Medical Performance Guarantees

General Performance Guarantee Provisions

Aetna Life Insurance Company (ALIC) provides health benefits administration and other services for the self-funded Aetna Choice POS II (CPII), and Open Access Aetna Select Medical and Health plans. The services set forth in this document will be provided by ALIC (hereinafter "Aetna").

Performance Objectives

Aetna believes that measuring the activities described below are important indicators of how well it services Williamson County. Aetna is confident that the Plan Administration, Claim Administration and Member Services provided to Williamson County will meet their high standards of performance. To reinforce Williamson County's confidence in Aetna's ability to administer their program, Aetna is offering guarantees in the following areas:

Performance Category	Minimum Standard	Proposed Penalty
Implementation		
• Implementation-100% Client Satisfaction	-Average evaluation score of 3.0 or higher -120 days or greater from business award to effective date	2.0%
• ID Card Production & Distribution	97% of ID cards mailed prior to 11/1/2014 upon receiving complete, accurate eligibility files by 10/1/2014	1.5%
Account Management		
• Overall Account Management	Average evaluation score of 3.0 or higher	2.0%
• **Claim Administration**		
• Turnaround Time	91.0% of claims processed within 12 *calendar days*	1.5%
• Financial Accuracy	99.2%	1.5%
Total Claim Accuracy	95.0%	1.5%
Member Satisfaction	Positive response rate of 80% or higher	1.5%
• **Member Services**		
• Telephone Service Factor	80.0% within 30 seconds	1.5%
• Abandonment Rate	2.5%	2.0%
Total		**15.0%**

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Guarantee Period

The guarantees described herein will be effective for a period of 12 months and will run from **November 1, 2014 through October 31, 2015** (hereinafter "guarantee period").

The performance guarantees shown below will apply to the self-funded Aetna Choice POS II (CPII), and Open Access Aetna Select Medical and Health plans administered under the Administrative Services Only Agreement ("Services Agreement"). These guarantees **do not** apply to non-Aetna benefits. In addition, our network guarantees do not apply to non-Aetna networks.

If Aetna processes runoff claims upon termination of the Services Agreement, performance guarantees of Turnaround Time, Financial Accuracy, and/or Total Claim Accuracy will not apply to such claims. Furthermore, performance guarantees described herein will not apply to the guarantee period claims if termination is prior to the end of the guarantee period. In addition, performance guarantees will not be reconciled and payouts will not occur until the full guarantee period administrative service fees have been paid. Failure to remit applicable service fees within the grace period may invalidate certain guarantees listed below

Aggregate Maximum

The maximum penalty adjustment will be equal to **15.0%** of actual base service fees collected. In no event will fees be adjusted by more than **30.0%** due to results of this guarantee and all other guarantees combined.

Administrative Service Fees at risk exclude commissions and charges collected outside of the monthly billed administrative services fees.

Termination Provisions

Termination of the guarantee obligations shall become effective upon written notice by Aetna in the event of the occurrence of (i), (ii) or (iii) below:

i. a material change in the plan initiated by Williamson County or by legislative action that impacts the claim adjudication process, member service functions or network management;

ii. failure of Williamson County to meet its obligations to remit administrative service fees or fund the Williamson County bank account as stipulated in the General Conditions Addendum of the Services Agreement;

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iii. failure of Williamson County to meet their administrative responsibilities (e.g., a submission of incorrect or incomplete eligibility information).

No guarantees shall apply for a guarantee period during which the Services Agreement is terminated by Williamson County or by Aetna.

Refund Process

At the end of each guarantee period, Aetna will compile its Performance Guarantees results. If necessary, Aetna will provide a "lump sum" refund for any penalties incurred by Aetna.

Measurement Criteria

Aetna's internal quality results for the unit(s) processing Williamson County's claims will be used to determine guarantee compliance for any Turnaround Time, Financial Accuracy, and/or Total Claim Accuracy Guarantees. The results for these guarantees will be calculated using industry accepted stratified audit methodologies.

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Implementation

Overall Implementation Guarantee (100% Client Satisfaction)

Guarantee: Aetna developed and utilizes the implementation team concept to carefully coordinate all aspects of the implementation. An Implementation Manager will be assigned to assemble Williamson County's implementation team and develop an Implementation Management Plan for the conversion to the new plan of benefits. This plan will outline the tasks to be accomplished, including the distribution of communication and open enrollment materials, and the successful transfer of eligibility data. The Management Plan will also indicate target dates for their completion.

Working with Williamson County's team, the Implementation Manager will help determine the implementation priorities. As new information becomes available and priorities change, the Implementation Management Plan will be updated. However, for the implementation to progress in a timely manner, Williamson County will be responsible for providing key information to the Implementation Manager as close to the target dates as possible (e.g., finalized account structure, finalized plan of benefits, accurate eligibility files, signed legal agreements).

Aetna is confident that Williamson County will be pleased with our implementation team approach and therefore we are offering an implementation performance guarantee. This guarantee is effective for the implementation period in the first guarantee period. The implementation period commences at the initial implementation meeting and runs through the implementation sign-off.

Penalty and Measurement Criteria: Via timely responses to the attached Implementation Evaluation Tool (provided at the end of this guarantee section), Williamson County agrees to make Aetna aware of possible sources of dissatisfaction throughout the implementation period. Each question will be given a rating of 1 - 5 with 1 = lowest, 5 = highest. Aetna will tally the results from the evaluation tool when received. Williamson County's responses to the attached evaluation tool will be used to facilitate a discussion between Williamson County, the Implementation Manager and the Account Executive in our Arlington, TX field office regarding the results achieved. If, at the end of the implementation process, the average score of the evaluations falls below a 3, Aetna will make a mutually agreed upon reduction in compensation, subject to a maximum reduction of **2.0%** of the guarantee period administrative service fees. In addition, there must be a time period of 120 days or greater from business award to effective date.

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ID Card Production and Distribution

Guarantee: Aetna guarantees that it will produce and mail 97% of ID cards to plan participants prior to the effective date of 11/1/2014 pending the receipt of complete, accurate and viable electronic enrollment files in-house, to Aetna, by 10/1/2014. In addition, plan design must be finalized at least 60 days prior to the effective date.

Definition: For all ***complete, accurate and viable*** enrollment data provided by Williamson County and accepted by the system by 10/1/2014, Aetna agrees to produce and mail 97% of ID cards by 11/1/2014 upon file receipt.

Penalty and Measurement Criteria: Aetna will reduce its compensation by **1.5%** of the guarantee period administrative service fees if Aetna fails to produce and mail 97% of ID cards to Williamson County's members by 11/1/2014 upon receiving the enrollment eligibility file by 10/1/2014 and Williamson County finalizing plan design at least 60 days prior to the effective date of 11/1/2014. Aetna's implementation team records will be used to determine whether ID cards were produced and mailed within the specified time frame.

Medical Performance Guarantees

Account Management

Overall Account Management Guarantee

Guarantee: Aetna will guarantee that the services (i.e., on-going financial, eligibility, drafting, and benefit administration and continued customer support) provided by the Field Office Account Management Staff and/or the Employer Service Team during the guarantee period will be satisfactory to Williamson County.

Penalty and Measurement Criteria: Via quarterly responses to the attached Account Management Evaluation Tool (provided at the end of this guarantee section) and this link **http://www.aetnasurveys.com/se.ashx?s=103ED34467D2D0E0**, Williamson County agrees to make Aetna aware of possible sources of dissatisfaction throughout the guarantee period. Williamson County's responses to the attached evaluation tool will evaluate account management services in the following categories: technical knowledge, professionalism, proactive management, accessibility and responsiveness of personnel. Each category will be given a rating of 1 - 5 with 1 = lowest, 5 = highest. Aetna will tally the results from the report card(s) when received. The results of the survey(s) will be used to facilitate a discussion between Williamson County and the Account Executive in our Arlington, TX field office regarding the results achieved and opportunities for improvement.

If all report cards based on the frequency of the guarantee are not completed and returned within 15 days after the end of the quarter, it will be assumed that the service provided to Williamson County is satisfactory and the guarantee is met. If the score on the first report card and the report card(s) for the subsequent survey(s) average a 3.0or higher, no credit is due. Satisfactory service would equal a score of 3.0 and would be based on the total average of 24 questions with a rating scale of 1 to 5. Should the score from the first report card and the average of the remaining report card(s) fall below a 3.0(meaning that service levels have not improved), Aetna will make a mutually agreed upon reduction in compensation, subject to a maximum reduction of **2.0%** of the guarantee period administrative service fees.

Medical Performance Guarantees

Claim Administration

Turnaround Time

Guarantee: Aetna will guarantee that the claim turnaround time during the guarantee period will not exceed 12 *calendar* days for 91.0% of the processed claims on a cumulative basis each year.

Definition: Aetna measures turnaround time from the claimant's viewpoint; that is, from the date the claim is received in the service center to the date that it is processed (paid, denied or pended). **Weekends and holidays are included in turnaround time.**

Penalty and Measurement Criteria: If the cumulative year turnaround time (TAT) exceeds the day guarantee as stated above, Aetna will reduce its compensation by an amount equal to 0.3% of the guarantee period administrative service fees for each full day that Turnaround Time exceeds 12 calendar days for 91.0% of all processed claims. There will be a maximum reduction of **1.5%** of the guarantee period administrative service fees.

If Williamson County has >3000 enrolled members, a computer generated turnaround time report for Williamson County's specific claims will be provided on a quarterly basis. If <3000 enrolled members, results will be reported at the site level. If the customer has multiple products, the minimum membership requirement will apply to each product.

Financial Accuracy

Guarantee: Aetna will guarantee that the guarantee period dollar accuracy of the claim payment dollars will be 99.2% or higher.

Definition: Financial accuracy is measured using industry accepted stratified audit methodology. The results are calculated by calculating the financial accuracy for a subset of claims (a stratum) and then extrapolating the results based on the size of the population and combining with the extrapolated results of the other strata. Each overpayment and underpayment is considered an error; they do not offset each other. Includes both manual and auto adjudicated claims.

Penalty and Measurement Criteria: Aetna will reduce its compensation by an amount equal to 0.3% of the guarantee period administrative service fees for each full 0.75% that financial accuracy drops below 99.2%. There will be a maximum reduction of **1.5%** of the guarantee period administrative service fees.

Medical Performance Guarantees

Aetna's audit results for the unit(s) processing Williamson County's claims will be used. Those results include Aetna's performance in processing ALL customers' claims handled by the unit(s) in question during the Guarantee period, not just your plan's claims. The results for these guarantees will be calculated using industry accepted stratified audit methodologies.

Total (Overall) Claim Accuracy

Guarantee: Aetna will guarantee that the guarantee period overall accuracy of the claim payments will not be less than 95.0%.

Definition: Overall accuracy is measured using industry accepted stratified audit methodology. Accuracy in each stratum (a subset of the claim population) is calculated by dividing the number of claims processed correctly by the total number of claims audited, and then extrapolating the results based on the size of the population and combining with the extrapolated results of the other strata.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.3% of the guarantee period administrative service fees for each full 0.75% that total claim accuracy drops below 95.0%. There will be a maximum reduction of **1.5%** of the guarantee period administrative service fees.

Aetna's audit results for the unit(s) processing Williamson County's claims will be used. Those results include Aetna's performance in processing ALL customers' claims handled by the unit(s) in question during the Guarantee period, not just your plan's claims. The results for these guarantees will be calculated using industry accepted stratified audit methodologies.

Member Satisfaction

Definition: Aetna will guarantee a positive response rate of 80.0% or better on the standard Aetna Performance Tracking Process. The survey is based on a randomly selected sample of actively enrolled members aged 18-64. Interviews are conducted on a continuous basis throughout the year.

Penalty and Measurement Criteria: Aetna will reduce its compensation by **1.5%** of the guarantee period administrative service fees if it fails to meet a positive response rate of 80.0% or better. Results of the Aetna Performance Tracking Process will be used as the measurement criteria. These surveys are performed based on statistically valid samples of members, by product across all customers.

Medical Performance Guarantees

Member Services

Telephone Service Factor (TSF)

Guarantee: Aetna will guarantee that the telephone service factor for the phone skill(s) providing Williamson County's customer service will not fall below 80.0% of all calls responded to within 30 seconds.

Definition: On an ongoing basis, Aetna measures telephone response time through monitoring equipment which produces a report on the telephone service factor. Total Service Factor measures the speed in which calls are answered by a Customer Service Professionals (CSPs) after being placed in queue by the auto attendant. This does not include the time the caller spent navigating through any auto attendant menus. TSF includes total calls (answered and abandoned) that are offered to CSPs. Interactive Voice Response (IVR) system calls are not included in the measurement of TSF. The TSF measure is reported as a percentage of calls answered within 30 seconds.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.3% of the guarantee period administrative service fees for each full percentage point that the cumulative telephone service factor falls below 80.0% for calls to be answered within 30 seconds, to a maximum reduction of **1.5%** of the guarantee period administrative service fees. Aetna's results for the phone skill(s) providing member service for Williamson County will be used.

Abandonment Rate

Guarantee: Aetna will guarantee that the average rate of telephone abandonment for the phone skill(s) providing Williamson County's member services will not exceed 2.5%.

Definition: On an ongoing basis, Aetna measures telephone response time through monitoring equipment that produces a report on the average abandonment rate. The abandonment rate measures the total number of calls abandoned divided by the number of calls accepted into the skill.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.4% of the guarantee period administrative service fees for each 1.0% that the average abandonment rate exceeds 2.5%. There will be a maximum reduction of **2.0%** of the guarantee period administrative service fees. Aetna's results for the phone skill(s) providing member services for Williamson County will be used.

Claim Target Guarantee

Group or Location: Full Replacement
Expected enrollment: 1,399 employees

We are pleased to offer a Claim Savings Guarantee that supports our commitment to Williamson County and your members. The Claim Target Guarantee is offered in addition to the proposed Operational Guarantees and Clinical Guarantees outlined under separate cover in this proposal.

Claim Target Guarantee

Illustrative Claim Projection Development

We guarantee Williamson County's Net Effective Trend for the 12-month guarantee period from November 1, 2014 through October 31, 2015. Outlined below is an illustration of the calculation for the guarantee period. *Dollar amounts are shown for illustrative purposes only.*

Option 1 – Match current Williamson County Plans

Proposed Aetna Enrollment of 1,308 active and pre-65 retirees / 3,610 members in current PPO to Aetna CPII Projection for the Guarantee Period (2014-15)		Factor
Base Year Medical Incurred Claim (per member per year) (a)		$5,000
The Differential Between the Proposed Plan Design and Base Year Plan Design (b)	X	1.0000
Discount Relativities (c)	X	0.9650
Medical Management & Integration Savings Factor (d)	X	0.9510
Trend Factor (e)	X	1.0950
2014-15 Projected Claim (per member per year)*	=	$5,024
Net Effective Trend (f)		0.5%

Proposed Aetna Enrollment of 91 active and pre-65 retirees / 254 members in current EPO to Aetna OA AS Projection for the Guarantee Period (2014-15)		Factor
Base Year Medical Incurred Claim (per member per year) (a)		$5,000
The Differential Between the Proposed Plan Design and Base Year Plan Design (b)	X	1.0000
Discount Relativities (c)	X	0.9650
Medical Management & Integration Savings Factor (d)	X	0.9510
Trend Factor (e)	X	1.0950
2014-15 Projected Claim (per member per year)*	=	$5,024
Net Effective Trend (f)		0.5%

(a) The base year medical claims will be:
- Finalized 6 months after the beginning of the guarantee period using the information provided by prior carriers
- Adjusted for plan design factors for changes in plan design from baseline period to projection period
- Adjusted for demographic and geographic shifts
- Adjusted to exclude all non-medical claims, including Pharmacy and Specialty Pharmacy Claims

(b) The plan value factor is guaranteed at the time of quotation.

(c) The discount relativities are guaranteed at the time of quotation.

Claim Target Guarantee

(d) The Medical Management Program Savings Factor accounts for the reduction in medical costs resulting from:
- The integration of our medical, pharmacy, radiology and behavioral health programs for Williamson County
- Our clinical and cost management programs, including MedQuery®, Aetna Health Connections℠ disease management program, Flex Medical Management and claims payment practices inherent in our programs relative to those in place over the base year. This represents the additional value we offer in these programs compared to current vendors and programs.
- **Williamson County must purchase Aetna Health Connections℠ program. The cost of this program is $4.20 PEPM and is not included in our proposed administrative fee.**

(e) The trend factor is guaranteed at the time of quotation.

(f) The Net Effective Trend reflects the total savings of our products and programs

Option 2 – Matches current PPO plan, plus includes Seton Health Alliance (SHA)

Proposed Aetna Enrollment of 910 active and pre-65 retirees / 2,075 members moving to Aetna Custom network OA AS Projection for the Guarantee Period (2014-15)		Factor
Base Year Medical Incurred Claim (per member per year) (a)		$5,000
The Differential Between the Proposed Plan Design and Base Year Plan Design (b)	X	1.0000
Discount Relativities (c)	X	0.9650
Medical Management & Integration Savings Factor (d)	X	0.9510
SHA Savings Factor (e)		0.9110
Trend Factor (f)	X	1.0950
2014-15 Projected Claim (per member per year)*	=	$4,577
Net Effective Trend (g)		-8.5%

Proposed Aetna Enrollment of 489 active and pre-65 retirees / 1,071 members moving to Aetna CPII Projection for the Guarantee Period (2014-15)		Factor
Base Year Medical Incurred Claim (per member per year) (a)		$5,000
The Differential Between the Proposed Plan Design and Base Year Plan Design (b)	X	1.0000
Discount Relativities (c)	X	0.9650
Medical Management & Integration Savings Factor (d)	X	0.9510
Trend Factor (f)	X	1.0950
2014-15 Projected Claim (per member per year)*	=	$5,024
Net Effective Trend (g)		0.5%

(a) The base year medical claims will be:
- Finalized 6 months after the beginning of the guarantee period using the information provided by prior carriers
- Adjusted for plan design factors for changes in plan design from baseline period to projection period
- Adjusted for demographic and geographic shifts
- Adjusted to exclude all non-medical claims, including Pharmacy and Specialty Pharmacy Claims

Claim Target Guarantee

(b) The plan value factor is guaranteed at the time of quotation.
(c) The discount relativities are guaranteed at the time of quotation.
(d) The Medical Management Program Savings Factor accounts for the reduction in medical costs resulting from:
- The integration of our medical, pharmacy, radiology and behavioral health programs for Williamson County
- Our clinical and cost management programs, including MedQuery®, Aetna Health Connections℠ disease management program, Flex Medical Management and claims payment practices inherent in our programs relative to those in place over the base year. This represents the additional value we offer in these programs compared to current vendors and programs.
- **Williamson County must purchase Aetna Health Connections℠ program. The cost of this program is $4.20 PEPM and is not included in our proposed administrative fee.**

(e) The ACO Savings factor is guaranteed at the time of quotation and assumes that a limited option Aetna Select plan is offered alongside an Aetna Choice POS II plan, with contributions structured so that a minimum of 65% of eligible members are enrolled in the ACO designated plan.
(f) The trend factor is guaranteed at the time of quotation.
(g) The Net Effective Trend reflects the total savings of our products and programs

Explanation of the Guarantee

We guarantee the process and the factors for developing the projected claims as noted. We will reconcile the Claim Target Guarantee annually. Any adjustments will be determined based on the table below. The maximum penalty adjustment will be equal to 20% of actual collected base service fees, excluding program fees at risk in the Clinical Guarantees. In no event will fees be adjusted by more than 30% of actual collected due to results of the claim-based performance guarantee and all other performance guarantees combined. Any reference to collected fees means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.

Actual Claims PMPY vs. Annual Projection	Fee Adjustment	Maximum Guarantee Period Adjustment
> 103%	2.0% fee reduction for each full 1.0% of difference of actual claims above target corridor	20%
<= 103%	No Adjustment	N/A

Claim Target Guarantee

Structure of the Guarantee

The Claim Target Guarantee assumes the following:

- **The claim factor analysis is completed at quotation.** The claim projection is illustrative. The assessment of our performance will be based on the actual claim projection, which will be calculated once the incurred claims for the base period are known.

- **Base year claim projections are finalized 6 months after the beginning of the guarantee period**. When establishing projected claims we will use November 1, 2013 through October 31, 2014 incurred claims paid through April 30, 2015.

- **Settlement of the guarantee is completed at least 6 months after the end of the guarantee period.** The settlement involves the development of the claim projection by multiplying the base year claims by the factors as outlined in the previous section, Illustrative Claim Projection Development. The base year claims will be adjusted for plan design, demographic and geographic factors, and will exclude all non-medical claims, including pharmacy and specialty pharmacy claims. The claim projection will be compared to the actual annual claims (excluding all non-medical claims, including pharmacy and specialty pharmacy claims) to determine the outcome of the guarantee. 2014-15 projection-year claims will be based on claims incurred in November 1, 2013 through October 31, 2014 and paid through April 30, 2015.

Claim Target Guarantee

Data Requirements for the Guarantee

Please send us the following information for last year's plan year (that is, the plan year just before the year covered by the guarantee). Information is due before the plan year covered by the guarantee. Include details only for the populations (members and products) covered by the guarantee.

- **Plan Design Information** (including plan design changes)

  For those members identified as in Aexcel Network areas, plan designs must be developed in such a way that there is preferential steerage towards Aexcel Network providers, creating a disincentive to go outside of Aetna's Aexcel Network for specialist visits. If no such plan design changes are made, Aetna can not guarantee the factor provided in the claim target for Aexcel and that section of the claim target guarantee will be excluded.

- **Membership Information** (including the following):

  For each month of the plan year prior to the year covered by the guarantee, a listing of members showing gender, date of birth, zip code, plan design, COBRA indicator

- **Claim Information** – Fee for Service Claims received in three extracts of the data, with the final extract to be used for the evaluation of the guarantee. Timeframes to be covered by the files are as follows:

	Incurred Time Period	Paid Time Period	Date Due to Aetna
Initial Extract of Data	Nov 2013 through Oct 2014	Nov 2013 through Oct 2014	November 15, 2014
Second Extract of Data	Nov 2013 through Oct 2014	Nov 2013 through Jan 2015	February 15, 2015
Final Extract of Data	Nov 2013 through Oct 2014	Nov 2013 through April 2015	May 15, 2015

  - Dimensions to be provided in the date: Incurred Month, Paid Month, Plan Design, Medical/Drug Indicator
  - Measures to be included on the data: Paid Claims

Claim Target Guarantee

In addition, we must receive 24 months of prior carrier medical and pharmacy data in order to guarantee our Medical Management Savings Factor for our clinical programs. If this data is not provided, we reserve the right to adjust the Medical Management Savings Factor.

- **Claim Information - Large Claims** by plan for claims paid in excess of $50,000.

Plan Design, Program and Engagement Requirements

A holistic approach to benefit and program design and support is necessary in order to impact trend appropriately. The following are requirements in order for this claim target guarantee to be valid. If any of these aspects are not instituted, the claim target guarantee may be eliminated or its parameters revised.

Plan Design

- Minimum Emergency Room copay of $100.
- Urgent Care copay that is at least $50less than Emergency Room copay.
- Steerage from hospital based services to free standing facilities.
- 100% coverage for preventive services.
- Minimum $500 deductible and $20 PCP/Specialist copays.

Programs

- MedQuery®
- Aetna Health Connections℠ disease management

Engagement and Communication

- Williamson County will provide meaningful incentives to encourage employees and eligible dependents to complete an annual Health Risk Assessment (HRA) and receive appropriate biometric screenings. We will provide the Health Risk Assessment module, administer the incentives that Williamson County chooses to adopt if Williamson County elects to offer financial incentives to encourage member participation in Aetna's Health Assessment and Healthy Living Programs and other wellness programs, and facilitate any onsite biometric screening activities that Williamson County chooses to pursue.

Claim Target Guarantee

Conditions for the Guarantee

- This guarantee only applies to claims incurred from November 1, 2014 through October 31, 2015 for active and pre-65 retirees members. COBRA and post-65 retirees, and disabled members are excluded.

- This guarantee assumes that 1,399 Active and pre-65 retirees subscribers will enroll in Aetna medical plans. If the enrolled group by product or in total varies in size by more than 10% from the assumption, or if the combined enrolled pre-65 retirees varies in size by more than 2% or comprise more than 5% of the total Aetna covered group, the guarantee may be revised.

- Aetna is assumed to be the full replacement vendor for medical, pharmacy and behavioral health coverage.

- We require a minimum enrollment of 1,300 employees in the quoted Aetna self-funded products.

- We have assumed that we will receive 24 months of prior carrier medical and pharmacy data in order to ensure effective execution of our clinical programs beginning on the effective date of November 1, 2014.

- The guarantee may be revised if there is a 5% or greater change in the projected cost factors related to the combination of geography, age, and gender in any site with at least 100 subscribers enrolled or a 10% change in the total number of subscribers enrolled in each individual Aetna product or in aggregate, including the impact of new or terminating locations and/or groups.

- All members covered by the guarantee are assumed to have only Aetna as the option for all products listed in the offer. Any changes to the product and service offerings could lead to the guarantee being revised or removed from consideration.

- There is a minimum employer contribution requirement of at least 50% of the total cost at each tier rate and the employer contribution percentage will not decline by more than 5 percentage points from the 2014-15 plan year by product.

- The guarantee may be revised if there are any acquisitions or divestitures by Williamson County.

Claim Target Guarantee

- At least 75% of eligible employees must participate in the employer's plan or at least 50% when excluding those providing proof of enrollment in a spouse's plan. Failure to meet this requirement may result in the guarantee being revised or removed.
- The medical plans must maintain a minimum network utilization of 90% for this guarantee to remain in effect.
- We reserve the right to revise or remove the guarantee entirely or for a specific group whose current plan design, claims experience, average member enrollment and/or census cannot be evaluated by Aetna.
- Claims for individuals for whom pre-existing conditions underwriting rules have been waived are excluded from this guarantee.
- Employees whose continuation in Aetna's benefit options stems from an involuntary termination occurring after the effective date shall not be included in this guarantee. In addition, any significant reduction in members in a specific geographic location may result in the guarantee being revised or removed.
- All non-medical claims, including Pharmacy and specialty Pharmacy claims, are excluded from the total incurred claims of both the base year and the guarantee period.
- Claims per individual per year paid in excess of $50,000 are excluded from the total incurred claims of both the base year and the guarantee period.
- We have assumed that the National Advantage Plan will be included for the guarantee period (11/1/2014-10/31/2015).
- We have assumed that our subrogation services through a third-party vendor are provided.
- We reserve the right to make appropriate changes to this guarantee if there are any changes to the current or proposed benefit plans or if there is a change in government laws or regulations that have a quantifiable impact on claim costs.
- No guarantees shall apply for a guarantee period during which the Services Agreement is terminated by either Customer or by Aetna.

Claim Target Guarantee

- We are relying on information from Williamson County and its representatives in establishing the rates and terms of this guarantee. If any of this information is inaccurate and has an impact on the cost of the programs, we reserve the right to revise or remove the guarantee from consideration.

- This guarantee cannot be offered in conjunction with Aggregate Stop Loss coverage or in conjunction with the Medical Discount Guarantee.

- Williamson County must purchase Aetna Health Connections℠ disease management program.

- Williamson County will provide meaningful incentives to encourage employees and eligible dependents to complete an annual Health Risk Assessment (HRA) and receive appropriate biometric screenings. We will provide the Health Risk Assessment module, administer the incentives that Williamson County chooses to adopt if Williamson County elects to offer financial incentives to encourage member participation in Aetna's Health Assessment and Healthy Living Programs and other wellness programs, and facilitate any onsite biometric screening activities that Williamson County chooses to pursue.

- The maximum adjustment will be 20% of actual collected base service fees, excluding fees at risk in the Medical Management Guarantees, for this Claim Target Guarantee. In no event will fees be adjusted by more than 30% of actual collected base service fees due to the results of the Claim Target Guarantee and all other performance guarantees combined.

Medical Financial Assumptions

We have made every effort to respond to Williamson County's request in a manner that reflects our existing and expected business practices for the contract period beginning on the effective date of November 1, 2014 continuing through October 31, 2015. If you decide to establish a business relationship with us, you will need to enter into a contractual agreement after we confirm benefits, services and fees in a Letter of Understanding.

Our quotation assumes that our standard contract provisions and claim settlement practices will apply unless otherwise stated.

Please refer to the Fee Exhibit for a list of the specific programs and services that we offer.

Medical Financial Assumptions

Underwriting Assumptions and Caveats

- **Services Agreement ("Contract") Period** – The contract period begins on the effective date of November 1, 2014.

- **Pricing and Underwriting Basis** – We have assumed that the proposed plan of benefits will be extended to the employee group(s) included on the census file that was submitted with the request for proposal. Our enrollment assumptions are shown on the fee exhibits. Our proposal assumes that coverage will not be extended to additional employee groups without review of supplemental census information and other underwriting information for appropriate financial review.

- **Participation Requirement** – There is a minimum requirement of 250 enrolled employees for administration of the proposed self-funded plan. However, any Performance Guarantee is contingent upon the total number of covered lives (i.e., the total number of Williamson County employees enrolled for coverage) set out in our proposal.

- **Plan Design** – These products are offered subject to the terms of our Benefit Review Document.

- **Health Care Reform Disclosure** – This proposal is intended to be compliant with healthcare reform.

  The Federal government released regulations related to grandfathering of health plans in existence on March 23, 2010. Under the health care reform legislation, health plans existing prior to the enactment of the legislation may be "grandfathered" and not subject to some of the mandated benefits and reform provisions. Changes in your benefit design as well as your contribution strategy may affect grandfathering. Plan sponsors are required to notify Aetna if their contribution rate changes for a grandfathered plan at any point during the plan year. On January 1, 2014, grandfathered plans need to comply with the requirement to cover dependent children up to age 26 on their parent's plan even if they have other employer sponsored coverage available.

  This proposal assumes your plan is not grandfathered.
  As a non-grandfathered plan, the plan will include benefits for preventive care as defined by regulation without cost sharing on in-network services.

Medical Financial Assumptions

This new business proposal includes the women's preventive care coverage requirements, e.g., coverage for contraceptive methods and counseling, breastfeeding support and equipment, and prenatal care.

Certain religious employers may be exempt from contraceptive services coverage requirements, or may be eligible for a religious accommodation.

Except for specific and limited scenarios described as transitional rules in the health care reform legislation, if a plan's grandfathered status has been lost, it cannot be regained. If, after reviewing the grandfathering rules with your benefit consultant or counsel, "Williamson County" determines that your coverage could be or is grandfathered, and you want to retain grandfathered status, you should contact Aetna for further instructions.

Retiree Only Plan Status Certification
Guidance issued by the Internal Revenue Service ("IRS"), Department of Labor ("DOL"), and Department of Health and Human Services ("HHS") has indicated that "retiree only" plans are exempt from the new benefit mandates under ACA including Medical Loss Ratio ("MLR") and rebate requirements for insured plans (Retiree only plans are subject to certain ACA fees and assessments). In order to demonstrate the establishment of a retiree only plan, a plan should maintain, separately from the plan for current (i.e., active) employees, a separate plan document and Summary Plan Description (SPD) and file a separate Form 5500. If you have a retiree only plan, and want to be considered exempt, please submit a retiree only certification form and required documentation to Aetna.

The benefits and fees within this proposal are subject to change pending any required approvals or future guidance from state or federal regulatory agencies. If you have questions, please contact your Sales/Account Executive.
Aetna reserves the right to modify its products, services, rates and fees, in response to legislation, regulation or requests of government authorities resulting in changes to plan benefits and to recoup any material fees, costs, assessments, or taxes due to changes in the law even if no benefit or plan changes are mandated.

Benefit Mandates – Essential Health Benefits
The ACA prohibits the application of annual and lifetime dollar limits for any Essential Health Benefits for all plans effective on or after January 1, 2014. To the extent that your current benefit plan includes such limits, this quote includes the removal of those limits.

Medical Financial Assumptions

Benefit Mandates – Member Out of Pocket Limit
For non-grandfathered plans effective or renewing on or after January 1, 2014, all in-network medical, behavioral health, and pharmacy member cost sharing must apply to the member out-of pocket (OOP) maximum. The OOP maximum value must also fall within the limits set under the tax law for high deductible health plans paired with HSA's, for 2014 the limit is $6,350/$12,700. This is subject to change based on future guidance or regulation.

Please note that existing regulations for Mental Health Parity already require group health plans to have shared out-of-pocket accumulators with medical benefits.

- **Transitional Reinsurance Contribution:**

  ACA Taxes and Fees - Notice of Self-Funded Group Health Plan's Financial Liability

  Any taxes or fees (assessments) applied to self-funded benefit plans related to the Affordable Care Act will be solely the obligation of the plan sponsor.

  Under Section 1341 of the Affordable Care Act, self-funded group health plans are responsible for paying an assessment to fund state-based non-profit reinsurance entities that will administer a high-risk pool for the individual market. The assessment is imposed for a limited number of years, beginning in 2014 and ending in 2016.

  The Secretary of Health and Human Services (HHS) provides the methods for determining the amount each self-funded group health plan is required to pay. Beginning in 2014, self-funded group health plans are required to submit membership counts and related payments to HHS. The administrative service fees that Aetna is presenting do not include any such plan sponsor liability or reporting services.

- **States' All payer Claims database (APCD) reporting** -State all payer claims database regulations require insurance carriers and third party administrators (TPAs) for self-funded plans to supply data to that state's all payer claims database (APCD). As a TPA for your self-funded plan, Aetna is required to submit health care claims data to states with APCDs for all insured and self-funded plans. However, in some states, the law indicates that providing the data for self-funded plans is voluntary. Aetna will provide your self-funded plan data to these states unless you inform us in writing that you do not wish us to do so.

Medical Financial Assumptions

- **Fee Guarantee** – The first-year fees for the self-funded coverages included in this proposal for the period November 1, 2014 continuing through October 31, 2015 are guaranteed according to the per-employee, per-month fees as illustrated on the financial exhibit(s). We guarantee that the second-year fees will increase over the first-year mature fees by 3%. We also guarantee that the third-year fees will increase over the second-year fees by 3%. We also guarantee that the fourth-year fees will increase over third-year fees by 4%. We also guarantee that the fifth-year fees will increase over fourth-year fees by 4%.

- **Fee Guarantee Parameters** – We reserve the right to recalculate the guaranteed fees using our then current book of business formula under the circumstances described below. In such case, Williamson County will be required to pay any difference between the fees collected and the new fees calculated retroactive to the start of the guarantee period. Aetna may recalculate:

1. If, for any product:

    a. There is a 10% decrease in the number of employees in aggregate from our enrollment assumptions or from any subsequently reset enrollment assumptions.
    b. The member-to-employee ratio increases by more than 10%. We have assumed a member-to-employee ratio of:
        - 2.28 for OA AS
        - 2.19 for CPII

2. If maximum account structure exceeds 80 units per product. Account structure determines the reporting format. During the installation process, we will work with Williamson County to finalize the account structure and determine which report formats will be most meaningful. Maximum total account structure includes Experience Rating Groups (ERGs), controls, suffixes, billing and claim accounts.

3. If a material change in the plan of benefits is initiated by Williamson County or by legislative or regulatory action.

4. If a material change is initiated by Williamson County or by legislative or regulatory action in the claim payment requirements or procedures, claim fiduciary option, alternate office processing usage, or any other change materially affecting the manner or cost of paying benefits.

Medical Financial Assumptions

5. If the agreement is terminated by Williamson County resulting in Aetna having to incur charges for maintaining plan structure to report and/or process runoff claims.

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

7. If Aetna Pharmacy Management (APM) is terminated by Williamson County.

8. If Aetna programs and services including, but not limited to, Informed Health® Line (IHL), are terminated by Williamson County.

9. If Williamson County terminates any other Aetna products not addressed within this financial package including, but not limited to, Dental products, and/or Pharmacy products.

10. If Williamson County places the products and services included in this multi-year fee guarantee out to bid, then this guarantee will be nullified.

11. If legislation, regulation or requests of government authorities result in material changes to plan benefits, Aetna also reserves the right to recoup any material fees, costs, assessments, or taxes due to changes in the law even if no benefit or plan changes are mandated.

12. If source documentation of the dependent limiting age, which is required for plan installation, is not received.

    In the absence of documentation from the current carrier(s), the fees consider the dependent limiting age is up to age 26 student/non-student based on health care reform legislation. The expected claims and, if applicable, the resultant claim target factors contemplate the change to a dependent limiting age of up to 26/26 student/non-student and may be amended upward upon receipt of the dependent eligibility documentation.

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

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

Medical Financial Assumptions

- **Claim Wire Billing Fees** - Claim wire billing fees refers to the portion of the total administrative expenses that will be charged through the claim wire as the services are rendered, and are subject to any future fee increases. These programs/services are excluded from the administrative fees as illustrated on the financial exhibits and will not appear as part of the monthly billing statement.

- **Claim Fiduciary (Option 6)** – Our proposal assumes that Aetna will act as claim fiduciary for all Level I (benefit review and determination of claims) appeals. Williamson County assumes claim fiduciary responsibility for all Level II (deciding appeals and final claims determination) appeals. The fee included for this service assumes a member-to-employee ratio range of 2.01 t 2.30.

- **External Review** – External Review is included in our self-funded proposal. External review uses outside vendors who coordinate a medical review through their network of outside physician reviewers.

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

- **Banking** – We have assumed that Williamson County provides funds through a Fed drawdown by Aetna wire transfer for drafts issued under the self-funded arrangement assumed in this proposal.

  We have assumed a $20,000 stockpiling point plus an end of month close-out request for fund wiring requests.

  We have assumed Williamson County will use no more than three primary banking lines. Additional wire lines and customized banking arrangements will result in an adjustment to the proposed pricing.

Medical Financial Assumptions

- **Support for SBC Draft Documents**
  At Williamson County's request and expense, we will provide assistance in connection with the preparation of draft Summaries of Benefits and Coverage (SBCs) subject to the direction, review and final approval of Williamson County. The development of draft SBCs by Aetna will be based on the benefits information Williamson County has provided and existing plan information from our benefit source system. We will include plan design information in the draft SBC relating to products or services administered under the Services Agreement by Aetna as well as any additional pharmacy or behavioral health carve out information or benefits information provided by the Williamson County or its delegate. SBCs are not required for "retiree-only plans" as defined by the ACA and Aetna will not be supporting generation of SBCs for "retiree-only plans".

  Williamson County has the responsibility to review and approve any SBCs and revisions thereto and to consult with Williamson County's legal counsel, at its discretion, in connection with said review and approval, as well as to disseminate the final SBC to Plan participants. We have no responsibility or liability for the content or distribution of any of the Williamson County's SBCs, regardless of the role we may have played in the preparation of the documents. The production of SBCs will not be subject to Service or Performance Guarantees.

  Provision of draft SBCs is subject to the following service pricing: $1,500 per draft SBC, with an annual charge not to exceed $15,000.

  Our preference is to collect this fee over the claim funding wire. This SBC charge will be processed into a unique CRS Draft Account so it can be easily segregated from other activity. We will send Williamson County a Claim Wire Billing (CWB) Notification email on the day after it records in CRS. This process is fully transparent and will show the fee as due and paid in all documentation such as the accounting package and Schedule C filing. As an alternative, we can send Williamson County a Direct Bill for this service.

- **Health Insurance Portability and Accountability Act (HIPAA)** - Our proposal assumes that Aetna will not be providing HIPAA certifications of coverage for terminated employees. We would be willing to provide HIPAA certifications for an additional charge of $0.29 per employee, per month.

Medical Financial Assumptions

- **Late Payment** - If Williamson County fails to provide funds on a timely basis to cover benefit payments as provided in the Agreement, and/or fails to pay service fees on a timely basis as provided in such Agreement, Aetna will assess a late payment charge. The current charges are:

  - late funds to cover benefit payments (e.g., late wire transfers after 24-hour request): 12.0% annual rate
  - late payments of service fees after 31 day grace period: 12.0% annual rate

  Aetna reserves the right to collect any incurred late payment charges through the claim wire on a monthly basis provided there is no other special payment arrangements in-force to fund any incurred late payment charges. Williamson County will be notified by Aetna in writing to obtain approval prior to billing any late payment charges through claim wire.

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

- **Advance Notification of Fee Change** – We will notify Williamson County of any fee change within 31 days of the fee change.

- **Consultant Compensation** – The quoted fees do not include consultant compensation.

- **Disclosure Statement** – We have various programs for compensating agents, brokers and consultants. If you would like information about compensation programs for which your agent, broker, or consultant is eligible; payments (if any) that we have made to your agent, broker, or consultant; or other material relationships your agent, broker, or consultant may have with us, you may contact your agent, broker, or consultant or your Aetna account representative. Information about our programs for compensating agents, brokers, or consultants is also available at **www.aetna.com**.

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

Medical Financial Assumptions

- **Transition Allowance** – We are including a transition allowance of up to $25,000 that may be used toward reasonable implementation and communication services procured by Williamson County to pay for transition-related expenses incurred during the November 1, 2014 through October 31,2015 plan year. These funds will be available as of the effective date of the period. We will make payment for transition-related expenses after Williamson County has presented the invoice(s) outlining the expenses they incurred. Any remaining amounts of the allowance after October 31, 2015 will be forfeited.

  Any amounts ("transition allowance") that we pay to a plan sponsor to offset or reimburse such plan sponsor for any expense or costs incurred as a result of contracting with Aetna for benefits plan administration services, will be paid in accordance with applicable law. Plan sponsors are advised to determine appropriate accounting for these payments with their own counsel or accountant. Any plan sponsor receiving a transition allowance or other payments from us that offset or reimburse expenses that would otherwise be paid from plan assets, should consult with their ERISA counsel to determine if such allowance must be credited to plan assets, and for additional counsel regarding the accounting for reporting of such payments.

- **Wellness Allowance** – We are including a wellness allowance of up to $50,000 that may be used toward reasonable wellness services procured by Williamson County from third-party vendors to pay for wellness-related expenses incurred during the November 1, 2014 through October 31,2015 plan year. This includes wellness fairs, biometric screenings, onsite flu vaccinations, etc. These funds will be available as of the effective date of the period. We will pay wellness-related expenses after Williamson County has presented the invoice(s) outlining the expenses they incurred. Invoices must be submitted to us within 60 days of the service being incurred. Any remaining amounts of the allowance after October 31, 2015 will be forfeited.

  A wellness allowance of $50,000 is available in November 1, 2015 through October 31, 2016 and November 1, 2016 through October 31, 2017 plan years. Please note, the allowance of $50,000 is available for each year and is forfeited at the end of each year if not fully utilized (it does not get rolled over for a cumulative amount).

Medical Financial Assumptions

Any amounts ("wellness allowance") that we pay to a plan sponsor to offset or reimburse such plan sponsor for any expense or costs incurred as a result of contracting with Aetna for benefits plan administration services, will be paid in accordance with applicable law. Plan sponsors are advised to determine appropriate accounting for these payments with their own counsel or accountant. Any plan sponsor receiving a wellness allowance or other payments from us that offset or reimburse expenses that would otherwise be paid from plan assets, should consult with their ERISA counsel to determine if such allowance must be credited to plan assets, and for additional counsel regarding the accounting for reporting of such payments.

- **Federal Mental Health Parity -** The Federal Mental Health Parity and Addiction Equity Act of 2008 applies to fully insured traditional and HMO, Middle Market (MM) & National Accounts (NA) commercial plans as well as self-funded Traditional and HMO MM & NA commercial plans for plan years beginning on or after October 3, 2009. This means many calendar year plans were required to comply with the Act by Jan. 1, 2010. The Interim Final Regulations applied to plan years beginning on or after July 1, 2010, so calendar year plans must comply with the regulations by January 1, 2011. However, given that this is a self-funded plan, it is ultimately up to Williamson County to comply with Federal Mental Health Parity. We can continue to make our recommendation regarding application and how we think their plan should be designed in order to comply but we are not in the position to provide self-funded plan sponsors legal advice. Therefore, Williamson County should speak to their own legal counsel and make the final determination related to compliance with Federal Mental Health Parity.

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

- **Data Integration (On-Going)** - Options and pricing for integrating claims data from an external vendor into one or more of our systems will vary depending on the scale of Williamson County's integration needs.

- **Health Care Reform and Dependent Eligibility Verification (DEV)** – The Affordable Care Act (ACA) expanded the terms under which a plan will be required to cover children under age 26. However, there are still reasons why dependent children may not be eligible for coverage.

Medical Financial Assumptions

Employers need to be vigilant in protecting their plan, especially when employees may be confused by changes under health care reform. We strongly recommend a dependent eligibility verification and maintenance program. This solution remains one of the most compelling means to obtain immediate savings and protect your health plan(s) from unnecessary claim expenditures. Our clients who have utilized our comprehensive DEV services have found between 4 and 8 percent of their covered dependents were in fact ineligible for coverage.

Dependent eligibility verification is completed through our subcontractor ACS and is available for all self-funded medical customers. There are two options Williamson County can choose from, initial audit or maintenance. In addition, this program can be customized to meet Williamson County's specific needs. The charge is on a per projectbasis, and varies by customer. If Williamson County is interested we would be happy to provide pricing. Billing is through our third party partner ACS.

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

Medical Financial Assumptions

Network Services

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

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

- **National Advantage™ Program** – Our National Advantage Program (NAP) includes three components: the base program, Facility Charge Review (FCR), and Itemized Bill Review (IBR). The base program offers access to contracted rates for medical claims that could otherwise be paid at billed charges under many indemnity plans, the out-of-network portion of network-based plans, or for emergency/medically necessary services not provided within the network. FCR provides reasonable charge allowance review for most inpatient and outpatient facility claims where a NAP contracted rate is not available. IBR reviews in-network facility charges that meet certain criteria and are not billed on a per-diem basis. The review may result in the elimination of certain types of charges before their adjudication.

Medical Financial Assumptions

Fees for the National Advantage Program are charged as a percentage of savings achieved by NAP. Savings are generally defined as the difference between the reference price and the NAP priced amount, where the reference price is typically defined as (a) for facility services, the amount billed by the provider; (b) for professional services, the 80th percentile of the applicable FAIR Health database; or (c) for claims reviewed under Itemized Bill Review, the in-network rate prior to removal of any non-payable charges identified through the claim review. Additional details and any exceptions to the general savings definition above are available upon request.

Our quoted fees assume that we will retain 50% of NAP savings. This percentage is not included in the per-employee, per-month fees. The fee is only charged when NAP rates are applied.

- **Institutes of Excellence™ Transplant Network** – As part of our National Transplant Program, a registered nurse is assigned to each member to assist with every phase of the transplant process, from evaluation through post-transplant recovery. The nurse coordinates care and assists your employees in accessing covered treatment through our contracted Institutes of Excellence (IOE) transplant network. The program also features dedicated claims and member services staff for special handling of patient claims and benefits issues. The IOE transplant network is our national network of facilities for transplants and transplant related services. Hospitals that have been selected to participate in our IOE transplant network have met enhanced quality thresholds for volumes and outcomes. The charge is on a per transplant basis, whether or not an IOE facility is used. The charge is based on each plan sponsor's specific utilization. Billing is through the claim wire process at the rate of $2,500 when a member is wait-listed for a transplant and $7,500 when a member's transplant procedure is complete.

Medical Financial Assumptions

Claim and Member Services

- **Policies and Claim Settlement Practices** – Our quotation assumes that our standard contract provisions and claim settlement practices will apply. If a material change is initiated by Williamson County or by legislative or regulatory action in the claim payment requirements or procedures, account structure, or any changes materially affecting the manner or cost of paying benefits, we reserve the right to adjust our proposal accordingly.

- **Run-In Claim Processing** – Our proposal excludes run-in claim processing from the prior carrier (claims incurred before the effective date of the plan).

- **Run-Off Claims Processing** – Our fees reflect an incurred (mature) claim base and take into account the expenses associated with the processing of run-off claims following cancellation, subject to the conditions of these financial assumptions.

- **Medical EOB Suppression** – Unless required by state law, we do not produce EOBs for Aetna Choice® POS II, Open Access™ Aetna Select℠, claims when there is no member liability. Our claim system automatically suppresses an EOB where benefits are assigned and the member's liability is either zero or consists of a copayment only. Additionally, EOBs are always available electronically through Aetna Navigator.

- **Claims Subrogation** – We have entered into an agreement with the firm of Rawlings & Associates to provide comprehensive subrogation services. A contingency fee of 30% is retained upon recovery for self-funded customers.

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

- **Medical Service Center** – We have assumed that claim administration and member services for the quoted plans will be provided centrally by the Arlington, Texas Service Center. Members will be able to reach the Member Service representatives Monday through Friday, from 8 a.m. to 6 p.m. or local time (based on where the member resides).

Medical Financial Assumptions

- **Patient Management Center** – Patient Management services for Williamson County will be administered by our regional Patient Management Centers.

- **Alternate Office Processing (AOP)** – We regularly use both internal and external claim adjudication services to meet service requirements of our business. These services may be located inside or outside of the United States. Aetna quality standards and controls apply to all claims regardless of where they are processed. Standard pricing assumptions are in effect based on type of product, auto-adjudication, plan design, and customer specific requirements. We may adjust service fees based on the above factors and/or where plan sponsors wish to limit use of Alternative Office Processing (AOP).

- **Third-Party Audits** –We do not typically charge to recoup internal costs associated with a third-party audit. We reserve the right to recover these expenses if significant time and materials are required.

- **Mental Health/Substance Abuse Benefits** – Our quotation assumes that mental health/substance abuse benefits are included.

Reporting

- **Aetna Informatics℠ Reporting and Consulting** – In addition to our electronic tool, Aetna Health Information Advantage, Williamson County will receive 5 hours of support for report generation and/or consulting services for customer data housed in Aetna Health Information Advantage.

- **Eligibility Transmission** – Our proposal assumes we will receive eligibility information weekly or biweekly, from Williamson County's location(s) and/or by Williamson County's designated vendor. Our preferred method of submission is via electronic connectivity. We do not charge for the first 4 Electronic Reporting (ELRs)/segments whether associated with one transmission or by multiple methods. Costs associated with more than 4 ELRs/segments or with any custom programming necessary to accept Williamson County's eligibility information and/or information coming from a designated vendor are not included in this proposal and will be assessed separately. During the installation, we will review all available methods of submitting eligibility information and identify the approach that best meets Williamson County's needs or the needs of their designated vendor.

Medical Financial Assumptions

Pharmacy

- **Self–Funded Pharmacy Fee Guarantee** – The administrative service fee for the first three policy periods will be $0.00 pepm. Aetna reserves the right to revise this guarantee if the number of lives changes by more than 10% from what was assumed.

- **Formulary Rebates** – We agree to provide 100% of rebates to Williamson County. We have provided a Rebate Guarantee for Williamson County showing the minimum amount of rebates Williamson County will receive. We have agreed to guarantee this minimum level of the manufacturer volume discounts we receive based on actual utilization of formulary drugs under contract (see separate Pharmacy Financial Guarantee Document).

- **Specialty Pharmaceutical Rebates** – All specialty pharmaceutical rebates earned on drugs administered and paid through the medical benefit rather than the pharmacy benefit will be retained by Aetna as compensation for Aetna's efforts in administering the Preferred Specialty Pharmaceutical Program.
- **Retail Pharmacy Discounts and Dispensing Fees** - The Retail Brand and Generic Discounts and Dispensing Fees offered may or may not be equal to the actual discounts and fees negotiated and paid to the Participating Pharmacies. The Retail Brand and Generic Discounts and Dispensing Fees may result in either a positive or negative margin for Aetna. Any positive margin may be retained by Aetna. Any negative margin will not be recouped by Aetna from Williamson County.

- **In-House Pharmacy** – Aetna has assumed 0.0% in-house pharmacy utilization. Aetna reserves the right to re-evaluate the proposed pricing if the actual in-house pharmacy utilization varies from this assumption.

- **Termination** - If (a) Williamson County terminates the Agreement prior to the date the APM rebate check is issued, or (b) the Agreement is terminated by Aetna for Williamson County's failure to meet its obligations to fund benefits or pay administrative fees (medical or APM) under the Agreement, Aetna will be entitled to deduct deferred administrative fees or other plan expenses due to the termination date from any rebate check due Williamson County following the termination date.

- **Early Termination** - If the Aetna Pharmacy Management (APM) is terminated by Williamson County prior to October 31, 2017, Aetna will retain any rebates not issued as of the APM cancellation date.

Pharmacy Financial Guarantees

All guarantees and underlying conditions set forth herein are subject and limited to Prescription Drugs dispensed by Participating Pharmacies.

I. Discount Guarantee

For the Contract Years November 1, 2014 through October 31, 2015, November 1, 2015 through October 31, 2016 and November 1, 2016 through October 31, 2017 (each hereinafter referred to as a "Contract Year"), Aetna will guarantee the Discount Savings Percentages for Brand and Generic Drugs as set forth in the chart below:

Williamson County's Pharmacy Discounts				
Contract Year	Retail Brand Discount (Post Rollback AWP basis)	Retail Generic Effective Discount*	Mail Order Brand (Post Rollback AWP basis) Discount	Mail Order Generic Effective Discount*
November 1, 2014 – October 31, 2015	16.00%	71.50%	24.00%	73.50%
November 1, 2015 – October 31, 2016	16.10%	71.70%	24.10%	73.70%
November 1, 2016 – October 31, 2017	16.20%	71.90%	24.20%	73.90%

* The above stated Retail and Mail Order Generic effective discounts are illustrative. Aetna will review Williamson County's utilization and reserves the right to modify the effective discount guarantees within the first 90 days of the effective date.

Retail Discount Reconciliation

The discount savings percentage will be calculated for Retail Drugs by dividing AWP less the ingredient cost for the drugs dispensed by the AWP for such drugs. The AWP and Ingredient Costs for MAC and Non MAC Generic Drugs will be combined for the purposes of the reconciliation.

$$\text{Discount Savings Percentage} = \frac{\text{AWP} - \text{Ingredient Cost}}{\text{AWP}}$$

Pharmacy Financial Guarantees

Reconciliation: Pharmacy data from Aetna's data warehouse will be analyzed. If the Discount Savings Percentage for Retail Drugs realized by Williamson County is less than the applicable Pharmacy Discount Savings Guarantee, Aetna shall pay to Williamson County an amount equal to the percentage difference multiplied by the applicable total AWP for such drugs.

Compound drug claims, claims that process at U&C, direct member reimbursement (DMR) claims, and claims for products dispensed by Aetna Specialty Pharmacy are excluded from the discount guarantees. Aetna reserves the right to exclude claims for over-the-counter products, supplies, vaccines, workers compensation claims, and in-house pharmacy or 340b claims from the discount guarantees.

Mail Order Discount Reconciliation

The discount savings percentage will be calculated for Mail Order Drugs by dividing the AWP less the ingredient cost for the drugs dispensed by the AWP for such drugs. The AWP and Ingredient Costs for MAC and Non MAC Generic Drugs will be combined for the purposes of the reconciliation.

$$\text{Discount Savings Percentage} = \frac{\text{AWP} - \text{Ingredient Cost}}{\text{AWP}}$$

Reconciliation: Pharmacy data from Aetna's data warehouse will be analyzed. If the Discount Savings Percentage for Mail Order Drugs realized by Williamson County is less than the applicable Pharmacy Discount Savings Guarantee, Aetna shall pay to Williamson County an amount equal to the percentage difference multiplied by the applicable total AWP for such drugs.

Compound drug claims, claims that process at U&C, direct member reimbursement (DMR) claims, and claims for products dispensed by Aetna Specialty Pharmacy are excluded from the discount guarantees. Aetna reserves the right to exclude claims for over-the-counter products, supplies, vaccines, workers compensation claims, and in-house pharmacy or 340b claims from the discount guarantees.

Pharmacy Financial Guarantees

II. Rebate Guarantee

For the Contract Years November 1, 2014 through October 31, 2015, November 1, 2015 through October 31, 2016 and November 1, 2016 through October 31, 2017 (each hereinafter referred to as a "Contract Year"), Aetna will pass through 100% of Rebates to Williamson County and guarantees that Williamson County shall receive the applicable minimum Rebate per script as indicated below:

Guaranteed Minimum			
Contract Year	Script Type	Minimum Guarantee Per Retail Script	Minimum Guarantee Per Mail Order Script
November 1, 2014 – October 31, 2015	Brand	$29.25	$76.25
November 1, 2015 – October 31, 2016	Brand	$30.50	$79.25
November 1, 2016 – October 31, 2017	Brand	$31.75	$83.00

Guarantee Reconciliation: If, for any given Contract Year, the actual average Rebate per script paid to Williamson County is less than the applicable Rebate Guarantee specified in the table above, Aetna will pay to Williamson County an amount equal to the difference between the applicable Rebate Guarantee and the actual average Rebate per script paid to Williamson County, multiplied by the total number of applicable scripts during such Contract Year. Any additional Rebates collected by Aetna above the Rebate Guarantee amounts during the Contract Year will be passed through to Williamson County in accordance with the first paragraph of this Section II. For the purposes of this Rebate guarantee, retail scripts shall include Claims for services rendered by the Aetna Specialty Pharmacy.

Pharmacy data from Aetna's systems will be analyzed. Collected Rebates will be released to Williamson County quarterly. Rebate allocations will be made within 180 days from the end of such allocation period. Rebates are not available for Claims arising from Participating Pharmacies dispensing Prescription Drugs subject to either their (i) own manufacturer rebate contracts or (ii) participation in the 340B Drug Pricing Program codified as Section 340B of the Public Health Service Act or other Federal government pharmaceutical purchasing program. Williamson County shall adopt the Aetna Formulary in order to be eligible to receive Rebates unless otherwise agreed upon by Williamson County and Aetna. Rebates are paid on Specialty Products dispensed through Participating Pharmacies and covered under the Plan. For the purposes of this guarantee, any penalty will be calculated based on the aggregate results across both retail and mail order.

Pharmacy Financial Guarantees

III. Dispensing Fee Guarantee

For the Contract Years November 1, 2014 through October 31, 2015, November 1, 2015 through October 31, 2016 and November 1, 2016 through October 31, 2017 (each hereinafter referred to as a "Contract Year"), Aetna will guarantee the Dispensing Fees set forth in the chart below.

	Retail Brand Per Script	Retail Generic Per Script	Mail Order Per Script
Williamson County's RX Dispensing Fee	$1.40	$1.40	$0.00

Compound drug claims, claims that process at U&C, direct member reimbursement (DMR) claims, and claims for products dispensed by Aetna Specialty Pharmacy are excluded from the dispensing fee guarantees. Aetna reserves the right to exclude claims for over-the-counter products, supplies, vaccines, workers compensation claims, and in-house pharmacy or 340b claims from the dispensing fee guarantees.

On an annual basis, Williamson County will be provided dispensing fee reporting from Aetna's data warehouse.

IV. Important Information about Aetna's Pharmacy Benefit Management Services

A. Customer acknowledges that from time to time, Aetna receives other payments from Prescription Drug manufacturers and other organizations that are not Prescription Drug Formulary Rebates and which are paid separately to Aetna or designated third parties (e.g., mailing vendors, printers). These payments are to reimburse Aetna for the cost of various educational programs. These programs are designed to reinforce Aetna's goals of maintaining access to quality, affordable health care for Plan Participants and Customers. These goals are typically accomplished by educating physicians and Plan Participants about established clinical guidelines, disease management, appropriate and cost-effective therapies, and other information. Aetna may also receive payments from Prescription Drug manufacturers and other organizations that are not Prescription Drug Formulary Rebates as compensation for bona fide services it performs, such as the analysis or provision of aggregated information regarding utilization of health care services and the administration of therapy or disease management programs.

These other payments are unrelated to the Prescription Drug Formulary Rebate arrangements, and serve educational as well as other functions. Consequently, these payments are not considered Rebates, and are not included in the Rebates provided to Customer, if any.

Pharmacy Financial Guarantees

B. Customer acknowledges that in evaluating clinically and therapeutically similar Prescription Drugs for selection for the Formulary, Aetna reviews the costs of Prescription Drugs and takes into account rebates negotiated between Aetna and Prescription Drug manufacturers. Consequently, a Prescription Drug may be included on the Formulary that is more expensive than a non-Formulary alternative before any Rebates Aetna may receive from a Prescription Drug manufacturer are taken into account. In addition, certain Prescription Drugs may be chosen for Formulary status because of their clinical or therapeutic advantages or level of acceptance among physicians even though they cost more than non-Formulary alternatives. The net cost to a self-funded plan sponsor for covered prescriptions will vary based on (i) the terms of Aetna's arrangements with Participating Pharmacies; (ii) the amount of the Plan Participant's copayment, coinsurance or deductible obligation under the terms of the plan; and (iii) the amount, if any, of Rebates to which Customer is entitled under its agreement with Aetna. As a result, a self-funded plan sponsor's actual claim expense per prescription for a particular Formulary Prescription Drug may in some circumstances be higher than for a non-Formulary alternative.

In prescription plans with copayment or coinsurance tiers, use of Formulary Prescription Drugs generally will result in lower costs to Plan Participants. However, where the prescription plan utilizes copayments or coinsurance calculated on a percentage basis, there could be some circumstances in which a Formulary Prescription Drug would cost the Plan Participant more than a non-Formulary Prescription Drug because (i) the negotiated Participating Pharmacy payment rate for the Formulary Prescription Drug may be more than the negotiated Participating Pharmacy payment rate for the non-Formulary Prescription Drug, and (ii) Rebates received by Aetna from Prescription Drug manufacturers do not reduce the amount a Plan Participant pays to the pharmacy for an individual prescription drug.

C. The charges that Aetna negotiates with Aetna Rx Home Delivery ("MOD") may be higher than the cost MOD pays for Prescription Drugs and the cost of the fulfillment services it provides. For these purposes, MOD's cost of purchasing Prescription Drugs takes into account discounts, credits and other amounts that it may receive from wholesalers, manufacturers, suppliers and distributors.

D. The Retail Brand and Generic Discounts and Dispensing Fees guaranteed hereunder may or may not be equal to the actual discounts and fees negotiated and paid by Aetna to the Participating Pharmacies. The Retail Brand and Generic Discounts and Dispensing Fees may result in either a positive or negative margin for Aetna. Any positive margin may be retained by Aetna. Any negative margin will not be recouped by Aetna from Williamson County.

Pharmacy Financial Guarantees

V. Conditions of Guarantees

The following conditions apply to these guarantees:

- These guarantees only apply to Claims under managed prescription drug benefits to be administered by Aetna, and will remain in force during the Contract Year.
- Aetna reserves the right to make appropriate changes to these guarantees if there are any changes to the current or proposed benefit plans and plan design. We have assumed that Aetna's standard formulary will be used.
- Brand Drug claims are expected to represent 16.4% of the total pharmacy Claims and MOD Claims are expected to represent 7.0% of the total pharmacy Claims. Aetna may revisit the structure or conditions of these guarantees if the overall brand or MOD utilization decreases by more than 15% from these assumptions.
- A total of 1,399 employees are expected to be enrolled in Aetna's pharmacy product. Aetna may revisit the structure or conditions of this guarantee if there are any significant changes in the population (i.e. geographic, demographic, or eligible mix) or if there is a change of greater than 15% of this enrollment.
- Aetna reserves the right to make appropriate changes to these guarantees if there are any significant changes in the composition of Aetna's pharmacy network or in Aetna's pharmacy network contract compensation rates, or the structure of the pharmacy stores/chains/vendors that are contracted with Aetna, including but not limited to disruption in the retail pharmacy delivery model, and bankruptcy of a chain pharmacy.
- Aetna reserves the right to revise these guarantees if (a) there is a change in government laws or regulations which have a significant impact on pharmacy claim costs, or (b) any material manufacturer rebate contracts with Aetna are terminated or modified in whole or in part, or (c) there is any legal action or Law that materially affects or could materially affect the manner in which Aetna administers the rebate program, or if an existing Law is interpreted so as to materially affect or potentially have a material affect on Aetna's administration of the program.
- Aetna reserves the right to modify its products, services, and fees, and to recoup any costs, taxes, fees, or assessments, in response to legislation, regulation or requests of government authorities. Any taxes or fees (assessments) applied to self-funded benefit plans related to The Patient Protection and Affordable Care Act (PPACA) will be solely the obligation of the plan sponsor. The pharmacy pricing that Aetna is presenting does not include any such plan sponsor liability.

Pharmacy Financial Guarantees

- If (a) Williamson County terminates the Agreement prior to the date the APM rebate check is issued, or (b) the Agreement is terminated by Aetna for Williamson County's failure to meet its obligations to fund benefits or pay administrative fees (medical or APM) under the Agreement, Aetna will be entitled to deduct deferred administrative fees or other plan expenses due to the termination date from any rebate check due Williamson County following the termination date.
- If the Aetna Pharmacy Management (APM) is terminated by Williamson County prior to October 31, 2017, Aetna will retain any rebates not issued as of the APM cancellation date.
- These guarantees are reconciled independently from each other and results from each guarantee do not have an impact on the reconciliation of others.

VI. Definitions

When used in these Aetna Pharmacy Management Financial Guarantees, capitalized terms shall have the following meanings except as otherwise defined:

"**Average Wholesale Price**" or "**AWP**" means the average wholesale price of a Prescription Drug as identified by Medispan (or other drug pricing service determined by Aetna). The applicable AWP for Prescription Drugs filled in (a) any Participating Pharmacy other than a mail service pharmacy will be the AWP on the date the drug was dispensed for the NDC for the package size from which the drug was actually dispensed, and (b) any mail service Participating Pharmacy will be the AWP on the date the drug was dispensed for the 11-digit NDC for the package size from which the drug was actually dispensed.

"**Brand Drug**" means a Prescription Drug with a proprietary name assigned to it by the manufacturer and distributor. Brand Drug does not include those drugs classified as a Generic Drug hereunder.

"**Calculated Ingredient Cost**" means the lesser of:

a. AWP less the applicable percentage Discount;
b. MAC; or
c. U&C Price.

The Calculated Ingredient Cost does not include the Dispensing Fee, the Cost Share or sales tax, if any.

"**Claim**" or "**Claims**" means any electronic or paper request for payment or reimbursement arising from a Participating Pharmacy providing Covered Services to a Plan Participant.

Pharmacy Financial Guarantees

"**Discount**" means the Calculated Ingredient Cost rate or MAC to be charged by Aetna to Customer for Prescription Drugs. The Discount excludes the Dispensing Fee, Cost Share and sales tax, if any.

"**Dispensing Fee**" means an amount agreed by Customer and Aetna in consideration of the costs associated with a Participating Pharmacy dispensing medication to a Plan Participant.

"**DMR Claim**" means a direct member (Plan Participant) reimbursement claim.

"**Generic Drug**" means a Prescription Drug, whether identified by its chemical, proprietary, or non-proprietary name that (a) is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient, or (b) is deemed by Aetna to be pharmaceutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient.

"**Law**" means any law, statute, rule, regulation, ordinance and other pronouncement having the effect of law of the United States of America, any foreign country or any domestic or foreign state, county, city or other political subdivision, or of any governmental or regulatory body, including without limitation, any court, tribunal, arbitrator, or any agency, authority, official or instrumentality of any governmental or political subdivision.

"**Maximum Allowable Cost**" or "**MAC**" means the cost basis for reimbursement established by Aetna, as modified from time to time, for the same dose and form of Generic Drugs which are included on Aetna's applicable MAC List.

"**MAC List(s)**" means the lists of MAC payment schedules for Prescription Drugs, devices and supplies identified as readily available as a Generic Drug or generally equivalent to a Brand Drug (in which case the Brand Drug may also be on the MAC List) and developed and maintained or selected by Aetna and that, in each case, are deemed to require or are otherwise capable of pricing management due to the number of drug manufacturers, utilization and/or pricing volatility.

"**On-Line Claim**" means a claim that (i) meets all applicable requirements, is submitted in the proper timeframe and format, and contains all necessary information, and (ii) is submitted electronically for payment to Aetna by a Participating Pharmacy as a result of provision of Covered Services to a Plan Participant.

"**Participating Pharmacy**" means a Participating Retail Pharmacy, Aetna Mail Order Pharmacy or Aetna Specialty Pharmacy.

Pharmacy Financial Guarantees

"**Prescription Drug**" means a legend drug that, by Law, cannot be sold without a written prescription from an authorized Prescriber. For purposes of this Agreement, insulin, certain supplies, and devices shall be considered a Prescription Drug.

"**Rebates**" shall mean certain monetary distributions made to Customer by Aetna under the pharmacy benefit and funded from retrospective amounts paid to Aetna (i) pursuant to the terms of an agreement with a pharmaceutical manufacturer, (ii) in consideration for the inclusion of such manufacturer's drug(s).

Aetna Demonstrating Value Scorecard

Aetna Demonstrating Value Scorecard

Aetna Demonstrating Value Scorecard

General Performance Guarantee Provisions

Aetna Life Insurance Company, on behalf of itself and its affiliates ("Aetna") provides health benefits administration and other services (set forth in this document) for the self-funded Aetna medical plans operated on behalf of Williamson County.

Performance Objectives

Aetna believes that measuring the activities described below is an important indicator of how well it services Williamson County. To reinforce Williamson County's confidence in Aetna's ability to administer its program, Aetna is offering guarantees for its Care Management Programs, which include Aetna Health Connections℠ - Disease Management, Member Satisfaction Surveys, and Case Management and Utilization Management.

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

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

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

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

Aetna Demonstrating Value Scorecard

	Minimum Standard	PEPM @ risk		Total @ risk
AHC-DM				
• Return on Investment	1:1	$ 4.20	pepm	$ 70,510
• Implementation	Score of 3 or greater	$ 0.20	pepm	$ 3,358
• Management Reports	Delivered within 90 days	$ 0.05	pepm	$ 839
• Clinical & Utilization Outcome Reports	Delivered within 90 days	$ 0.05	pepm	$ 839
• Opt Out Rate	less than 5%	$ 0.20	pepm	$ 3,358
• Nurse Engagement Rate	50%	$ 0.20	pepm	$ 3,358
• Sustained Nurse Engagement	60%	$ 0.20	pepm	$ 3,358
• Depression Screening	90%	$ 0.20	pepm	$ 3,358
Clinical Outcome Improvement Rates			pepm	$ -
• Lipid Lowering Drug Usage	70%	$ 0.10	pepm	$ 1,679
• Diabetic HbA1c testing	75%	$ 0.10	pepm	$ 1,679
• Asthma-controller medications	80%	$ 0.10	pepm	$ 1,679
• Cholesterol monitoring	75%	$ 0.10	pepm	$ 1,679
Case Management/Utilization Management				
• Case Management ROI	1:1	$ 0.20	pepm	$ 3,358
• Precertification ROI	2:1	$ 0.20	pepm	$ 3,358
• Concurrent Review ROI	2:1	$ 0.20	pepm	$ 3,358
• Case Management Engagement Rate	85%	$ 0.20	pepm	$ 3,358
• Discharge Planning	95%	$ 0.20	pepm	$ 3,358
• Case Management Plan	95%	$ 0.20	pepm	$ 3,358
• Post Discharge Outbound Call	90%	$ 0.20	pepm	$ 3,358
• Regional Case Management Screening Rate	95%	$ 0.20	pepm	$ 3,358
• High Claimant Screening Rate	95%	$ 0.20	pepm	$ 3,358
• UM Touch Rate	85%	$ 0.20	pepm	$ 3,358
• Depression Screening	90%	$ 0.20	pepm	$ 3,358
Member Satisfaction Surveys				
• AHCDM ; IHL, CM	90%	$ 0.20	pepm	$ 3,358
Total		$ 8.10		**$ 135,983**
	Employees in above programs:	1,399		

Aetna Demonstrating Value Scorecard

Guarantee Period

The guarantee period shall be represented as a one-year guarantee for the period for the implementation of the programs and the year immediately following the implementation such as November 1, 2014 through October 31, 2015 and shall be on an annual basis thereafter, upon the mutual agreement of the parties (hereinafter "guarantee period").

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

Performance guarantees described herein will not apply if Services Agreement termination occurs prior to the end of the guarantee period. Performance guarantees are subject to enrollment requirements outlined on the attached conditions and assume Aetna Pharmacy Management is fully integrated.

Aggregate Maximum

Aetna will place at risk $8.10 PEPM of the collected Care Management programs guarantee period administrative service fees. The Care Management guarantee period administrative service fees will be calculated at the end of the respective guarantee period and will be based on the total number of Williamson County employees enrolled in the underlying medical plans that also offer the services of the programs for each guarantee period. In no event will the total program fees be adjusted by more than 30% of actual collected fees due to the results of this guarantee document and all other service-based performance guarantees combined. Any reference to collected fees means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.

Financial Conditions

- If actual enrollment increases or decreases by 10%, Aetna retains the right to revise the performance guarantees.
- MedQuery® is an essential component of disease management and must be included.
- This guarantee assumes both medical and pharmacy programs are administered by Aetna.
- For customers utilizing an external vendor for onsite biometric screenings, this guarantee assumes Aetna will receive those external feeds.
- Members enrolled in the medical and pharmacy plans are also enrolled in the Aetna Health Connections Disease Management Program.

- This guarantee assumes that Williamson County's under age 65 population is structured separately from the over age 65 population for accounting/reporting purposes with Aetna, as this guarantee excludes populations that are over age 65 with Medicare primary. If the two populations are not separate, Aetna retains the right to revise the performance guarantees.
- This guarantee assumes the average member age of Williamson County's enrolled Aetna medical plan participants is greater than 34.
- This guarantee assumes that the member/employee ratio for Williamson County is at least 2:1.
- For Aetna Health Connections Disease Management, claim and Rx history must be received by Aetna within the Aetna stated acceptable format for data feeds within one month of the program effective date in order to honor the terms of this guarantee. If Aetna does not receive acceptable file feeds within one month of the programs effective date, then the basis of the guarantee will be book-of business results for the guarantee period. If an external Rx vendor is being utilized, ongoing bi-weekly feeds must be received by specified dates.
- For Aetna Health Connections Disease Management, if program termination occurs within 180 days after the guarantee period, Aetna reserves the right to revert the basis of the guarantee to concurrent book-of business results rather than customer-specific results.
- Williamson County must purchase Aetna Health Connections℠ program. The cost of this program is $4.20 PEPM and is not included in our proposed administrative fee.

Refund Process

Aetna shall provide Williamson County with its final results performance guarantees with the annual accounting after the end of the respective guarantee period. Reporting that outlines associated savings for the contract period is estimated to be available at the end of the third quarter following the close of the respective guarantee period. If the guarantees have not been met, at Williamson County's sole discretion, Aetna shall (1) provide a cash payment to Williamson County for the amount due as a result of Aetna's non-compliance within thirty (30) days of Williamson County's receipt of such results or (2) reduce the following month(s)'s administrative fee payment by the amount due by Williamson County.

Termination Provisions

Termination of the guarantee obligations shall become effective upon written notice by Aetna in the event of the occurrence of (i), (ii) or (iii) below:

i. A material change in the plan initiated by Williamson County or by legislative action that impacts the claims adjudication process, member services functions, medical management or network management

ii. Failure of Williamson County to meet its obligations to pay administrative services fees or fund claim payment wires under the Services Agreement

iii. Failure of Williamson County to meet its administrative responsibilities (for example, a submission of incorrect or incomplete eligibility information)

No guarantees shall apply to Aetna Health Connections - Disease Management Program for a guarantee period during which Williamson County terminates its participation in this program prior to the end of such guarantee period.

No guarantees shall apply for a guarantee period during which the Services Agreement is terminated by Williamson County or Aetna prior to the end of such guarantee period.

Aetna Health Connections℠ – Disease Management Program

AHC-DM Return on Investment (ROI)

Guarantee: Aetna will guarantee that the savings associated with the Disease Management Program will be equal to one times the Disease Management guarantee period administrative service fee of $4.20 per employee per month (PEPM) to a maximum of the total fee. The guarantee will be reconciled annually using an appropriate combination of an avoided cost methodology for resolved Care Considerations and results from Aetna's most current Disease Management Program evaluation. Book-of-business results will be used.

Penalty/Measurement: The guarantee will be reconciled annually using an appropriate combination of an avoided cost methodology for resolved Care Considerations and results from Aetna's most current Disease Management evaluation. Aetna is willing to place 100 percent of the Disease Management and MedQuery guarantee period administrative service fees at risk. There is no penalty should the ratio of savings to program costs be greater than a 1:1 ratio. If the ratio of achieved savings to the total service fees paid for Disease Management and MedQuery is less than a 1:1 ratio, Aetna will reduce its compensation to ensure Williamson County will save one times the service fees paid for these programs. There will be a maximum reduction of one times the combined Disease Management and MedQuery guarantee period administrative service fees.

Aetna Demonstrating Value Scorecard

Example for ROI: If the guarantee period administrative fees for the MedQuery program are $150,000 we will guarantee that the guarantee period MedQuery program savings will be equal to the fees paid. If actual guarantee period MedQuery program savings are $100,000, the guarantee period administrative fee reduction would be $50,000. This $50,000 reduction would lower the service fees paid to $100,000 resulting in a 1:1 ratio of program savings to program costs.

AHC-DM Implementation

Guarantee: Aetna is confident that Williamson County will be pleased with our implementation of this program; therefore, we are offering an implementation performance guarantee. Via timely responses to the attached Implementation Evaluation Tool (provided at the end of this guarantee section), Williamson County agrees to make Aetna aware of possible sources of dissatisfaction throughout the implementation period. Each question will be given a rating of 1 to 5 with 1 as the lowest and 5 as the highest. Aetna will tally the results from the evaluation tool when received. Williamson County's responses to the attached evaluation tool will be used to facilitate a discussion between Williamson County and the Account Executive in our Arlington, Texas field office regarding the results achieved. Aetna guarantees it will achieve a score of 3 or higher at the end of the implementation process.

Penalty and Measurement Criteria: Aetna will place $0.20 per employee, per month of the guarantee period administrative service fees at risk for this metric.

Disease Management Reports

Guarantee: Aetna will make AHC-DM Quarterly Activity Reports available to Williamson County within 90 days after the end of the reporting period via Aetna's website.

Penalty and Measurement Criteria: Aetna will place $0.05 per employee, per month of the guarantee period administrative service fees at risk for this metric.

Aetna Demonstrating Value Scorecard

Clinical and Utilization Outcome Reports

Guarantee: Aetna will guarantee Williamson County that Aetna Health Connections Disease Management Outcomes Quarterly Reports will be delivered to the customer within 90 days after the close of the quarter. The report requires 12 months of incurred data with a 3-month lag. Within these reports, Aetna will display clinical and utilization outcome data for Disease Management members for each clinical cluster. For example, for diabetes, the calculations are based upon all acute inpatient admissions for Disease Management Program members identified for diabetes, regardless of the reason for the inpatient stay.

Penalty and Measurement Criteria: Aetna will place $0.05 per employee, per month of the guarantee period administrative service fees at risk for this metric.

AHC-DM Opt Out Rate

Guarantee: Aetna will guarantee an opt out rate of no more than 5 percent in its AHC-DM program. Opt out is defined as:

$$\frac{\text{Members who opt out during a telephone call}}{\text{Total number of members identified for the DM Program}}$$

Appropriate performance guarantee reports will be used to reconcile this guarantee annually. Results are calculated on a book-of-business basis.

Penalty and Measurement Criteria: Aetna will place $0.20 per employee, per month of the guarantee period administrative service fees at risk for this metric as follows:

- > 10 percent - Aetna returns 100 percent of the fee allocated to this component
- <10 percent, but > 5 percent - Aetna returns 50 percent of the fee allocated to this component

Aetna Demonstrating Value Scorecard

AHC-DM Nurse Engagement Rate

Guarantee: Aetna will guarantee an engagement rate of 50 percent or better in its AHC-DM program. Engagement is defined as:

$$\frac{\text{Cumulative RN engaged YTD *}}{\text{All members with outreach completed minus UTR **}}$$

* Includes unique cumulative members who participated in the highest level of intervention (nurse engagement) during the year

** Includes all unique cumulative members reached. (Calculation: enrolled w/RN engagement + supportive engagement)

The metric does not include unable-to-reach (UTR) members. Appropriate performance guarantee reports will be used to reconcile this guarantee annually. Results are calculated on a book-of-business basis.

- < 40 percent - Aetna returns 100 percent of the fee allocated to this component
- 40 percent, but < 50 percent - Aetna returns 50 percent of the fee allocated to this component

AHC-DM Sustained Nurse Engagement

Guarantee: A minimum of 60 percent nurse-engaged participants will complete a minimum of 3 nursing calls. This excludes members moved to the quarterly call program and those members that were identified in the last quarter. Results are calculated on a book-of-business basis.

Penalty and Measurement Criteria: Aetna will place $0.20 per employee, per month of the guarantee period administrative service fees at risk for this metric as follows:

- < 50 percent - Aetna returns 100 percent of the fee allocated to this component
- 50 percent, but < 60 percent - Aetna returns 50 percent of the fee allocated to this component

Aetna Demonstrating Value Scorecard

AHC-DM Depression Screening

Guarantee: Aetna will guarantee that 90 percent of members 18 years or older enrolled in an AHC-DM Program will be screened for depression. Results are calculated on a book-of-business basis.

Penalty and Measurement Criteria: Aetna will place $0.20 per employee, per month of the guarantee period administrative service fees at risk for this metric as follows:

- < 85 percent - Aetna returns 100 percent of the fee allocated to this component
- 85 percent, but < 90 percent - Aetna returns 50 percent of the fee allocated to this component

Clinical Performance

Guarantee: Aetna will guarantee to maintain and/or improve the compliance levels of clinical outcomes for members identified with certain conditions. The clinical guarantees assume that Aetna receives 24 months of prior carrier medical and pharmacy data to set a baseline for the guarantees. This medical and pharmacy data will be loaded into Aetna systems and the Care Engine. Member claim data must be present for 10 months in the prior carrier data to be considered for the clinical guarantee metrics. The guaranteed targets for 2014 are as follows:

- Coronary Artery Disease (CAD)/Peripheral Artery Disease (PAD) members –CAD members using lipid lowering drugs in the past 12 months.
    - All CAD/PAD, Cardiovascular Disease (CVD) and Diabetes Management (DM) members participating in the AHC-DM Program for a minimum of 6 months during the current guarantee period will achieve a minimum 5 percent improvement in the difference between the baseline compliance rate and the target compliance rate, up to a 70 percent target compliance level, at which point the guarantee will be to maintain the target compliance.

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

    - If Aetna achieves the target compliance level of 70%, Aetna returns none of the fee.
    - If Aetna does not achieve the target compliance level of 70% but does achieve a minimum five percent improvement between the baseline rate and the target rate, Aetna returns none of the fee.
    - If neither of these conditions is met, Aetna will return $0.10 per employee, per month.

- Diabetic members –Diabetic members receiving an HbA1c test in the past 12 months.
  - All diabetic members participating in the AHC-DM Program for a minimum of 6 months during the current guarantee period will achieve a minimum 5 percent improvement in the difference between the baseline compliance rate and the target compliance rate, up to 75 percent target compliance level, at which point the guarantee will be to maintain the target compliance.

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

  - If Aetna achieves the target compliance level of 75%, Aetna returns none of the fee.
  - If Aetna does not achieve the target compliance level of 75% but does achieve a minimum five percent improvement between the baseline rate and the target rate, Aetna returns none of the fee.
  - If neither of these conditions is met, Aetna will return $0.10 per employee, per month.

- Asthmatic members –Asthmatic members using appropriate controller medications in the past 12 months.
  - All persistent asthmatic members participating in the AHC DM program for a minimum of 11 months during the current guarantee period and identified as a persistent asthmatic for at least 6 months will achieve a minimum 5 percent improvement in the difference between the previous year result and the target compliance rate, up to an 80 percent target compliance level, at which point the guarantee will be to maintain the target compliance.

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

  - If Aetna achieves the target compliance level of 80%, Aetna returns none of the fee.
  - If Aetna does not achieve the target compliance level of 80% but does achieve a minimum five percent improvement between the baseline rate and the target rate, Aetna returns none of the fee.
  - If neither of these conditions is met, Aetna will return $0.10 per employee, per month

Aetna Demonstrating Value Scorecard

- CAD/PAD members –CAD/PAD members have their cholesterol monitored in the past 12 months.
  - All CAD/PAD, CVD and DM members participating in the AHC-DM Program for a minimum of 6 months during the current guarantee period will achieve a minimum 5 percent improvement in the difference between the baseline compliance rate and the target compliance rate, up to a 75 percent target compliance level, at which point the guarantee will be to maintain the target compliance.

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

  - If Aetna achieves the target compliance level of 75%, Aetna returns none of the fee.
  - If Aetna does not achieve the target compliance level of 75% but does achieve a minimum five percent improvement between the baseline rate and the target rate, Aetna returns none of the fee.
  - If neither of these conditions is met, Aetna will return $0.10 per employee, per month.

Reconciliation example:
If a customer's baseline compliance rate is 50 percent and the target compliance rate for the metric is 70 percent, the guarantee will be to improve the rate from the current 50 percent to 51 percent in the following year [(70 percent-50 percent) * 5 percent].

In order to reconcile clinical outcome guarantees using customer-specific results, the customer must have at least 3,000 employees enrolled in the Aetna medical plan. Additionally, for any individual clinical outcome, there must be a minimum of 30 members participating to reconcile the outcome using customer-specific results. For customers with fewer than 3,000 employees or for an individual outcome for which there are less than 30 members participating, the Aetna book-of-business results will be used to reconcile the guarantee. All clinical outcome improvement guarantees will be reconciled annually using the AHC-DM Annual Clinical Outcomes Report.

Case Management and Utilization Management

Case Management Return on Investment

Guarantee: Aetna will guarantee that the savings associated with case management will be equal to one and a half times the case management guarantee period administrative service fee $0.91 PEPM to a maximum of the total fee. Self-insured book-of-business results will be used to reconcile the guarantee annually using Aetna's most current annual Case Management ROI Study.

Aetna Demonstrating Value Scorecard

Penalty and Measurement Criteria: Aetna will place $0.20 per employee, per month of the guarantee period administrative service fees at risk for this metric.

Precertification Return on Investment

Guarantee: Aetna will guarantee that the savings associated with precertification will be equal to two times the precertification guarantee period administrative service fee of $0.61 PEPM to a maximum of the total fee. Book-of-business results will be used to reconcile the guarantee annually using Aetna's latest full year National Precertification ROI Report.

Penalty and Measurement Criteria: Aetna will place $0.20 per employee, per month of the guarantee period administrative service fees at risk for this metric.

Concurrent Review Return on Investment

Guarantee: Aetna will guarantee that the savings associated with concurrent review will be equal to two times the concurrent review guarantee period administrative service fee of $1.01 PEPM to a maximum of the total fee. Book-of-business results will be used to reconcile the guarantee annually using Aetna's most current annual Concurrent Review ROI Study.

Penalty and Measurement Criteria: Aetna will place $0.20 per employee, per month of the guarantee period administrative service fees at risk for this metric.

Case Management Engagement Rate

Guarantee: Aetna will guarantee an engagement rate of 85 percent or better in its AHC-Case Management Program. Engagement is defined as:

$$\frac{\text{Cumulative engaged cases during the year (member and or provider completed clinical call)*}}{\text{Cases eligible for outreach and we reach during the year**}}$$

* The numerator is calculated as total cumulative members/cases engaged in the highest level of the program (nurse/provider engagement) during the year

** The denominator is calculated as all cumulative members/cases or providers identified during the year and where the member is reached during the year

Aetna Demonstrating Value Scorecard

Results are commercial members only. The metric does not include unable-to-reach (UTR) members. Appropriate performance guarantee reports will be used to reconcile this guarantee annually. Results are calculated on a self-insured book-of-business basis.

Penalty and Measurement Criteria: Aetna will place $0.20 per employee, per month of the guarantee period administrative service fees at risk for our Case Management Engagement Rate guarantee as follows:

- < 75 percent - Aetna returns 100 percent of the fee allocated to this component
- 75 percent, but < 80 percent - Aetna returns 50 percent of the fee allocated to this component
- 80 percent, but < 85 percent - Aetna returns 20 percent of the fee allocated to this component

Discharge Planning

Guarantee: Aetna will guarantee that 95 percent of cases targeted for discharge planning will have activity documented by Patient Management. Self-insured book-of-business results will be used to reconcile the guarantees annually using the appropriate performance guarantee report.

Penalty and Measurement Criteria: Aetna will place $0.20 per employee, per month of the guarantee period administrative service fees at risk for our Discharge Planning guarantee as follows:

- < 80 percent - Aetna returns 100 percent of the fee allocated to this component
- 80 percent, but < 90 percent - Aetna returns 50 percent of the fee allocated to this component
- 90 percent, but < 95 percent - Aetna returns 20 percent of the fee allocated to this component

Case Management Plan

Guarantee: Aetna will guarantee that 95 percent of cases accepted for case management will have a documented case management plan within 12 business days of the start of the event. Self-insured book-of-business results will be used to reconcile the guarantees annually using the appropriate performance guarantee report.

Penalty and Measurement Criteria: Aetna will place $0.20 per employee, per month of the guarantee period administrative service fees at risk for our Case Management Plan guarantee as follows:

- < 80 percent - Aetna returns 100 percent of the fee allocated to this component
- 80 percent, but < 90 percent - Aetna returns 50 percent of the fee allocated to this component
- 90 percent, but < 95 percent - Aetna returns 20 percent of the fee allocated to this component

Aetna Demonstrating Value Scorecard

Post Discharge Outbound Call Rate

Guarantee: Aetna will guarantee that 90 percent of members newly identified for case management outreach as a result of an inpatient hospital stay excluding maternity, newborns, behavioral health, coordination of benefits (COB), Medicare, skilled nursing facility (SNF), transplants (NME) and rehabilitation admissions, will have an outbound member call (attempt or success) documented within 7 business days following the member's documented discharge date. This assumes timeliness of notification of a discharge by a facility provider (defined as notification of discharge within 48 hours or first business day, whichever is sooner). Self-insured book-of-business results will be used to reconcile the guarantee annually using the appropriate performance guarantee report.

Penalty and Measurement Criteria: Aetna will place $0.20 per employee, per month of the guarantee period administrative service fees at risk for our Post Discharge Outbound Call Rate guarantee as follows:

- < 75 percent - Aetna returns 100 percent of the fee allocated to this component
- 75 percent, but < 85 percent - Aetna returns 50 percent of the fee allocated to this component
- 85 percent, but < 90 percent - Aetna returns 20 percent of the fee allocated to this component

Regional Case Management Screening Rate

Guarantee: Aetna will guarantee that 95 percent of all impactable members (defined as those members with PULSE scores of 13+ with two or more actionability flags (for example, noncompliance of chronic medical therapy, recent high ER or inpatient facility usage, high nonpar $$, etc.) will be screened for case management. Self-insured book-of-business results will be used to reconcile the guarantee annually using the appropriate performance guarantee report.

Penalty and Measurement Criteria: Aetna will place $0.20 per employee, per month of the guarantee period administrative service fees at risk for our Case Management Screening Rate guarantee as follows:

- < 80 percent - Aetna returns 100 percent of the fee allocated to this component
- 80 percent, but < 90 percent - Aetna returns 50 percent of the fee allocated to this component
- 90 percent, but < 95 percent - Aetna returns 20 percent of the fee allocated to this component

Aetna Demonstrating Value Scorecard

Regional Case Management High Claimant Screening Rate

Guarantee: Aetna will guarantee that 95 percent of all unique members with claims in excess of $75,000 will have at least one Patient Management intervention (except actions related solely to hospital care) along the continuum of care, as evidenced by case management screening, and/or enrollment in Aetna's Disease Management Program, and/or participation in the National Medical Excellence Program® (NME) and/or through pre-or post-hospitalization outbound call attempts. Self-insured book-of-business results will be used to reconcile the guarantee annually using the appropriate performance guarantee report.

Penalty and Measurement Criteria: Aetna will place $0.20 per employee, per month of the guarantee period administrative service fees at risk for our High Claimant Screening Rate guarantee as follows:

- < 80 percent - Aetna returns 100 percent of the fee allocated to this component
- 80 percent, but < 90 percent - Aetna returns 50 percent of the fee allocated to this component
- 90 percent, but < 95 percent - Aetna returns 20 percent of the fee allocated to this component

Utilization Management Touch Rate

Guarantee: Aetna will guarantee that 85 percent of all inpatient stays, excluding non-high-risk maternity stays, will be touched by at least one Utilization Management (UM) program. Self-insured book-of-business results will be used to reconcile the guarantee annually.

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

Penalty and Measurement Criteria: Aetna will place $0.20 per employee, per month of the guarantee period administrative service fees at risk for our Utilization Management Touch Rate guarantee as follows:

- < 75 percent - Aetna returns 100 percent of the fee allocated to this component
- 75 percent, but < 80 percent - Aetna returns 50 percent of the fee allocated to this component
- 80 percent, but < 85 percent - Aetna returns 20 percent of the fee allocated to this component

Aetna Demonstrating Value Scorecard

Depression Screening

Guarantee: Aetna will guarantee that 90 percent or more of qualified new cases in the Case Management, NME and Beginning Right programs will be screened for depression. Self-insured book-of-business results for Case Management, NME and Beginning Right will be used to reconcile the depression screening guarantee annually using the appropriate performance guarantee report.

Penalty and Measurement Criteria: Aetna will place $0.20 per employee, per month of the guarantee period administrative service fees at risk for this metric as follows:

- < 85 percent - Aetna returns 100 percent of the fee allocated to this component
- 85 percent, but < 90 percent - Aetna returns 50 percent of the fee allocated to this component

Member Satisfaction Surveys

Aetna will guarantee an overall positive response rate of 90 percent or better on medical management program surveys administered during the guarantee period. Member satisfaction surveys will be administered for each individual program and then averaged equally across the surveys to derive one overall member satisfaction survey result for 2014 (for instance, for a customer offering 3 surveys, each result would be blended equally 33.3%). The surveys will be administered on a book-of-business basis. Customer-specific surveys are available for an additional charge.

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

Penalty and Measurement Criteria: Aetna will place $0.20 per employee, per month of the guarantee period administrative service fees at risk for this guarantee.

Aetna Health Connections – Disease Management Program Participant Satisfaction

Guarantee: Aetna will guarantee a blended positive response rate of 90 percent or better on the program surveys administered during the guarantee period. The survey is based on a statistically valid, randomly selected sample size of AHC-DM participants ages 18 to 64.

Aetna Demonstrating Value Scorecard

Informed Health® Line Program Participant Satisfaction

Guarantee: Aetna will guarantee a blended positive response rate of 90 percent or better on the program surveys administered during the guarantee period. The survey is based on a statistically valid, randomly selected sample size of Informed Health Line participants ages 18 to 64.

Case Management Program Participant Satisfaction

Guarantee: Aetna will guarantee a blended positive response rate of 90 percent or better on the program surveys administered during the guarantee period. The survey is based on a statistically valid, randomly selected sample size of case management participants ages 18 to 64

Dental Performance Guarantees

General Performance Guarantee Provisions

Aetna Life Insurance Company (ALIC) provides health benefits administration and other services for the self-funded Dental Preferred Provider Organization (Dental PPO) plan. The services set forth in this document will be provided by ALIC (hereinafter "Aetna").

Performance Objectives

Aetna believes that measuring the activities described below are important indicators of how well it services Williamson County. Aetna is confident that the Plan Administration, Claim Administration and Member Services provided to Williamson County will meet their high standards of performance. To reinforce Williamson County's confidence in Aetna's ability to administer their program, Aetna is offering guarantees in the following areas:

Summary of Performance Standards and Penalties

Performance Category	Minimum Standard	Proposed Penalty
Implementation		
• Implementation	Average evaluation score of 3.0 or higher	3.0%
Account Management		
• Overall Account Management	Average evaluation score of 3.0 or higher	2.0%
Claim Administration		
• Turnaround Time	93.0% of claims processed within 14 calendar days	2.0%
• Financial Accuracy	99.0%	2.0%
• Total Claim (Overall) Accuracy	95.0%	2.0%
Member Services		
• Average Speed of Answer	25 Seconds	2.0%
• Abandonment Rate	2.0%	2.0%
Total		**15.0%**

Dental Performance Guarantees

Guarantee Period

The guarantees described herein will be effective for a period of 12 months and will run from **November 1, 2014 through October 31, 2015** (hereinafter "guarantee period").

The performance guarantees shown below will apply to the self-funded *Dental PPO plan* administered under the Administrative Services Only Agreement ("Services Agreement"). These guarantees ***do not*** apply to non-Aetna benefits and/or networks (e.g., passive networks, customer specific networks).

If Aetna processes runoff claims upon termination of the contract, performance guarantees of Turnaround Time, Financial Accuracy, and/or Total Claim Accuracy will not apply to such claims. Furthermore, performance guarantees described herein will not apply to the guarantee period claims if termination is prior to the end of the guarantee period.

Aggregate Maximum

The maximum penalty adjustment will be equal to **15.0%** of actual base service fees collected. In no event will fees be adjusted by more than **20.0%** due to results of this guarantee and all other guarantees combined.

Termination Provisions

Termination of the guarantee obligations shall become effective upon written notice by Aetna in the event of the occurrence of (i), (ii) or (iii) below:

I. a material change in the plan initiated by Williamson County or by legislative action that impacts the claim adjudication process, member service functions or network management;

II. failure of Williamson County to meet its obligations to remit administrative service fees or fund the Williamson County bank account as stipulated in the General Conditions Addendum of the Services Agreement;

III. failure of Williamson County to meet their administrative responsibilities (e.g., a submission of incorrect or incomplete eligibility information).

No guarantees shall apply for a guarantee period during which the Services Agreement is terminated by Williamson County or by Aetna.

Dental Performance Guarantees

Refund Process

At the end of each guarantee period, Aetna will compile its Performance Guarantees results. If necessary, Aetna will offset future administrative service fees by an amount equal to any penalties incurred by Aetna unless directed by Williamson County to provide a "lump sum" refund.

Measurement Criteria

Aetna's Dental Operations team internal quality results will be used to determine guarantee compliance for any Financial Accuracy and/or Total Claim Accuracy Guarantees. The results for these guarantees will be calculated using industry accepted stratified audit methodologies and will include ALL customers within Dental Operations.

Dental Performance Guarantees

Implementation

Overall Implementation Guarantee

Guarantee: Aetna developed and utilizes the implementation team concept to carefully coordinate all aspects of the implementation. An Implementation Manager will be assigned to assemble Williamson County's implementation team and develop an Implementation Management Plan for the conversion to the new plan of benefits. This plan will outline the tasks to be accomplished, including the distribution of communication and open enrollment materials and the successful transfer of eligibility data. The Management Plan will also indicate target dates for their completion.

Working with Williamson County's team, the Implementation Manager will help determine the implementation priorities. As new information becomes available and priorities change, the Implementation Management Plan will be updated. However, for the implementation to progress in a timely manner, Williamson County will be responsible for providing key information to the Implementation Manager as close to the target dates as possible (e.g., finalized account structure, finalized plan of benefits, accurate eligibility files, signed legal agreements).

Aetna is confident that Williamson County will be pleased with our implementation team approach and therefore we are offering an implementation performance guarantee. This guarantee is effective for the implementation period in the first guarantee period. The implementation period commences at the initial implementation meeting and runs through the implementation sign-off.

Penalty and Measurement Criteria: Via timely responses to the attached Implementation Evaluation Tool (provided at the end of this guarantee section), Williamson County agrees to make Aetna aware of possible sources of dissatisfaction throughout the implementation period. Each question will be given a rating of 1 - 5 with 1 = lowest, 5 = highest. Aetna will tally the results from the evaluation tool when received. Williamson County's responses to the attached evaluation tool will be used to facilitate a discussion between Williamson County, the Implementation Manager and the Account Executive in our field office regarding the results achieved. If, at the end of the implementation process, the average score of the evaluations falls below a 3.0, Aetna will make a mutually agreed upon reduction in compensation, subject to a maximum reduction of **3.0%** of the guarantee period administrative service fees.

Dental Performance Guarantees

Account Management

Overall Account Management Guarantee

Guarantee: Aetna will guarantee that the services (i.e., on-going financial, eligibility, drafting, and benefit administration and continued customer support) provided by the Field Office Account Management Staff and/or the Employer Service Team during the guarantee period will be satisfactory to Williamson County.

Penalty and Measurement Criteria: Via quarterly/semi-annual responses to the attached Account Management Evaluation Tool (provided at the end of this guarantee section) and this link **http://www.aetnasurveys.com/se.ashx?s=103ED34467D2D0E0**, Williamson County agrees to make Aetna aware of possible sources of dissatisfaction throughout the guarantee period. Williamson County's responses to the attached evaluation tool will evaluate account management services in the following categories: technical knowledge, accessibility of personnel, responsiveness of personnel, interpersonal skills, communication skills (written and oral) and overall assessment of the services provided to Williamson County. Each category will be given a rating of 1 - 5 with 1 = lowest, 5 = highest. Aetna will tally the results from the report card(s) when received. The results of the survey(s) will be used to facilitate a discussion between Williamson County and the Account Executive in our field office regarding the results achieved and opportunities for improvement.

If all report cards based on the frequency of the guarantee are not completed and returned (for Quarterly, within 15 days after the end of the quarter, for Semi-Annual, within 15 days after the six month period, for Annual after 15 days after the end of the policy period), it will be assumed that the service provided to Williamson County is satisfactory and the guarantee is met. If the score on the first report card and the report card(s) for the subsequent survey(s) average a 3.0or higher, no credit is due. Satisfactory service would equal a score of 3.0 and would be based on the total average of 24 questions with a rating scale of 1 to 5. Should the score from the first report card and the average of the remaining report card(s) fall below a 3.0 (meaning that service levels have not improved), Aetna will make a mutually agreed upon reduction in compensation, subject to a maximum reduction of **2.0%** of the guarantee period administrative service fees.

Dental Performance Guarantees

Claim Administration

Turnaround Time

Guarantee: Aetna will guarantee that the claim turnaround time during the guarantee period will meet or exceed 93.0% of the processed claims within 14 calendar days on a cumulative basis each year.

Definition: Aetna measures turnaround time from the claimant's viewpoint; that is, from the date the claim is received in the service center to the date that it is processed (paid, denied or pended). **Weekends and holidays are included in turnaround time.**

Penalty and Measurement Criteria: If the cumulative year turnaround time (TAT) falls below the percentage guarantee as stated above, Aetna will reduce its compensation by an amount equal to 0.75% of the guarantee period administrative service fees for each 1.0% that Turnaround Time falls below 93.0%. There will be a maximum reduction of **2.0%** of the guarantee period administrative service fees.

If Williamson County has >3000 enrolled members, a computer generated turnaround time report for Williamson County's specific claims will be provided on a quarterly basis. If <3000 enrolled members, results will be reported at the Dental Operations team level. If the customer has multiple products, the minimum membership requirement will apply to each product.

Dental Performance Guarantees

Financial Accuracy

Guarantee: Aetna will guarantee that the guarantee period dollar accuracy of the claim payment dollars will be 99.0% or higher.

Definition: Financial accuracy is measured using industry accepted stratified audit methodology. The results are calculated by calculating the financial accuracy for a subset of claims (a stratum) and then extrapolating the results based on the size of the population and combining with the extrapolated results of the other strata. Each overpayment and underpayment is considered an error; they do not offset each other. This includes both manual and auto adjudicated claims.

Penalty and Measurement Criteria: Aetna will reduce its compensation by an amount equal to 0.75% of the guarantee period administrative service fees for each full 1.0% that financial accuracy drops below 99.0%. There will be a maximum reduction of **2.0%** of the guarantee period administrative service fees.

Aetna's Dental Operations team audit results will be used. Those results include Aetna's performance in processing ALL customers' claims handled by Dental Operations during the Guarantee period, not just the Williamson County plan's claims. The results for these guarantees will be calculated using industry accepted stratified audit methodologies.

Dental Performance Guarantees

Total Claim Accuracy

Guarantee: Aetna will guarantee that the guarantee period overall accuracy of the claim payments will not be less than 95.0%.

Definition: Overall accuracy is measured using industry accepted stratified audit methodology. Accuracy in each stratum (a subset of the claim population) is calculated by dividing the number of claims processed correctly by the total number of claims audited, and then extrapolating the results based on the size of the population and combining with the extrapolated results of the other strata.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.75% of the guarantee period administrative service fees for each full 1.0% that total claim accuracy drops below 95.0%. There will be a maximum reduction of **2.0%** of the guarantee period administrative service fees.

Aetna's Dental Operations team audit results will be used. Those results include Aetna's performance in processing ALL customers' claims handled by Dental Operations during the Guarantee period, not just the Williamson County plan's claims. The results for these guarantees will be calculated using industry accepted stratified audit methodologies.

Dental Performance Guarantees

Member Services

Average Speed of Answer

Guarantee: Aetna will guarantee that the average speed of answer for the Dental Operations team providing Williamson County's member services will not exceed 25 seconds

Definition: On an ongoing basis, Aetna measures telephone response time through monitoring equipment that produces a report on the average speed of answer. Average speed of answer is defined as the amount of time that elapses between the time a call is received into the telephone system and the time a representative responds to the call. The result expresses the sum of all waiting times for all calls answered by the queue divided by the number of incoming calls answered. ASA measures the average speed of answer for all callers answered. Interactive Voice Response (IVR) system calls are not included in the measurement of ASA.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.75% of the guarantee period administrative service fees for each full second that the average speed of answer exceeds 25 seconds. There will be a maximum reduction of **2.0%** of the guarantee period administrative service fees. Aetna's Dental Operations team results will be used. Those results include performance for ALL customers' within Dental Operations.

Abandonment Rate

Guarantee: Aetna will guarantee that the average rate of telephone abandonment for the Dental Operations team providing Williamson County's member services will not exceed 2.0%.

Definition: On an ongoing basis, Aetna measures telephone response time through monitoring equipment that produces a report on the average abandonment rate. The abandonment rate measures the total number of calls abandoned divided by the number of calls accepted into the unit.

Penalty and Measurement Criteria: Aetna will reduce its compensation by 0.75% of the guarantee period administrative service fees for each 1.0% that the average abandonment rate exceeds 2.0%. There will be a maximum reduction of **2.0%** of the guarantee period administrative service fees. Aetna's Dental Operations team results will be used. Those results include Aetna's performance for ALL customers' within Dental Operations.

Dental Performance Guarantees

Please have an authorized individual sign the performance guarantee ASC amendment letter, signifying your acceptance of the arrangement, and return the original to us for our files.

Pharmacy Performance Guarantees

General Performance Guarantee Provisions

Aetna Life Insurance Company (ALIC) provides benefits administration and other services for the self-funded pharmacy plans. The services set forth in this document will be provided by ALIC (hereinafter "Aetna").

Performance Objectives

Aetna believes that measuring the activities described below are important indicators of how well we service Williamson County. We are confident that pharmacy administration services provided to Williamson County will meet their high standards of performance. To reinforce Williamson County's confidence in Aetna's ability to administer their program, we are offering guarantees in the following areas:

Performance Guarantee Category	Minimum Standard	Proposed Penalty
Implementation		
• Implementation	Refer to Medical	Refer to Medical
• ID Card Production & Distribution	Refer to Medical	Refer to Medical
Account Management		
• Overall Account Management	Refer to Medical	Refer to Medical
Retail Claim Administration		
• Turnaround Time – Paper Claims	P = 95.0% within a weighted average of 5 business days of receipt and 99.0% within a weighted average of 10 business days of receipt;	$4,000
Mail Order Claim Administration		
• Turnaround Time – Clean Claims	95.0% within an average of 2 business days of receipt	$4,000
• Turnaround Time – Claims Requiring Intervention	90.0% within an average of 5 business days of receipt	$4,000
• Mail Order Dispensing Accuracy	99.95%	$4,000
Member Services		
• Call Quality	95.0%	$4,000
Total		**$20,000**

Pharmacy Performance Guarantees

Guarantee Period

The guarantees described herein will be effective for a period of 12 months and will run from **November 1, 2014 through October 31, 2015** (hereinafter "guarantee period").

The performance guarantees shown below will apply to the self-funded Aetna Pharmacy Management plans administered under the Administrative Services Only Agreement ("Services Agreement"). These guarantees do not apply to non-Aetna benefits or networks.

Aggregate Maximum

In total, Aetna agrees to place **$20,000** at risk through the Performance Guarantees outlined in this document. Our offer assumes 1,399 employee lives. Aetna reserves the right to revisit the guarantees if there is a change in enrollment of more than 15%.

Termination Provisions

Termination of the guarantee obligations shall become effective upon written notice by Aetna in the event of the occurrence of (i), (ii) or (iii) below:

i. a material change in the plan initiated by Williamson County or by legislative action that impacts the claim adjudication process, member service functions, pharmacy network management or rebates;
ii. failure of Williamson County to meet its obligations to remit administrative service fees or fund the Williamson County bank account as stipulated in the General Conditions Addendum of the Services Agreement;
iii. failure of Williamson County to meet their administrative responsibilities (e.g., a submission of incorrect or incomplete eligibility information).

No guarantees shall apply for a guarantee period during which the Services Agreement is terminated by Williamson County or by Aetna.

Penalty Reconciliation and Refund Process

At the end of each guarantee period, Aetna will compile the Performance Guarantees results. If necessary, Aetna will provide a refund to Williamson County for any penalties incurred.

Pharmacy Performance Guarantees

Retail Claim Administration

Turnaround Time – Paper Claims Guarantee

Guarantee: Aetna will guarantee that the claim payment processing turnaround time for all retail pharmacy claims submitted on paper will be 95.0% within a weighted average of 5 business days of receipt and 99.0% within a weighted average of 10 business days of receipt.

Definition: Total percentage of claims processed is measured as the number of claims processed within specified number of days divided by the total number of claims audited.

Penalty and Measurement Criteria: A penalty of $1,000 will apply for each 0.25% that the actual turnaround time for reimbursement of paper claims submitted falls below the guaranteed level of 95.0% within a weighted average of 5 business days of receipt and 99.0% within a weighted average of 10 business days of receipt. There will be a maximum penalty of **$4,000**. Guarantee results will be measured based on Aetna's book of business.

Pharmacy Performance Guarantees

Mail Order Claim Administration

Turnaround Time - Clean Claims Guarantee

Guarantee: Aetna guarantees that at least 95.0% of all mail order claims not requiring intervention will be dispensed and shipped within an average of 2 business days of receipt.

Definition: For the respective guarantee period, turnaround time for claims, not requiring intervention is determined by assessing the average time, in business days, that it takes prescriptions to be processed and shipped from the Aetna Rx Home Delivery pharmacy.

Penalty and Measurement Criteria: A penalty of $2,000 will apply for each full day that the average turnaround time of 95.0%of all mail order claims not requiring intervention exceeds an average of 2 business days. There will be a maximum penalty of **$4,000.** Guarantee results will be measured based on Aetna's book of business.

Turnaround Time – Claims Requiring Intervention Guarantee

Guarantee: Aetna guarantees that at least 90.0% of all mail order claims requiring intervention will be dispensed and shipped within an average of 5 business days of receipt.

Definition: For the respective guarantee period, turnaround time for claims, requiring intervention is determined by assessing the average time, in business days, that it takes prescriptions to be processed and shipped from the Aetna Rx Home Delivery pharmacy.

Penalty and Measurement Criteria: A penalty of $2,000 will apply for each full day that the average turnaround time of 90.0%of all mail order claims requiring intervention exceeds an average of 5 business days. There will be a maximum penalty of **$4,000**. Guarantee results will be measured based on Aetna's book of business.

Pharmacy Performance Guarantees

Mail Order Dispensing Accuracy Guarantee

- Correct drug dispensed to correct member
- Correct drug, strength, dosage form
- Correct instructions provided to the member for use

Guarantee: Aetna guarantees that at least 99.95% of all mail order prescriptions will be dispensed correctly for drug, strength, form, instructions, and patient.

Definition: For the respective guarantee period, total dispensing accuracy is measured as the number of prescriptions with no errors divided by the total number of prescriptions dispensed.

Penalty and Measurement Criteria: A penalty of $1,000 will apply for each 0.2% that the actual percentage of all mail order prescription dispensing accuracy falls below the target of 99.95%. There will be a maximum penalty of **$4,000**. Guarantee results will be measured based on Aetna's book of business.

Member Services

Call Quality Guarantee

Guarantee: Aetna will guarantee that **95.0%** of calls will meet Aetna's quality standards as determined by a random sample from the call monitoring program.

Definition: Quality rate determined by the number of sampled calls without errors divided by the total number of sampled calls.

Penalty and Measurement Criteria: A penalty of $1,000 will apply for each 0.25% that the Call quality rate falls below 95.0%. There will be a maximum penalty of **$4,000**. Aetna's results for the unit(s) providing member services for Williamson County will be used.

Dental PPO Discount Savings Attachment
Attachment B

Guarantee Period: November 1, 2014 through October 31, 2015

In-Network PPO Discount Savings	Percent of PPO Discount Guarantee PEPM at Risk
36.00% or greater	0%
34.00% - 35.99%	25%
32.00% - 33.99%	50%
30.00% - 31.99%	75%
< 30.0%	100%

	Standard Aetna PPO Network
Quoted ASC Fee PEPM:	$2.86
Projected Enrolled Employees:	1,268
Projected Annual ASC Fee:	43,518
PPO Discount Guarantee PEPM at Risk:	$0.25
Projected Percentage of Service Fee at Risk through Discount Savings Guarantee:	8.5%
Guaranteed PPO Discount Percentage:	**36.0%**

Dental PPO Discount Savings Guarantee
Attachment A

Dental Discount Guarantee: In year 1 (November 1, 2014 through October 31, 2015), Aetna will guarantee the savings that result from negotiated arrangements with providers participating in our dental Preferred Provider Organization (PPO). The target savings were calculated on an aggregate basis taking the weighted average of the projected network discounts and employee enrollments by network.

Definition: Aetna will calculate the client's actual in-network discount savings within the PPO networks by way of the following equation:

$$\text{Actual Discount Savings Percentage} = \frac{\{\text{In-Network Provider Savings (in dollars)}^*\}}{\{\text{Trended allowed In-Network FAIR Health Average Charges (in dollars)}\}}$$

* For the eligible services provided, the difference between the average charges for the area as determined under the trended FAIR Health Benchmark Database Profile and the allowed negotiated fees.

This measurement will be reported using data from Aetna's Informatics data warehouse. Specifically, the Provider Network Experience report within the standard Dental Utilization Report package will be utilized. This report will be generated on a policy year basis.

Penalty: If the actual discount savings percentage is below 36.0%, Aetna will decrease Williamson County's PPO dental service fee by a percentage as outlined in Attachment B. The maximum penalty will be 8.5% of the PPO dental service fee.

Dental PPO Discount Savings Guarantee
Attachment A

Assumptions:

- In no event will fees be adjusted by more than 20% due to the results of the discount guarantee and all service based performance guarantees combined.
- This guarantee only applies to the in-network PPO dental claims and Aetna directly contracted networks and will remain in force during the period November 1, 2014 through October 31, 2015.
- The final guarantee reconciliation will be based upon policy year incurred claims, including 2 months of claim runoff.
- This guarantee only applies to dental fees and excludes medical and/or pharmacy.
- Subsidiaries or divisions added to Williamson County after the plan's effective date will not be eligible to participate in this guarantee.