City of SACRAMENTO

City Council Report

915 I Street, 1st Floor
Sacramento, CA 95814
www.cityofsacramento.org

File ID: 2018-01389 | Published for 10-Day Review 10/11/2018 | **Review Item 01**

Title: (Agreement/Contract for Review) Agreement with UnitedHealthcare for Medicare Retiree Medical Insurance

Location: Citywide

Recommendation: Accept and publish for review a Motion authorizing the City Manager or the City Manager's designee to execute a health carrier agreement with UnitedHealthcare estimated at $1.4 million; and continue to October 23, 2018, for approval.

Contact: Samantha Wallace, Human Resources Manager, (916) 808-7657, Department of Human Resources

Presenter: None

Attachments:
1-Description/Analysis
2-Agreement
3-UnitedHealthcare Benefits Summary

Description/Analysis

Issue Detail: Council approved labor agreements require the City to provide health insurance to eligible employees and retirees. The City currently contracts with Kaiser Permanente, Western Health Advantage, Sutter Health Plus, and Health Net to provide these benefits. Consistent with the City's procurement policy, a Request for Proposals (RFP) was issued in April 2018 seeking qualified health insurance carriers to provide medical benefit services at the same level of service over the same geographical service coverage areas to our employees and retirees.

No responses were received that provided alternatives to current providers for City employees or non-Medicare retirees. Therefore, Human Resources does not recommend replacement of any of the current providers. The City received one response to the RFP from UnitedHealthcare for a Medicare retiree plan. For Medicare retirees, the City currently contracts with Kaiser Permanente and Health Net.

After a thorough evaluation of the proposal from UnitedHealthcare, it is in the City's best interest, and that of its Medicare retirees, to eliminate the Health Net Seniority Plus plan in 2019 and contract with UnitedHealthcare for the UnitedHealthcare® Group Medicare Advantage PPO plan. The 2019 premium for the Health Net Seniority Plus plan is estimated to be $439.56 per enrollee. The 2019 premium for the UnitedHealthcare® Group Medicare Advantage PPO plan will be $354.96 per enrollee.

Advantages to offering the UnitedHealthcare® Group Medicare Advantage PPO plan to Medicare retirees include:

- Lower monthly premiums than the City's Health Net Seniority Plus plan for the same $15 co-pay amount.
- Coverage available in all 50 United States and 5 United States territories. The Health Net plan is only available in California.
- House call visits and member incentives for eye exams, routine screenings, annual wellness and physical visits.
- Increased level of coverage for vision services.

Policy Considerations: Through the competitive bid process, an RFP was published. After review of the proposal and the services offered by our current providers, it was determined UnitedHealthcare has the experience and capability to provide services to Medicare retirees at a lower cost than the current Health Net plan, while expanding available coverage to Medicare retirees who live outside California.

Economic Impacts: None.

Environmental Considerations: None.

Sustainability: Under the California Environmental Quality Act (CEQA) guidelines, administrative activities do not constitute a project and are therefore exempt from review.

Commission/Committee Action: None

Rationale for Recommendation: Council approved labor agreements require the City to provide health insurance to eligible employees and retirees. It is in the City's best interest, and that of its Medicare retirees, to contract with health carriers that are able to provide quality medical insurance at the lowest possible cost.

Financial Considerations: City retiree health contributions are approved in Labor Agreements and the Unrepresented Resolution. Funding for City retiree health contributions is approved each year through the annual budget process. Because the annual health premium payments to UnitedHealthcare for enrollees is estimated at $1.4 million including city and retiree contributions.

Local Business Enterprise (LBE): Although UnitedHealthcare provides services in the Sacramento region, their headquarters are located outside the region.

City of SACRAMENTO
Office of the City Clerk

CONTRACT ROUTING SHEET

Contract Cover/Routing Form: Must Accompany ALL Contracts; however, it is NOT part of the contract.

General Information (Required)

Original Contract # (supplements only): _____ Supplement/Addendum #: _____

Assessor's Parcel Number(s): _____

Contract Effective Date: 01/01/2019 Contract Expiration Date (if applicable): _____

$ Amount (Not to Exceed): _____ Adjusted $ Amount (+/-): _____

Other Party: United Healthcare Insurance Company

Project Title: The Medicare Advantage with Prescription Drug Benefit

Project #: Group #EGC101075 Bid/RFQ/RFP #: _____

City Council Approval: YES if YES, Council File ID#: 2018-01389

Contract Processing Contacts

Department: Human Resources Project Manager: Samantha Wallace

Contract Coordinator: Katherine Robbins Phone Ext. 1562

Department Review and Routing

Accounting: _____ 9-25-18
(Signature) (Date)

Supervisor: _____
(Signature) (Date)

Division Manager: _____ 9/25/18
(Signature) (Date)

Other: CAO _____ 9/25/18
(Signature) (Date)

Special Instruction/Comments (i.e. recording requested, other agency signatures required, etc.)

----------FOR CLERK & IT DEPARTMENTS ONLY – DO NOT WRITE BELOW THIS LINE----------

----------Date Received Stamp(s)----------

MEDICARE ADVANTAGE WITH PRESCRIPTION DRUG BENEFIT GROUP AGREEMENT

This Medicare Advantage with Prescription Drug Benefit Group Agreement ("Agreement"), Group number EGC101075, is entered into effective as of January 1, 2019 (the "Effective Date") between UnitedHealthcare Insurance Company on behalf of itself and its affiliates (collectively "United"), and City of Sacramento ("Group"). All defined terms shall be as described in this Agreement unless stated otherwise.

RECITAL OF FACTS

United is a Medicare Advantage plan sponsor certified by the Centers for Medicare & Medicaid Services ("CMS") to offer Medicare Advantage and prescription drug benefit plans.

Group is an employer or other entity which sponsors an employee welfare benefit plan and desires to provide a United Medicare Advantage Plan for its Eligible Retirees and their Eligible Dependents.

AGREEMENT

NOW THEREFORE, in consideration of the application of Group for the benefits provided under this Agreement and in consideration of the periodic payment of the Plan Beneficiary Premium on behalf of Members in advance as they become due, United agrees to provide Covered Services to Members subject to all terms and conditions of this Agreement.

SECTION 1 - DEFINITIONS

Centers for Medicare & Medicaid Services ("CMS") is a Federal agency within the United States Department of Health and Human Services and is responsible for administering various Medicare programs.

Coinsurance is the portion of medical expenses for a service the Member must pay out-of-pocket, usually a fixed percentage. Coinsurance is usually applied after a deductible or Copayment requirement is met. Coinsurance is in addition to the Plan Beneficiary Premium.

Copayment(s) is a fixed dollar amount payable to a health care provider or pharmacy by the Member when the Member receives a health care service or product that is covered by the Plan. Copayments are in addition to the Plan Beneficiary Premium.

Covered Services are the health care services and products covered pursuant to the current terms of the Plan. Covered Services also include Medicare Part D eligible prescription drugs and drug products covered pursuant to the current terms of the Plan, in compliance with Medicare Laws and Regulations.

Eligible Dependent(s) is any person defined as a qualified dependent by Group, who meets all the eligibility requirements of Group and the Plan, and who is eligible to enroll in a plan under the Medicare Laws and Regulations and who permanently resides within the Service Area.

Eligible Retiree(s) is a former Group employee who has met the minimum required retiree participation conditions as determined by Group, who is eligible to enroll in a plan under the Medicare Laws and Regulations, who meets the eligibility and enrollment requirements of the Plan, and who permanently resides in the Service Area.

Enrollment is the enrollment of Group's Eligible Retirees and Eligible Dependents into the Plan by Group. Enrollment is conditioned upon acceptance of the Eligible Retiree or Eligible Dependent by United and by CMS, the execution of this Agreement by United and by Group, and the receipt of Plan Beneficiary Premium by United.

Evidence of Coverage ("EOC") is the document supplied by United and issued to Members disclosing and setting forth the health care benefits and terms and conditions of coverage of the Plan to which Members are entitled. The EOC is incorporated fully into this Agreement by reference.

Group is the single employer or other entity identified above.

Group Contribution is the amount of the Plan Beneficiary Premium applicable to each Member which is paid by Group.

Low Income Subsidy ("LIS") is a low-income subsidy provided to a LIS-eligible Member for the cost of the Member's premium or drug cost-sharing coverage under a Plan that provides Part D prescription drug benefit coverage, as described in Medicare Laws and Regulations.

Medicare Laws and Regulations are, collectively, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the "MMA"), the Medicare Improvements for Patients and Providers Act of 2008, the Patient Protection and Affordable Care Act, the regulations implementing the Medicare Advantage provisions at 42 CFR Part 422, together with guidance, instruction and other directives from CMS relating to Medicare Advantage Plans, and as applicable the regulations implementing the Medicare Part D Plan provisions of the MMA at 42 CFR Part 423, together with guidance, instruction and other directives from CMS relating to the Medicare Part D Plan.

Medicare Part D Plan is a Medicare Part D prescription drug benefit plan.

Member is the Eligible Retiree and/or Eligible Dependent who is eligible and covered by the Plan.

Open Enrollment Period is the annual period established by Group, or if no Open Enrollment Period is declared by Group, another period required by CMS, during which all eligible and prospective Group Eligible Retirees and Eligible Dependents may enroll in the Plan.

Plan is the Medicare Advantage with prescription drug benefit plan described in this Agreement, subject to modification, amendment or termination pursuant to the terms of this Agreement and the Plan.

Plan Beneficiary Premium is an amount established by United to be paid to United by or on behalf of each Member enrolled in the Plan for coverage under the Plan. If the Plan provides coverage for prescription drugs, the Plan Beneficiary Premium may include late enrollment penalties as assessed by CMS for those Members who did not have creditable prescription drug coverage for a period that exceeds sixty-three (63) calendar days from or after eligibility for Medicare Part D Plan. Plan Beneficiary Premium will not include Income Related Monthly Adjustment Amounts (IRMAA), if any, as assessed and billed to Member by the Social Security Administration to certain individuals with higher incomes. Member is responsible for the payment of IRMAA and if not paid, Member will be disenrolled from the Plan by CMS.

Proprietary Business Information is nonpublic information, trade secrets, and other data including, but not limited to, sales and marketing information, management systems, strategic plans and other information about the disclosing party's business, industry, products and services, plans, specifications, operation methods, pricing, costs, techniques, manuals, know-how and other intellectual property, in written, oral or other tangible form, provided by one party to another or its representative, and all information, documents, technology, products, and services containing or derived from Proprietary Business Information which was or may have been transmitted, given or made available to or viewed by one party or another in the course of the receiving party's relationship. United's Proprietary Business Information shall include, but not be limited to, discounts and other financial provisions related to United's network of healthcare providers and claims data from which those financial provisions can be derived and financial provisions related to prescription drug products covered, the prescription drug list, reimbursement rates, compensation arrangements and all other financial provisions related to the pharmacy. This information is collectively known as "United Financial PBI".

Service Area is a geographic area approved by CMS within which a Plan Member must permanently reside in order to enroll in the Plan.

SECTION 2 - ELIGIBILITY AND ENROLLMENT

2.01 Eligibility. The Plan specifies the coverage for which Eligible Retirees and Eligible Dependents are eligible, in consideration of their continued entitlement to Medicare Part A and enrollment in Part B, and in consideration of United's receipt of any specified Plan Beneficiary Premium. Only persons with Medicare Parts A and B are allowed to be enrolled in the Plan. The Member is responsible for paying the appropriate premiums for Medicare Part A and/or Part B.

2.02 Submission of Eligibility List and Enrollment Election Forms. Group shall submit Eligible Retirees and Eligible Dependents information (the "Group Eligibility List"), as communicated by United and consistent with CMS requirements. The Group Eligibility List is subject to modification by United based upon acceptance or rejection of Enrollment by United and CMS.

2.02.01 Enrollment/Election. A properly completed Enrollment form must be submitted to United by Group for each Eligible Retiree and Eligible Dependent to be enrolled in the Plan. In its discretion, United may accept a uniform group Enrollment (without individual enrollment election forms and usually in an electronic file format) if such group Enrollment is conducted pursuant to Medicare Laws and Regulations. If Group utilizes the group enrollment process to enroll its Eligible Retirees and Eligible Dependents in the Plan, Group will make available to its Eligible Retirees and Eligible Dependents the ability to opt out of the enrollment in a manner that allows its Eligible Retirees and Eligible Dependents to enroll in another plan of their choice on a timely basis and in accordance with Medicare Laws and Regulations.

2.02.02 Time of Enrollment. All Enrollment forms shall be completed and submitted by Group to United during the Open Enrollment Period. The EOC applicable to the Plan includes information regarding Initial Enrollment Period and Special Enrollment Period, as defined by CMS, during which Eligible Retirees and Eligible Dependents may enroll in the Plan outside of the Open Enrollment Period.

Group shall forward all completed or amended Enrollment forms for receipt by United. Group acknowledges that any Enrollment form not received by United consistent with CMS timing requirements may be rejected by United or may result in a later effective date of coverage.

2.02.03 Enrollment Notice to Eligible Retiree and Eligible Dependent. Group shall provide a written notice, prepared by United, to Eligible Retirees and Eligible Dependents at the commencement of the Open Enrollment Period and throughout the year to persons who become eligible at times other than during the Open Enrollment Period. The written notice shall provide notice of the availability of coverage under the Plan.

2.02.04 Enrollment Record Retention. Group's record of Member's enrollment election must exist in a format that can be easily, accurately and quickly reproduced for later reference by each individual Member, United and/or CMS, as necessary, and be maintained by Group for the term of this Agreement and for ten (10) years thereafter.

2.03 Commencement of Coverage. The commencement date of coverage under the Plan shall be effective in accordance with the terms of this Agreement and Medicare Laws and Regulations (or, if applicable, in accordance with the eligibility date CMS communicates to United). United's acceptance of each Member's Enrollment is contingent upon receipt of the applicable Plan Beneficiary Premium payment and CMS' confirmation of enrollment.

2.04 Involuntary Disenrollment. In the event a Member no longer meets Group's eligibility requirements for participation in the Plan, Group and/or Member shall provide written notice to United of such Member's disenrollment from the Plan or Group shall provide notice via the monthly Group Eligibility List submission, if applicable. Such notice, regardless of medium, shall include the reason for disenrollment. Group shall notify United thirty (30) calendar days prior to the proposed effective date of disenrollment. Disenrollment generally cannot be effective prior to the date Group submits the disenrollment notice.

In the case of a Member who no longer meets Group's eligibility requirements for participation in the Plan or in the case of termination of this Agreement in accordance with Section 6, Group will issue prospective notice to Member of the termination a minimum of twenty-one (21) calendar days prior to the effective date of said termination. Such notice must advise Member of other insurance options that may be available through Group. Group will also advise such Member that the disenrollment action means the Member will not have coverage. If the Plan provides coverage for prescription drugs, the Notice must include information about the potential for late-enrollment penalties that may apply in the future.

The effective date of disenrollment always falls on the last calendar day of a month. In the case of a Member no longer meeting Group's eligibility requirements, Group will send United notice of a Member's termination from the Plan by the first calendar day of the month for an effective date of the last calendar day of that month. All notifications received after the first calendar day of the month will result in a termination effective date of the last calendar day of the following month. Group agrees to pay any applicable Plan Beneficiary Premium through the last calendar day of the month in which Member is enrolled.

2.05 Voluntary Disenrollment. In the event a Member elects to discontinue being covered by the Plan, United must receive a written notice signed by Member that complies with CMS requirements. In the event Group submits Member voluntary disenrollment via the Group Eligibility List, Group must include in the Group Eligibility List the date Member advised Group of disenrollment. The effective date of disenrollment always falls on the last calendar day of a month. Disenrollment generally cannot be effective prior to the date Member advises Group of

disenrollment or Member submits the Member's signed, written disenrollment notice. Group agrees to pay any applicable Plan Beneficiary Premium through the last calendar day of the month in which Member is enrolled.

2.06 Disenrollment Record Retention. Group's record of Member's election to disenroll must exist in a format that can be easily, accurately and quickly reproduced for later reference by each individual Member, United and/or CMS, as necessary, and be maintained by Group for at least ten (10) years following the effective date of the Member's disenrollment from the Plan.

2.07 Retroactive Adjustments to Enrollment. No retroactive adjustments may be made beyond ninety (90) calendar days for any additions to or terminations of Eligible Retiree, Eligible Dependent or Member or changes in coverage classification not reflected in United's records at the time United calculates and bills for Plan Beneficiary Premium.

SECTION 3 - GROUP OBLIGATIONS, PLAN BENEFICIARY PREMIUM AND COPAYMENTS

3.01 Notices to Member. If Group or United terminates this Agreement pursuant to Section 6 below, Group shall promptly notify all Members enrolled through Group of the termination of their coverage in the Plan. Such notification will include any other plan options that may be available through Group. Group shall provide such notice by delivering to each Member a true, legible copy of the notice of termination sent from United to Group, or from Group to United, at the Member's then current address. Group shall promptly provide United with a copy of the notice of termination delivered to each Member, along with evidence of the date the notice was provided. In the event that United terminates Member's enrollment in the Plan for non-payment of Plan Beneficiary Premium or United's non-renewal of this Agreement, Members will receive notice of termination from United.

If United or Group makes any changes affecting Members' benefits or obligations under the Plan, including but not limited to, increasing the Plan Beneficiary Premium payable by Member, increasing Copayments or Coinsurance or reducing Covered Services, unless the change is to be communicated by United through the Annual Notice of Change process, the party promulgating the change shall promptly notify all Members enrolled through Group of the applicable change. If Group promulgates the change and is required to provide notice to Members, Group shall provide such notice by delivering to each Member a true, legible copy of the notice of the applicable change at the Member's then current address. When required by CMS, Group shall promptly provide United with a copy of any notice delivered to each Member, along with evidence of the date the notice was provided. United shall have no responsibility to Members in the event Group fails to provide the notices required by this Section 3.01.

3.02 Plan Beneficiary Premium. Plan Beneficiary Premium will be paid to United by the Due Date in accordance with Section 3.03 below. Group shall pay or ensure payment of any portion of Plan Beneficiary Premium for Members for which Group is responsible. Each Member is responsible for paying to United or Group, as applicable, any portion of Plan Beneficiary Premium for which he or she is responsible. When agreed by United and Group, United will bill each Member for Member's amount of the Plan Beneficiary Premium. United shall arrange for Covered Services under the Plan only for those Members for whom the applicable Plan Beneficiary Premium has been paid.

3.02.01 Late Enrollment Penalty. Plan Beneficiary Premium may include any late enrollment penalties as determined applicable by CMS. The late enrollment penalty ("LEP") is based on the combination of a percentage of the national average Part D bid amount set by CMS and the number of months a beneficiary has not enrolled in a Medicare Part D plan, when eligible or a Member does not have creditable coverage (coverage containing a prescription drug benefit that is equivalent to Medicare Part D). The LEP is communicated to United by CMS upon confirmation of Member enrollment by CMS. In the event Member is assessed a LEP by CMS, United will bill the LEP directly to Group. Otherwise, upon Group's written authorization, United will bill the LEP directly to Member. In the case where United bills Member directly for Plan Beneficiary Premium, United will bill the LEP directly to the applicable Member.

3.03 Due Date. Plan Beneficiary Premium is due in full on a monthly basis by check or electronic transfer and must be paid directly by Group and/or by Member, as applicable, to United on or before the first business day of the month for which the premium applies ("Due Date"). Failure to pay the Plan Beneficiary Premium on or before the Due Date may result in termination of the Member from the Plan in accordance with eligibility requirements as determined by the Group, the procedures set forth in the EOC and Medicare Laws and Regulations. For payments due from Group, United reserves the right to assess Group an administrative fee of five percent (5%) of the monthly premium prorated on a thirty (30)-day month for each day it is delinquent thereafter. This fee will be assessed solely

at United's discretion. In the event that deposit of payments not made in a timely manner are received by United after termination of Group, the depositing or applying of such funds does not constitute acceptance, and such funds shall be refunded by United within twenty (20) business days of receipt, if United, in its sole discretion, does not reinstate Group.

3.04 Modification of Plan Beneficiary Premium and Benefits.

3.04.01 Modification of Plan Beneficiary Premium. Plan Beneficiary Premium may be modified by United upon thirty (30) calendar day's written notice to Group. Any such modification shall take effect commencing the first full month following the expiration of the thirty (30) day notice period.

3.04.02 Modification of Benefits or Terms. Covered Services and Covered Part D Drugs, as set forth in the EOC, as well as other terms of coverage under the Plan may be modified by United upon thirty (30) calendar days' written notice to Group. Any such modification shall take effect commencing the first full month following the expiration of the thirty (30) day notice period or on a later date specified in the notice.

3.05 Effect of Payment. Except as otherwise provided in this Agreement, only Members for whom the Plan Beneficiary Premium is received by United are entitled to benefits under the Plan, and then only for the period for which such payment is received.

3.06 Adjustments to Payments. Any imposition of or increase in any premium tax, guarantee or uninsured fund assessments, or other governmental charges relating to or calculated in regard to the Plan Beneficiary Premium shall be automatically added to the Plan Beneficiary Premium as of their legislative effective dates, as permitted by law. In addition, any change in law or regulation that significantly affects United's cost of operation can result in an increase in the Plan Beneficiary Premium, in an amount to be determined by United, as of the next available date of Plan Beneficiary Premium adjustment, as permitted by law.

3.07 Member/Marketing Materials. Group shall provide United with copies of any and all materials relating to the coverage available through the Plan that Group intends to disseminate to Eligible Retiree, Eligible Dependent or Member. All materials relating to the Plan and/or United shall be subject to review and written approval by United prior to its distribution by Group. Group understands that the Plan is subject to federal and state regulatory oversight, and that Eligible Retiree, Eligible Dependent or Member materials and marketing materials (including, but not limited to, cover letters accompanying direct mail kits, announcement mailings, etc.) may be required to be filed with, reviewed and approved by, CMS or state regulators prior to use. Group agrees not to distribute such material prior to receipt of written approval of the material by United. Group shall assume all liabilities and damages arising from Group's unauthorized dissemination of Eligible Retiree, Eligible Dependent or Member materials and/or marketing materials. Group also agrees to comply with all relevant federal and state regulatory requirements regarding the distribution and fulfillment of Eligible Retiree, Eligible Dependent or Member materials and/or marketing materials and applicable timeframes.

3.08 Employer/Union-Only Group Part D Prescription Drug Plan Obligations. Pursuant to Medicare Laws and Regulations, Group acknowledges and agrees to comply with the following obligations with respect to the Plan:

3.08.01 Uniform Premium Requirements: Group may determine how much of a Member's Plan Beneficiary Premium Group will subsidize, subject to the following conditions in determining the Plan Beneficiary Premium subsidy:

a. Group can subsidize different amounts for different classes of Members in the Plan provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried v. hourly). Different classes cannot be based on eligibility for Low Income Subsidy individuals;

b. Group cannot vary the Plan Beneficiary Premium subsidy for individuals within a given class of Members, other than as is required for the CMS-assessed late enrollment penalty; and

c. Group cannot charge a Member for prescription drug coverage provided under the Plan for more than the sum of his or her monthly Plan Beneficiary Premium attributable to basic prescription drug coverage and 100% of the monthly Plan Beneficiary Premium attributable to his or her supplemental prescription drug coverage (if any).

3.08.02 Low Income Subsidy: For all Plan Low Income Subsidy eligible individuals:

a. United will administer Low Income Premium Subsidy (LIPS) credits. Pursuant to federal regulations, the LIPS amount must first be used to reduce the portion of the monthly Plan Beneficiary Premium attributable to basic prescription drug coverage paid by Member, with any remaining portion of the LIPS amount then applied toward the portion of the monthly Plan Beneficiary Premium attributable to basic prescription drug coverage paid by Group. If, however, United does not or cannot directly bill Group's Members, CMS will waive this up-front reduction requirement and permit United to directly refund the amount of the LIPS to the Member.

b. If the sum of Member's and Group's monthly Plan Beneficiary Premium is less than the amount of the LIPS credit, any amount of the LIPS credit above the total Plan Beneficiary Premium must be returned to CMS; and

c. If the LIPS credit for which a Member is eligible is less than the portion of the monthly Plan Beneficiary Premium paid by Member, Group shall communicate to Member the financial consequences for Member of enrolling in the Plan as compared to enrolling in another Medicare Part D Plan with a monthly beneficiary premium equal to or below the LIPS amount.

d. Any LIPS credit due to Member and/or Group must be applied within forty-five (45) calendar days of receipt.

e. To enable United to appropriately administer LIPS disbursements, Group shall complete and return an annual attestation issued by United.

i. The attestation validates the Group's current billing procedures and is used to determine the recipient of LIPS disbursements.

ii. The lack of an up-to-date attestation will default the disbursement of LIPS to Member regardless of prior year attestation information.

iii. United will not refund Group for LIPS disbursements made to Member during periods prior to an adequate attestation being completed and returned.

iv. In order to collect and redistribute misappropriated LIPS disbursements made to Group, United reserves the right to bill Group who has received LIPS disbursements on behalf of Member due to incorrect attestation information.

f. United shall provide reporting to Group for Members currently receiving LIPS disbursements. These reports will identify Member by name and display their respective monthly disbursements. These reports are intended to allow Group to recoup, if applicable, any remaining portion of the LIPS credit (payment that remains after the LIPS credit is used to exhaust the monthly Plan Beneficiary Premium attributable to basic prescription drug coverage paid by the Member). If the reported amount exceeds $30, the amount distributed would likely cover multiple months. Group would only be allowed to recoup the difference between the monthly Plan Beneficiary Premium and the monthly LIPS credit amount. In these cases, a request for a more detailed report from United should be sought before attempting to recoup LIPS disbursements.]

SECTION 4 - RELATIONSHIPS OF AND BETWEEN PARTIES

4.01 Relationship of Parties. United is not the agent or representative of Group. Group is not the agent or representative of United.

4.02 Roles. United shall not be deemed or construed as an employer or as an employee for any purpose with respect to the administration or provision of benefits under Group's benefit plan. United shall not be responsible for fulfilling any duties or obligations of an employer or an employee with respect to Group's benefit plan. This Agreement is a business transaction between two unrelated parties.

SECTION 5 - TERM OF AGREEMENT; RENEWAL PROVISIONS

The term of this Agreement shall be one (1) year, commencing on the Effective Date, unless this Agreement is terminated as provided herein. Following the Effective Date and after United has provided one month of services this Agreement is deemed executed by the parties. This Agreement shall automatically renew for a one (1) year term on each anniversary of the Effective Date, unless terminated as provided herein. Renewal of this Agreement shall be subject to modification of rates and benefits pursuant to Section 3.04.

SECTION 6 - TERMINATION

6.01 Termination by Group. Group may terminate this Agreement by giving a minimum of sixty (60) calendar day's written notice of termination to United, to allow processing time for United to notify Member with a minimum of twenty-one (21) calendar days advance notice of termination. Group termination shall always be effective on the last day of the month. Group shall continue to be liable for Plan Beneficiary Premium for all Members enrolled in this Plan through Group until the date of termination or, if later, the termination date indicated by CMS.

6.02 Termination by United.

6.02.01 This Agreement shall terminate, in whole or in part as the case may be, for one or more of the following events and notices of termination shall be sent by United within 90 (ninety) days of the effective date of termination, or as otherwise required by CMS.

a. termination or non-renewal of United's contract with CMS;

b. termination or non-renewal with respect to a Service Area or a portion of a Service Area in which Member resides, as applicable.

c. if United no longer issues the Plan or any group health benefit plans within the applicable market, as permitted by law;

d. if Group fails to abide by and enforce the conditions of Enrollment set forth in this Agreement;

e. if Group no longer meets United's minimum contribution or participation requirements;

f. non-renewal of this Agreement by United at the end of the then current term.

g. in the event of a filing by or against the Group of a petition for relief under the Federal Bankruptcy Code,

h. any jurisdiction prohibits a party from administering the Plan under the terms of this Agreement, or imposes a penalty on the Plan, Group or United and such penalty is based on the services specified in this Agreement. In this situation, the party may immediately discontinue the Agreement's application in such jurisdiction. Notice must be given to the other party when reasonably practical. The Agreement will continue to apply in all other jurisdictions.

6.02.02 Termination for Nonpayment of Plan Beneficiary Premium. United may terminate this Agreement in the event Group or its designee, or Member fails to remit Plan Beneficiary Premium, including LEP, in full by the Due Date to United by giving written notice of termination of this Agreement to Group. Nonpayment of Plan Beneficiary Premium includes, but is not limited to, payments returned due to non-sufficient funds and post-dated checks. Such notice shall specify that payment of all unpaid Plan Beneficiary Premium must be received by United within fifteen (15) calendar days of the date of issuance of the notice, and that if payment is not received within the fifteen (15) day period, no further notice shall be given, and coverage for all Members enrolled in this Plan shall automatically be terminated effective at the end of the month for which Plan Beneficiary Premium has been actually received by United, subject to compliance with notice requirements.

6.02.03 Termination for Breach. United may terminate this Agreement if Group breaches any term, covenant or condition of this Agreement and fails to cure such breach within thirty (30) calendar days after United sends written notice of such breach to Group. United's written notice of breach shall make specific reference to Group's action causing such breach. If Group fails to cure its breach subject to United's satisfaction within thirty (30) calendar days after United sends notice of such breach to Group, United may terminate this Agreement at the end of the thirty (30) day notice period.

6.02.04 Termination for Providing Misleading or Fraudulent Information. United may terminate this Agreement thirty (30) calendar days after United sends written notice to Group if Group provides materially misleading or fraudulent information to United in any Group questionnaire or is aware that materially misleading or fraudulent information has been provided on Eligible Retiree, Eligible Dependent or Member Enrollment forms.

6.02.05 For Loss of Group's Office Location within Service Area. Group acknowledges that in the event of such change of Group's office location, a modification to Plan Beneficiary Premium may be necessary. In the event of a change of Group's office location, the parties shall negotiate any changes requested by either party to the Plan Beneficiary Premium. In the event that the parties are unable to reach agreement regarding modified Plan

Beneficiary Premium, United may terminate Group upon thirty (30) calendar days' written notice prior to such termination.

6.03 Return of Prepayment Premium Fees Following Termination. In the event of termination by either party (except in the case of fraud or deception in the use of United services or facilities, or knowingly permitting such fraud or deception by another), United will, within thirty (30) calendar days, return to Group the pro-rata portion of money paid to United which corresponds to any unexpired period for which payment has been received, together with amounts due on claims, if any, less any amounts due to United. United's exercise of its termination rights under Section 6.02 above does not waive United's right to payment by Group for all coverage provided, including late fees as provided in Section 3.03 above.

SECTION 7 - MISCELLANEOUS PROVISIONS

7.01 United Names, Logos and Service Marks. United reserves the right to control all use of its name, product names, symbols, logos, trademarks, and service marks currently existing or later established. Group shall not use United's name, product names, symbols, logos, trademarks, or service marks or otherwise reference United in any form of publication or media without obtaining the prior written approval of United.

7.02 Assignment. Group may not assign this Agreement or any rights or obligations under this Agreement to anyone without United's written consent.

7.03 Subcontractors. United can use its affiliates or subcontractors to perform United's services under this Agreement. United will be responsible for those services to the same extent that United would have been had it performed those services without the use of an affiliate or subcontractor.

7.04 Governing Law. This Agreement shall be construed and enforced in accordance with the laws of the State of Connecticut (without regard to the legislative or judicial conflicts of laws/rules of any state), except to the extent superseded by federal law.

7.05 Severability. The invalidity or unenforceability of any provision of this Agreement will not affect the validity or enforceability of any other provision. However, it is intended that a court of competent jurisdiction construe any invalid or unenforceable provision of this Agreement by limiting or reducing it so as to be valid or enforceable to the extent compatible with applicable law.

7.06 Amendments. Except as may otherwise be specified in this Agreement, this Agreement may be amended only by both parties agreeing to the amendment in writing, executed by a duly authorized person of each party.

7.07 Waiver/Estoppel. Nothing in this Agreement is considered to be waived by any party, unless the party claiming the waiver receives the waiver in writing. No breach of this Agreement is considered to be waived unless the non-breaching party waives it in writing. A waiver of one provision does not constitute a waiver of any other. A failure of either party to enforce at any time any of the provisions of this Agreement, or to exercise any option which is herein provided in this Agreement, will in no way be construed to be a waiver of such provision of this Agreement.

7.08 Notices. Any notices, demands, or other communications required under this Agreement will be in writing and may be provided via electronic means or by United States Postal Service by certified or registered mail, return receipt requested, postage prepaid, or delivered by a service that provides written receipt of delivery.

7.09 Acceptance of Agreement. Group may accept this Agreement either by execution of this Agreement or by making its initial Plan Beneficiary Premium payment to United on or before the Effective Date. In the event acceptance of this Agreement is made with the initial payment of the Plan Beneficiary Premium, Group shall provide United with an executed copy of this Agreement within sixty (60) calendar days of such payment. Acceptance by any of these methods shall render all terms and provisions of this Agreement binding on the parties.

7.10 Entire Agreement. This Agreement, with its exhibits, constitutes the entire agreement between the parties governing the subject matter of this Agreement. This Agreement replaces any prior written or oral communications or agreements between the parties relating to the subject matter of this Agreement. The headings and titles within this Agreement are for convenience only and are not part of the Agreement.

7.11 No Third Party Beneficiaries. Except as otherwise expressly indicated in this Agreement, nothing in this Agreement shall confer upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

7.12 Superseding of Other Agreements. The Plan replaces and supersedes any previous Plan between United and Group.

7.13 Indemnification. The parties each agree to indemnify, defend and hold the other party, and its affiliates, harmless, and to accept all legal and financial responsibility for any liability (including reasonable attorneys' fees) arising out of its own failure to perform its material obligations as set forth in this Agreement, or under Medicare Laws and Regulations.

7.14 ERISA. United makes no representations or determinations regarding whether the arrangement contemplated by this Agreement constitutes an employee welfare benefit plan under the Employee Retirement Income Security Act ("ERISA"), 29 USC § 1001 et seq. This determination is solely the responsibility of Group. United will administer this Agreement in accordance with the requirements of Medicare Laws and Regulations and applicable state laws and is not responsible for complying with the provisions of ERISA or administering any applicable obligations that may arise under ERISA, including those relating to claims procedures or appeals, providing summary plan descriptions, required filings, member materials or disclosures. United is neither the plan administrator nor named fiduciary of the employee benefit welfare plan, as those terms are used in ERISA.

7.15 Proprietary Business Information. Each party will limit the use of the other's Proprietary Business Information to only the information required to administer the Plan, to perform under this Agreement, or as otherwise permitted under this Agreement. Neither party will disclose the other's Proprietary Business Information to any person or entity other than to the disclosing party's employees, subcontractors, or authorized agents needing access to such information to administer the Plan, to perform under this Agreement, or as otherwise permitted under this Agreement, except that United's Financial PBI cannot be disclosed by Customer to any third party without United's express written consent. This provision shall survive the termination of this Agreement.

7.16 Mediation and Arbitration. The parties will work together in good faith to resolve any disputes about their business relationship. If the parties are unable to resolve the dispute within thirty (30) calendar days following the date one party sent written notice to the other party, and if any party wishes to pursue the dispute, the pursuing party may request non-binding mediation, within ninety (90) calendar days following the date one party sent written notice to the other party, facilitated by a third-party neutral mutually agreeable to both parties. The mediation shall be held in Hennepin County, Minnesota. If agreement is not reached at the mediation, the pursuing party may submit the dispute to arbitration in accordance with the rules of the American Arbitration Association. In no event may arbitration be initiated more than one (1) year following the sending of written notice of the dispute, and no dispute may be initiated before the pursuing party submits to non-binding mediation. Any arbitration proceeding under this Agreement shall be conducted in Hennepin County, Minnesota. The arbitrators may construe or interpret but shall not vary or ignore the terms of this Agreement, shall have no authority to award any punitive or exemplary damages and shall be bound by controlling law. Each party shall be responsible for its own costs, including attorneys' fees, incurred in connection with any arbitration. The parties acknowledge that because this Agreement affects interstate commerce, the Federal Arbitration Act applies. Notwithstanding the provisions of this Section 8, if any party would reasonably suffer irreparable and immediate injury as a result of another party's breach or violation of any provision of this Agreement for which there would be no adequate remedy at law, such party may seek preliminary and other injunctive relief against any such breach or violation in a court having jurisdiction over the parties and the subject matter of the dispute.

7.17 Protected Health Information Certification. In executing this Agreement, Group certifies that as plan sponsor it has in place appropriate Plan documents necessary to demonstrate compliance with applicable privacy requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations as amended from time to time (collectively, "HIPAA"). The Group further certifies that its Plan documents meet the following requirements: (a) Plan documents describe employees or classes of employees or other persons under the control of the plan sponsor to be given access to the protected health information to be disclosed, provided that any employee or person who receives protected health information relating to payment under, health care operations of, or other matters pertaining to the group health plan in the ordinary course of business must be included in such description; (b) restrict the access to and use by such employees and other persons described in the above to the plan administration functions that the Plan Sponsor performs for the group health plan; (c) provide an effective mechanism for resolving any issues of noncompliance by persons described above with the plan document provisions required by law; and (d) the Plan documents comply with the requirements of 45 C.F.R. Section 164.504(f)(2) and that the plan sponsor will safeguard and limit the use and disclosure of protected health information that the plan sponsor may receive from United to perform the plan administration functions.

Specifically, the plan sponsor will:

a. Not use or further disclose the information other than as permitted or required by the plan documents or as required by law;

b. Ensure that any agents, including a subcontractor, to whom it provides protected health information received from United, agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information;

c. Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor;

d. Report to United any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

e. Make available protected health information in accordance with 45 CFR §164.524;

f. Make available protected health information for amendment and incorporate any amendments to protected health information in accordance with 45 CFR §164.526;

g. Make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528;

h. Make its internal practices, books and records relating to the use and disclosure of protected health information received from United available in response to an inquiry from United or an appropriate regulatory entity for purposes of determining compliance with federal privacy requirements;

i. If feasible, return or destroy all protected health information received from the United that the plan sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement.

City of Sacramento
915 I Street
Sacramento, CA 95814

By: _____
Authorized Signature

Print Name: _____

Print Title: _____

Date: _____

UnitedHealthcare Insurance Company
185 Asylum Street
Hartford, CT 06103-3408

By: Greta Redmond
Authorized Signature

Print Name: Greta Redmond, FSA, MAAA

Print Title: VP

Date: September 14, 2018

APPROVED AS TO FORM:

CITY ATTORNEY

City of Sacramento

Performance Guarantees

The below performance guarantees (these "Performance Guarantees") are effective for the term of this Agreement. provided, however, United may specify to Group new Performance Guarantees upon a subsequent anniversary of the Effective Date . Any new Performance Guarantees must be in writing between the parties and shall supersede and replace these Performance Guarantees. With respect to the aspects of United's performance addressed in this exhibit, these fee adjustments are Group's exclusive financial remedies.

These Performance Guarantees will become effective upon the later of (1) the Effective Date of this Agreement; or (2) the date this Agreement is signed by both parties. In the event these Performance Guarantees become effective later than the Effective Date of this Agreement: (1) quarterly guarantees will become effective beginning with the next calendar quarter following signature of this Agreement by both parties and (2) annual guarantees will become effective commencing with the next anniversary of the Effective Date following the date this Agreement is signed by both parties.

These Performance Guarantees can be modified to the degree necessary to carry out the intent of the parties. United shall not be required to meet any of these Performance Guarantees or amendments thereto to the extent United's failure to meet these Performance Guarantees is due to fire, embargo, strike, war, accident, act of God, acts of terrorism; or United's required compliance with any law, regulation, or governmental agency mandate; or anything beyond United's reasonable control.

Total Fees at Risk for all Medicare Advantage Medical Performance Guarantees		**2% of total employer paid premium annually**
Product		**National PPO plan**
Member Phone Service		
Phone service guarantees and standards apply to Member calls made to the customer care center that primarily services Group members.		
Abandonment Rate		
Definition	The percentage of calls queued that abandon (hang up) will be no greater than the percentage set forth.	
Measurement	The percentage of calls queued that abandon (hang up) before being answered by a representative.	5%
▪ Criteria	Standard system tracking reports.	
▪ Level	Group Retiree Medicare Advantage book of business.	
▪ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Customer Service Level		
Definition	The percentage of answered member calls that are answered within the parameters set forth.	
Measurement	Percentage of calls answered.	80%
▪ Criteria	Time answered in seconds, on average. Standard system tracking reports.	30 seconds
▪ Level	Group Retiree Medicare Advantage book of business.	

▪ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Claims Operations		
Dollar Accuracy		
Definition	Claims dollars paid accurately will not be less than the designated percent.	
Measurement	Percentage of claims dollars paid accurately.	99%
▪ Criteria	Standard Claims Operations Report.	
▫	Statistically significant random sample of claims processed is reviewed to determine the percentage of claim processed without payment errors. Measurement: (Sample Claim Dollars Paid - Mispaid) / Sample Claim Dollars Paid.	
▪ Level	Cosmos Platform - Medicare and Retirement PPO Book of Business.	
▪ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Procedural Accuracy		
Definition	Procedural accuracy rate of not less than the designated percent.	
Measurement	Percentage of claims processed without procedural (i.e. non-financial) errors.	97%
▪ Criteria	Standard Claims Operations Report.	
▫	Statistically significant random sample of claims processed is reviewed to determine the percentage of claim processed without payment errors.	
▪ Level	Cosmos Platform - Medicare and Retirement PPO Book of Business.	
▪ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Payment Accuracy		
Definition	Claims Payment Accuracy Percentage will not be less than the designated percent.	
Measurement	Percentage of sampled claims paid without errors.	97%
▪ Criteria	Standard Claims Operations Report.	
▫	(Number of Sampled Claims - Number of Sampled Claims with Financial Defects) / Number of Sampled Claims.	
▪ Level	Cosmos Platform - Medicare and Retirement PPO Book of Business.	
▪ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	

Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Claims Time to Process in 30 calendar days		
Definition	The percentage of all claims United receives will be processed within the designated number of calendar days of receipt.	
Measurement	Percentage of clean claims processed (Par and Non Par Providers, including paid and un paid claims).	95%
	Calendar days after receipt.	30
▪ Criteria	Standard Claims Operations Report.	
▪ Level	Cosmos Platform - Medicare and Retirement PPO Book of Business.	
▪ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Eligibility File		
Eligibility File Load		
Definition	Member Applications processed within the designated number of calendar days of receipt of properly completed applications.	
Measurement	Percentage of member applications or enrollment files processed within seven (7) calendar days of receipt (must be received by ***12:00 noon EST*** otherwise they are considered received on the following calendar day) (BUSINESS decision to identify when the clock starts ticking).	95%
▪ Criteria	Standard system tracking reports; the guarantee is waived for member applications that cannot be processed because they have been not properly completed.	
▪ Level	Customer specific.	
▪ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Fulfillment - ID Cards		
Initial ID Card Distribution		
Definition	ID Cards will be postmarked within the parameters set forth.	
Measurement	Percentage of ID cards mailed within seven (7) calendar days of receiving CMS approval.	99%
▪ Criteria	Calculated on the actual number of cards mailed within seven (7) calendar days divided by the total number of member applications.	
▪ Level	Customer specific.	
▪ Period	Annual enrollment period.	
Payment Period	Annually.	

Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Claim Operations - Pharmacy		
Electronic Claim Turnaround Time		
Definition	The number of seconds taken to process all clean electronic pharmacy claims received.	
Measurement	Percentage of claims processed : As measured by the total elapsed time from the point a transaction is received by United's pharmacy system from the dispensing pharmacy until the submitted transaction is adjudicated and appropriate claim payment information is issued.	99%
▪ Criteria	Time to process, not to exceed.	3 seconds
▪ Level	Book of Business (UHCMR).	
▪ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Retail Paper Claims Paid in 14 Days (PROMPT PAY DMR CLAIMS)		
Definition	The percentage of all clean pharmacy claims United receives will be processed within the designated number of business days of receipt.	
Measurement	Percentage of clean pharmacy claims processed.	99%
▪ Criteria	Time to process, in calendar days or less after receipt of clean claim.	14
▪ Level	Book of Business (UHCMR).	
▪ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Retail and Mail Order Claim Processing Accuracy		
Definition	Accuracy rate of not less than the designated percent.	
Measurement	Percentage of paper and electronic clean pharmacy drug claims processed accurately and with no errors.	99%
▪ Criteria	Statistically significant random sample of clean pharmacy claims processed is reviewed to determine the percentage of claims processed without errors.	
▪ Level	Book of Business (UHCMR).	
▪ Period	Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Mail Order Average Dispensing Time - Intervention Required		
Definition	Average dispensing time, for all mail order prescriptions that require administrative or clinical intervention, no greater than as set forth.	
Measurement	Percentage of mail order prescriptions dispensed.	100%

▪ Criteria	Average dispensing time in business days.	5
▪ Level ▪ Period	Average dispensing time is derived by dividing the total whole days to dispense all prescriptions by the total number of prescriptions dispensed, based on the date a prescription order is received and the date the order is shipped. Orders where the prescriber or Participants fails to respond will be excluded. Book of Business (UHCMR). Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Mail Order Average Dispensing Time - No Intervention		
Definition	Average dispensing time for all mail order prescriptions that require no administrative or clinical intervention, no greater than as set forth.	
Measurement	Percentage of mail order prescriptions dispensed.	100%
▪ Criteria	Average dispensing time in business days.	2
▪ Level ▪ Period	Average dispensing time is derived by dividing the total whole days to dispense all prescriptions by the total number of prescriptions dispensed, based on the date a prescription order is received and the date the order is shipped. Book of Business (UHCMR). Reported quarterly.	
Payment Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
Mail Order Dispensing Accuracy		
Definition	Mail order dispensing accuracy rating of the guaranteed percentage.	
Measurement	Percentage of prescriptions dispensed accurately.	99.99%
▪ Criteria	External feedback will be collected and tracked from individuals receiving prescriptions for home delivery. This guarantee is conditional upon utilization of United's standard pharmacy management claim processing protocols.	
▪ Level ▪ Period	Book of Business (UHCMR). Reported quarterly.	
Fees at Risk	Annually (aggregated results). Percentage of fees at risk for this metric.	Total at risk divided equally between all measures
POS System Availability		
Definition	United guarantees that the pharmacy point of service system will be available a minimum of the displayed percentage of the time, not including scheduled downtime for maintenance, system updates, and telecommunication failures.	
Measurement	Percentage of time the system is available.	99.80%

▪ Criteria	United's internal systems measures.	
▪	Book of Business (UHCMR).	
▪ Level	Reported quarterly.	
▪ Period	Annually (aggregated results).	
Fees at Risk	Percentage of fees at risk for this metric.	Total at risk divided equally between all measures

Benefit Highlights

CITY OF SACRAMENTO 15882
Effective January 1, 2019 to December 31, 2019

This is a short description of your plan benefits. For complete information, please refer to your Summary of Benefits or Evidence of Coverage. Limitations, exclusions, and restrictions may apply.

Medical Benefits

Benefits covered by Original Medicare and your plan

	In-Network	Out-of-Network
Doctor's office visit	Primary Care Provider: $15 copay	Primary Care Provider: $15 copay
	Specialist: $15 copay	Specialist: $15 copay
Preventive services	$0 copay for Medicare-covered preventive services. Refer to the Evidence of Coverage for additional information.	
Inpatient hospital care	$0 copay per stay	$0 copay per stay
Skilled nursing facility (SNF)	$0 copay per day up to 100 days	$0 copay per day up to 100 days
Outpatient surgery	$0 copay	$0 copay
Outpatient rehabilitation (physical, occupational, or speech/language therapy)	$0 copay	$0 copay
Diagnostic radiology services (such as MRIs, CT scans)	$0 copay	$0 copay
Lab services	$0 copay	$0 copay
Outpatient x-rays	$0 copay	$0 copay
Therapeutic radiology services (such as radiation treatment for cancer)	$0 copay	$0 copay
Ambulance	$0 copay	$0 copay
Emergency care	$50 copay (worldwide)	
Urgently needed services	$20 copay (worldwide)	$20 copay (worldwide)
Annual medical out-of-pocket maximum	Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of $3,400 each plan year	

Additional benefits and programs not covered by Original Medicare

	In-Network	Out-of-Network
Routine physical	$0 copay; 1 per plan year*	$0 copay; 1 per plan year*
Chiropractic care	$5 copay (Unlimited visits per plan year)*	$5 copay (Unlimited visits per plan year)*

	In-Network	Out-of-Network
Dental	Included. See your Summary of Benefits or Evidence of Coverage for more details	Included. See your Summary of Benefits or Evidence of Coverage for more details
Foot care - routine	$15 copay (Up to 12 visits per plan year)*	$15 copay (Up to 12 visits per plan year)*
Hearing - routine exam	$0 copay (1 exam every 12 months)*	$0 copay (1 exam every 12 months)*
Hearing aids	Plan pays up to $500 (every 3 years)*	Plan pays up to $500 (every 3 years)*
Vision - routine eye exams	$15 copay (1 exam every 12 months)*	$15 copay (1 exam every 12 months)*
Vision - eyewear	Plan pays up to $365 eyewear allowance every 2 years. Plan pays up to $100 contact lens allowance in lieu of eyewear allowance every 2 years.*	Plan pays up to $365 eyewear allowance every 2 years. Plan pays up to $100 contact lens allowance in lieu of eyewear allowance every 2 years.*
Fitness program through SilverSneakers®	Stay active with a basic gym membership at a participating location at no extra cost to you.	
NurseLine	Speak with a registered nurse (RN) 24 hours a day, 7 days a week	
Virtual Behavioral Visits	See and speak to specific mental health professionals using your computer or mobile device. Find participating mental health professionals online at www.UHCRetiree.com.	
Virtual Doctor Visits	See and speak to specific doctors using your computer or mobile device. Find participating doctors online at www.UHCRetiree.com.	

*Benefits are combined in and out-of-network

Prescription Drugs

	Your Cost	
Initial Coverage Stage	Network Pharmacy (30-day retail supply)	Mail Service Pharmacy (90-day supply)
Tier 1: Generic	$10 copay	$20 copay
Tier 2: Preferred brand	$20 copay	$40 copay
Tier 3: Non-preferred drug	$50 copay	$100 copay
Tier 4: Specialty tier	25% coinsurance	25% coinsurance
Coverage gap stage	After your total drug costs reach $3,820, the plan continues to pay its share of the cost of your drugs and you pay your share of the cost	
Catastrophic coverage stage	After your out-of-pocket costs (what you pay including coverage gap discount program payments) reach the $5,100 limit for the plan year, you move to the Catastrophic Coverage Stage. In this stage, you will continue to pay the same cost share that you paid in the Initial Coverage Stage	