A Renewal Proposal for:

City of Sugar Land
3332131
1/1/2018

Last Modified: 07.10.2017

Date Printed: 7/19/2017

City of Sugar Land

Current Plan Renewal - ASO

1/1/2018

ASO Fees and Stop Loss Rates

ASO Fees - Current		HSA	Kelsey	Total
Administrative Service Fees		$ 14.32	$ 14.32	$ 121,147
Network Access Fees		$ 20.61	$ 19.05	$ 163,260
MotivateMe	HBHP	$ -	$ -	$ -
Third Party Interface Fee	Stop Loss Interface Fee	$ 1.20	$ 1.20	$ 10,152
HSA Fee		$ 5.24	$ -	$ 7,043
Total PEPM ASO Fee		**$ 41.37**	**$ 34.57**	
Employees		112	593	
Current Annual Administrative & Access Fees		**$ 55,601**	**$ 246,000**	**$ 301,601**

ASO Fees - Proposed From 1/1/2018 to 12/31/2018		HSA	Kelsey	Total	% Change
Administrative Service Fees		$ 14.32	$ 14.32	$ 121,147	0.0%
Network Access Fees		$ 20.61	$ 19.05	$ 163,260	0.0%
MotivateMe	HBHP	$ -	$ -	$ -	
Third Party Interface Fee	Stop Loss Interface Fee	$ 1.20	$ 1.20	$ 10,152	0.0%
HSA Fee		$ 5.24	$ -	$ 7,043	0.0%
Total PEPM ASO Fee		**$ 41.37**	**$ 34.57**		
Employees		112	593		
Proposed Annual Administrative & Access Fees		**$ 55,601**	**$ 246,000**	**$ 301,601**	**0.0%**

Total Fixed Cost - Current	**$**	**301,601**	
Total Fixed Cost - Proposed	**$**	**301,601**	**0.0%**

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Guaranteed Cost Funding
NonParticipating
January 01, 2018 - December 31, 2018

Tier	Expected Lives	Current Rates	Renewal Rates*
Dental PPO			
Employee Only	178	$44.50	$44.50
Employee + Spouse	81	$78.26	$78.26
Employee + Child(ren)	60	$76.46	$76.46
Employee + Family	127	$117.40	$117.40
Annual Cost	446	$372,260	$372,260
Percent Change (Renewal vs Current)			**0.0%**

**The above quoted rates do not include any commissions.*

Tier	Expected Lives	Current Rates	Quoted Rates*
Dental HMO [K1-V9]			
Employee Only	116	$15.70	$15.70
Employee + Spouse	36	$26.70	$26.70
Employee + Child(ren)	33	$36.92	$36.92
Employee + Family	87	$44.45	$44.45
Annual Cost	256	$89,721	$89,721
Percent Change (Renewal vs Current)			**0.0%**

**The above quoted rates do not include any commissions.*

Plan Code: 1006

Cigna Vision Solution for City of Sugar Land

Effective Date : 1/1/2018

Renewal quote completed by Cigna Dental & Vision Underwriting on July 3, 2017

Voluntary Fully Insured Quote (Per Employee Per Month) *15% Minimum Participation Required*

	Subs Count	Current	Renewal	% change
Employee Only	294	**$5.77**	**$5.77**	
Employee + Spouse	117	**$11.56**	**$11.56**	**0%**
Employee + Child(ren)	93	**$11.67**	**$11.67**	
Employee + Family	214	**$18.37**	**$18.37**	

**No broker commissions are included in this quote.*
**Voluntary: Medical and/or dental subscribers can elect to not enroll in vision. Does not refer to contribution levels.*
**Quote is valid for 90 days and includes claim processing, network access, customer service, policy and certificate, and standard vision reporting. The fee also includes two vision specific ID cards, mailed directly to the member's home address (unless other arrangements are made in advance).*
**Our Cigna Vision proposal is contingent upon selecting Cigna for your dental and/or medical coverage.*
**Rates are guaranteed for one year.*
**Cigna Healthcare's vision products are "excepted benefits" and not subject to Essential Health Benefit requirements.*
**The quoted rates include the cost of the Health Insurance Assessment fees (PPACA) for 2016. Rates for 2017 do not include Health Insurance Assessment fees (PPACA). Rates for 2018 and later, will be adjusted to include applicable PPACA fees imposed for that time period. Cigna reserves the right to modify quoted rates, as necessary, consistent with any future change in regulation.*

Cigna Vision Network offers one of the largest national routine vision networks, with 77,746+ optometrists and ophthalmologists at over 26,232 locations nationwide, including private practice and national and regional retail locations.
Please be aware that the Cigna Vision Network is different from the Cigna medical networks.

Renewal Plan Design - PPO - Scheduled

Frequency is 12 months for exams, 12 months for lenses, 12 months for contact lenses, and 24 months for frames.

Benefit	In-Network	Out-of-Network
Examination Copay	$10	n/a
Materials Copay	$20	n/a
Exam	Covered in Full	$45 allowance
Single Vision Lenses	Covered in Full	$32 allowance
Lined Bifocal Lenses	Covered in Full	$55 allowance
Lined Trifocal Lenses	Covered in Full	$65 allowance
Lenticular Lenses	Covered in Full	$80 allowance
Contact Lenses (retail allowance)		
Elective	$130 allowance	$105 allowance
Therapeutic	Covered in Full	$210 allowance
Frame (retail allowance)	$130 allowance	$71 allowance

In-Network Benefits Include:

- One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction, and prescription for glasses
- One pair of standard prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms)
- Additional lens enhancements, minimum 20% savings including but not limited to:
  -Customer Pays:
  - Standard Polycarbonate: covered under plan for under 18 years of age; up to $40 for adults
  - Oversize lenses: covered under plan
  - Rose Tints: #1 and #2 - covered under plan
  - All plastic dyed Tints: up to $17
  - Standard photochromic: up to $82¤ Standard anti-reflective coating: min. 20% save, $45 out-of-pocket max.
  - Standard anti-reflective coating: up to $45
  - Standard scratch/ultraviolet coating: up to $17
  - Standard progressives: up to $65
  - Provider participation is 100% voluntary, please check with your Eye Care Professional for any offered discounts.
- One frame of choice covered up to retail plan allowance, plus a 20% savings on amount that exceeds frame allowance.
- One pair or a single purchase supply of contact lenses - in lieu of lenses and frame benefit, (may not receive contact lenses and frames in same benefit year). Allowance applied towards cost of supplemental contact lenses professional services (including the fitting and evaluation), and contact lens materials.
- Healthy Rewards® - Vision Network Savings Program:
  - Minimum 20% savings on additional purchases of frames and/or lenses, including lens options, with a valid prescription; offered savings does not apply to contact lens materials. Check with your Cigna Vision Network Provider for details.

Benefits are underwritten or administered by Cigna. This information is intended as a summary of benefits only. It does not describe all the terms, provisions and limitations of your plan. Network providers are independent contractors solely responsible for your routine vision examination and products.

Proposed Renewal Terms and Conditions

A. General Terms of this Renewal Proposal

Cigna HealthCare is pleased to present this Proposal for renewal for an Administrative Services Only group Medical, Dental, Vision, Pharmacy, and Behavioral Health benefit plan (the "Plan") sponsored by City of Sugar Land. This proposal is valid for 60 days from its original date of release, 07/01/2017. Any revisions or updates made to this proposal will not renew this valid timeframe unless expressly communicated by Cigna Healthcare.

The information contained in this Proposal by Cigna HealthCare is proprietary and highly confidential. It is being provided with the understanding that It will not be used by the employer, its representatives or consultants for any purpose other than the evaluation of The Proposal. Under no circumstances is any of the information contained herein (including excerpts, summaries, extracts, and evaluations thereof) to be used, disseminated, disclosed or otherwise communicated to any person or entity other than The employer, its representatives and consultants, and their respective employees who are directly involved in The evaluation process.

Renewal Caveats
Cigna HealthCare may revise or withdraw this renewal proposal if:

- there is a change to the effective date of the quote
- Plan modifications are requested
- Cigna may pay on your behalf any applicable state tax or assessment imposed upon your plan by drawing upon the bank account.
- less than 200 employees or less than 70% of total eligible employees enroll in the Plan
- the employer changes its level of contribution toward the cost of the coverage
- enrollment increases or decreases by 10.0% or more, by product, from the enrollment assumptions used in establishing the rates and/or fees set forth herein.
- Benefit Advisor Fees/Commissions are requested to be different than Net
- it is requested to interface with a third party vendor
- it is requested to provide optional services beyond those listed here as being included in the quote: $3,000
- assumes and is conditioned upon client at all times maintaining a minimum bank account balance determined by Cigna (but no less than $10,000) based upon plan funding (i.e., insured or self-insured), frequency of account funding, specific vendor banking institution requirements for cash flow and frequency. Calculation of the bank account balance will be based on average daily claim activity that can range from 1-8 days and include adjustments for non-daily activity (e.g. prescription drug benefits and network access fees when applicable
- administration of the Plan will require more than the following:
  - Billing lines : 33
  - Billing and Claim Branch Benefit Options: 47
- it is not the exclusive provider of Medical, Dental, Vision, Pharmacy, or like products for all of City of Sugar Land employees in all worksites

- it is requested to provide stop loss coverage different than what is outlined in the case specific Stop Loss proposal output provided by the Stop Loss Underwriter.

- it does not receive current audited financial statements (income statement, balance sheet, statement of sources and uses of funds) from City of Sugar Land and approve the quote upon evaluation of those statements.
- there is any reimbursement arrangement (“gap” cards, etc.) that subsidizes or reduces the out-of-pocket obligation of covered persons under the policy.

B. Scope and Application of this Proposal
Unless otherwise indicated, this Proposal:

- assumes that the group health plan or health insurance coverage to which this proposal applies will not be a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the) and that it will be subject to all requirements of the Act applicable to a group health plan or health insurance coverage unless otherwise specified in writing.

- assumes applicable requirements of the Patient Protection and Affordable Care Act will be implemented on the effective date/renewal date unless you direct otherwise.

- The plan presented has an actuarial value, determined by Cigna HealthCare, of 60% or greater. This determination was made using Cigna HealthCare's manual rating application which may produce an actuarial value slightly different than the official HHS calculator. Although we would expect any deviation to be small, you will have to consult with your actuarial consultant for a more precise determination of the plan's actuarial value. Cigna HealthCare does not provide actuarial certifications.

- does not include paying on behalf of the Plan the Comparative Effectiveness Research Fee required under section 4376 of the Internal Revenue Code as added by the Patient Protection and Affordable Care Act. Cigna HealthCare is prohibited from calculating, collecting and paying the fee on behalf of the Plan.

- supersedes and renders null and void any prior Cigna HealthCare offer or proposal with respect to the Plan

- presents financial terms that must be accepted on a packaged basis

- reflects the claims and administrative savings realized by packaging the following specialty coverages with medical: Dental, Vision, Pharmacy, Behavioral Health

- does not apply to retirees 65 or older for managed care Plans or part-time or seasonal employees for any plan

- includes fixed charges for behavioral care services arranged by Cigna Behavioral Health, Inc. However, this may not apply in certain states.

- includes capitated charges for the provision of Hi-Tech Radiology services by eviCore (formerly known as MedSolutions, Inc.). However, this may not apply in certain states.

- Includes charges made by third parties for care management programs to contain the cost of specific health services/items and/or improve adherence to evidence-based guidelines to promote patient safety and efficient care (e.g., charges for management of diagnostic cardiology, radiation therapy, musculoskeletal procedures and medical oncology) when applicable.

- Notwithstanding the foregoing guarantee, Cigna may revise any charges at any time if Cigna is (i) required to pay any tax or assessment, or (ii) incur additional costs in administering the contract as a result of any state or federal law.

- includes the Network Savings Program (NSP) and other Cost Containment programs designed to contain costs with respect to charges for health care services/supplies that are covered by the Plan. For administering these programs, Cigna retains a portion of the savings or recoveries generated.

- excludes charges for converting a qualified customer of a group plan to an individual plan.

- Proposal assumes that the Employer is responsible for costs of external review required under federal law when requested by plan participants the cost of which may be between $500 - $4,000 per review.
- includes a maximum reimbursable charge for out-of-network coverage equal to of a fee schedule developed by Cigna HealthCare based upon a methodology similar to that used by Medicare to determine the allowable fee for similar services in the geographic market or 80th percentile of charges made by providers of such service or supply in the geographic area where the service is received.

- is based on Cigna Healthcare being selected as the stop-loss insurer. In the event Cigna HealthCare is selected as claim administrator but not the stop-loss carrier and is requested to interface with a third party stop-loss insurer, an additional charge will be assessed, dependent on the pooling level and may vary depending on the frequency of reporting requested by the stop-loss insurer. CHLIC will provide its standard reporting only after the stop loss carrier and Employer have executed CHLIC's standard Hold Harmless/Confidentiality agreement. The information provided by Cigna HealthCare shall be based on paid-claim data only. Information is not provided for any incurred-but-not-paid claims or projected claims. In addition, information related to pre-certification, case management, course of treatment or prognosis will not be provided.

- establishes a Wellness/Health Improvement Fund (the "Fund") in the amount of $100,000
- The Wellness/Health Improvement Fund will be used to defray the cost of Cigna designated and arranged health and wellness programs for employees (e.g., biometric screenings, flu shots, etc.) and to reward participation in wellness programs.
- Wellness/Health Improvement Fund may be accessed during the period from 01/01/2018 - 12/31/2018. The Fund may not be accessed following notice of termination of the Cigna HealthCare agreement. Unused Funds cannot be rolled over and Cigna HealthCare must pre-approve use of the Fund.

- Assumes a non-Cigna HealthCare Pharmacy Benefit Manager administers oral or other self-administered anti-cancer prescription medication claims at a copayment/coinsurance level that is no less favorable than that for intravenous or injected anti-cancer medication prescribed for the same purpose and covered under employer's Cigna HealthCare plan. This assumption is applicable only if: (a) employer has contracted with a PBM (not Cigna HealthCare); (b) employer's plan is either insured, or, if self-funded, not subject to ERISA (i.e., is a church, government or association plan); and (c) employer's Cigna HealthCare plan is situsued in IA, HI, NM, OR, NJ, NE, VA, MA, NV, FL, ME, GA or a state with similar chemotherapy coverage law, or covers one or more individuals residing in CO, OK, VT, WA, TX, LA, MO, OH or or in a state with similar extraterritorial chemotherapy coverage mandate.

- does not apply to individuals unless employed by the policyholder or an entity that participates in an association or trust that is the policyholder.

- In order to implement the requested benefit design, different funding arrangements (i.e., insured, self-insured and/or HMO) involving affiliated Cigna companies may be required with respect to plan participants residing in certain states.

- assumes dental and/or vision products are excepted. In order to maintain this excepted status, the Plan must ensure that when/if dental and/or vision products are offered, they are offered as a separate election for the employee.

Cigna HealthCare may have an agreement with your benefit advisor, under which the benefit advisor may be paid for providing marketplace intelligence or for the performance of administrative services. The qualification for and amount of this payment may be based upon overall business growth and/or retention levels. Any such payment is funded through Cigna HealthCare's general overhead.

The benefit advisor may qualify for incentive payment (monetary or non-monetary) from Cigna HealthCare. For example, the benefit advisor may receive payment based upon new sales, new customer growth or retention. This incentive payment is funded from Cigna HealthCare's general overhead.

Cigna HealthCare sponsors programs to inform benefit advisors about Cigna HealthCare's plan coverage and services (including producer advisory councils). The cost of these events is funded through Cigna HealthCare's general overhead.