participating Pharmacy** | **Non-Participating Pharmacy** |  |
| Calendar Year Maximum  Out-of-Pocket | $4,350 per person  $8,700 per family | |  |
| **Retail** |  |  |  |
| Day Supply | 30/60/90 | 30/60/90 |  |
| Generic | $5/$10/$10 | $5/$10/$10 + 20% of eligible charges |  |
| Preferred Brand | $25/$50/$50 | $25/$50/$50 + 20% of eligible charges |  |
| Non-Preferred Brand | $50/$100/$100 | $50/$100/$100 + 20% of eligible charges |  |
| Preferred Insulin | $5/$10/$10 | $5/$10/$10 + 20% of eligible charges |  |
| Other Insulin | $25/$50/$50 | $25/$50/$50 + 20% of eligible charges |  |
| Preferred Diabetic Supplies | No Charge | 20% of eligible charges |  |
| Other Diabetic Supplies | $25/$50/$50 | $25/$50/$50 + 20% of eligible charges |  |
| **Injectables & Specialty Drug** | **30-day supply only** | |  |
| Specialty Calendar Year Maximum Out-of-Pocket | $2,500 per person | |  |
| Specialty Generic | 10% of eligible charges (up to $200 per fill) | |  |
| Specialty Preferred Brand | 20% of eligible charges (up to $300 per fill) | |  |
| Specialty Non-Preferred Brand | 30% of eligible charges (up to $400 per fill) | |  |
| Oral Oncology | $30 | |  |
| **Mail Order** | **Participating Mail Pharmacy** | **Non-Participating Mail Pharmacy** |  |
| Day Supply | 30/60/90 | Not Covered |  |
| Generic | $5/$10/$10 | Not Covered |  |
| Preferred Brand | $25/$50/$50 | Not Covered |  |
| Non-Preferred Brand | $50/$100/$100 | Not Covered |  |
| Preferred Insulin | $5/$10/$10 | Not Covered |  |
| Other Insulin | $25/$50/$50 | Not Covered |  |
| Preferred Diabetic Supplies | No Charge | Not Covered |  |
| Other Diabetic Supplies | $25/$50/$50 | Not Covered |  |
| Injectables and Specialty Drug | Not Covered | Not Covered |  |

Footnotes applicable to Medical:

*\* Deductible does not apply.*

*\*\* In a separate attachment, please include the proposed rate on a tiered basis for the Reversing Heart Disease Program (in-network $20 per session/once per lifetime and not covered out-of-network), Supportive Care (in-network 90-days/12 month period and not covered out-of-network), and fully insured in-network chiropractic benefit (in-network $15 per visit limited to 20 visits per calendar year and not covered out-of-network).*

*✝ The Medicare Part D drug plan is optional.*

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| **INSURED** |  |  |  |
| **Proposal Sheet 15A** | | | |
| **Medicare Advantage LPPO Plan ONLY– EUTF Medicare Retiree and Medicare Retiree Spouses ONLY** | | | |
| **Premium Rate Table (Fully Insured)** | | | |
| ***Complete the following table on a monthly, per capita tiered basis ONLY*** | | | |
|  |  |  |  |
| The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. The EUTF reserves the right to carve-out the prescription drugs from this proposal. | | | |

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| **EUTF Medicare Advantage LPPO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL*** | | | | |
| **Monthly Medical (Excluding DM/IHM) Benefit Cost:** | | | | |
| Medicare Retiree |  |  |  |  |
| Medicare Retiree + Medicare Spouse |  |  |  |  |
| **Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:** | | | | |
| Medicare Retiree |  |  |  |  |
| Medicare Retiree + Medicare Spouse |  |  |  |  |
| **Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Monthly Administration and Retention:** | | | | |
| Medicare Retiree |  |  |  |  |
| Medicare Retiree + Medicare Spouse |  |  |  |  |
| **Total Medical Premium (Including DM/IHM and Administration and Retention):** | | | | |
| Medicare Retiree |  |  |  |  |
| Medicare Retiree + Medicare Spouse |  |  |  |  |
| **Monthly ACA Fees to be Added to the Above Total Medical Premium** | | | | |
| **Insurer Fee:** | | | | |
| Medicare Retiree |  |  |  |  |
| Medicare Retiree + Medicare Spouse |  |  |  |  |

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| **EUTF Medicare Advantage LPPO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***PRESCRIPTION DRUG (optional)*** | | | | |
| **Monthly Benefit Cost:** | | | | |
| Medicare Retiree |  |  |  |  |
| Medicare Retiree + Medicare Spouse |  |  |  |  |
| **Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Monthly Administration and Retention:** | | | | |
| Medicare Retiree |  |  |  |  |
| Medicare Retiree + Medicare Spouse |  |  |  |  |
| **Total Prescription Drug Premium (Including Administration and Retention):** | | | | |
| Medicare Retiree |  |  |  |  |
| Medicare Retiree + Medicare Spouse |  |  |  |  |
| **Monthly ACA Fees to be Added to the Above Total Prescription Drug Premium** | | | | |
| **Insurer Fee:** | | | | |
| Medicare Retiree |  |  |  |  |
| Medicare Retiree + Medicare Spouse |  |  |  |  |

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| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
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|  |  |  |  |  |
| **Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): \_\_\_\_\_%** | | | | |
| NOTES:  (1) The EUTF reserves the right to offer multiple carrier options.  (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable. | | | | |
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| **Authorized Signature** |  |  |  |  |
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| **Title** |  |  |  |  |
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| **Name of Company** |  |  | **Date** |  |

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| **INSURED** |  |  |  |
| **Proposal Sheet 15B** | | | |
| **Medicare Advantage LPPO and Non-Medicare Plans – EUTF Retirees** | | | |
| **Premium Rate Table (Fully Insured)** | | | |
| ***Complete the following table on a monthly, per capita tiered basis ONLY*** | | | |
|  |  |  |  |
| The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. The EUTF reserves the right to carve-out the prescription drugs from this proposal. | | | |

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| **EUTF Medicare Advantage LPPO and Non-Medicare Plans** | **Contract**  **Period 1** | | **Contract**  **Period 2** | | **Contract**  **Period 3** | | **Contract**  **Period 4** | |
| **Non-Medicare** | **Medicare** | **Non-Medicare** | **Medicare** | **Non-Medicare** | **Medicare** | **Non-Medicare** | **Medicare** |
| ***MEDICAL*** | | | | | | | | |
| **Monthly Medical (Excluding DM/IHM and Chiropractic) Benefit Cost:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):** | N/A | | \_\_\_\_\_% | | \_\_\_\_\_% | | \_\_\_\_\_% | |
| **Monthly Administration and Retention:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Total Medical Premium (Including DM/IHM, Chiropractic, and Administration and Retention):** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Monthly ACA Fees to be Added to the Above Total Medical Premium** | | | | | | | | |
| **Insurer Fee:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |

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| **EUTF Medicare Advantage LPPO Plan** | **Contract**  **Period 1** | | **Contract**  **Period 2** | | **Contract**  **Period 3** | | **Contract**  **Period 4** | |
| **Non-Medicare** | **Medicare** | **Non-Medicare** | **Medicare** | **Non-Medicare** | **Medicare** | **Non-Medicare** | **Medicare** |
| ***PRESCRIPTION DRUG (optional)*** | | | | | | | | |
| **Monthly Benefit Cost:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):** | N/A | | \_\_\_\_\_% | | \_\_\_\_\_% | | \_\_\_\_\_% | |
| **Monthly Administration and Retention:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Total Prescription Drug Premium (Including Administration and Retention):** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Monthly ACA Fees to be Added to the Above Total Prescription Drug Premium** | | | | | | | | |
| **Insurer Fee:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |

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| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
|  |  |  |  |  |
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|  |  |  |  |  |
| **Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): \_\_\_\_\_%** | | | | |
| NOTES:  (1) The EUTF reserves the right to offer multiple carrier options.  (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable. | | | | |
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| **Authorized Signature** |  |  |  |  |
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| **Title** |  |  |  |  |
|  |  |  |  |  |
| **Name of Company** |  |  | **Date** |  |

**Retiree**

**HSTA VB – 90/10 PPO Plan**

**Table and Proposal Sheets #16**

|  |  |  |  |
| --- | --- | --- | --- |
| **NON-MEDICARE RETIREE** |  |  |  |
| **HSTA VB – 90/10 PPO PLAN** |  |  |  |
| **TABLE AND PROPOSAL SHEETS #16** | | | |
|  |  |  |  |
| Detailed benefits information is provided in Exhibit E. Please note any deviation in proposed benefits in the charts below. Unless noted it will be assumed that proposed benefits match the requested benefits exactly. You must agree to a “no loss, no gain” provision with the current benefit plan. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis. | | | |

| **TABLE 16 – NON-MEDICARE RETIREE** | | | |
| --- | --- | --- | --- |
| **Plan Design** | **HSTA VB 90/10 PPO PLAN** | | **NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS** |
| **MEDICAL** | **Provided by HMSA** | |  |
| **General** | **In-Network** | **Out-of-Network\*** |  |
| Calendar Year Deductible | None | $100 per person  $300 per family |  |
| Calendar Year Maximum  Out-of-Pocket | $2,000 per person  $6,000 per family | |  |
| Lifetime Benefit Maximum | $2,000,000 per person | |  |
| Plan Year Benefit Maximum | None | |  |
| **PHYSICIAN SERVICES** | **MEMBER PAYS** | |  |
| Physician Office Visit  (including primary care and specialist office visits) | 10% | 30% |  |
| Annual Health Exam | No Charge  (up to CY dollar max depending on age) | No Charge\*\*  (up to CY dollar max depending on age) |  |
| Diabetes Prevention Program\*\*\* | No Charge  (one program/  lifetime) | Not Covered |  |
| Immunizations | No Charge | 30% |  |
| Well Child Care Visits | No Charge | 30%\*\* |  |
| Maternity | 10% | 30% |  |
| Screening Mammography | 10% | 30% |  |
| Advance Care Planning | No Charge | 30% |  |
| **EMERGENCY SERVICES** | | | |
| Emergency Room | 10% | 10%\*\* |  |
| Ambulance | 10% | 30% |  |
| **INPATIENT HOSPITAL SERVICES** | | | |
| Room and Board | 10% | 30% |  |
| Ancillary Services | 10% | 30% |  |
| Physician Services | 10% | 30% |  |
| Surgery | 10% | 30% |  |
| Anesthesia | 10% | 30% |  |
| Mental Health Services | 10% | 30% |  |
| **OUTPATIENT SERVICES** | | | |
| Chemotherapy | 10% | 30% |  |
| Radiation Therapy | 10% | 30% |  |
| Lab and Pathology | 10% | 30% |  |
| Diagnostic Testing and X-ray  (including genetic testing and counseling) | 10% | 30% |  |
| Allergy Testing | 10% | 30% |  |
| Surgery | 10% | 30% |  |
| Anesthesia | 10% | 30% |  |
| Mental Health Services | 10% | 30% |  |

| **TABLE 16 – NON-MEDICARE RETIREE** | | | |
| --- | --- | --- | --- |
| **Plan Design** | **HSTA VB 90/10 PPO PLAN** | | **NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS** |
| **OTHER SERVICES** | | | |
| Durable Medical Equipment | 10% | 30% |  |
| Hearing Aids | 10%  (one device per ear every 60 months) | 30%  (one device per ear every 60 months) |  |
| Home Health Care | No Charge  (150 visits/CY) | 30%  (150 visits/CY) |  |
| Hospice Care | No Charge | Not Covered |  |
| Supportive Care\*\*\* | No Charge  (90 days/  12-month period) | Not Covered |  |
| Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities) | 10%  (120 days/CY) | 30%  (120 days/CY) |  |
| Physical and Occupational Therapy | 10% | 30% |  |
| Reversing Heart Disease Program\*\*\* | $20 per session  (one program/  lifetime) | Not Covered |  |
| Chiropractic Services | $12  (20 visits/CY)  through American Specialty Health Group, Inc. | Not Covered |  |
| **PRESCRIPTION DRUGS** | **Provided by CVS/caremark** | |  |
|  | **Participating Pharmacy** | **Non-Participating Pharmacy\*** |  |
| Calendar Year Maximum  Out-of-Pocket | None | |  |
| **Retail** |  |  |  |
| Day Supply | 30/60/90 | 30/60/90 |  |
| Generic | $5/$9/$9 | $5/$9/$9 + 30% of eligible charges |  |
| Brand | $15/$27/$27 | $15/$27/$27 + 30% of eligible charges |  |
| Insulin | $5/$9/$9 | $5/$9/$9 + 30% of eligible charges |  |
| Diabetic Supplies | No Charge | No Charge |  |
| Oral Contraceptives | Subject to applicable generic/brand copayments | 30% of eligible charges |  |
| Injectables & Specialty Drug | Subject to applicable generic/brand copayments. Specialty drugs are not available through mail order and only dispensed up to a 30-day supply. | |  |
| Oral Oncology | No Charge | 30% of eligible charges |  |
| **Mail Order** | **Participating Mail Pharmacy** | **Non-Participating Mail Pharmacy** |  |
| Day Supply | 30/60/90 | Not Covered |  |
| Generic | $5/$9/$9 | Not Covered |  |
| Brand | $15/$27/$27 | Not Covered |  |
| Insulin | $5/$9/$9 | Not Covered |  |
| Diabetic Supplies | No Charge | Not Covered |  |
| Oral Contraceptives | Subject to applicable generic/brand copayments | 30% of eligible charges |  |
| Injectables & Specialty Drug | Not Covered | Not Covered |  |

**NOTE: Prescription drug benefits are currently provided under separate contracts.**

Footnotes applicable to Medical:

*\* Out-of-Network benefits are limited to usual customary and reasonable charges.*

*\*\* Deductible does not apply.*

*\*\*\* The Diabetes Prevention, Reversing Heart Disease, and Supportive Care programs are currently pilot programs approved through December 31, 2020. In a separate attachment, please include the proposed rate on a tiered basis to continue these programs into the term of the new contract.*

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| **MEDICARE RETIREE** |  |  |  |
| **HSTA VB – 90/10 PPO PLAN** |  |  |  |
| **TABLE AND PROPOSAL SHEETS #16 Continued** | | | |
|  |  |  |  |
| Detailed benefits information is provided in Exhibit E. Please note any deviation in proposed benefits in the charts below. Unless noted it will be assumed that proposed benefits match the requested benefits exactly. You must agree to a “no loss, no gain” provision with the current benefit plan. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis. | | | |

| **TABLE 16 Continued – MEDICARE RETIREE** | | | |
| --- | --- | --- | --- |
| **Plan Design** | **HSTA VB 90/10 PPO PLAN** | | **NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS** |
| **MEDICAL** | **Provided by HMSA** | |  |
| **General** | **In-Network** | **Out-of-Network\*** |  |
| Calendar Year Deductible | None | $100 per person  $300 per family |  |
| Calendar Year Maximum  Out-of-Pocket | $2,000 per person  $6,000 per family | |  |
| Lifetime Benefit Maximum | $2,000,000 per person | |  |
| Plan Year Benefit Maximum | None | |  |
| **PHYSICIAN SERVICES** | **MEMBER PAYS** | |  |
| Physician Office Visit (including primary care and specialist office visits) | 10% | 30% |  |
| Annual Wellness Visit  (Covered under Medicare) | No Charge | No Charge\*\* |  |
| Annual Health Exam | No Charge  (up to CY dollar max depending on age) | No Charge\*\*  (up to CY dollar max depending on age) |  |
| Diabetes Prevention Program\*\*\* | No Charge  (one program/  lifetime) | Not Covered |  |
| Immunizations | No Charge | 30% |  |
| Well Child Care Visits | No Charge | 30%\*\* |  |
| Maternity | 10% | 30% |  |
| Screening Mammography | 10% | 30% |  |
| Advance Care Planning | No Charge | 30% |  |
| **EMERGENCY SERVICES** | | | |
| Emergency Room | 10% | 10%\*\* |  |
| Ambulance | 10% | 30% |  |
| **INPATIENT HOSPITAL SERVICES** | | | |
| Room and Board | 10% | 30% |  |
| Ancillary Services | 10% | 30% |  |
| Physician Services | 10% | 30% |  |
| Surgery | 10% | 30% |  |
| Anesthesia | 10% | 30% |  |
| Mental Health Services | 10% | 30% |  |
| **OUTPATIENT SERVICES** | | | |
| Chemotherapy | 10% | 30% |  |
| Radiation Therapy | 10% | 30% |  |
| Lab and Pathology | 10% | 30% |  |
| Diagnostic Testing and X-ray  (including genetic testing and counseling) | 10% | 30% |  |
| Allergy Testing | 10% | 30% |  |
| Surgery | 10% | 30% |  |
| Anesthesia | 10% | 30% |  |
| Mental Health Services | 10% | 30% |  |
| **OTHER SERVICES** | | | |
| Durable Medical Equipment | 10% | 30% |  |
| Hearing Aids | 10%  (one device per ear every 60 months) | 30%  (one device per ear every 60 months) |  |
| Home Health Care | No Charge  (150 visits/CY) | 30%  (150 visits/CY) |  |
| Hospice Care | No Charge | Not Covered |  |
| Supportive Care\*\*\* | No Charge  (90 days/  12-month period) | Not Covered |  |
| Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities) | 10%  (120 days/CY) | 30%  (120 days/CY) |  |
| Physical and Occupational Therapy | 10% | 30% |  |
| Reversing Heart Disease Program\*\*\* | $20 per session  (one program/  lifetime) | Not Covered |  |
| Chiropractic Services | $12  (20 visits/CY)  through American Specialty Health Group, Inc. | Not Covered |  |
| **MEDICARE PART D PRESCRIPTION DRUGS** | **Provided by SilverScript** | |  |
|  | **Participating Pharmacy** | **Non-Participating Pharmacy** |  |
| Calendar Year Maximum  Out-of-Pocket | None | |  |
| **Retail** |  |  |  |
| Day Supply | 30/60/90 | 30/60/90 |  |
| Generic | $3/$9/$9 | $3/$9/$9 + 30% of eligible charges |  |
| Brand | $9/$27/$27 | $9/$27/$27 + 30% of eligible charges |  |
| Insulin | $3/$9/$9 | $3/$9/$9 + 30% of eligible charges |  |
| Diabetic Supplies | No Charge  Meters: Covered by Medicare Part B and the HSTA VB 90/10 PPO medical plan. | 30% of eligible charges  Meters: Covered by Medicare Part B and the HSTA VB 90/10 PPO medical plan. |  |
| Injectables & Specialty Drug | Specialty medications are subject to the applicable Generic/Brand copay. Specialty drugs are not available through mail order and only dispensed up to a 30-day supply. | |  |
| Oral Oncology | No Charge | 30% of eligible charges |  |
| **Mail Order** | **Participating Mail Pharmacy** | **Non-Participating Mail Pharmacy** |  |
| Day Supply | 30/60/90 | Not Covered |  |
| Generic | $3/$9/$9 | Not Covered |  |
| Brand | $9/$27/$27 | Not Covered |  |
| Insulin | $3/$9/$9 | Not Covered |  |
| Diabetic Supplies | No Charge | Not Covered |  |

**NOTE: Prescription drug benefits are currently provided under separate contracts.**

Footnotes applicable to Medical:

*\* Out-of-Network benefits are limited to usual customary and reasonable charges.*

*\*\* Deductible does not apply.*

*\*\*\* The Diabetes Prevention, Reversing Heart Disease, and Supportive Care programs are currently pilot programs approved through December 31, 2020. In a separate attachment, please include the proposed rate on a tiered basis to continue these programs into the term of the new contract.*

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| **INSURED, RISK SHARING** |  |  |  |
| **Proposal Sheet 16A** | | | |
| **90/10 PPO Plan – HSTA VB Retiree** | | | |
| **Premium Rate Table (Insured with Risk Sharing-Surplus Refund)** | | | |
| ***Complete the following table on a monthly, per capita tiered basis ONLY*** | | | |
|  |  |  |  |
| The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. If the total benefit paid at the end of the runout period is less than the proposed benefit cost, the excess amount will be refunded to the EUTF. The EUTF reserves the right to carve-out the prescription drugs from this proposal. | | | |

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| **HSTA VB 90/10 PPO Plan** | **Contract**  **Period 1** | | **Contract**  **Period 2** | | **Contract**  **Period 3** | | **Contract**  **Period 4** | |
| **Non-Medicare** | **Medicare** | **Non-Medicare** | **Medicare** | **Non-Medicare** | **Medicare** | **Non-Medicare** | **Medicare** |
| ***MEDICAL*** | | | | | | | | |
| **Monthly Medical (Excluding DM/IHM and Chiropractic) Benefit Cost:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Monthly Chiropractic Benefit Cost:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):** | N/A | | \_\_\_\_\_% | | \_\_\_\_\_% | | \_\_\_\_\_% | |
| **Monthly Administration and Retention:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Total Medical Premium (Including DM/IHM, Chiropractic, and Administration and Retention):** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Monthly ACA Fees to be Added to the Above Total Medical Premium** | | | | | | | | |
| **Insurer Fee:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **HSTA VB 90/10 PPO Plan** | **Contract**  **Period 1** | | **Contract**  **Period 2** | | **Contract**  **Period 3** | | **Contract**  **Period 4** | |
| **Non-Medicare** | **Medicare** | **Non-Medicare** | **Medicare** | **Non-Medicare** | **Medicare** | **Non-Medicare** | **Medicare** |
| ***PRESCRIPTION DRUG*** | | | | | | | | |
| **Monthly Benefit Cost:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):** | N/A | | \_\_\_\_\_% | | \_\_\_\_\_% | | \_\_\_\_\_% | |
| **Monthly Administration and Retention:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Total Prescription Drug Premium (Including Administration and Retention):** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Monthly ACA Fees to be Added to the Above Total Prescription Drug Premium** | | | | | | | | |
| **Insurer Fee:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |

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| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
|  |  |  |  |  |
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|  |  |  |  |  |
| **Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): \_\_\_\_\_%** | | | | |
| NOTES:  (1) The EUTF reserves the right to offer multiple carrier options.  (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable. | | | | |
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| **Authorized Signature** |  |  |  |  |
|  |  |  |  |  |
| **Title** |  |  |  |  |
|  |  |  |  |  |
| **Name of Company** |  |  | **Date** |  |
| **SELF-INSURED** | |  |  |  |
| **Proposal Sheet 16B** | | | | |
| **90/10 PPO Plan – HSTA VB Retiree** | | | | |
| **Target Claims, Retention and Fees Tables (Self-Insured ASO)** | | | | |
| ***Complete the following table based upon enrollment census and claims assumptions provided.*** | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **HSTA VB 90/10 PPO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL*** | | | | |
| **Monthly Medical ASO Fees (PEPM):** | | | | |
| PPO Leasing/Network Access Fees |  |  |  |  |
| Claims Adjudication Fee |  |  |  |  |
| Utilization Management Fees |  |  |  |  |
| Disease Management (DM) |  |  |  |  |
| Integrated Health Management (IHM) |  |  |  |  |
| Other\* |  |  |  |  |
| **Total Medical ASO Fees (PEPM):** |  |  |  |  |
| **Total Medical ASO Fees by Tier:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Estimated Medical Claims Cost:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

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| --- | --- | --- | --- | --- |
| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| \* ID Cards, Wellness, Provider Directory, Booklets/SPDs, Data Reporting, Medical Info Line, Banking, Any Start-up Cost, etc. | | | | |
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|  |  |  |  |  |
| **Authorized Signature** |  |  |  |  |
|  |  |  |  |  |
| **Title** |  |  |  |  |
|  |  |  |  |  |
| **Name of Company** |  |  | **Date** |  |

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| --- | --- | --- | --- |
| **MINIMUM PREMIUM** |  |  |  |
| **Proposal Sheet 16C** | | | |
| **90/10 PPO Plan – HSTA VB Retiree** | | | |
| **Premium Rate Table (Insured with Limited Risk Sharing)** | | | |
| ***Complete the following table on a monthly, per capita tiered basis ONLY*** | | | |
|  | | | |
| The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. The EUTF will pay the Medical ASO Fees, and actual medical claims up to the Maximum Medical Claims Cost indicated below. If the total claims paid at the end of the runout period is greater than the Maximum Medical Claims Cost indicated below, the excess amount will not be collected from the EUTF. Only actual claims and fees up to the targeted claim maximum will be charged. The EUTF reserves the right to carve-out the prescription drugs from this proposal. | | | |

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| **HSTA VB 90/10 PPO Plan** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| ***MEDICAL*** | | | | |
| **Monthly Medical ASO Fees (PEPM):** | | | | |
| PPO Leasing/Network Access Fees |  |  |  |  |
| Claims Adjudication Fee |  |  |  |  |
| Utilization Management Fees |  |  |  |  |
| Disease Management (DM) |  |  |  |  |
| Integrated Health Management (IHM) |  |  |  |  |
| Other\* |  |  |  |  |
| **Total Medical ASO Fees (PEPM):** |  |  |  |  |
| **Total Medical ASO Fees by Tier:** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |
| **Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):** | N/A | \_\_\_\_\_% | \_\_\_\_\_% | \_\_\_\_\_% |
| **Maximum Medical Claims Cost (paid by EUTF):** | | | | |
| Single |  |  |  |  |
| Two-Party |  |  |  |  |
| Family |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| \* ID Cards, Wellness, Provider Directory, Booklets/SPDs, Data Reporting, Medical Info Line, Banking, Any Start-up Cost, etc. | | | | |
|  |  |  |  |  |
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| **Authorized Signature** |  |  |  |  |
|  |  |  |  |  |
| **Title** |  |  |  |  |
|  |  |  |  |  |
| **Name of Company** |  |  | **Date** |  |

**Retiree**

**HSTA VB – Closed Panel HMO Plan**

**Table and Proposal Sheets #17**

|  |  |  |  |
| --- | --- | --- | --- |
| **NON-MEDICARE RETIREE** |  |  |  |
| **HSTA VB – CLOSED PANEL HMO PLAN** | | | |
| **TABLE AND PROPOSAL SHEETS #17** | | | |
|  |  |  |  |
| Detailed benefits information is provided in Exhibit E. Please note any deviation in proposed benefits in the charts below. Unless noted it will be assumed that proposed benefits match the requested benefits exactly. You must agree to a “no loss, no gain” provision with the current benefit plan. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on tiered basis. | | | |

| **TABLE 17 – NON-MEDICARE RETIREE** | | |
| --- | --- | --- |
| **Plan Design** | **HSTA VB CLOSED PANEL HMO PLAN** | **NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS** |
| **MEDICAL** | **Provided by Kaiser** |  |
| **General** | **HMO Network** |  |
| Calendar Year Deductible | None |  |
| Calendar Year Maximum  Out-of-Pocket | $2,000 per person  $6,000 per family |  |
| Lifetime Benefit Maximum | None |  |
| Plan Year Benefit Maximum | None |  |
| **PHYSICIAN SERVICES** | **MEMBER PAYS** |  |
| Physician Office Visit  (including primary care and specialist office visits) | $15 |  |
| Annual Health Exam | No Charge |  |
| Diabetes Prevention Program | No Charge |  |
| Immunizations | No Charge |  |
| Well Child Care Visits | No Charge |  |
| Maternity | No Charge for routine prenatal visits, delivery, and one postpartum visit |  |
| Screening Mammography | No Charge |  |
| Advance Care Planning | No Charge (Continuing Care) |  |
| **EMERGENCY SERVICES** | | |
| Emergency Room | $50 in area / 20% out |  |
| Ambulance | 20% |  |
| **INPATIENT HOSPITAL SERVICES** | | |
| Room and Board | No Charge |  |
| Ancillary Services | No Charge |  |
| Physician Services | No Charge |  |
| Surgery | No Charge |  |
| Anesthesia | No Charge |  |
| Mental Health Services | No Charge |  |
| **OUTPATIENT SERVICES** | | |
| Chemotherapy | $15 |  |
| Radiation Therapy | $15 |  |
| Lab and Pathology | $15 |  |
| Diagnostic Testing and X-ray | $15 |  |
| Allergy Testing | $15 |  |
| Surgery | $15 |  |
| Anesthesia | $15 |  |
| Mental Health Services | $15 |  |
| **OTHER SERVICES** | | |
| Durable Medical Equipment | 20% (50% Diabetes Equipment) |  |
| Hearing Aids | $500 allowance  (up to 2 hearing aids every 36 months) |  |
| Home Health Care | No Charge |  |
| Hospice Care | No Charge |  |
| Skilled Nursing Facility Care | No Charge  (100 days/benefit period) |  |
| Physical and Occupational Therapy | $15 (Outpatient) |  |
| Chiropractic Services | $12 (20 visits/CY)  through American Specialty Health Group, Inc. |  |
| **PRESCRIPTION DRUGS** | **Provided by Kaiser** |  |
| Calendar Year Maximum  Out-of-Pocket | Applies towards the medical maximum  out-of-pocket |  |
| **Retail** |  |  |
| Day Supply | 30/60/90 |  |
| Generic | $10/$20/$30 |  |
| Brand | $10/$20/$30 |  |
| Insulin | $10/$20/$30 |  |
| Diabetic Supplies | 50% of applicable charges |  |
| Oral Contraceptives | 50% of applicable charges |  |
| Injectables & Specialty Drug | $10 up to a 30-day supply  Not all drugs can be mailed; restrictions and limitations apply. |  |
| Oral Oncology | No Charge |  |
| **Mail Order** |  |  |
| Day Supply | 30/60/90 |  |
| Generic | $10/$20/$20 |  |
| All Covered Brand | $10/$20/$20 |  |
| Insulin | Not available through Mail Order |  |
| Diabetic Supplies | 50% of applicable charges |  |
| Oral Contraceptives | 50% of applicable charges |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **MEDICARE RETIREE** |  |  |  |
| **HSTA VB – CLOSED PANEL HMO PLAN** | | | |
| **TABLE AND PROPOSAL SHEETS #17 Continued** | | | |
|  |  |  |  |
| Detailed benefits information is provided in Exhibit E. Please note any deviation in proposed benefits in the charts below. Unless noted it will be assumed that proposed benefits match the requested benefits exactly. You must agree to a “no loss, no gain” provision with the current benefit plan. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a percent and PMPM basis. | | | |

| **TABLE 17 Continued – MEDICARE RETIREE** | | |
| --- | --- | --- |
| **Plan Design** | **HSTA VB CLOSED PANEL HMO PLAN** | **NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS** |
| **MEDICAL** | **Provided by Kaiser** |  |
| **General** | **HMO Network** |  |
| Calendar Year Deductible | None |  |
| Calendar Year Maximum  Out-of-Pocket | $2,000 per person  $6,000 per family |  |
| Lifetime Benefit Maximum | None |  |
| Plan Year Benefit Maximum | None |  |
| **PHYSICIAN SERVICES** | **MEMBER PAYS** |  |
| Physician Office Visit  (including primary care and specialist office visits) | $15 |  |
| Annual Wellness Visit | No Charge |  |
| Annual Health Exam | No Charge |  |
| Medicare Diabetes Prevention Program | No Charge |  |
| Immunizations | No Charge |  |
| Screening Mammography | No Charge |  |
| Advance Care Planning | No Charge (Continuing Care) |  |
| **EMERGENCY SERVICES** | | |
| Emergency Room | $50 |  |
| Ambulance | 20% |  |
| **INPATIENT HOSPITAL SERVICES** | | |
| Room and Board | No Charge |  |
| Ancillary Services | No Charge |  |
| Physician Services | No Charge |  |
| Surgery | No Charge |  |
| Anesthesia | No Charge |  |
| Mental Health Services | No Charge |  |
| **OUTPATIENT SERVICES** | | |
| Chemotherapy | $15 |  |
| Radiation Therapy | $15 |  |
| Lab and Pathology | No Charge |  |
| Diagnostic Testing and X-ray | No Charge |  |
| Allergy Testing | $15 |  |
| Surgery | $15 |  |
| Anesthesia | $15 |  |
| Mental Health Services | $15 |  |
| **OTHER SERVICES** | | |
| Durable Medical Equipment | 20% (including Diabetes Equipment) |  |
| Hearing Aids | $500 allowance  (up to 2 hearing aids every 36 months) |  |
| Home Health Care | No Charge |  |
| Hospice Care | No Charge (Home Hospice Only) |  |
| Skilled Nursing Facility Care | No Charge  (100 days/benefit period) |  |
| Physical and Occupational Therapy | $15 (Outpatient) |  |
| Chiropractic Services | $12 (20 visits/year)  through American Specialty Health Group, Inc. |  |
| **PRESCRIPTION DRUGS** | **Provided by Kaiser** |  |
| Calendar Year Maximum  Out-of-Pocket | Applies towards the medical maximum  out-of-pocket |  |
| **Retail** |  |  |
| Day Supply | 30/60/90 |  |
| Generic | $10/$20/$30 |  |
| Brand | $10/$20/$30 |  |
| Insulin | $10/$20/$30 |  |
| Diabetic Supplies | 20% of applicable charges |  |
| Injectables & Specialty Drug | $10 up to a 30-day supply  Not all drugs can be mailed; restrictions and limitations apply. |  |
| Oral Oncology | $10/$20/$30 |  |
| **Mail Order** |  |  |
| Day Supply | 30/60/90 |  |
| Generic | $10/$20/$20 |  |
| Brand | $10/$20/$20 |  |
| Insulin | Not available through Mail Order |  |
| Diabetic Supplies | 20% of applicable charges |  |

|  |  |  |  |
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| **INSURED** |  |  |  |
| **Proposal Sheet 17** | | | |
| **Closed Panel HMO Plan – HSTA VB Retiree** | | | |
| **Premium Rate Table (Fully Insured)** | | | |
| ***Complete the following table on a monthly, per capita tiered basis ONLY*** | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **HSTA VB Closed Panel HMO Plan** | **Contract**  **Period 1** | | **Contract**  **Period 2** | | **Contract**  **Period 3** | | **Contract**  **Period 4** | |
| **Non-Medicare** | **Medicare** | **Non-Medicare** | **Medicare** | **Non-Medicare** | **Medicare** | **Non-Medicare** | **Medicare** |
| ***MEDICAL AND PRESCRIPTION DRUG*** | | | | | | | | |
| **Monthly Medical and Prescription Drug (Excluding DM/IHM and Chiropractic) Benefit Cost:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Monthly Chiropractic Benefit Cost:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):** | N/A | | \_\_\_\_\_% | | \_\_\_\_\_% | | \_\_\_\_\_% | |
| **Monthly Administration and Retention:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Total Medical and Prescription Drug Premium (Including DM/IHM, Chiropractic, and Administration and Retention):** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |
| **Monthly ACA Fees to be Added to the Above Total Medical and Prescription Drug Premium** | | | | | | | | |
| **Insurer Fee:** | | | | | | | | |
| Single |  |  |  |  |  |  |  |  |
| Two-Party |  |  |  |  |  |  |  |  |
| Family |  |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- |
| **Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:** | **Contract**  **Period 1** | **Contract**  **Period 2** | **Contract**  **Period 3** | **Contract**  **Period 4** |
| **DM/IHM Services (PEPM):** |  |  |  |  |
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| NOTES:  (1) The EUTF reserves the right to offer multiple carrier options.  (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable. | | | | |
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| **Authorized Signature** |  |  |  |  |
|  |  |  |  |  |
| **Title** |  |  |  |  |
|  |  |  |  |  |
| **Name of Company** |  |  | **Date** |  |