Memorandum

To: Board of Trustees
Fresno City Employees Health & Welfare Trust

From: Andrew Desa, Consulting Actuary

Date: June 15, 2022

Re: Stop-Loss Renewal, Effective July 1, 2022

Our office has been working with the stop-loss broker to obtain quotes for the July 1, 2022 renewal. Proposals were requested from fourteen carriers, including the incumbent (HCC). Following some back-and-forth we now have a firm proposal from HCC. Two other carriers have provided preliminary quotes (not firm until pending large claim review).

The attached exhibit summarizes the results. The highlights are as follows:

- Time is a factor. HCC’s proposal expires June 20. Additional updated information could be required by HCC and their offer could change if the decision is delayed, which may or may not have an impact on the rate but there is always that risk.

- Due to significant ongoing large claims activity, HCC is proposing a 56% premium increase effective July 1, 2022. Nine carriers declined to bid due to being unable to provide competitive rates. Two other carriers (Optum and Ullico) have provided preliminary proposals of 51% and 48% premium increases, respectively. However, both of those bidders have not firmed up their proposals and they will likely include lasers.

- Given the significant increase, we requested an alternative deductible of $550,000. The current deductible has been in place since 2016. Increasing the deductible to $550,000 would result in a premium increase of 40%.

- We, as well as the broker, recommend renewing with the incumbent (HCC). This is currently the only firm offer and will likely be the most competitive after accounting for lasers. Given that the deductible has been $500k for many years and there is a large renewal increase this year, we recommend increasing the deductible to $550k.

- There are no lasers being included in the HCC renewal effective July 1, 2022.
As a reminder, this policy has been with HCC since July 1, 2018. Prior to that it was underwritten by BSC Insurance. The deductible is $500k. The Trust has a separate reserve for claims between $350k and $500k.

HCC is continuing to include the experience refund negotiated previously. If the loss ratio is lower than 70% at the expiration of the policy, HCC will provide a refund equal to 50% of the difference between the actual loss ratio and 70%, up to a maximum of 10% of premium. The refund is paid in two installments and the Trust must renew with HCC in the following policy year (the year after earning the refund) to be eligible.

Our previously presented projections assumed a 10% stop-loss renewal. Given that stop-loss premiums represent approximately 2% of total expenses, the difference in the projected and actual stop-loss renewal does not have a material impact on the projections (0.1 reserve month difference between actual renewal and projected).

The current contract is on a 12/18 basis (covers claims incurred in the prior 12 month period and paid in following 18 months). HCC has continued to quote on a 12/18 basis.

The policy covers retirees and includes coverage for prescription drugs.

Please let me know if you have any questions on this renewal.

Enclosures

cc:  Tom Georgouses
     Diana Cavazos
     Michael Moss, Esq.
## EXHIBIT I
Fresno City Employees Health & Welfare Trust
7/1/2022 Stop-Loss Renewal

<table>
<thead>
<tr>
<th>Specifications</th>
<th>Current</th>
<th>$500,000 Deductible</th>
<th>$550,000 Deductible</th>
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<tbody>
<tr>
<td></td>
<td>HCC</td>
<td>HCC</td>
<td>Optum</td>
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<tr>
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<td>$500,000</td>
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<td>$500,000</td>
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<tr>
<td>Specific Contract Type</td>
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<td>12/18</td>
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<tr>
<td>Laser</td>
<td>No</td>
<td>No</td>
<td>TBD</td>
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<tr>
<td>Premium Rate</td>
<td>$29.03</td>
<td>$45.39</td>
<td>$43.07</td>
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<tr>
<td>% Change</td>
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<td>50.5%</td>
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<tr>
<td>Estimated Annual Premium</td>
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<td>$2,032,700</td>
<td>$1,957,100</td>
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<td>Annual Dollar Change</td>
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<td>$657,000</td>
<td>$628,700</td>
</tr>
<tr>
<td>Disclosures</td>
<td>Firm Offer</td>
<td>Not Firm(^1)</td>
<td>Not Firm(^1)</td>
</tr>
<tr>
<td>Experience Refund</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

\(^1\)Pending Large Claim Review
Diana Cavazos | HealthComp

From: Michael Lima <Michael.Lima@fresno.gov>
Sent: Tuesday, June 28, 2022 5:33 PM
To: Shane Archer; Andrew Desa
Cc: Michael Moss; Tom Georgouses | HealthComp; Diana Cavazos | HealthComp
Subject: RE: Action Required: Fresno City Employees H&W Trust - Stop Loss Renewal Effective July 1, 2022 - Application
Attachments: 2022_23 Stop Loss Application Fresno.pdf

Hello!

Here you go. Please let me know if I filled it out incorrectly. Thanks!

Mike Lima

From: Shane Archer <Shane.Archer@fresno.gov>
Sent: Tuesday, June 28, 2022 11:14 AM
To: Andrew Desa <andrewd@rael-letson.com>; Michael Lima <Michael.Lima@fresno.gov>
Cc: Michael Moss <mmoss@mossfirm.org>; Tom Georgouses <tgeorgouses@healthcomp.com>; Diana Cavazos HealthComp <dcavazos@healthcomp.com>
Subject: Re: Action Required: Fresno City Employees H&W Trust - Stop Loss Renewal Effective July 1, 2022 - Application

I approve the document.

Thanks,

Shane

From: Andrew Desa <andrewd@rael-letson.com>
Sent: Monday, June 27, 2022 10:34:59 AM
To: Michael Lima; Shane Archer
Cc: Michael Moss; Tom Georgouses; Diana Cavazos HealthComp
Subject: Action Required: Fresno City Employees H&W Trust - Stop Loss Renewal Effective July 1, 2022 - Application

External Email: Use caution with links and attachments

Hi Mike/Shane –
Attached is the application for stop loss effective July 1, 2022. This document reflects the renewal that you both previously approved (renewal with incumbent HCC, increased deductible from $500k to $550k, no lasers, stop loss experience refund included).

HCC has indicated that they can only reflect one signature on the documents. Therefore, similar to last year:

- **Mike L.** – can you please provide the signatures where requested (initial pages 1-3, sign pages 4-5)
- **Shane** – we will just need written approval by email that you approve the document. You do not need to sign the document.

This document was reviewed by Mike M, HealthComp, and myself.

Thanks,

**Andrew Desa**  
ASA, MAAA  
Consulting Actuary

2929 Campus Drive, Suite 400  
San Mateo, CA 94403  
650-356-2327 Tel  
andrewd@rael-letson.com  
www.rael-letson.com

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**From:** Michael Lima  
**Sent:** Wednesday, June 15, 2022 3:30 PM  
**To:** Shane Archer  
**Cc:** Tom Georgouses  
**Subject:** RE: Action Required: Fresno City Employees H&W Trust - Stop Loss Renewal Effective July 1, 2022

---

Hi Andrew!

I’m not crazy about the proposal. But, I’m not sure if there’s much of a choice if we still want Stop Loss coverage. I support your recommendation to renew with HCC at the $550K deductible. Thanks!

Mike Lima

---

**From:** Shane Archer  
**Sent:** Wednesday, June 15, 2022 2:26 PM  
**To:** Andrew Desa  
**Cc:** Tom Georgouses  
**Michael Lima**  
**Michael Moss**  
**Diana Cavazos**
Hi Andrew,

I approve of your recommendation to renew with HCC at the $550K deductible.

Thank you for your work on this.

Shane

---

From: Andrew Desa <andrewd@rael-letson.com>
Sent: Wednesday, June 15, 2022 2:03:21 PM
To: Michael Lima; Shane Archer
Cc: Tom Georgouses; Michael Moss; Diana Cavazos HealthComp
Subject: Action Required: Fresno City Employees H&W Trust - Stop Loss Renewal Effective July 1, 2022

External Email: Use caution with links and attachments

Mike/Shane –

We have been working with the stop loss broker and HealthComp for the stop loss renewal effective July 1, 2022.

Attached is a memo with the details. The highlights are as follows:

- It was a very tough renewal. There is significant large claims activity, with some of that for ongoing large claims. As a result, many of the would be bidders declined to bid.
- HCC is proposing a 56% premium increase. There are two preliminary proposals from other carriers but they are not firm. Those carriers continue to want additional details on current claims activity and it is looking like they would include numerous lasers in any potential firm offer they provide.
- The current deductible of $500k has been in place since 2016. We requested an alternative $550k deductible and that would result in a 40% premium increase versus current.
- The difference between our assumed stop loss renewal and actual renewal does not have a material impact on the projections we provided previously. The actual renewal is resulting in a 0.1 reserve month difference at June 30, 2023 versus what was presented in March.
- We recommend renewing with HCC at the higher $550k deductible.

The deadline to respond to HCC is June 20th.

Please let me know if you approve of our recommendation to renew with HCC at the $550k deductible or if you wish to discuss.
Thanks,

Andrew Desa  
ASA, MAAA  
Consulting Actuary

2929 Campus Drive, Suite 400  
San Mateo, CA 94403  
650-356-2327 Tel  
andrewd@rael-letson.com  
www.rael-letson.com

Rael & Letson  
We understand your plans.®
STOP LOSS INSURANCE  
HCC LIFE INSURANCE COMPANY  
Three Town Park Commons, 225 TownPark Drive, Suite 350  
Kennesaw, Georgia 30144  (800-447-0460)  

APPLICATION

1. Full Legal Name of Applicant and Address:  
Fresno City Employees Health and Welfare Trust  
621 Sante Fe Street  
Fresno, CA 93721  
Telephone No.: (559)499-2450

2. Applicant is a/an (check one):  
☐ Single Employer Plan  
☐ Student Plan  
☐ Union or Taft Hartley Plan  
☐ Association Plan or MEWA  
☐ Other:

3. Policy Period: Effective Date: 07/01/2022  
Expiration Date: 06/30/2023

4. Full Legal Name of Affiliates, Subsidiaries and other major locations to be included in coverage:  
Address of Affiliates or Subsidiaries:  
☒ None  
☐ See attached listing

5. Nature of Business of the Applicant to be Insured:  
Pension, Health & Welfare Funds

6. Contact Person at Applicant:

7. Enter full name of the Medical Benefit Plan(s): Fresno City Employees Health and Welfare Trust  
A signed copy of such Medical Benefit Plan(s) will form part of this contract.

8. Name and Address of Claims Administrator: HealthComp, LLC 621 Santa Fe  Fresno, CA 93721

9. Agent of Record: Stealth Partner Group LLC

10. Estimated Initial Enrollment:  
Composite: 3732 Total Covered Units: 3,732

11. Retirees Covered:  
☒ Yes  
☐ No

12. The Utilization Review vendor will be: Blue Shield of California

13. Deposit Premium (Minimum of first month's estimated premium): $151,855.08  
Please review the deposit premium on the Monthly Premium Accounting Worksheet.

14. SPECIFIC STOP LOSS INSURANCE:  
☒ Yes  
☐ No

A. Covered Expenses Paid under the Medical Benefit Plan for the following Plan Benefits are covered for Specific Stop Loss Insurance (not included unless checked):  
☒ Medical  
☒ Prescription Drug Card  
☐ Prescription Drugs Under Medical  
☐ Other:

B. Specific Deductible in each Policy Period per Covered Person: $550,000

C. Contract Basis: 12/18  
Covered Expenses Incurred from 07/01/2022 through 06/30/2023, and Paid from 07/01/2022 through 12/31/2023.

If a claim is eligible under two different Contract Bases, it may only be filed for reimbursement in the earliest Contract Basis under which it is eligible.

D. Specific Policy Period Reimbursement Maximum per Covered Person: Unlimited

E. Monthly Specific Premium Rates:  
Composite: $40.69

F. Specific Percentage Reimbursable: 100%

G. Specific Terminal Liability Option:  
☐ Yes  
☒ No
15. AGGREGATE STOP LOSS INSURANCE:  □ Yes  □ No
A. Covered Expenses Paid under the Medical Benefit Plan for the following Plan Benefits are covered for Aggregate Stop Loss Insurance (not included unless checked):
   □ Medical  □ Dental  □ Weekly Income  □ Vision  □ Prescription Drug Card
   □ Prescription Drugs Under Medical  □ Other:
B. Minimum Annual Aggregate Deductible:
   (Subject to the Definition of Minimum Annual Aggregate Deductible in the Policy)
C. Contract Basis:
   If a claim is eligible under two different Contract Bases, it may only be filed for reimbursement in the earliest Contract Basis under which it is eligible.
D. Aggregate Policy Period Reimbursement Maximum:
E. Monthly Aggregate Factors:
   | Monthly Factors | Combined | Medical | Dental | Weekly Income | Vision | Prescription Drugs |
F. Aggregate Percentage Reimbursable: 0%
G. Loss Limit:
   For the purposes of Aggregate Stop Loss Insurance, the Loss Limit is the maximum amount of Covered Expenses Incurred by each Covered Person, which can be used to satisfy the Annual Aggregate Deductible.
H. Monthly Deductible Advance Reimbursement Option:  □ Yes  □ No
I. Aggregate Terminal Liability Option:  □ Yes  □ No
J. Aggregate Premium:
   1. □ Annual Premium payable in advance for Policy Period:
   2. □ Monthly Premium rate per Covered Unit:
   3. □ Monthly Deductible Advance Reimbursement premium per Covered Unit per month:
   4. □ Aggregate Terminal Liability Option premium per Covered Unit per month:

SPECIAL LIMITATIONS:
HCCL MSL-2020 APP CA  Applicant’s Initials:  
Page 2 of 4
It is understood and agreed by the Applicant that:

1. The Applicant is financially sound, with sufficient capital and cash flow to accept the risks inherent in a "self-funded" health care plan, and
2. The Claims Administrator retained by the Applicant will be considered the Applicant's agent, and not the Company's agent, and
3. All documentation requested by the Company must be received within 90 days of the Policy effective date, is subject to review by the Company and may require adjustment of rates, factors, and / or Special Limitations to accommodate for abnormal risks, and
4. The Stop Loss Insurance applied for herein will not become effective until accepted by the Company, and
5. Premiums are not considered paid until the premium check is received by the Company, is paid according to the rates set forth in the Application, and all items required to issue the Policy have been returned to the Company. Premiums are subject to refund should any outstanding policy requirement not be met within 90 days of the Policy's effective date, and
6. This Application will be attached to and made a part of the Policy issued by the Company, and
7. The Medical Benefit Plan(s) attached shall be the basis of any Stop Loss Insurance provided by the Company and such Medical Benefit Plan(s) conforms with all applicable State and Federal statutes, and
8. Any reimbursement under the Stop Loss Insurance provided by the Company shall be based on Covered Expenses Paid by the Applicant in accordance with the Medical Benefit Plan(s) attached hereto, and
9. After diligent and complete review, the representations made in this Application, the disclosures made, and all of the information provided for underwriters to evaluate the risk, are true and complete.

FRAUD STATEMENT:
Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

DISCLOSURE OF ARBITRATION:
The Policy requires binding arbitration to settle disputes, including disputes involving medical malpractice.

Full Legal Name of Applicant: Fresno City Employees Health and Welfare Trust

Dated at __________ p.m. this ______ day of ______, 20__

__________________________
Officer / Partner Signature (print name) __________________________
Licensed Agent Signature (print name)

For HGC Life Insurance Company Use Only: ACCEPTANCE
Accepted on behalf of the Company, this _____ day of _____________________, 20__

By: ___________________________ Title: ___________________________

Policy No.: ______________________
HCC LIFE INSURANCE COMPANY
STOP LOSS POLICY
EXPERIENCE CREDIT ADVANTAGE ENDORSEMENT

Policy Number: HCL34264
Policyholder: Fresno City Employees Health and Welfare Trust
Effective Date of Endorsement: 07/01/2022

You and We agree that the above Policy is amended as follows:

The Policy is eligible for the Experience Credit Advantage program from HCC Life Insurance Company. If at expiration of the Policy Period and the end of the claim filing period, the Policy has gross loss ratio lower than 70%, You will be entitled to 50% of the gross profit of the Policy Period in the form of a premium credit, subject to a maximum of 10% of paid premium during the Policy Period.

The premium credit shall be applied and paid to You during the next renewal Policy Period. You must renew coverage in order to take advantage of the premium credit available. If the sale of Your Policy involved a commission paid to a producer, the commission percentage shall be subtracted from the 70% for the gross loss ratio calculation. Upon Termination or Expiration without renewal, all premium credit under this program is forfeited.

Calculation Formula

\[ \text{Gross annual specific (and aggregate if applicable) premium} \times \text{Gross loss ratio threshold (70% minus commission %, if applicable)} = \text{Eligible experience refund premium} \]
\[ - \text{Paid claims} = \text{Eligible gross profit} \]
\[ \times 50\% \text{ profit share} = \text{Total eligible premium credit} \]

THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN STATED ABOVE.

Fresno City Employees Health and Welfare Trust
Full Legal Name of Applicant/Policyholder

[Signature] Michael Lien
Officer/Partner Signature (print name)

Witnessed (Licensed Agent) Signature

June 29, 2022
Signed At / Date Signed

FOR HCC LIFE INSURANCE COMPANY USE ONLY:

ACCEPTANCE

Accepted on behalf of the Company, this ______ day of ________________________, 20_____

By: ____________________________
Title: ____________________________
Hi Andrew!

I’ve made two small changes on page 64. Please see the attached document. My vote is that it’s now ready to send. Thanks!

Mike Lima

Hi Mike –

Thank you for your review and comments. I have addressed the comments in the attached redline version (added my responses to your comments and made change where appropriate) and have also attached the clean version with those changes.

In summary:

- I would suggest to keep the reference for pre-cert as page 11. Page 12 is regarding continuity of care. Note that the top of page 11 is regarding pre-cert which is why the reference is through page 11.
- The penalty message on page 20 was intended to point to the schedule of benefits on page 22 as listed currently, but I agree that it is confusing. I have updated instead to point to page 10.
- Added page number references to the Continuation of Coverage section.
- Updated to reflect your formatting changes.
- Have updated to say Vacant in the trustee list now that we have the formal letter announcement from the FPOA.

Thanks,

Andrew Desa
ASA, MAAA
Consulting Actuary
Hi Andrew!

Back to you with a few tweaks and a couple of comments. Once the comments are addressed, I’m good with it. Thanks!

Mike Lima

---

From: Andrew Desa <andrewd@rael-letson.com>
Sent: Tuesday, June 21, 2022 1:19 PM
To: Michael Lima <Michael.Lima@fresno.gov>; President@fceamail.com
Cc: Tom Georgouses <tgeorgouses@healthcomp.com>; Diana Cavazos HealthComp <dcavazos@healthcomp.com>; Michael Moss <mmoss@mossfirm.org>
Subject: Action Required: Fresno City Employees H&W Trust - SPD effective July 1, 2022
Importance: High

**External Email: Use caution with links and attachments**

Hi Mike/Sam –

Attached is redline version of the SPD for the Plan Year beginning July 1, 2022. This has been drafted and reviewed by HealthComp, Mike M., and myself. I am also attaching a clean copy with the redline changes accepted for convenience (includes updated page numbers once all redlines have been removed).

The redline version will show all the updates, but the highlights are as follows:

- Update all dates where appropriate (e.g., July 1, 2021 to July 1, 2022).
- Vision Provider change from MESVision to EyeMed.
- Include information on EPIC Hearing Healthcare and the benefit allowance.
• Update for recent compliance (e.g. No Surprises Act).
• Update the schedule of benefits to clarify that non-network benefits are covered up to Usual & Customary Charges.
• Update the special enrollment rights subsection to clarify when coverage becomes effective.
• Update the grievance process subsection based on guidance from the California Department of Managed Health Care.

One outstanding item that may be updated in the final version is the Trustee list in ‘General Plan Information’ towards the end of the document. We have not received a formal letter from the FPOA with regards to Jo so we will continue to include her. If we receive the letter prior to finalizing the SPD, we can make the appropriate change in the SPD.

We ask for any comments or your approval by June 28th.

Thanks,

Andrew Desa
ASA, MAAA
Consulting Actuary

2929 Campus Drive, Suite 400
San Mateo, CA 94403
650-356-2327 Tel
andrewd@rael-letson.com
www.rael-letson.com
From: Andrew Desa <andrewd@rael-letson.com>
Sent: Tuesday, June 21, 2022 12:19 PM
To: Michael Lima <Michael.Lima@fresno.gov>; FCEA President <President@fceemail.com>
Cc: Tom Georgouses <tgeorgouses@healthcomp.com>; Diana Cavazos HealthComp <dcavazos@healthcomp.com>; Michael Moss <m moss@mossfirm.org>
Subject: Action Required: Fresno City Employees H&W Trust - SPD effective July 1, 2022
Importance: High

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We ask for any comments or your approval by June 28th.

Thanks,

Andrew Desa
ASA, MAAA
Consulting Actuary
July 29, 2022

Dear Trustees of the Board,

Optum Rx will be presenting our copay card solution programs at the August 10, 2022 Board Meeting. In preparation for the meeting, I am sharing a copy of our presentation and put together a short summary for you below.

Updated savings analysis for Accumulator Adjustment and Variable Copay was ran using Fresno City Employees Health and Welfare Trust’s plan year (7/1/2021 – 6/30/2022) data.

- Estimated net annual savings of $460K
- The earliest implementation date is October 1, 2022
- 151 unique members are filling specialty products through Optum Specialty Pharmacy
  - 95 members have used a copay card and would receive notification (accumulator adjustment letter included on page 12 of the presentation deck)
  - 37 members are filling specialty products with a copay card program available, and the products are part of the Variable Copay Program
    - Outreach will be made to assist members with enrolling into the copay card program (copay assistance promotion letter included on page 13 of the presentation deck)
  - 19 members are filling specialty products with no copay assistance program available
- Impacted members will be lettered 30 days in advance
- Copay Card Solution reporting will be provided quarterly and shared during Board Meetings. Sample reports provided on pages 15 and 16 of the presentation deck
  - The sample reports contain actual data from a comparable client (14,500 lives) who went live with Accumulator Adjustment and Variable Copay Solution on 7/1/2022. This client experienced a net savings of more than $36K during the first month of the program

Accumulator reporting was ran using Fresno City Employees Health and Welfare Trust’s plan year (7/1/2021 – 6/30/2022) data.

- 24 members hit their prescription only out-of-pocket (OOP) maximum during the plan year
  - Four members have specialty product utilization
  - Zero of the four members are using copay cards today therefore, they will not be impacted by the addition of the Accumulator Adjustment Program
  - Two of the four members are filling specialty products which have copay assistance available, and outreach will be made to assist with enrolling
During the May 11th Board Meeting, some of the Trustees had concerns regarding how the programs function and member experience. Sara Gonzales Sr. Business Manager with Optum Specialty Pharmacy will be joining me in-person at the next Board Meeting. She will walk you through the member experience and is prepared to answer any questions you may have. We’ve included a slide regarding the member experience on page 8 of the deck and an FAQ regarding Variable Copay on page 14.

Please feel free to route questions to me in advance of the meeting. I’m looking forward to seeing everyone in a couple of weeks.

Kindest regards,
Carolyn

Carolyn Martinez (she/her)
Account Manager, Public Sector | Optum Rx

O 1-612-428-6104  
M 1-702-708-1849  
carolyn.martinez@optum.com
Copay Card Solutions Overview

August 10, 2022

Sara Gonzales
Sr. Business Manager, Specialty Business Solutions
Government, Labor and Trust

Carolyn Martinez
Account Manager, Public Sector

Shannon Ross
Director, Public Sector
Specialty advocates help patients overcome the cost hurdle

Enabling access with copay assistance

People with complex conditions often face difficulty affording their medications. All specialty patients are screened by their Patient Care Coordinator for financial assistance needs.

<table>
<thead>
<tr>
<th>Needs based</th>
<th>Non-needs based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foundation programs</td>
<td>Patient assistance programs</td>
</tr>
<tr>
<td>Independent non-profit foundations</td>
<td>Manufacturer-sponsored</td>
</tr>
</tbody>
</table>

$99.5 M 
Foundation financial assistance delivered to patients in 2021

$715 M 
Copay card assistance delivered to patients in 2021
## Copay card overview

### What are copay cards?
- Also known as coupons
- Issued by drug manufacturers
- Designed to help members pay for out-of-pocket expense

### Where do you get them?
- On the manufacturer’s website
- Through a provider
- By calling a customer service line ("pharma hub")

### How do they work?
- Act as secondary insurance
- Pinged with what member owes
- Funds contributed to buy down member cost share at point of sale

### How much do they pay?
- Amount varies by medication
- Most have an annual limit
- Some cover as much as $32K a year

### Cost of medication - Amount plan pays = Amount member owes

Cost of medication - Amount plan pays = Amount member owes

Copay card applied

Member pays remainder
Accumulator adjustment solution

Provides **real-time solution** to prevent copay card dollars from being included in members’ accumulators (deductibles and out-of-pocket maximums)

<table>
<thead>
<tr>
<th>Without accumulator adjustment</th>
<th>With accumulator adjustment</th>
</tr>
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<tbody>
<tr>
<td>$2,000 applied to deductible</td>
<td>$5 applied to deductible</td>
</tr>
<tr>
<td>$2,000 applied to out-of-pocket max</td>
<td>$5 applied to out-of-pocket max</td>
</tr>
</tbody>
</table>
Accumulator Adjustment Opportunity

Reporting date range: Jul 2021 – Jun 2022

Projected program savings PMPM: $0.96

Program savings analysis

- Estimated annual dollars removed from accumulators $117,368.00
- Requires Optum Specialty Pharmacy exclusivity with no grace fills

**Savings are soft/cost avoidance

Optum

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Variable copay

The more copay card dollars redeemed, the less the plan pays for remaining drug cost

**How it works:**

**With** variable copay solution

- $1,000 member copay
- $1,000 copay card
- $150 Program fees
- $3,150 plan payment

**Without** variable copay solution

- $100 member copay
- $100 copay card
- $3,900 plan payment

With variable copay, plan saves $750
Variable Copay Opportunity

Reporting date range: Jul 2021 – Jun 2022

Projected program savings PMPM: $4.59

Program savings analysis

- Estimated projected annual plan paid savings $562,449
- Program fees $150 per impacted claim, estimated annual fees $102,600
- **Estimated net annual savings $459,849**
- This program requires Optum Specialty exclusivity and the Copay Card Accumulator Adjustment program
- Results may vary by utilization given the year to year drug mix and population may change

**Hard savings

Optum

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Member experience with Copay Cards

At Optum Specialty Pharmacy

Member signs up for Copay Card

Pharmacy processes the COB claim

Copay card covers the inflated copay amount for member, thus pulling away cost from the plan sponsor

Member cost share is reduced by the copay card and accumulators are adjusted

Personalized interactions to drive adoption and improve savings

“Optum Rx provides me access to affordable medications and is my advocate for good health.”
Copay Card Solutions Member Level Impact

- 151 unique members filling specialty products through Optum Specialty Pharmacy
- 95 members have used a copay card and would receive member notification (accumulator adjustment member letter) regarding the Accumulator Adjustment program
  - We do not letter members regarding Variable Copay Program
- 37 members are filling specialty products with a copay card program available, and the products are part of the Variable Copay Program
  - Outreach will be made to assist members with enrolling into the copay card program (copay assistance promotion letter)
- 19 members are filling specialty products with no copay assistance programs available
Rx Only Out-of-Pocket Maximum Impact

- During plan year July 1, 2021 – June 30, 2022, Fresno City Employees Health and Welfare Trust had 24 members hit their Rx only OOP
- Four members have specialty product utilization
- Zero of the four members are using copay assistance today
- Two of the four members are filling specialty products which have copay assistance available, and outreach would be made to assist with enrolling
Appendix
Dear [To the parent(s)/guardian(s) of] <member first name><member last name>,

Many people look for ways to help save on high cost brand-name medications. One way is to use copay cards from drug manufacturers. Copay cards can lower your prescription drug out-of-pocket (OOP) costs, but there may be limits on how much you can save each year.

Starting <effective date> if you use a copay card to pay for your prescription(s), the amount covered by the copay card will not count toward your out-of-pocket (OOP) maximum. What you pay out of pocket (your member cost share) will be applied to your OOP maximum.

In the example below, your copay card covers $350 of your medication cost of $400. Your member cost share of $50 is the only amount that counts toward your OOP maximum.

**How it works:**

<table>
<thead>
<tr>
<th>Your medication costs $400</th>
<th>Your copay card covers $350</th>
<th>Your member cost share is $50*</th>
</tr>
</thead>
</table>

*This cost share amount applies to your OOP maximum

Questions? We're here to help.
Call the number on your member ID card. Thank you for letting us serve you and to help you make the best use of your pharmacy benefits.

Sincerely,
The Optum Rx team
Copay Assistance Promotion
Member Letter Template

Month DD, YYYY

Dear [To the parent(s)/guardians of] <MEMBER FIRST NAME><MEMBER LAST NAME>,

Our records show that you are taking one or more specialty medications that are eligible for copay assistance.

Copay card programs are often used to help lower a patient’s copay/coinsurance amount and help save on out-of-pocket costs throughout the year.

To learn more about drug manufacturer copay card programs and enroll, call Optum® Specialty Pharmacy at 1-855-427-4682. We are available 24/7 and ready to help.

Thanks for letting us serve you. We’re here to help you make the best use of your pharmacy benefits.

Sincerely,

The Optum Rx Team
FAQ: How Variable Copay Works

1. Initiate prescription
   • Member fills a specialty medication at Optum Specialty Pharmacy
   • Member is enrolled (or can be enrolled) in a manufacturer-sponsored coupon program
   • Register coupon on the patient’s profile

2. Claim is adjudicated
   • Generic product identifier (GPI) identifies in-scope medication
   • Variable copay table replaces plan design with GPI-specific member cost share

3. Coupon is maximized
   • Send the responsibility of cost share to the manufacturer coupon
   • Coupon pays, covering the member cost share

4. Patient is protected
   • Member never pays more than the stipulated maximum amount a member is expected to pay, or the manufacturer patient pay (MPP) — e.g., $0, $5, $10 for in-scope medications
   • If a manufacturer discontinues a coupon program (a rare occurrence), the patient protection mechanism will make sure that the member continues to only pay the MPP and the plan protects the member at the point of sale

5. Prescription is filled, and price is adjusted
   • Medications are fulfilled as usual with variable copay mechanisms working on the back end
   • Coupon dollars are applied towards member cost share and removed from accumulators (i.e. do not count toward member deductibles) through accumulator adjustment program
   • Reports shows savings
## Sample Reporting: Copay Card Summary

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<tr>
<th>Pharmacy Name</th>
<th>Carrier ID</th>
<th>Account ID</th>
<th>Group ID</th>
<th>Unique Member (Count)</th>
<th>Copay Card Claims (Count)</th>
<th>Copay Card Paid</th>
<th>Pharmacy Debit</th>
<th>Total Copay Card Not Applied</th>
<th>Variable Copay Claims (Count)</th>
<th>Variable Copay Savings</th>
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Reporting period July 1, 2022 – July 28, 2022. This client has approximately 14,500 lives. They added Accumulator Adjustment and Variable Copay July 1, 2022. Net savings for variable copay $36,279. This client is on track to save approximately $435K for the plan year.
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<th>NDC Label Name</th>
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<th>Submitted Date</th>
<th>Ingredient Cost</th>
<th>Dispensing Fee</th>
<th>Client Allowed Amount</th>
<th>Client Amount Due</th>
<th>Patient Pay</th>
<th>Coupon Amount</th>
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<td>DUPLEN INJ 300MG/ML</td>
<td>JUL 6, 2022</td>
<td>JUL 8, 2022</td>
<td>$0</td>
<td>N</td>
<td>$0</td>
<td>$0</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PLEGRIUM INJ 30MG</td>
<td>JUL 8, 2022</td>
<td>JUL 10, 2022</td>
<td>$0</td>
<td>N</td>
<td>$0</td>
<td>$0</td>
<td>N</td>
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<td></td>
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<tr>
<td>VERJUZI INJ 30MG/ML</td>
<td>JUL 8, 2022</td>
<td>JUL 10, 2022</td>
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<td>N</td>
<td>$0</td>
<td>$0</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>HUMIRA PEN INJ 40MG/ML</td>
<td>JUL 11, 2022</td>
<td>JUL 13, 2022</td>
<td>$0</td>
<td>N</td>
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<tr>
<td>DUPLIDE INJ 300MG/ML</td>
<td>JUL 7, 2022</td>
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<td>$0</td>
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<td>$0</td>
<td>$0</td>
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<td></td>
</tr>
<tr>
<td>TYMLOS INJ</td>
<td>JUL 13, 2022</td>
<td>JUL 15, 2022</td>
<td>$0</td>
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<td>$0</td>
<td>$0</td>
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<td></td>
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<tr>
<td>DUPLIDE INJ 300MG/ML</td>
<td>JUL 28, 2022</td>
<td>JUL 30, 2022</td>
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<td>$0</td>
<td>$0</td>
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<tr>
<td>HUMIRA PEN INJ 40MG/ML</td>
<td>JUL 11, 2022</td>
<td>JUL 13, 2022</td>
<td>$0</td>
<td>N</td>
<td>$0</td>
<td>$0</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HUMIRA PEN INJ 40MG</td>
<td>JUL 13, 2022</td>
<td>JUL 15, 2022</td>
<td>$0</td>
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<td>$0</td>
<td>N</td>
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<td></td>
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</tr>
<tr>
<td>DUPLIDE INJ 100MG/ML</td>
<td>JUL 13, 2022</td>
<td>JUL 15, 2022</td>
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<td>$0</td>
<td>$0</td>
<td>N</td>
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</tr>
<tr>
<td>HUMIRA PEN INJ 40MG/ML</td>
<td>JUL 19, 2022</td>
<td>JUL 21, 2022</td>
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<td>$0</td>
<td>$0</td>
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<tr>
<td>TREMPYRA INJ 15MG/ML</td>
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<td>$0</td>
<td>$0</td>
<td>N</td>
<td></td>
<td></td>
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<tr>
<td>STELARA INJ 15MG/ML</td>
<td>JUL 26, 2022</td>
<td>JUL 28, 2022</td>
<td>$0</td>
<td>N</td>
<td>$0</td>
<td>$0</td>
<td>N</td>
<td></td>
<td></td>
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<tr>
<td>HUMIRA PEN INJ 40MG/ML</td>
<td>JUL 22, 2022</td>
<td>JUL 24, 2022</td>
<td>$0</td>
<td>N</td>
<td>$0</td>
<td>$0</td>
<td>N</td>
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<td></td>
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<tr>
<td>OTEZLA TAB 20MG</td>
<td>JUL 28, 2022</td>
<td>JUL 30, 2022</td>
<td>$0</td>
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<td>$0</td>
<td>$0</td>
<td>N</td>
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<td></td>
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<tr>
<td>SUBLOCADASE INJ 50MG</td>
<td>JUL 19, 2022</td>
<td>JUL 21, 2022</td>
<td>$0</td>
<td>N</td>
<td>$0</td>
<td>$0</td>
<td>N</td>
<td></td>
<td></td>
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<tr>
<td>ACTEMRA INJ 15MG/ML</td>
<td>JUL 26, 2022</td>
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<td>$0</td>
<td>N</td>
<td>$0</td>
<td>$0</td>
<td>N</td>
<td></td>
<td></td>
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<tr>
<td>AVONEX PEN KIT 30MCG</td>
<td>JUL 15, 2022</td>
<td>JUL 17, 2022</td>
<td>$0</td>
<td>N</td>
<td>$0</td>
<td>$0</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HUMIRA PEN INJ 40MG/ML</td>
<td>JUL 22, 2022</td>
<td>JUL 24, 2022</td>
<td>$0</td>
<td>N</td>
<td>$0</td>
<td>$0</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HUMIRA KIT 40MG/0.5</td>
<td>JUL 17, 2022</td>
<td>JUL 19, 2022</td>
<td>$0</td>
<td>N</td>
<td>$0</td>
<td>$0</td>
<td>N</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>TYMLOS INJ</td>
<td>JUL 27, 2022</td>
<td>JUL 29, 2022</td>
<td>$0</td>
<td>N</td>
<td>$0</td>
<td>$0</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Good afternoon,

OptumRx is excited to let you know that we are now offering digital member materials for Employer Group Waiver Plans (EGWP). This would be in lieu of printed materials for the below items ONLY:

- Evidence of Coverage
- Abridged Formulary Booklet
- Pharmacy Directory

The member would receive a Locator Page (Sample template is attached for reference) in their welcome kit rather than the printed booklets above. All other materials aside from the list above would be mailed (Annual notification of change, summary of benefits, opt-out letters and welcome letter with ID card).

OptumRx will have physical booklets on hand in the event that a member calls to request one.

Please let me know if you are interested in moving digital. Client elections are due by August 4, 2022.

Thank you,
Carolyn

Carolyn Martinez (she/her)
Account Manager, Public Sector | Optum Rx

O 1-612-428-6104
M 1-702-708-1849
carolyn.martinez@optum.com

Optum

Upcoming PTO Alert: 7/5
Business Travel: 6/29 – 6/30
Office Closure: 7/4 Independence Day
Your 2023 Optum Rx® Pharmacy Directory [Formulary] [Evidence of Coverage]

If you would like a Pharmacy Directory [Formulary] [Evidence of Coverage] mailed to you, please call Optum Rx.

Optum Rx Member Services
Phone (toll free): <client general TFN>
TTY users: 711
Hours of operation: 24 hours a day, 7 days a week
Website: optumrx.com <or URL>

About our Pharmacy Network
We call the pharmacies on this list our “network pharmacies” because we have made arrangements with them to provide prescription drugs to plan members. In most cases, your prescriptions are covered under this plan only if they are filled at a network pharmacy or through our home delivery pharmacy service. You are not required to continue going to the same pharmacy to fill your prescription. You can switch to any other network pharmacy at any time. We will fill prescriptions at non-network pharmacies under certain circumstances.

To locate a network pharmacy near you, visit our website at optumrx.com and click on the “Pharmacy Locator” tool (found under the “Member Tools” tab).

[About our Formulary Drug List
A formulary is a list of covered drugs selected by your plan in consultation with Optum Rx and a team of healthcare providers. It represents the prescription therapies believed to be a necessary part of a quality treatment program. This plan will generally cover the drugs listed in our formulary as long as the drug is medically necessary, you fill the prescription at an Optum Rx network pharmacy, and you follow all other plan rules.

If we make a negative utilization management change to our formulary (i.e. add prior authorization, quantity limit, and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier), or if we remove a brand name or generic drug from the formulary, we must notify affected members at
least 60 days before the change becomes effective. If the member requests a refill of the drug, and there was a utilization management change, we must provide the member with a 60-day supply of the drug when they fill their prescription, along with the notice of formulary change. If we remove a drug, we must provide the member a 30-day supply.

There are 3 ways to get updated information about covered drugs for your plan:
- Visit our website at optumrx.com and click on the “Drug Information” tool (found under the “Member Tools” tab).
- Visit our website at optumrx.com and download a copy of the formulary from the “Programs & Forms” page (found under the “Information Center” tab).
- Call Optum Rx at the number located on your member ID card to have a copy mailed to you.

[About our Evidence of Coverage]
The Evidence of Coverage booklet is part of our contract with you. It tells you how to use your Medicare prescription drug coverage through our plan, explains your rights and responsibilities, what is covered, and what you pay as a member of the plan. Each calendar year, Medicare allows us to make changes to the plans that we offer and requires we provide this information to our members annually.

There are 2 ways to get an updated Evidence of Coverage booklet for your plan:
- Visit our website at optumrx.com and download a copy of the Evidence of Coverage from the “Programs & Forms” page (found under the “Information Center” tab).
- Call Optum Rx at the number listed on your member ID card to have a copy mailed to you.]
Agenda

1. Regulation Overview
2. Product Offerings & Pricing
3. Client Next Steps
CAA Section 204 RxDC High Level Review

**Reporting Submission Deadline:** December 27, 2022, for plan year 2020 & 2021. All subsequent years to be submitted *annually*, by June 1st.

**Who Must Submit:** Fully-insured plans, self-insured plans, & FEHB. Grandfathered/Grandmothered & ERISA status is not taken into consideration and must also submit. Medicare, Medicaid, Workers’ Compensation, and other excepted benefits are excluded.

**Purpose:** To provide insight into increased spending on prescription drug spend with reporting on rebates, total spending, & PBM financials.

### Plan Lists
- **P1:** Individual and Student Market Plan List
- **P2:** Group Health Plan List
- **P3:** FEHB Plan List

### Data Files
- **D1:** Premium and Life Years
- **D2:** Spending by Category
- **D3:** Top 50 Most Frequent Brand Drugs
- **D4:** Top 40 Most Costly Drugs
- **D5:** Top 50 Drugs by Spending Increase
- **D6:** Rx Totals
- **D7:** Rx Rebates by Therapeutic Class
- **D8:** Rx Rebates for the Top 25 Drugs

### Narrative Response
- **One** Word document or PDF addressing the following:
  - Employer size for self-funded plans
  - Wellness services
  - Drugs missing from the CMS crosswalk
  - Drugs covered under hospital or medical benefits
  - Prescription drug rebate descriptions
  - Allocation methods for prescription drug rebates
  - Impact of prescription drug rebates

Data is to be *aggregated* according to market segment, state, and issuer/TPA, with multiple plans within one single file per file type. As the regulation allows for multiple entities to submit on behalf of a plan, coordination with client and other providers will be required. Of the 12 required files, OptumRx anticipates creating and submitting D3 – D8 to HIOS, as well as help preparing the pertinent narrative responses.
Product Offerings – Health Plans & TPAs

**Basic – No Cost**

OptumRx Responsibility:
- Providing PBM Name and PBM EIN for client completion of P files
- Providing PBM financials for clients where OptumRx retains spread, as well as any fees & other remuneration.
- Providing Total Spending for D3 – D8
- Providing Rebates Retained by PBM & Net Transfer of Fees for D7 & D8 files for each Therapeutic Class (D7) and Top 25 Rebate Drugs (D8)

Client Responsibility:
- Providing CAG crosswalk to map CAGs to appropriate market segment and state
  - Drug Code to provide for D3 – D6 & D8
- Creating and submitting all files

**Comprehensive - $500 per downstream benefit plan, capped at $25,000 per client**

OptumRx Responsibility:
- Providing PBM Name and PBM EIN for client completion of P files
- Providing aggregated D3 – D8 files formatted for submission by TPA
- Providing PBM financial for D6 file
  - Only provided for downstream plans if not pass-through

Client Responsibility:
- Providing CAG crosswalk to map CAGs to appropriate market segment and state
  - Drug Code to be provided for D3 – D6 & D8 if other prescription drug vendors.
- Updating data prior to submission to reflect any fees/rebates retained by TPA
- Finalizing and submitting all files

**Pricing is per reference year for the entire D3 – D8 file-set.**

Basic & Comprehensive Products targeted towards TPA & Health Plan clients that typically have all plan-specific data and any cost-share reductions/reinsurance amounts but might request more advanced reporting support.

If a HP/TPA downstream client would like its own file from ORx, additional fees will apply.
Product Offerings – Direct ASO Clients

**Premium 1 - $1,000**

**OptumRx Responsibility:**
- Providing PBM Name and PBM EIN provided for client completion of P files
- Providing aggregated D3 – D8 files submitted to CMS by PBM

**Client Responsibility:**
- Providing CAG crosswalk to map CAGs to appropriate market segment and state. Client must coordinate with reporting entity of D2 file to ensure ORx data is not more granular, per regulation.

**Premium 2 - $5,000**

**OptumRx Responsibility:**
- Providing PBM Name and PBM EIN for client completion of P files
- Providing formatted file specific to client for self submission
- Removing client from aggregated ORx file

**Client Responsibility:**
- Providing CAG crosswalk to map CAGs to appropriate market segment and state

---

**Pricing is per reference year for the entire D3 – D8 file-set.**

**Premium Products targeted towards direct clients that have no downstream plans where OptumRx has all necessary data**
CAA Section 204 RxDC Reporting: Client Timeline

- **July 2022**
  - **July Client Discussions**
    - Proposed Optum processes, timelines, product offerings & service levels
    - Support client decision making needs
    - Crosswalk development

- **August 2022**
  - **July - August Client Decisions**
    - Clients confirm service level
    - Contracting

- **Sept 2022**
  - **September Client Action**
    - Clients to submit crosswalks to Account Manager by 9/1/22

- **Oct 2022**
  - Finalize Client Inputs Development Work

- **Nov 2022**
  - Testing

**November - December**
Clients Files Begin to be Available
- 11/15: Basic & Comprehensive Products
- 12/1: Premium 1 & Premium 2 Products

**Dec 2022**
12/27/22 Effective Date
Appendix
Purpose of Reporting

Spending on prescription drugs is rising more quickly than total spending on health care services. To understand the increase, the Tri-Agencies, OPM, & CMS need to know more about prescription drug costs and how rebates and incentives from drug manufacturers influence health care expenses. As such, insurance companies and employer-based health plans must submit information about prescription drugs and health care spending.

Section 204 of the Consolidated Appropriations Act requires insurance companies and employer-based health plans to submit information about:

- Spending on prescription drugs and health care services
- Prescription drugs that account for the most spending
- Drugs that are prescribed most frequently
- Prescription drug rebates from drug manufacturers
- Premiums and cost-sharing that patients pay

The data submitted by insurance companies and employer-based health plans will help to:

- Identify major drivers of increases in prescription drug and health care spending
- Understand how prescription drug rebates impact premiums and out-of-pocket costs
- Promote transparency in prescription drug pricing

What information will be publicly released?

CMS will publish findings about prescription drug pricing trends and the impact of prescription drug rebates on patient out-of-pocket costs. You will be able to download the report from this page or from the websites of the Department of Labor or the Department of the Treasury.

Source: Prescription Drug Data Collection (RxDC) | CMS

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Plan Files Explained

Plan files are required by the regulation to provide insight into each group health plan and/or issuer that is submitting RxDC files.

These files are broken out into three groups – Individual & Student Market, Group Health Plans, and FEHB Plans. Plans only need to submit the P file(s) that apply to their coverage.

Within these files, identifying information for the plans is required, as well as details surrounding any TPA or PBM that the plan is contracted with. Additionally, particulars surrounding the state situs, plan participants, and plan year are required. Think of these as plan rosters or plan demographic files.

Why Is OptumRx Not Reporting?

OptumRx does not have access to this information, and it would be a large undertaking to obtain and house this information. Additionally, our unfamiliarity with this data could lead to unintended errors. Due to this and that the files also contain information for other vendors, clients will be required to complete these files and submit via the RxDC Module within HIOS.

More Information

File formats for the plan files can be found here. The files are to be submitted in a csv format.

Information on creating a HIOS account can be found via CMS Reference Guide.
### At A Glance: RxDC Product Offerings

<table>
<thead>
<tr>
<th>Product</th>
<th>Best Suited For</th>
<th>PBM EIN</th>
<th>Extract of PBM Pricing</th>
<th>Aggregate File D3 – D8</th>
<th>ORx To Submit</th>
<th>Client To Submit</th>
<th>Pricing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic</td>
<td>Health Plans TPAs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Health Plans TPA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
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<td>Direct ASO Clients</td>
<td></td>
<td></td>
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<tr>
<td>Premium 2</td>
<td>Direct ASO Clients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$ $</td>
</tr>
</tbody>
</table>

Product targets are determined by evaluating what plan-specific data, cost-share reductions/reinsurance amounts clients have access to, and where additional support may be required.

All clients requiring any support from OptumRx must sign a contract addendum with selected support *and* complete the mandated RxDC Client Crosswalk to provide mapping instructions from RxClaim CAG to appropriate market segment and state.
### At A Glance: RxDC Product Offerings – TPA’s / Health Plans

<table>
<thead>
<tr>
<th>Product</th>
<th>Best Suited For</th>
<th>PBM EIN</th>
<th>Extract of PBM Pricing</th>
<th>Aggregate File D3 – D8</th>
<th>ORx To Submit</th>
<th>Client To Submit</th>
<th>Pricing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic</strong></td>
<td>Health Plans TPAs</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Comprehensive</strong></td>
<td>Health Plans TPA</td>
<td>✔️</td>
<td></td>
<td></td>
<td>✔️</td>
<td>✔️</td>
<td>$</td>
</tr>
</tbody>
</table>

Product targets are determined by evaluating what plan-specific data, cost-share reductions/reinsurance amounts clients have access to, and where additional support may be required.

All clients requiring any support from OptumRx must complete the mandated RxDC Client Crosswalk to provide mapping instructions from RxClaim CAG to appropriate market segment and state. Depending on product selection, Total Rx Spending Under Non-Pharmacy Benefits must also be furnished by clients for completion of D6 file.
## At A Glance: RxDC Product Offerings – Direct ASO Clients

<table>
<thead>
<tr>
<th>Product</th>
<th>Best Suited For</th>
<th>PBM EIN</th>
<th>Extract of PBM Pricing</th>
<th>Aggregate File D3 – D8</th>
<th>ORx To Submit</th>
<th>Client To Submit</th>
<th>Pricing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium 1</td>
<td>Direct ASO Clients</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>Premium 2</td>
<td>Direct ASO Clients</td>
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<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>$</td>
</tr>
</tbody>
</table>

Product targets are determined by evaluating what plan-specific data, cost-share reductions/reinsurance amounts clients have access to, and where additional support may be required.

All clients requiring any support from OptumRx must complete the mandated RxDC Client Crosswalk to provide mapping instructions from RxClaim CAG to appropriate market segment and state. Depending on product selection, Total Rx Spending Under Non-Pharmacy Benefits must also be furnished by clients for completion of D6 file.
RxDC File Creation

DATA INPUT

State/Market Segment Crosswalk
Rebates*
Pharmacy Pricing
Drug Utilization
CMS RxDC Crosswalk

DATA OUTPUT

Data Transformation & File Creation

Basic Data Extract
Comprehensive RxDC Aggregated Files
Premium 1 RxDC Aggregated Files
Premium 2 RxDC Aggregated Files

Data is compiled from multiple sources and undergoes transformation into client requested product

*All data that is compiled by OptumRx is based on adjudicated values & status of rebate cycles. Future year files will reflect any modifications within the 'Restated' fields.

Confidential property of Optum. Do not distribute or reproduce without express permission from Optum.
# RxD C Data Files Overview

<table>
<thead>
<tr>
<th>D1: Premium and Life Years</th>
<th>D2: Spending by Category</th>
<th>D3: Top 50 Most Frequent Brand Drugs</th>
<th>D4: Top 50 Most Costly Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides the average monthly premiums paid by employees and employers, as well as life years of plans and any earned premium amounts or premium equivalents.</td>
<td>Provides the total spending and total cost sharing for claims with dates of service during the reference year. Totals are separated by category &amp; exclude prescription drug benefit.</td>
<td>Provides information on the number of paid claims, total spending and total cost sharing for the top 50 most frequently dispensed brand name drugs.</td>
<td>Provides information on the number of paid claims, total spending and total cost sharing for the top 50 most costly drugs.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D5: Top 50 Drugs by Spending Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides information on the number of paid claims, total spending and total cost sharing for the top 50 drugs with the greatest spending increase from the year prior to the reference year.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D6: Rx Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides the total prescription spending amounts covered under pharmacy benefits, as well as details surrounding PBM financials and total rebate amounts.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D7: Rx Rebates by Therapeutic Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides the rebate totals retained by the PBM, plan/issuer/carrier, and passed to members, categorized by therapeutic class.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D8: Rx Rebates for the Top 25 Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides information on the number of paid claims, total spending, total cost sharing, and total rebate amounts for the top 25 drugs with the greatest amount of rebates.</td>
</tr>
</tbody>
</table>

OptumRx to provide data/files for D3 – D8
What Data is Needed From Clients?

Crosswalk
- To receive the Client attributes required to build the output files
- To direct OptumRx which claims to use for each plan, state, and market segment to comply with regulation aggregation parameters
- Crosswalk headers cannot be modified in anyway

Product Selection
- Obtain individual client selection in order to determine what level of service to provide

RxDC Addendum
- To receive contractual agreement to provide the data to the client and or upload on their behalf and allow invoicing for services
  - Pricing exceptions are available and should follow the standard procedure
Client Checklist

- Obtain a HIOS ID from CMS, if one is not already assigned. This will allow for submission of 'plan owned' files.
- Be granted access to the RxDC Module within HIOS in order to upload files
- Determine support required, complete product selection, and addendum
- Complete RxDC Client Crosswalk to provide what state and market segment maps to RxClaim CAG. Pages 4 & 8 - 10 of the RxDC Reporting Instructions provides further details on applicability
- Obtain applicable TPA or PBM EIN and Entity Name for Plan Files
- Basic & Comprehensive: Provide ORx listing of applicable drug codes for D3 - D6, & D8
- Comprehensive: Modify Data Files to include any retained rebates/fees and Total Rx Spending Under Non-Pharmacy Benefit
- Premium 1 & Premium 2: Create and submit any applicable Plan File and Data File 1 and 2
- Premium 1 & Premium 2: Supply ORx with Total Rx Spending Under Non-Pharmacy Benefit
- Premium 2: Submit complete Data File set via HIOS portal
- Clients who prepare own files should house data as the regulation requires plans to provide prior year data or restated values in subsequent files
- All: Submit applicable Plan Files via the RxDC Module in HIOS
- All: Annually provide updated RxDC Client Crosswalk
# Market Segment

Market segments are defined by the regulation as follows:

<table>
<thead>
<tr>
<th>Market Segment</th>
<th>Abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual market, excluding the student market</td>
<td>Individual market</td>
</tr>
<tr>
<td>Student market</td>
<td>Student market</td>
</tr>
<tr>
<td>Fully-insured small group market</td>
<td>Small group market</td>
</tr>
<tr>
<td>Fully-insured large group market, excluding the FEHB line of business</td>
<td>Large group market</td>
</tr>
<tr>
<td>Self-funded group health plans offered by small employers</td>
<td>SF small employer plans</td>
</tr>
<tr>
<td>Self-funded group health plans offered by large employers</td>
<td>SF large employer plans</td>
</tr>
<tr>
<td>FEHB line of business</td>
<td>FEHB plans</td>
</tr>
</tbody>
</table>
CMS Provided RxDC Crosswalk

The RxDC Crosswalk is to be used to:

1. Map individual NDCs to the appropriate representative RxDC drug name ingredient or brand name and drug code
2. Map individual NDCs that treat the same condition to the appropriate representative RxDC therapeutic class and therapeutic code
   - There could be multiple therapeutic classes assigned to a group of drugs. In this case, report all classes, separated by a pipe.

If drug or therapeutic class not available on RxDC Crosswalk, assign the value that is felt to be most accurate. Details surrounding this decision will need to be documented in the Narrative section. Crosswalk update frequency is unknown.

<table>
<thead>
<tr>
<th>11-Digit NDC</th>
<th>RxDC Drug Name</th>
<th>RxDC Drug Code</th>
<th>RxDC Therapeutic Class</th>
<th>RxDC Class Code</th>
<th>RxDC Brand Indicator</th>
<th>NDC Data Source</th>
<th>Therapeutic Class Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>000021200300</td>
<td>floxetapir [Amyvid]</td>
<td>R14272250101001</td>
<td>Radiographic Contrast Agent</td>
<td>001803050101</td>
<td>1.FDA Only</td>
<td>EPC</td>
<td></td>
</tr>
<tr>
<td>000021200500</td>
<td>floxetapir [Amyvid]</td>
<td>R14272250101001</td>
<td>Radiographic Contrast Agent</td>
<td>001803050101</td>
<td>1.FDA Only</td>
<td>EPC</td>
<td></td>
</tr>
<tr>
<td>000021210300</td>
<td>flixutarpic [Taqvid]</td>
<td>R25718380101001</td>
<td>Radiographic Contrast Agent</td>
<td>001803050101</td>
<td>1.FDA Only</td>
<td>EPC</td>
<td></td>
</tr>
<tr>
<td>000021210500</td>
<td>flixutarpic [Taqvid]</td>
<td>R25718380101001</td>
<td>Radiographic Contrast Agent</td>
<td>001803050101</td>
<td>1.FDA Only</td>
<td>EPC</td>
<td></td>
</tr>
<tr>
<td>000021433001</td>
<td>dulaglutide [Trulicity]</td>
<td>R15532910101001</td>
<td>GLP-1 Receptor Agonist</td>
<td>001784000101</td>
<td>1.Both</td>
<td>EPC</td>
<td></td>
</tr>
<tr>
<td>000021433601</td>
<td>dulaglutide [Trulicity]</td>
<td>R15532910101001</td>
<td>GLP-1 Receptor Agonist</td>
<td>001784000101</td>
<td>1.Both</td>
<td>EPC</td>
<td></td>
</tr>
<tr>
<td>000021433801</td>
<td>dulaglutide [Trulicity]</td>
<td>R15532910101001</td>
<td>GLP-1 Receptor Agonist</td>
<td>001784000101</td>
<td>1.Both</td>
<td>EPC</td>
<td></td>
</tr>
<tr>
<td>000021434001</td>
<td>dulaglutide [Trulicity]</td>
<td>R15532910101001</td>
<td>GLP-1 Receptor Agonist</td>
<td>001784000101</td>
<td>1.Both</td>
<td>EPC</td>
<td></td>
</tr>
<tr>
<td>000021434601</td>
<td>dulaglutide [Trulicity]</td>
<td>R15532910101001</td>
<td>GLP-1 Receptor Agonist</td>
<td>001784000101</td>
<td>1.Both</td>
<td>EPC</td>
<td></td>
</tr>
<tr>
<td>000021436601</td>
<td>gailcanezumab [Emgality]</td>
<td>R20588460101001</td>
<td>Calcitonin Gene-related Peptide</td>
<td>001595170101</td>
<td>1.Both</td>
<td>EPC</td>
<td></td>
</tr>
<tr>
<td>000021436611</td>
<td>gailcanezumab [Emgality]</td>
<td>R20588460101001</td>
<td>Calcitonin Gene-related Peptide</td>
<td>001595170101</td>
<td>1.Both</td>
<td>EPC</td>
<td></td>
</tr>
</tbody>
</table>
Data Complexity

- Data Elements across the files will be required from multiple sources when compiled:
  - Plan demographic details
  - PBM/TPA identifiers
  - Information on drugs covered outside of pharmacy benefit (Rx Totals)
- Obtaining client aggregation data via a CAG crosswalk as RxClaim currently does not store plans via state and/or market segment
- Determining aggregation and collating files accordingly
- Coordinating file submission if multiple reporting entities
- Integrating the RxDC Crosswalk for drug identifiers and therapeutic class as reporting is done via a proxy Drug Code
- Data elements with very precise definitions, requiring the integration of fields from various areas of RxClaim
- Mass evaluation of prior year adjudication and rebate activity to appropriately identify the top values for each report type and corresponding state and market segment.
- Restated values for prior year rebates cycles need to be provided as CMS recognizes that the rebate lifecycle can last up to 18 months and will not be complete by June 1st of each year.
- Outside of the regulation complexity, there is the internal complexity of coordinating work with multiple parties, including RxTrack, Legal, Regulatory, Rebates, etc.
<table>
<thead>
<tr>
<th>Product</th>
<th>Client Arrangement</th>
<th>Client Characteristics</th>
<th>Client Responsibility</th>
<th>OptumRx Responsibility</th>
<th>Cost</th>
</tr>
</thead>
</table>
| Basic     | Health Plans TPAs  | • Client preference would be to compile and submit reporting on their own & require limited support  
• Pass-through pricing  
• Robust reporting capabilities  
• Deeper insight into pricing and rebates  
• Client has plan-specific data  
• Client known cost-share reductions & re-insurance amounts  
• Downstream clients | • Creation of HIOS account and RxDC module access, if needed  
• Completed CAG to State & Market Segment Crosswalk  
• Drug Code for D3 - D6, & D8  
• Creating RxDC Files, inclusive of rebate arrangements, downstream ASO client specific files, cost-share reductions, or reinsurance  
• Submitting all RxDC Files:  
  • Completion of applicable Plan Files and Data Files 1 & 2  
  • Submission of applicable Plan Files and Data Files 1 & 2  
  • Collating/formatting D3 - D8  
  • Submission of Data Files 3 – 8 | PBM Name and EIN for P files  
• Total Spend D3 - D8  
• PBM Financials D6, as applicable  
• Rebates Retained by PBM D7 - D8  
• Net Transfer of Fees & Other Remuneration D7 - D8  
• Top 25 Rebates D8, as applicable | $0         |
| Comprehensive | Health Plans TPAs  | • Client preference would be to compile and submit reporting on their own & require limited support  
• Client has plan-specific data  
• Client known cost-share reductions & re-insurance amounts  
• Does not have 100% pass-through pricing  
• Downstream clients | • Creation of HIOS account and RxDC module access, if needed  
• Completed CAG to State & Market Segment Crosswalk  
• Drug Code for D3 - D6, & D8  
• Modification of RxDC Files to reflect fees/rebates retained by TPA & HIX cost-share  
• Submitting all RxDC Files:  
  • Completion of applicable Plan Files and Data Files 1 & 2  
  • Submission of applicable Plan Files and Data Files 1 & 2  
  • Submission of Data Files 3 – 8 | PBM Name and EIN for P files  
• PBM Financial for D6, as applicable  
• Compiling an aggregated file set for D3 - D8 in required format for self submission | $500 per downstream entity*, capped at $25,000 |

*Downstream entity is defined as Benefit Plan or, in the case of a TPA, per downstream Benefit Plan

**Should a downstream client of a Health Plan or TPA want their own set of files directly from Optum, additional fees will apply.**
# Direct ASO Product Comparison Chart

<table>
<thead>
<tr>
<th>Product</th>
<th>Client Arrangement</th>
<th>Client Characteristics</th>
<th>Client Responsibility</th>
<th>OptumRx Responsibility</th>
<th>Cost</th>
</tr>
</thead>
</table>
| Premium 1 | ASO | • Direct Employer Groups  
• Coalitions  
• Labor & Trust  
• No downstream entities | • Creation of HIOS account and RxDC module access, if needed  
• Completed CAG to State & Market Segment Crosswalk  
• Completion of applicable Plan Files and Data Files 1 & 2  
• Submission of applicable Plan Files and Data Files 1 & 2 | • PBM Name and EIN for P files  
• Compiling an aggregated file set for D3 - D8 for submission by Optum | $1,000 |
| Premium 2 | ASO | • Direct Employer Groups  
• Coalitions  
• Labor & Trust  
• No downstream entities | • Creation of HIOS account and RxDC module access, if needed  
• Completed CAG to State & Market Segment Crosswalk  
**Submitting RxDC Files, including:**  
• Completion of applicable Plan Files and Data Files 1 & 2  
• Submission of applicable Plan Files and Data Files 1 & 2  
• Submission of Data Files 3 - 8 | • PBM Name and EIN for P files  
• PBM financials for D6, as applicable  
• Compiling an aggregated file set for D3 - D8 in required format for self submission | $5,000 |
Client Crosswalk – Basic & Comprehensive Products

<table>
<thead>
<tr>
<th>OptumRx Provided</th>
<th>Client Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>RxClaim Environment</td>
<td>Client ID</td>
</tr>
<tr>
<td></td>
<td>Client Name</td>
</tr>
<tr>
<td></td>
<td>Carrier ID</td>
</tr>
<tr>
<td></td>
<td>Carrier Name</td>
</tr>
<tr>
<td></td>
<td>Account ID</td>
</tr>
<tr>
<td></td>
<td>Account Name</td>
</tr>
<tr>
<td></td>
<td>Group ID</td>
</tr>
<tr>
<td></td>
<td>Group Name</td>
</tr>
<tr>
<td></td>
<td>Issuer or TPA Name (Optional for Basic)</td>
</tr>
<tr>
<td></td>
<td>Issuer or TPA EIN (Optional for Basic)</td>
</tr>
<tr>
<td></td>
<td>State</td>
</tr>
<tr>
<td></td>
<td>Market Segment</td>
</tr>
<tr>
<td></td>
<td>D3 Top 50 Most Frequent Brand Drugs</td>
</tr>
<tr>
<td></td>
<td>D4 Top 50 Most Costly Drugs</td>
</tr>
<tr>
<td></td>
<td>D5 Top 50 Drugs by Spending Increase</td>
</tr>
<tr>
<td></td>
<td>D8 Top 25 Rebates</td>
</tr>
<tr>
<td></td>
<td>Aggregation Restriction</td>
</tr>
</tbody>
</table>

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# Client Crosswalk – Premium 1 & Premium 2 Products

<table>
<thead>
<tr>
<th>OptumRx Provided</th>
<th>Client Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>RxClaim Environment</td>
<td>Client ID</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
References

CMS CCIIO Product Page
Prescription Drug Data Collection (RxDC) | CMS

Regulation

Reporting Instructions

Templates

RxDC Crosswalk
Fresno City Employees Health & Welfare Trust Board Meeting
Fresno City Employees Health & Welfare Trust

2021 / 2022
Year-End Review
Average Cost Per Participant Monthly

Fresno City Employees H & W Trust July 21 – June 22

July  | August | September | October | November | December | January | February | March | April | May | June

$1,800.00
$1,600.00
$1,400.00
$1,200.00
$1,000.00
$800.00
$600.00
$400.00
$200.00
$0.00

HealthComp
Average Cost Per Participant Year to Date

Fresno City Employees H & W Trust
Jul 21 – Jun 22
Average Cost Per 12 Month Rolling Average

Fresno City Employees H & W Trust
June 2021 – July 2022

[Graph showing the average cost per 12 month rolling average for Fresno City Employees H & W Trust from 2013 to 2022, with a slight increase trend over the years.]
Claims by Coverage Type

Excludes PUD HMO
Medical Claims by Insured Type

- Children, 29%
- Spouse, 29%
- Employee, 42%
Average Monthly Cost – Medical, Vision, and Prescription Drugs

- Active
- Retiree
- Medicare

- 12/13
- 13/14
- 14/15
- 15/16
- 16/17
- 17/18
- 18/19
- 19/20
- 20/21
- 21/22
Average Monthly Cost – Medical, Vision, and Prescription Drug

Self-Pay

COBRA

12/13
13/14
14/15
15/16
16/17
17/18
18/19
19/20
20/21
21/22
## Average Paid Amount Per Medical Claim

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/13</td>
<td>$202.02</td>
<td>+4.50%</td>
</tr>
<tr>
<td>13/14</td>
<td>$189.82</td>
<td>(6.00%)</td>
</tr>
<tr>
<td>14/15</td>
<td>$213.78</td>
<td>+12.60%</td>
</tr>
<tr>
<td>15/16</td>
<td>$200.66</td>
<td>(9.30%)</td>
</tr>
<tr>
<td>16/17</td>
<td>$192.86</td>
<td>(9.60%)</td>
</tr>
<tr>
<td>17/18</td>
<td>$252.60</td>
<td>+30.90%</td>
</tr>
<tr>
<td>18/19</td>
<td>$269.35</td>
<td>+6.20%</td>
</tr>
<tr>
<td>19/20</td>
<td>$269.88</td>
<td>+0.20%</td>
</tr>
<tr>
<td>20/21</td>
<td>$257.21</td>
<td>(4.70%)</td>
</tr>
<tr>
<td>21/22</td>
<td>$272.89</td>
<td>+6.10%</td>
</tr>
</tbody>
</table>
### Average Number of Medical Claims PEPM

<table>
<thead>
<tr>
<th>Year</th>
<th>Average</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/13</td>
<td>2.94</td>
<td>+0.9%</td>
</tr>
<tr>
<td>13/14</td>
<td>3.00</td>
<td>+2.1%</td>
</tr>
<tr>
<td>14/15</td>
<td>3.00</td>
<td>0.0%</td>
</tr>
<tr>
<td>15/16</td>
<td>2.95</td>
<td>(1.7%)</td>
</tr>
<tr>
<td>16/17</td>
<td>3.18</td>
<td>+7.8%</td>
</tr>
<tr>
<td>17/18</td>
<td>2.94</td>
<td>(7.6%)</td>
</tr>
<tr>
<td>18/19</td>
<td>3.00</td>
<td>+2.0%</td>
</tr>
<tr>
<td>19/20</td>
<td>2.76</td>
<td>+8.0%</td>
</tr>
<tr>
<td>20/21</td>
<td>2.91</td>
<td>+5.4%</td>
</tr>
<tr>
<td>21/22</td>
<td>2.94</td>
<td>+1.02%</td>
</tr>
</tbody>
</table>
Average Monthly Cost - Dental
Medical / Prescription Drug Costs

<table>
<thead>
<tr>
<th>Year</th>
<th>MM</th>
<th>RX</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/13</td>
<td>$594</td>
<td>$245</td>
</tr>
<tr>
<td>14/15</td>
<td>$641</td>
<td>$245</td>
</tr>
<tr>
<td>16/17</td>
<td>$614</td>
<td>$275</td>
</tr>
<tr>
<td>18/19</td>
<td>$744</td>
<td>$309</td>
</tr>
<tr>
<td>19/20</td>
<td>$832</td>
<td>$307</td>
</tr>
<tr>
<td>20/21</td>
<td>$745</td>
<td>$262</td>
</tr>
<tr>
<td>21/22</td>
<td>$798</td>
<td>$319</td>
</tr>
</tbody>
</table>

MM: Medical | RX: Prescription

HealthComp
Prescription Drug Costs

<table>
<thead>
<tr>
<th>Year</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/13</td>
<td>$245</td>
</tr>
<tr>
<td>14/15</td>
<td>$245</td>
</tr>
<tr>
<td>16/17</td>
<td>$275</td>
</tr>
<tr>
<td>18/19</td>
<td>$309</td>
</tr>
<tr>
<td>18/19</td>
<td>$307</td>
</tr>
<tr>
<td>20/21</td>
<td>$319</td>
</tr>
<tr>
<td>21/22</td>
<td>$262</td>
</tr>
<tr>
<td>20/21</td>
<td>$297</td>
</tr>
<tr>
<td>20/21</td>
<td>$308</td>
</tr>
<tr>
<td>21/22</td>
<td>$338</td>
</tr>
</tbody>
</table>
Prescription Drug Percentage Changes

- 2.94% (12/13)
- 1.00% (13/14)
- 12.24% (14/15)
- 12.36% (15/16)
- 1.00% (16/17)
- -14.70% (17/18)
- 17.87% (18/19)
- -7.41% (19/20)
- 3.57% (20/21)
- 9.74% (21/22)
Medical Claims Costs
Percentage Changes

<table>
<thead>
<tr>
<th>Year</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/13</td>
<td>5.51%</td>
</tr>
<tr>
<td>13/14</td>
<td>-4.14%</td>
</tr>
<tr>
<td>14/15</td>
<td>12.65%</td>
</tr>
<tr>
<td>15/16</td>
<td>-7.64%</td>
</tr>
<tr>
<td>16/17</td>
<td>3.72%</td>
</tr>
<tr>
<td>17/18</td>
<td>21.17%</td>
</tr>
<tr>
<td>18/19</td>
<td>10.58%</td>
</tr>
<tr>
<td>19/20</td>
<td>-10.49%</td>
</tr>
<tr>
<td>20/21</td>
<td>-0.53%</td>
</tr>
<tr>
<td>21/22</td>
<td>6.54%</td>
</tr>
</tbody>
</table>
Total Medical Charges: $191,959,533
Excludes Rx

Charges vs. Paid

Paid: $33,230,949
Not Paid: $115,330,180
Not Paid by Reason

Total Not Paid: $115,330,180

- COB 3%
- CoPay 0%
- Coinsurance 4%
- Duplicate 5%
- Not Covered 16%
- Discount 70%
Thank you
Memorandum

To: Board of Trustees
Fresno City Employees Health & Welfare Trust

From: Andrew Desa, Consulting Actuary

Date: August 10, 2022

Re: Consultant’s Report for August 10, 2022 Board of Trustees Meeting - Elite Medical – Health Screenings & Vaccinations

Elite Medical provides biometric screening and vaccination events. They have provided this service for the Trust for the last four years. Only vaccinations were provided in 2020 and 2021 (no biometric screenings). COVID-19 vaccinations and high dose flu shots were first offered in 2021.

1. Utilization for 2020 and 2021 and Elite’s fees for the prior 2021 event are shown below. Please note that we have not yet received the proposed fees for this year’s event.

<table>
<thead>
<tr>
<th>Elite Medical</th>
<th>2020 Count (Units)</th>
<th>2021 Count (Units)</th>
<th>2021 Unit Cost</th>
<th>2021 Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biometric Health Screening</td>
<td>n/a</td>
<td>n/a</td>
<td>$ 48.00</td>
<td>n/a</td>
</tr>
<tr>
<td>Influenza Vaccine</td>
<td>637</td>
<td>290</td>
<td>$ 27.50</td>
<td>$ 7,975</td>
</tr>
<tr>
<td>Pneumonia Vaccine</td>
<td>62</td>
<td>43</td>
<td>$144.00</td>
<td>$ 6,192</td>
</tr>
<tr>
<td>High-Dose Influenza Vaccine</td>
<td>N/A</td>
<td>10</td>
<td>$ 65.30</td>
<td>$ 653</td>
</tr>
<tr>
<td>COVID-19 Vaccine</td>
<td>N/A</td>
<td>0</td>
<td>$ 40.00</td>
<td>$ 0</td>
</tr>
<tr>
<td>Total</td>
<td>699</td>
<td>343</td>
<td></td>
<td>$14,820</td>
</tr>
</tbody>
</table>

2. High-dose influenza shots can continue to be offered for the upcoming event. High-dose influenza shots are intended for adults 65 and older as it offers a higher immune response. The high-dose influenza shots must be purchased in advance and must be purchased in packages of ten. Unused doses are not able to be refunded.

3. Due to COVID-19, we have requested information on additional safety protocols that are in place. Elite Medical has informed us the following day of event protocols are in place:

- Onsite temperature checks
- Evaluation of symptoms
- Medical team in full personal protective equipment (PPE)
- Social distance markers
• Sterilization of all equipment between participants
• Disposal of all hazardous waste and medical consumables
• Assistance with registration process
• Hand sanitizer availability at each station

4. The vaccinations in 2021 took place on October 22nd – November 3rd.

This item will be discussed at your August 10, 2022 meeting. If there are any questions before or after that meeting, please let me know.

AD:nt
July 20, 2022

Fresno City Employees Health & Welfare Trust Board of Trustees
621 Santa Fe
Fresno, CA 93721

RE: Fresno City Employees Health and Welfare Trust MHPAEA NQTL Recommendation Completion Document

Dear Trustees:

We appreciate the opportunity to execute a MHPAEA NQTL for Fresno City Employees Health & Welfare Trust. The process has included the gathering of pertinent information regarding your plan designs, communications with your plan vendors and reviewing Fresno City Employees Health & Welfare Trust medical claims data in order to provide the determination that Fresno City Employees Health & Welfare Trust, in accordance with the Consolidated Appropriations Act, 2021 (the Appropriations Act or CAA 2021) Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) does not impose a Non Mental Health/Substance Use Disorder, “MH/SUD,” benefits more stringently than the processes, strategies, evidentiary standards, or other factors used in applying limitation with respect to Medical/Surgical, “M/S,” benefits.

It is with pleasure that we have performed this analysis and review; have drafted the MHPAEA NQTL report for Fresno City Employees Health & Welfare Trust and have reviewed our findings with you. In our meeting there were several items that required your attention prior to sending you a final report. Please review this list and acknowledge receipt by “checking” each box in the right-hand column; signing on the last page; and returning this letter to us by email. We will send the final report to you promptly.

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>1</th>
<th>Recommendation: Given the list is not inclusive and may change, consider removing the examples and identify the single definitive source of information.</th>
</tr>
</thead>
</table>

We understand this recommendation is for clarification. This is not an NQTL but serves to clarify the SPD and adjust to new rules and regulations.
PRE-CERTIFICATION

Before services are provided, you or your provider can determine whether a procedure or treatment program is covered and may also receive a recommendation for an alternative Service. Failure to contact Blue Shield as described below or failure to follow the recommendations of Blue Shield for these services will result in a reduced benefit or may result in non-payment if Blue Shield determines that the service is not a covered Service.

The plan requires pre-certification from Blue Shield for the following services:

1. Select injectable drugs administered in the physician office setting. Prior certification is based on Medical Necessity, appropriateness of therapy, or when effective alternatives are available. NOTE: Your Preferred or Non-Preferred Physician must obtain prior authorization for select injectable drugs administered in the physician's office. Failure to obtain prior authorization or to follow the recommendations of Blue Shield for select injectable drugs may result in non-payment by the Plan if the service is determined not to be a covered Service; in that event you may be financially responsible for services rendered by a Non-Preferred Physician.

2. Home Health Care, Home Infusion/Injectable Care, PKU related formulas and Special Food Products and partial hospitalization for mental health or substance use disorder services.

3. Admission into an approved Hospice Program as specified under Hospice Program Services in the Covered Services section.

4. Clinical Trial for Cancer. Persons who have been accepted into an approved clinical trial for cancer as defined under the Covered Services section must obtain prior authorization from Blue Shield in order for the routine patient care delivered in a clinical trial to be covered.

5. Durable Medical Equipment, including but not limited to motorized wheelchairs, insulin, infusion pumps, and CPAP (Continuous Positive Air Pressure) machines.

6. Surgery which may be considered to be Cosmetic in nature rather than Reconstructive (e.g., eyelid surgery, rhinoplasty, abdominoplasty, or breast reduction) and those Reconstructive Surgeries which may result in only minimal improvement in function or appearance. The Reconstructive Surgery Benefit is limited to Medically Necessary surgeries and procedures.

7. Arthroscopic surgery of the temporomandibular joint (TMJ).


9. Hospital and Skilled Nursing Facility admissions (see the subsequent Hospital and Skilled Nursing Facility Admissions section for more information).

10. Other services and procedures as determined by BlueShield. A list of services and procedures requiring prior authorization can be obtained by your provider by going to www.blueshieldca.com or by calling 1-800-541-6662.

1. Consider keeping the text that is highlighted.
2. By identifying “mental health” in “2.” the parity of MH/SUD with M/S could be debated. The concept is already clearly identified in the benefit of services, therefore consider not confusing/repeating the concept in this section. Precert for MH/SUD is from Halcyon, so that serves as an additional reason to avoid identifying MH in this list.

2 Clarification: Assume conditions of pregnancy only pertains to 6 rows. Consider inserting a break to designate new section of the Medical Plan Schedule of Benefit.

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☐ We understand this recommendation is for clarification. This is not an NQTL but serves to clarify the SPD and adjust to new rules and
<table>
<thead>
<tr>
<th>CONDITIONS OF PREGNANCY (For covered employee and/or spouse only.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal and Postnatal Office Visits</td>
</tr>
<tr>
<td>Physician's Hospital Visits</td>
</tr>
<tr>
<td>Normal Delivery and Cesarean Section</td>
</tr>
<tr>
<td>Complication of Pregnancy, Including Therapeutic Abortion</td>
</tr>
<tr>
<td>Newborns' and Mothers' Health Protection Act Compliant</td>
</tr>
<tr>
<td>No pre-certification is required for minimum length of stay of a 48-hour hospital stay following an uncomplicated normal delivery and a 96-hour length of hospital stay following a Cesarean section delivery. However, Federal Law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours as applicable. Pre-certification is required for a longer stay than described above.</td>
</tr>
<tr>
<td>Voluntary Sterilization</td>
</tr>
<tr>
<td>For employee and spouse only</td>
</tr>
<tr>
<td>Blood, Blood Plasma, Blood Derivatives and Blood Factors</td>
</tr>
<tr>
<td>Ambulance (UCR is defined as 175% of Medicare allowable for an ambulance)</td>
</tr>
<tr>
<td>Chemotherapy and Radiation Therapy</td>
</tr>
<tr>
<td>Hospice Care</td>
</tr>
<tr>
<td>The plan covers charges by Providers that are licensed as certified home health agencies</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
</tr>
<tr>
<td>Purchase or rental in excess of $1,000 must be pre-certified by Blue Shield.</td>
</tr>
</tbody>
</table>

3 Note: Well done for parity between M/S and MH/SUD.

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MENTAL HEALTH AND SUBSTANCE ABUSE CARE

SCHEDULE OF BENEFITS

All Inpatient Services must be pre-certified, except emergencies, by Halcyon Behavioral at (888) 425-4800.

FAILURE TO PRE-CERTIFY MEDICALLY NECESSARY SERVICES THAT REQUIRE PRE-CERTIFICATION MAY RESULT IN A REDUCTION OF YOUR BENEFITS BY UP TO 50%.

For maximum coverage, all outpatient care must be performed by a Halcyon Behavioral Network provider.

Outpatient Care

First Outpatient treatment visit, one per family, is provided at no cost to you or your family through Halcyon Behavioral.

SUMMARY OF SERVICE (Mental Health Treatment)

<table>
<thead>
<tr>
<th>Inpatient Mental Health Care</th>
<th>Halcyon Behavioral Network Provider Benefits</th>
<th>Non-Network Provider Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>All inpatient services must be pre-authorized by Halcyon Behavioral.</td>
<td>$250 co-pay then *80% of Halcyon Behavioral's contract rate after the Deductible</td>
<td>$250 co-pay then *50% after the Deductible</td>
</tr>
</tbody>
</table>

SUMMARY OF SERVICE (Substance Abuse Treatment)

<table>
<thead>
<tr>
<th>Inpatient Substance Abuse Care</th>
<th>Halcyon Behavioral Network Provider Benefits</th>
<th>Non-Network Provider Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>All inpatient services must be pre-authorized by Halcyon Behavioral.</td>
<td>$250 co-pay then *80% of Halcyon Behavioral's contract rate after the Deductible</td>
<td>$250 co-pay then *50% after the Deductible</td>
</tr>
</tbody>
</table>

We understand this recommendation is for clarification. This is not an NQTL but serves to clarify the SPD and adjust to new rules and regulations.
4. Consider rewording. Chiropractic “diagnostic x-ray” is identified as a benefit on page 25 and then “diagnostic scanning” is excluded on page 26. For clarification, either remove x-ray as a chiropractic benefit or clarify, “all scanning, except x-rays, are excluded” on page 26.

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CHIROPRACTIC PLAN EXCLUSIONS AND LIMITATIONS
The following are specifically excluded from this agreement or have specific limitations:

- Services not documented as necessary and appropriate or classified as experimental or investigational chiropractic care
- Diagnostic scanning, including Magnetic Resonance Imaging (MRI), CAT scan and/or other types of diagnostic scanning

5. Consider ensuring parity “as written” between M/S and MH/SUD.

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NON-EMERGENCY
The Plan pays Hospital and Medical services, as outlined on pages 20 through 22, based upon whether a Network or Non-Network Provider is used. Plan Benefits will be greater if a Network Provider is used.

1. Routine Outpatient Medical Services should be obtained from your Primary Care Physician. You may use Blue Shield Specialists for some outpatient services without obtaining pre-certification. Specialist pre-certification is still required for certain medical services.

While emergency responses are available if needed, normally you should allow 72 hours for pre-certification.

2. Inpatient and certain Outpatient Hospital Services require pre-certification (laboratory and radiology services do not require Pre-Certification, except as noted above).

3. In order to receive benefits for the following services, please refer to the applicable page numbers noted below:
   a. Physical Therapy, Occupational Therapy and Speech-Language Therapy – Please refer to page 23
   b. Chiropractic – please refer to pages 26-26
   c. Mental Health – call Halcyon Behavioral for routine Mental Health Care – (888) 425-4800 – please refer to page 27
   d. Dental – please refer to pages 43-54
   e. Benefits paid for routine Obstetric/Gynecological exams, and Pap smears apply toward the routine Annual Physical Exam

1) If “routine” is defined as “preventative,” then consider substituting the word so that the wording matches the benefit of services terms.

2) Try to avoid using terms such as “some,” or “certain.” For medical services. Better to write, “services as defined by XXX or through XXX.”
3) Page 27 is the Medicare schedule of benefit and not “mental health.” Page 24 is Mental Health.

4) Recommend removing the word “routine” in “c.” since there is no definition of “routine” on page 24.

5) In “3.” consider moving each vendor to equal status to medical, or at least move the “Mental Health” vendor information to the same outline status as medical. MH/SUD has to be on equal footing with M/S.

6) Recommendation: MH/SUD emergency services cannot be more stringent than M/S emergency services. The term “partial” generally only applies to MH/SUD, yet it is equivalent to “outpatient” care, and therefore in writing the precertification requirement for MH are more stringent.

Consider removing the term “partial” as seen below. If the concept of “partial” has a medical equivalent, then to create parity, add the concept to medical.

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7) Consider removing reference to mental illness in this section. Optimal to keep the section generic. Further, the terms are defined “under the hospitalization benefit described above” so the information in this paragraph is redundant. No need to create focus on a more stringent application of MH/SUD.

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☐ We understand this recommendation requires a language change to provide parity between M/S and MH/SUD. As written this is more stringent for MH/SUD.

☐ We understand this recommendation is for clarification. This is not an NQTL but serves to clarify the SPD and adjust to new rules and regulations.
Once again, we appreciate the opportunity to work with you and will continue to support Fresno City Employees Health & Welfare Trust. MedExpert has prepared the analysis required by CAA, 2021, Section 203 for the completion of MHPAEA NQTL report.

To acknowledge receipt of this document, please sign below. By signing this document, MedExpert can release the MHPAEA NQTL report to you, understanding that any required changes as identified above, will be executed.

Regards,

Mary R. Hiller
Executive Director, Knowledge Engineering
1300 Hancock Street
Redwood City, CA  94063

For Fresno City Employees Health & Welfare Trust
Acceptance of Recommendations

______________________________
Signature

______________________________
Name  Mr. Shane Archer

______________________________
Title

______________________________
Date
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Regards,

Mary R. Hiller
Executive Director, Knowledge Engineering
1300 Hancock Street
Redwood City, CA 94063

For Fresno City Employees Health & Welfare Trust
Acceptance of Recommendations

Signature ____________________________

Name Mr. Shane Archer

Title CHAIR

Date 8-04-22

MedExpert
For Fresno City Employees Health & Welfare Trust

Signature

Name Mr. Michael Lima

Title Vice-Chairperson

Date 8/4/2022