MEDICARE AGREEMENT

This Medicare Agreement is by and between the Contractor entities identified in Section 1.2 below (collectively, "Contractor" or "Aetna") and the City of New York acting through the Mayor's Office of Labor Relations – Employee Benefits Program on behalf of the Labor Management Health Insurance Policy Committee for the New York City Health Benefits Program with an office at 22 Cortlandt Street, 12th Floor, New York, NY 10007 (the "City") relating to Contractor's offering of certain Medicare Plans to the City's eligible retirees and dependents (the "Contract"). This Contract takes effect on the "Effective Date" (as defined below) and remains in force until terminated, consistent with this Contract.

WHEREAS, the City and Municipal Labor Committee ("MLC"), an umbrella organization for municipal unions, negotiate on a variety of matters, including collective bargaining regarding health benefits pursuant to their obligations under the New York Collective Bargaining Law; and

WHEREAS, to aid in the administration of the negotiated health benefits agreements, the City and the MLC established the Labor Management Health Insurance Policy Committee ("Committee") for the MLC and City representatives to meet on a regular basis to discuss City health insurance benefits; and

WHEREAS, the Employee Benefits Program ("EBP") is a division of the Mayor's Office of Labor Relations ("OLR"), and OLR is acting under the authority of the New York City Administrative Code Section 12.126(d) as the administrator of the New York City Health Benefits Program ("HBP"); and

WHEREAS, on October 30, 2020 OLR's request for authorization to enter into a Negotiated Acquisition to solicit a Medicare Advantage plan under Medicare Part C for the Medicare eligible retirees and dependents of the City of New York who are eligible for the City's Health Benefits Program was approved by the City Chief Procurement Officer; and

WHEREAS, OLR issued a public notice for a negotiated acquisition (EPIN:0021N002) in conformance with the New York City Procurement Policy Board Rules ("PPB") and had otherwise advertised in order to solicit vendors through the Notice of Intent to provide health benefits services in the form of a Medicare Advantage plan under Medicare Part C for the Medicare eligible retirees and dependents of the City of New York who are eligible for the City's Health Benefits Program; and

WHEREAS, the Contractor, submitted a response for such services, as provided for in the public notice for a negotiated acquisition, in the form of an expression of interest to OLR; responses were evaluated by an evaluation committee pursuant to PPB Section 3-04; and

WHEREAS, after an awarded vendor withdrew their response to provide such services, OLR determined the Contractor's response, as runner-up, to be most advantageous to the City, taking into consideration technical expertise, price, contract terms, and other factors set forth in the negotiated acquisition solicitation; and

WHEREAS, the City desires to appoint the Contractor to provide a Medicare Advantage PPO Plan under Medicare Part C and a standalone Medicare prescription drug plan under Medicare Part D for City of New York Retirees, and their Dependents, and

NOW, THEREFORE, in consideration of the terms and conditions contained herein, the parties hereby agree as follows

This Contract constitutes the following documents, which are hereby incorporated by reference:

- ATTACHMENT A: The calendar year 2023 **Evidence of Coverage** for the Medicare Advantage plan and standalone Medicare prescription drug plan issued to Members in connection with this Contract, including the attached Schedule of Copayments/Coinsurance (referred to as the "EOCs", as defined in Section 8.3 of this Contract). In ATTACHMENT A, there are two EOCs for Members enrolled in the standalone Medicare prescription

drug plan: (1) an EOC for Members who reside in the continental United States, and (2) an EOC for Members who reside in the United States Territories. The EOCs are issued by Contractor to Members on an annual basis and are incorporated herein by reference. Upon request, Contractor will provide the City with a copy of the EOCs issued to Members in future calendar years.

- ATTACHMENT B: **Medicare Advantage and Part D Rate Summary.**
- ATTACHMENT C: **Medicare Advantage Retrospective Experience Refund Agreement.**
- ATTACHMENT D**: Medicare Advantage/Medicare Part D Performance Guarantees.**
- ATTACHMENT E: **Medicare Advantage Plan Benefit Information and Plan Design.**

Attachments B, C, D, and E are issued by Contractor to the City in connection with the original issuance and renewal of this Contract and are collectively referred to herein as the "Financial Documents"

- ATTACHMENT F: **CMS/Regulatory Requirements Addendum and Plan Sponsor Certification Addendum.**
- ATTACHMENT G: **Summary Implementation Plan.**
- ATTACHMENT H: **Section 12.1 – Prior Authorization**
- ATTACHMENT I: **2023 List of Prescription Drugs - Supplemental Benefit Part D Rider.** This list of prescription drugs covered as a supplemental benefit under Contractor's standalone Medicare prescription drug plan will be updated by Contractor on an annual basis, subject to the review and consent of the City and MLC, and are incorporated herein by reference.
- ATTACHMENT J: **Specialty Drugs Subject to Prior Authorization.**
- The **Notice of Intent to Negotiate- Exhibit A – Program Requirements** ("Program Requirements").
- **Appendix A – General Provisions Governing Contract for Consultants, Professional, Technical Human, and Client Services** ("Appendix A")
- **Appendix B – Identifying Information Rider** ("Appendix B").
- The City's **Group Application** (the "Group Application").
- Any riders, amendments, inserts or attachments issued pursuant to any of the foregoing documents.

The EOCs, Financial Documents, List of Prior Authorization, List of Prescription Drug Supplemental Benefit Rider, Implementation Plan, Program Requirements, Appendix A, Appendix B, and Group Application are collectively referred to as the "Incorporated Documents."

Contractor and the City agree as follows:

Section 1. <u>COVERAGE</u>

1.1. **<u>Covered Benefits.</u>** The Financial Documents identify the fully-insured Medicare Plan(s) (the "Plan(s)") offered by Contractor to the City under this Contract for the corresponding time periods and the service area(s) (the "Service Area(s)") where the Plans are offered. The Plans offered to Members include a Medicare Advantage PPO plan ("MA plan") and a standalone Medicare Prescription Drug plan ("PDP"). Contractor shall provide coverage to Members for all of the health care and pharmacy services and supplies that are covered by the Plan(s) consistent with the EOCs and Mandates (as defined in Section 8.7) (the "Covered Benefits").

1.2. **<u>Contractor Insurers.</u>** Contractor's Medicare Advantage PPO Plans are offered by Aetna Life Insurance Company. With regard to such Plans, "Contractor" means Aetna Life Insurance Company.

Contractor's PDPs are offered by SilverScript Insurance Company. With regard to such Plans, "Contractor" means SilverScript Insurance Company.

1.3 **<u>Notice of Breach or Directives of the Commissioner</u>**. Contractor shall not be deemed to have breached a

material term or condition of the Contract and shall not be deemed to have refused or failed to proceed with the services under the Contract when and as directed by the Commissioner unless the Commissioner has sent the Contractor a Notice, citing this subsection of the Contract, identifying the issue, and affording the Contractor an opportunity to come into compliance within 30 days of the Contractor's receipt of said Notice, or any longer period agreed to by the Parties.

The Contractor shall furnish or make available a Plan identification card, subject to review by the City, EOCs and all other CMS-required documents to each Member enrolled in the Plan.

1.4 **Nonparticipating Healthcare Providers**. When Medicare Covered Benefits are provided by Medicare eligible nonparticipating health care providers ("non-participating providers"), the Member's coinsurance, if any, for such Medicare Covered Benefits will be based on either Medicare allowed or Medicare's limiting charge (up to 115% of Medicare allowed amounts), where applicable. If the non-participating provider has opted out of Medicare, the Member is responsible for the non-participating provider's billed charge, pursuant to ATTACHMENT E. Payments for out-of-network emergency services will be governed by applicable federal and state law and CMS requirements.

Section 2. TERM

2.1 **Initial Term.** Subject to the conditions described in this Section 2.1: (1) the initial term of this Contract (the "Initial Term") will be for five (5) years and four (4) months beginning at 12:01a.m. on September 1, 2023 (the "Effective Date"); (2) coverage under the MA plan will commence on the Effective Date; (3) coverage under the PDP will commence on September 1, 2023 for Members who are enrolled in a group health plan (other than the commercial group health plan offered by the City to its Medicare-eligible retirees and their dependents that includes coverage for supplemental benefits that are secondary to original Medicare)("Supplement Plan")) offered by the City or an individual standalone Medicare prescription drug plan prior to the Effective Date; and (4) coverage under the PDP will commence on January 1, 2024 for Members who are enrolled in the Supplement Plan offered by the City and have Emblem's Part D rider prior to the Effective Date.

The Parties acknowledge and agree that Contractor's performance of services under this Contract requires the collection, analysis, and testing of enrollment data and systems; development and completion of retiree, Member, and provider education and communications; and other critical activities in advance of the Effective Date to ensure an orderly implementation of the Plans ("Plan Implementation"). As such, City agrees to provide Contractor with a minimum of six (6) continuous months for Plan Implementation prior to the Effective Date (the "Implementation Period"). City and Contractor agree to work cooperatively to ensure an orderly Plan Implementation. Attached hereto as Attachment G is a timeline for the Plan Implementation.

The Implementation Period will be suspended upon the issuance of a temporary restraining order, injunction, or other federal or state court order that in the reasonable estimation of the City impacts or limits Contractor's ability to successfully execute the Plan Implementation (a "Disruptive Event"). In the case of a Disruptive Event, the City may unilaterally extend the original Effective Date of the Contract and the original effective dates of the Plans as described in this Section 2.1 (collectively, "Contract and Plan Effective Dates") for a period of up to twelve months with new effective dates and implementation plan, and the Contract and Financial Documents shall be amended to reflect these changes.

If the Disruptive Event continues after any twelve-month extension of the original Contract and Plan Effective Dates by the City ("the Discretionary Period"), the Parties shall promptly meet and confer to negotiate in good faith a further consensual suspension or extension of the Implementation Period and/or Contract and Plan Effective Dates. Following the meet and confer, if the Parties agree to a suspension or extension of the Implementation

Period and/or Contract and Plan Effective Dates during the Discretionary Period, the Parties agree to promptly execute an amendment to this Contract or an amendment following the final resolution of the Disruptive Event to: (1) reflect the change to the Contract and Plan Effective Dates, and (2) amend the Financial Documents to reflect only the change to the Contract and Plan Effective Dates. If changes are also made by the City to the duration of the Initial Term (as defined in Section 2.1 of this Contract) and Subsequent Term (as defined in section 2.2 of this Contract) during the Discretionary Period, the Financial Documents will be further amended by the Parties to account for such changes by mutual written agreement of the Parties. During the Discretionary Period, if the Parties cannot reach agreement on an amendment, the City can terminate the Contract prior to the Effective Date, as extended by the City, and the Contractor can terminate the contract prior to the Effective Date, as extended by the City: (i) if the Disruptive Event is ongoing and (ii) with a minimum of sixty days' notice to the City indicating Contractor's intent to terminate. In no way shall this Section 2.1 be construed as limiting or otherwise interfering with the City's rights to terminate the Contract pursuant to Section 10 of Appendix A.

2.2 **Subsequent Terms.** This Contract may renew for up to three (3) subsequent two-year renewal terms (each a "Subsequent Term") after the Initial Term unless sooner terminated prior to the commencement of a Subsequent Term consistent with Article 10 of Appendix A or Sections 2 or 5 of this Contract.

Following renewal of the Contract for three (3) Subsequent Terms, this Contract will thereafter renew for two-year renewal terms (each an "Additional Subsequent Term") unless sooner terminated prior to the commencement of an Additional Subsequent Term consistent with Article 10 of Appendix A or Sections 2 or 5 of this Contract.

If the Contract renews after the Initial Term, the Premium for each Subsequent Term and Additional Subsequent Term will be determined in accordance with ATTACHMENT B.

2.3 All of the City's current Medicare-eligible retirees and Medicare-eligible dependents age 65 and older, except for those Medicare-eligible retirees and their eligible dependents age 65 and older currently enrolled in HIP VIP retiree health plan or who have waived City Health Benefits, ("Eligible Enrollees") will automatically be enrolled in the MA plan. Eligible Enrollees who do not wish to be enrolled in the MA plan on the Effective Date will have the ability to opt-out into the HIP VIP retiree health plan only or waive coverage.

Eligible Enrollees enrolled in the HIP VIP retiree health plan as of the Effective Date of the MA plan will be permitted to elect to enroll in the MA plan beginning on September 1, 2023. The City will enroll the Eligible Enrollees enrolled in the HIP VIP in the MA plan and provide enrollment information to the Contractor.

If the City notifies Contractor in writing prior to April 1, 2023 that it will implement the scenario described in Option B or Option C as set forth in ATTACHMENT B, Eligible Enrollees will be permitted to opt-out of the MA plan and enroll in the Supplement Plan effective September 1, 2023.

If the City elects after April 1, 2023 or at any later date during the Initial Term or any Subsequent Term or Additional Subsequent Term to implement the scenario described in Option B or Option C (as set forth in ATTACHMENT B), Eligible Enrollees will be permitted to opt-out of the MA plan into the Supplement Plan effective no earlier than September 1, 2024, so long as City provides Contractor with at least six months advanced written notice. Contractor will have a three-month implementation period to prepare for an opt-out process, which will be followed by a two-month opt-out period.

Section 3. PREMIUMS

3.1 **Premiums.** A monthly premium will be billed to the City. If City and Contractor agree to change the billing method applicable to the Plan(s) after the Initial Term, the Financial Documents will indicate the billing method(s) that apply to the Plan(s) under this Contract. In all cases, the "Premium Due Date" shall be the Effective Date and the 1st day of each succeeding calendar month.

Contractor will charge the City a monthly premium (the "Premium") determined by Contractor based on the Premium in effect on the Premium Due Date, as stated in the Financial Documents. The City shall pay all Premium to Contractor on or before each Premium Due Date. Membership as of each Premium Due Date will be determined by Contractor in accordance with Contractor's Member records.

During the Initial Term or any Subsequent Term or Additional Subsequent Term of this Contract, the Contractor may change the Covered Benefits and/or the Premiums as a result of changes in requirements mandated by CMS or federal law and/or regulations, or changes in benefit provisions agreed to by the Parties in writing. The Financial Documents further describe when the Premium may change as a result of changes in requirements mandated by CMS or federal law and/or regulations. The Contractor will provide written notice to the City not less than 105 days from the effective date of any such benefit change (other than mutually agreed upon benefit changes for which notice shall be agreed upon by the Contractor and the City) or such shorter notice as may be required to comply with CMS or federal laws and/or regulations.

In the event the City chooses to offer the Supplement Plan to Eligible Enrollees during the Initial Term or during any Subsequent Term or Additional Subsequent Term **and** the City chooses to charge a premium for the Supplement Plan that is less than the full additional incremental cost, the City will provide Contractor with at least 120 days' advance written notice of such choice. Contractor may, upon at least 60 days' written notice to the City, change the Premium for the MA plan retroactive to the effective date that coverage commences for the Senior Care Plan. The MA plan Premium change, if any, shall be determined subject to mutual written agreement of the Parties, and the Parties agree to amend the Financial Documents to reflect any such Premium change. If the Parties cannot agree to the MA plan Premium change, the Premium will be as specified in ATTACHMENT B.

If the City does not meet the terms of the Financial Documents, as determined and agreed upon by the Contractor and the City, the Contractor may change the Premium, effective not less than 90 days after giving notice to the City after the Contractor and the City have determined that the City does not meet such terms of the Financial Document.

A Premium payment check does not constitute payment until it is honored by a bank. Contractor may return a check issued against insufficient funds without making a second deposit attempt.

Contractor may accept a partial payment of Premium without waiving the right to collect the entire amount due. If the Contract terminates for any reason, the City will continue to be held liable for all Premiums due and unpaid before the termination.

3.2 **Membership Adjustments.** Contractor may make retroactive additions of Members at its discretion based upon Contractor's eligibility and enrollment guidelines consistent with all CMS Mandates. Such additions are subject to the payment of all applicable Premiums.

Contractor may also make retroactive adjustments to the City's billings for the termination of Members consistent with CMS guidelines.

Section 4. ENROLLMENT/DISENROLLMENT

4.1 **Enrollment.** The City shall determine eligibility and offer enrollment in the Plan(s) in compliance with all applicable Mandates as follows:

- The City shall enable all eligible retirees and dependents to enroll in the Plan(s) within 31 days of becoming eligible to receive coverage under the Plan(s).
- Only eligible retirees and dependents may be enrolled in the Plan.
- To be enrolled in the Plan, eligible retirees and dependents must timely file an application for enrollment for themselves. Dependents who are eligible to enroll in the Plan shall be enrolled upon the timely filing of an application on such dependent's behalf.
- On an ongoing basis, the City or its designee shall have the opportunity to submit Plan applications to add new, transferred and newly eligible retirees and dependents to the group of Members initially enrolled under this Plan.
- The effective date of coverage for any such additional Member whose application is accepted by Contractor shall be in accordance with the EOCs and CMS requirements in effect at the time the Member's Plan application is approved.
- With such frequency as the Parties shall agree, the City or its designee shall furnish Contractor with notice setting forth deletions and changes to information provided in a Member's initial Plan application.
- An eligible retiree or dependent who is determined by the City or its designee to be ineligible for enrollment in the Plan shall be reported by the City or its designee as a deletion from the listing of Members reasonably in advance of such Member's termination. Contractor shall provide notice of termination to such Member in accordance with the EOCs and CMS requirements, and the Member's Plan coverage shall terminate in accordance with such notice

4.2 **MA Plan Deductible.** The Parties agree that Members enrolled in the MA plan will not be responsible for payment of a deductible in calendar year 2023. For calendar years beginning on and after January 1, 2024, Members enrolled in the MA plan will be responsible for payment of an annual deductible, as described in the Member's EOC.

4.3 **Enrollment/Disenrollment Processing.** The Contractor shall bear responsibility for enrollment and disenrollment Plan transactions. The Contractor shall perform the enrollment/disenrollment function in accordance with all applicable Mandates, including Mandates relating to timeframes for processing and submission of such transactions.

Contractor will not be liable to Members for the fulfillment of any Plan obligation before Contractor receives enrollment and eligibility information for the Member in a form satisfactory to Contractor. The City must notify Contractor of the date in which a Member's eligibility ceases for the purpose of termination of coverage under this Contract.

Section 5. TERMINATION.

5.1 Termination by Contractor.

a. **Termination With Cause.** In addition to the terms set forth in Appendix A, if the City fails to make in full any payment due under this Contract within the Grace Period, the Contractor may request termination of this Contract, by providing the City with at least sixty (60) days' advance written notice of the proposed date of termination. If the City fails to make full payment prior to the proposed date of termination set forth in the notice, the Contractor may in its sole discretion terminate this Contract. Contractor may also terminate this Contract with cause if the City is not in compliance with Mandates with respect to this Contract.

b. **Termination Without Cause.** Contractor may terminate this Contract without cause after the Initial Term by providing the City with written notice no later than September 1, 2028. If Contractor provides such termination notice to the City, the Parties agree that: (1) the term of the Contract will be extended for 12 months through December 31, 2029; and (2) the Premium for the 16-month period beginning on September 1, 2028 and ending on December 31, 2029 may be adjusted by Contractor in accordance with the methodology set forth in ATTACHMENT B. Thereafter, Contractor may terminate this Contract by providing the City with at least 16 months written notice prior to the beginning of a Subsequent Term or an Additional Subsequent Term (e.g., no later than September 1, 2027 for the first Subsequent Term).

c. **Other Contractor Termination Rights**. This Contract may also be terminated by Contractor effective upon any January 1 of any year if Contractor will no longer offer any of the products most recently offered to the City in any Service Areas covered under this Contract, because CMS terminates or otherwise non-renews the Contractor's CMS Contract. This Contract may also be terminated by Contractor in accordance with Section 2.1 of this Contract.

5.2 **Effect of Termination.** No termination of this Contract will relieve Contractor or the City from any obligation incurred under this Contract before the date of termination. When terminated, this Contract and all coverage provided hereunder will end at 12:00 midnight on the effective date of termination. In the event of termination for any reason, City must continue to pay all Premiums due and unpaid before the termination, including Premiums due during the Grace Period. A termination by the Contractor under Section 2 or Section 5.1 of this Contract shall be treated as a termination by the City other than for cause, which is described in Article 10.1 of Appendix A, and the Parties' remaining obligations shall be determined in accordance with that provision. To the extent that Article 10.2(B) of Appendix A is deemed applicable, the City hereby agrees in advance, that it is terminating this Contract without cause (i.e., in a manner other than for cause), and hereby exercising the discretion referenced in such section, upon notice by the Contractor that it wishes to terminate do the circumstances set forth in Section 2 or Section 5.1, hereof.

Section 6. PRIVACY AND SECURITY OF INFORMATION

6.1 **Compliance with Privacy and Security Laws.** In addition to the terms set forth in Appendix A and Appendix B, Contractor and the City shall each abide by all Mandates regarding the confidentiality and the safeguarding of individually identifiable health and other personal information, including the privacy and security requirements of HIPAA.

6.2 **Disclosure of Protected Health Information.** In addition to the terms set forth in Appendix A, if the City determines that it needs protected health plan information ("PHI"), as defined in HIPAA, in connection with administration of the Plan, any such request shall be in accordance with 45 C.F.R. § 164.504(f) and other applicable Mandates.

Contractor will not share PHI with the City, unless Contractor confirms that: (1) the City has a legitimate business need for the PHI, (2) the release of PHI to the City complies with all Mandates, and (3) the City certifies compliance with such Mandates (including, but not limited to, Section 164.504(f) of the HIPAA Privacy Rule). Contractor will not share with the City or its designee's Member data related to certain diagnosis (e.g., substance abuse, behavioral health, HIV/AIDs, etc.) if prohibited under Mandates. Contractor will require that the City sign a Plan Sponsor Certification in the form attached hereto to ensure compliance with all Mandates prior to the release of PHI.

Section 7. RELATIONSHIP BETWEEN CONTRACTOR & NETWORK PROVIDERS

The relationship between Contractor and providers contracted with Contractor to participate in the Plan(s)' provider network ("Network Providers") is a contractual relationship among independent contractors. Network Providers are not agents or employees of Contractor nor is Contractor an agent or employee of any Network Provider. Network Providers are not "Subcontractors" of the Contractor, as that term is defined in Section 8.11 of this Contract and Appendix A.

Network Providers are solely responsible for any health services rendered to their patients. Contractor makes no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any Network Provider. A Network Provider's participation in the provider network for the Plan(s) may be terminated at any time without advance notice to the City or Members, subject to Mandates. Network Providers provide health care diagnosis, treatment and services for Members. Contractor administers and determines Plan benefits.

Section 8. DEFINITIONS

8.1. "CMS" means the Centers for Medicare and Medicaid Services.

8.2. "CMS Contract" means the contract between Contractor and CMS under which Contractor offers the Plan(s) in the applicable time period.

8.3. "EOCs" means the Evidence of Coverage, which is a document issued pursuant to this Contract that outlines coverage for Members under the Plan(s). The EOC includes the Schedule of Copayments/Coinsurance and any riders or amendments.

8.4. "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

8.5. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations promulgated thereunder.

8.6. "Mandates" means applicable laws, regulations and government requirements in effect during the Term of this Contract including, without limitation, applicable Medicare laws, regulations and CMS requirements (including CMS manuals, memo guidance and other directives).

8.7. "Member" is a Medicare beneficiary who: (1) has enrolled in the Plan(s) and whose enrollment in the Plan(s) has been confirmed by CMS, and (2) is eligible to receive coverage under the Plan(s), subject to the terms and conditions of this Contract and the EOC.

8.8. "Party, Parties" means Contractor and the City.

8.9 "Records," as well as "books," "data," "documents," "information," and "other evidence," as those terms are used in Article 5 of Appendix A, shall mean records created by the City and delivered to the Contractor by the City for the exclusive use of the Contractor under this Contract. Furthermore, in that Article 5, such terms shall not be construed in a manner as to interfere with the Contractor's obligations under the Mandates with respect to such matters.

8.10 "Subcontractor" means an entity other than Aetna Life Insurance Company or SilverScript Insurance Company that, during the Term, is engaged by either Aetna Life Insurance Company or SilverScript Insurance Company for the sole purpose of providing the City with administrative services to support offering the Plan to be provided under this Contract. The terms "subcontract" or "subcontract or purchase order" mean an agreement between the Contractor and a Subcontractor entered into during the Term for the sole purpose of providing the City with the coverage to be provided under this Contract. The Term "Subcontractor" does not mean an agreement between Contractor and a pharmacy or provider of medical items or services for the Plan. The definitions set forth in this Section 8.10 shall apply to all documents comprising this Contract, including, but not limited to, this document, Appendix A, and Appendix B (the Identifying Information Rider).

8.11 "Term" means the Initial Term or any Subsequent Term.

Section 9. MISCELLANEOUS

9.1. **Legal Authority To Contract.** The City represents, agrees and warrants that is legally able to enter into this Contract with Contractor. The City further represents that it is not working with and does not have legal liability to any entity other than Contractor concerning the Plan.

9.2. **Disease Management and Care Management Programs.** From time to time, Contractor may offer programs that are designed to improve quality of care, ensure access to Covered Benefits or coordinate care delivered to Members under the Plan(s) ("Disease and Care Management Programs"). Contractor will administer Disease and Care Management Programs consistent with any applicable Mandates. The City acknowledges that Contractor may alter or discontinue the Disease and Care Management Program offered to Members upon 60 days advanced written notice to the City and consent of the City, consistent with all Mandates.

9.3. **Claim Determinations, Administration of Covered Benefits & Ownership of Claims Data.** Contractor is a fiduciary for the purpose of Section 503 of Title 1 of ERISA. Contractor is responsible for determining whether and to what extent eligible individuals and beneficiaries are entitled to coverage, in accordance with all Mandates... Contractor's review of claims may include the use of commercial software and other tools to take into account factors such as an individual's claims history, a provider's billing patterns, complexity of the service or treatment, amount of time and degree of skill needed and the manner of billing, in accordance with all Mandates.

In addition to the terms set forth in Article 6 of Appendix A, all documents, records, reports and data, including data recorded in Contractor processing systems, related to the receipt, processing and payment of claims, including all claim histories, shall be the property of Contractor to be preserved in accordance with all Mandates. In the event that this Contract is terminated by either Party, Contractor agrees to provide claims data needed by the City's successor carrier to facilitate transition of care for Members, consistent with Mandates.

9.4 **Conflict.** In the event of a conflict between the terms of this Contract and any of the Incorporated Documents or among any of the Incorporated Documents, the order of priority shall be as the listing of Incorporated Documents set forth in the second paragraph of this Contract. Any riders, amendments, inserts and attachments shall have the same priority as the document to which they are attached.

In the event of any express or implied conflict between the provisions of this Contract and Appendix A, the following order of priority shall govern: (1) first, the body and exhibits of this Contract shall govern; (2) thereafter, the General Provisions listed in Appendix A.

9.5 **Third Parties.** This Agreement does not give any rights or impose any obligations on third parties except as specifically provided herein. Nothing in this Agreement shall be construed as creating any third party beneficiaries.

9.6 **Non-Discrimination.** The City shall not encourage or discourage enrollment in the Plan(s) based on health status or health risk and shall follow all applicable Mandates on non-discrimination.

9.7 **Use of the Contractor Name and all Symbols, Trademarks, and Service Marks.** Contractor controls the use of its name and all symbols, trademarks, and service marks presently existing or subsequently established. The City shall not use any of them in advertising or promotional materials or in any other way without Contractor's prior written consent. The City shall stop any and all use immediately upon Contractor's request or upon termination of this Contract.

9.8 **Coordination of Benefits.** This Section 9.8applies solely if the City is a Member's former employer and the Member sustains a work-related injury before he or she leaves employment, regardless of when symptoms become evident. In such event, the City shall protect Contractor's interests in any workers' compensation claims or settlements with any Member by reimbursing Contractor for all paid medical expenses which have occurred as a result of the work-related injury that is compensable or settled in any manner. Upon Contractor's request, the City shall provide Contractor with information needed to meet CMS coordination of benefit of requirements with respect to Members who have outstanding workers compensation claims involving the City.

9.9 **Clerical Errors.** Clerical errors or delays by Contractor in keeping or reporting data relative to coverage will not reduce or invalidate a Member's coverage. Upon discovery of an error or delay, an adjustment of Premiums shall be made. Contractor will modify or replace an EOC or other Member document issued in error consistent with Mandates.

9.10 **Misstatements.** If any fact as to the City or a Member is found to have been misstated, an equitable adjustment of Premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

9.11 **Confidential Information**. In addition to the terms of Appendix A, the term "Confidential Information" includes, but is not limited to, this Contract or any information of Contractor (whether oral, written, electronic, visual or fixed in any tangible medium of expression) relating to Contractor's services, operations, systems, programs, inventions, techniques, suppliers, customers and prospective customers, contractors, costs and pricing data, trade secrets, know-how, processes, plans, designs and other information of or relating to Contractor's business.

- **Confidentiality Obligations**. The City shall not disclose or make use of any Confidential Information except as permitted under this Contract without the prior written consent of Contractor, which consent may be conditioned upon the execution of a confidentiality agreement. The City may disclose Confidential Information of the Contractor only to its employees, agents, consultants, or authorized representatives who have a need to know the Confidential Information in order to accomplish the purpose of this Contract and who (A) have been informed of the confidential and proprietary nature of the Confidential Information, and (B) with respect to agents, consultants or authorized representatives, have agreed in writing not to disclose it to others and to treat it in accordance with the requirements of this Section. Consistent with Section 9.11 of the CMS/Regulatory Requirements Addendum, in the event the City is required to furnish any Confidential Information pursuant to a public records act, the City shall notify Contractor prior to disclosure so that Contractor may determine whether to exercise any rights it may have to protect such information from disclosure. The City shall be responsible to the other Party for any breach of this Agreement by its respective employees, agents, consultants, or authorized representatives.
- **Permitted Disclosure of Confidential Information**. The foregoing shall not apply to such Confidential Information to the extent: (A) the information is or becomes generally available or known to the public through no fault of the City; (B) the information was already known by or available to the City prior to the disclosure by the other party on a non-confidential basis; (C) the information is subsequently disclosed to the receiving party by a third party who is not under any obligation of confidentiality to the disclosing party; (D) the information has already been or is hereafter independently acquired or developed by the City without violating any confidentiality agreement or other similar obligation; or(E) the information is required to be disclosed pursuant to a non-appealable court order. Except in accordance with the requirements of this Section 9.11, neither the City nor its employees, agents, consultants, or authorized representatives may disclose, or permit to be disclosed, Confidential Information of

the Contractor as an expert witness in any proceeding, or in response to a request for information by oral questions, interrogatories, document requests, subpoena, civil investigative demand, formal or informal investigation by any government agency, judicial process or otherwise. If the City, or any of its respective employees, agents, consultants, or authorized representatives, is requested to disclose the Confidential Information of the Contractor for any of the reasons described in the preceding sentence the City shall give prompt prior written notice to the Contractor to allow the Contractor to seek an appropriate protective order or modification of any requested disclosure. If the City is ultimately legally compelled to disclose such Confidential Information, the City shall disclose the minimum required pursuant to the court order or other legal compulsion.

- **Remedies**. Any unauthorized disclosure or use of Confidential Information would cause Contractor immediate and irreparable injury or loss that may not be adequately compensated with money damages. Accordingly, in addition to the remedies specified in Appendix A, if the City fails to comply with this Section 9.11, the Contractor will be entitled to specific performance including immediate issuance of a temporary restraining order or preliminary injunction enforcing this Contract, and to judgment for any and all claims, liabilities, demands, damages, losses, costs or expenses of any kind, including, without limitation, reasonable attorneys' fees and expenses caused by the breach, and to any other remedies provided by law or in equity.

9.12 **Compliance with Mandates.** Contractor and the City shall comply with all Mandates applicable to the performance of their respective obligations under this Agreement. Contractor and the City shall comply with the applicable provisions of the CMS/Regulatory Addendum, which is designed to ensure Contractor's and the City's compliance with specific Mandates. This Contract shall be deemed to incorporate all Mandates, as they change from to time, and to the extent that the Mandates conflict with the terms of this Contract, the Mandates shall have precedence.

The Parties acknowledge and agree that pursuant to § 1856(b)(3) of the Social Security Act, the Medicare Advantage and Part D standards set forth in 42 C.F.R. 422 and 42 C.F.R. 423 supersede any State or local laws, regulations, contract requirements, or other standards that would otherwise apply to the Plan, with the exception of State licensing laws and regulations and State laws and regulations relating to plan solvency ("Federal Preemption Standard").

9.13 **Amendments.** This Contract may be amended as follows:

- This Contract shall be deemed to be automatically amended to conform with all Mandates promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over Contractor;

or

- By mutual written agreement between both Parties.

Section 10 – RIGHT TO AUDIT

The following individuals and/or entities may conduct audits related to this Contract, based on the following general guidelines, subject to the requirements and limitations of HIPAA:

10.1 Not more than once each calendar year during the term of this Contract and for the prior contract year, the City or the City's independent outside auditor whom the City engages to conduct annual audits of the City's Services, may

inspect and audit, or cause to be inspected and audited, the books and records of the Contractor concerning all the Contractor Services provided under this Contract, subject to confidentiality requirements in Network Providers. Data elements that are tied to confidential agreements between Aetna, Caremark and other third parties (e.g. providers, manufacturers) would be limited to the extent permitted by such contracts and data elements that are tied to these contracts may be redacted or masked.

10.2 In addition to the audits described in Section 10.1 above, the Parties acknowledge that representatives of a regulatory or accreditation agency with jurisdiction over the Plan may also inspect and audit the Contractor's books and records with a copy of the audit notice from the regulatory body.

10.3 The City and the Contractor shall reasonably cooperate with representatives of each other, with independent accountants and consultants retained by the City or the Contractor, and with representatives of any regulatory or accreditation agency, to conduct any inspection or audit.

10.4 All audits conducted by the City (or any agents of the City) shall be made during normal business hours, on the Contractor's premises, and in accordance with the Contractor's audit policy, which may be revised from time to time following thirty (30) days written notice ("Audit Notice"). The audit notice shall specify the scope of the audit, including the time period being audited (subject to the limitations set forth in Section 10.1 above), and the subject matter of the audit ("Audit Scope"). All audits shall be conducted without undue interference to the audited party's business activity, and in accordance with reasonable audit practices.

10.5 The Contractor shall be required to provide minimum necessary (in accordance with HIPAA) requested electronic data to the City (or its auditor) within thirty (30) days of the Contractor's receipt of the audit notice in accordance with Section 10.1 above. Such requested data shall be made available by the Contractor for on-site review. The Contractor shall not be required to provide access to its network.

10.6 In the event any questions are raised, or any additional requests for information or documents or data related to the Audit Scope are reasonably requested, by the City (or its auditor) during any audit, and the parties mutually agree that such additional requests are reasonably within the Audit Scope, the Contractor shall be obligated to respond to all such questions, and produce all additional information, documents and/or data within thirty (30) business days of receipt of such questions or requests. If the Contractor cannot fully respond in said time period, the Contractor shall provide whatever responses and materials it can within that period, and a written statement as to when the Contractor will respond fully.

10.7 In the event that an Audit concludes that the Contractor has violated its obligations or the material terms of this Contract, and the Contractor disputes said audit findings, the Contractor must set forth the basis for its dispute, with all supporting documentation, within thirty (30) business days of the Contractor's receipt of the disputed findings. The Contractor shall provide sufficient documentation to permit adequate review of the disputed issues and have the burden of demonstrating that the City's (or its auditor's) conclusions are incorrect. To the extent the parties mutually agree that the Contractor fails to provide documentation substantiating any part of its position, or fails to meet its burden of proof, the Contractor shall waive its right to further dispute the matter. After receiving any documentation from the Contractor, the City (or its auditor) shall review said documentation and advise the Contractor whether the City has changed its audit findings or conclusions. However, to the extent the Contractor maintains a HITRUST Certification by a qualified third party auditor, and such certification covers the scope of services to be provided by the Contractor to the City, then the determination that the Contractor has violated its obligations or the material terms of this Contract shall be based on the Parties' mutual Contract.

10.8 In the event that the Contractor disputes the City's (or its auditor's) findings, and the 's basis for dispute is that the City required or authorized certain activity, procedures, mechanisms or calculations to occur that are the subject of the dispute, the Contractor shall have the burden of providing documentary evidence demonstrating its allegations.

If the Contractor is unable to provide such evidence, the Contractor shall not have the right to claim that the City required or authorized the matter. The following terms shall control the City's audits of the Contractor:

10.9 The City shall have the right to select its own auditor provided, however, that such auditor shall be independent and objective. However, the City's auditor shall not be an individual or entity that is a competitor of, or has a material conflict with, the Contractor that the Parties reasonably agree, after expeditious consideration, could jeopardize the integrity of the audit. The City also agrees not to select any auditor paid on a contingency basis, or pay any auditor on such a basis or other similar basis. The City agrees all audit remuneration must be on a flat fee, or hourly, basis.

10.10 The Contractor shall be obligated to cooperate reasonably with the City and its auditor's efforts to audit. The City may conduct audits of claims, benefits, eligibility, performance guarantees, and the Contractor's compliance with Financial Documents as provided in the Contract for the prior contract year and some data elements may be limited as per 10.1 above.

10.11 Notwithstanding the foregoing or anything to the contrary in this Section 10, the Contractor shall not be required to furnish documents or records that it deems proprietary or sensitive, except to persons or entities who have executed a confidentiality and indemnification Contract. Any audit of claims may only relate to claims processed during the then-current and immediately preceding calendar year (the "Audit Period"). The scope of the audit shall be agreed to in writing by the Parties prior to the commencement of the audit. An audit performed pursuant to Section 10.1 shall be the final audit for the Audit Period and for any prior Audit Period unless otherwise agreed to in writing by the Parties.

10.12 Auditor(s) must execute a confidentiality and indemnification Contract with the Contractor pertaining to the Contractor's Proprietary and Confidential Information prior to conducting an audit.

10.13 The City shall provide to the Contractor copies of all final audit reports at such time as they are made available by the auditor to the City. The City shall notify the Contractor of any material discrepancies found during the course of the audit. The Contractor is entitled to respond to such findings prior to the issuance of the final report. The Contractor reserves the right to terminate any audit being performed by or for the City if the Contractor reasonably determines that the confidentiality of its information is not properly being maintained or if the Contractor reasonably determines that the City or auditor is not following the Contractor's audit policy.

10.14 The Contractor reserves the right to charge a fee to the City for expenditure of time by the Contractor's employees in completing any audit provided, however, that such fees shall (i) not exceed the reasonable costs incurred by the Contractor, and (ii) be limited to costs associated with: (1) pulling claims in excess of a mutually agreed on statistically valid sample size of claims; and (2) supporting a site visit longer than five (5) days in duration.

10.15 Notwithstanding the foregoing, the Parties acknowledge and agree that the powers, duties, and obligations of the Comptroller of the City of New York pursuant to the provisions of the New York City Charter shall not be diminished, compromised or abridged in any way.

Section 11 – REPORTING REQUIREMENTS

11.1 The MA Review Committee shall be composed of representatives and designated consultants from the City and representatives from the MLC and its designated consultants. Members of the MA Review Committee from the MLC and its designated consultants must sign a confidentiality agreement with the Contractor, and Contractor will not provide Member PHI or personally identifiable data (PII) to the MLC. The Contractor agrees to meet with the MA Review Committee no less than once a quarter to discuss any issues related to the administration of the Plans and to present and discuss with the MA Review Committee the reports listed in this Section 11.

Contractor shall provide timely reporting to the MA Review Committee in accordance with the requirements set forth in this Section 11 or as may be modified by mutual agreement of the Parties. Contractor shall also timely provide ad hoc reports to the MA Review Committee as agreed upon by mutual agreement of the Parties. Unless otherwise indicated, all reports shall be submitted in mutually agreed upon formats. Any reports provided to City by Contractor shall be the property of Contractor and are considered "Confidential Information" as defined in Section 9.11 of this Contract.

11.2 Contractor shall provide the following reports to the City and the MLC on a monthly basis:

- Eligibility reconciliation file to contain, at a minimum, the 'Member's contract number, demographics, enrollment date, and cancel date.
- Monthly standard utilization and cost reports for both medical (MA plans) and pharmacy (PDP).
- MA plan network utilization by market set forth as a percent of claims paid in network vs. out of network.
- MA plan provider recruitment status report for providers nominated by Member, City and/or Union.
- MA plan prior authorization approvals / denials reporting.
- MA plan program reporting – meals, non-emergency transportation, OTC benefit, Healthy Rewards and SilverSneakers.
- Appeals and grievances reports. **These reports will be submitted on a monthly, quarterly, and annual basis.**
- Monthly performance standard outcomes.
- Member Services utilization reports (i.e., web traffic, number of –calls - Call Center Operations Reporting and the nature of the members' inquiries).
- Part C and Part D Medicare Monthly Membership Reports (MMR), including all fields as received from CMS. The monthly MMR should be submitted by the end of the corresponding month.

11.3 Contractor shall provide the following reports to the City and the MLC on a quarterly basis:

- Performance standard report, indicating Contractor's performance for all performance standard measurements and whether standards were met. Reports must provide monthly performance data as well as quarterly aggregates.
- Quarterly reporting on the MA plan cost, utilization, and clinical performance. Reporting shall also include legislative updates. This report should be produced 60 days after the end of the reporting quarter with a one-month lag. Contractor shall present this report to City staff and its designees.
- Union retiree education by Labor Liaison – measured by staff meeting education, retiree chapter meetings and Medicare eligibility meeting education.

11.4 Contractor shall provide the following reports to the City and the MLC on an annual basis:

- MA plan Member satisfaction survey, which will include; overall Member satisfaction on MA plan benefits and services, network access, member services, claims and care management.
- MA plan customer service satisfaction survey – on mutually agreed service metrics.
- MA plan network utilization and network growth.
- Annual MA plan utilization reporting - provided 90 days with a 2-month lag.
- Annual standard PDP/pharmacy utilization.
- MA plan provider collaboration performance and Member attribution by market.
- Annual MA plan risk score reporting.
- Part C and Part D Model Output Reports (MOR) provided no more often than annually, including all fields as received from CMS. The MOR should be provided within 30 days of Contractor's receipt of this report from CMS.

Section 12 – PRIOR AUTHORIZATION. Contractor has established a program for the MA plan that requires prior authorization for certain limited procedures based on the applicable terms of the MA plan (including, but not limited to, medical necessity) ("Prior Authorization"). Contractor may directly perform such Prior Authorization or may delegate such Prior Authorization to a third-party vendor that it contracts with ("Prior Authorization ("PA") Vendor"), consistent with Mandates. Non-contracted providers are not required to seek Prior Authorization for services from Contractor; however, Contractor reserves the right to retrospectively review claims submitted by non-contracted providers and may deny coverage if the services are not medically necessary and/or not covered under the MA plan.

12.1 **Prior Authorization Waiver**.

Consistent with Mandates, Contractor will agree that for the Initial Term of this Contract, Prior Authorization will not be required with respect to the procedures listed in ATTACHMENT H that Contractor's PA Vendor typically reviews. The list of procedures set forth in ATTACHMENT H will be maintained and updated by Contractor every two years, subject to the review and consent of the City and MLC. The foregoing does not preclude Contractor from continuing to require providers to notify Contractor when a Member obtains these procedures for clinical purposes, including, but not limited to, monitoring potential Member safety concerns and situations of overutilization of services by specific providers when compared to Contractor's book of business. Two years after the Effective Date and every two years thereafter, the Parties will mutually evaluate the impact of the waiver of Prior Authorization described herein and discuss in good faith whether changes are appropriate to this Section 12.1, including modification of the list in ATTACHMENT H and use of the PA Vendor (including the particular current designated third-party vendor).

12.2 **Additional Waiver of Prior Authorization**. For an additional $15 PMPM, Contractor will waive Prior Authorization for additional services/items, except as set forth below. Every two years, the Parties will mutually review waiver of Prior Authorization described in this section 12.2 and determine, in good faith, whether changes are appropriate to this Section 12.2.

Only the following services/items will be subject to Prior Authorization under the MA plan:

- Acute hospital inpatient, long-term acute care, acute physical rehabilitation, skilled nursing facility, and home care services.
- Services/items that are not covered by Medicare.
- Services that could be considered experimental and investigational in nature.
- Services that are cosmetic in nature (e.g., breast augmentation, removal of excessive skin/tummy tuck or eyelid surgery).
- Select Part D medications.
- Specialty medications, some of which are Part B medications, as set forth in ATTACHMENT J, which may be amended from time to time.
- Select drugs, therapies, procedures, services, and technologies covered by Medicare after the Effective Date of the MA plan, subject to mutual agreement of the Parties.

Additionally, for the avoidance of doubt, Contractor may resume Prior Authorization for the procedures listed in ATTACHMENT H after the Initial Term as described in Section 12.1, unless otherwise mutually agreed to by the Parties.

12.3 **Retrospective Reviews**. Contractor agrees, on a quarterly basis, to conduct selective retrospective reviews of the following types of cases: i) cases where denials were issued upfront, but the Member did not appeal; and ii) cases where the original denial was appealed by the Member and the decision was upheld by the Contractor's appeal

reviewer, triggering an automatic referral to Maximus, CMS' independent review organization. Additionally, Contractor will review cases where the original Prior Authorization request was denied that the Member appealed, which led the Contractor's appeal reviewer to overturn the denial. Contractor will use this added quarterly review process to identify key learnings that it can use to improve its Prior Authorization processes.

12.4 **National Quality Advisory Committee**. Contractor will extend an invitation to an independent licensed and credentialed physician reviewer mutually named by City and Contractor to join Contractor's National Quality Advisory Committee ("NQAC"). The NQAC's responsibility is to review Contractor's utilization management and quality policies and provide input on the development, revision, and retirement of such policies.

12.5 **120 Day Prior Authorization Process.** For the first 120 days following the Effective Date of the MA plan, Contractor will: (1) implement a claim edit that will prevent an automatic denial of medical services rendered by in-network providers that are not submitted for Prior Authorization and pay such claims, and (2) send a letter to the in-network provider and the Member receiving such medical services to educate them regarding the MA plan's Prior Authorization requirements.

12.6 **Emergency & Urgently Needed Services.** Contractor will comply with 42 C.F.R. § 422.113, as may be amended from time to time, with respect to Prior Authorization and "emergency or urgently needed services", as those terms are defined by CMS in this regulation ("Emergency or Urgently Needed Services"). Specifically, consistent with this CMS regulation: (1) no Plan materials provided by Contractor to Members will contain instructions to obtain Prior Authorization with respect to Emergency or Urgently Needed Services, and (2) no Plan materials furnished by Contractor to providers, including contracts, will contain instructions to seek Prior Authorization before a Member has been stabilized.

Section 13 - DISPUTE RESOLUTION

Except as provided in ATTACHMENT B, the Parties shall first attempt in good faith to resolve any dispute arising out of or relating to this Contract promptly by negotiation between executives and or officials who have authority to settle the controversy and who are at a higher level of management than the persons with direct responsibility for administration of this Contract.

If the dispute is not resolved by negotiation as detailed above, the Parties agree to then try in good faith to settle the dispute by non-binding mediation before resorting to the dispute resolution procedure set forth in Section 12.03 of Appendix A. Unless either Party disagrees, the mediator that will conduct the mediation will be Martin F. Scheinman of Scheinman Arbitration & Mediation Services. If either Party does not agree to appoint Mr. Scheinman as the mediator, another mediator to conduct such mediation will be selected by mutual agreement of the Parties. The mediation will be conducted pursuant to procedures provided by the mediator and agreed to by both Parties. The cost of the non-binding mediation will be borne by the Contractor.

Pursuant to Section 12.03(C) of Appendix A, Contractor agrees that during the pendency of the dispute resolution processes described in this Section 13 (except when related to the City's non-payment of any Premium amounts owed under this Contract), Contractor must continue to perform services in accordance with this Contract and as directed by the City.

Signed as of the Effective Date.

Contractor:

By: _____

Richard A. Frommeyer

Vice President, Group Medicare

City of New York acting through the Mayor's Office of Labor Relations – Employee Benefits Program on behalf of the Labor Management Health Insurance Policy Committee for the New York City Health Benefits Program

By:_____

Renee Campion

OLR Commissioner

Approved as to Form and
Certified as to Legal Authority

By:_____
Acting Corporation Counsel

Date:_____

ATTACHMENT F

CMS/REGULATORY REQUIREMENTS ADDENDUM

The following provisions describe critical regulatory requirements that apply to all plan sponsors offering Contractor group Medicare plans, and they are included in this Contract to ensure Contractor and City's compliance with Mandates.

Section 1.0 CMS Uniform Premium Requirements.

1.1 **Medicare Advantage – Premium Requirements**. This Section 1.1 applies only if Contractor is offering a Medicare Advantage PPO Plan to Members, and City and Members are paying any portion of the Premium for the Medicare Advantage benefit ("MA Premium").

The City will comply with the following conditions with respect to any subsidization of MA Premium and any required MA Premium contribution by the Member:

- The City may subsidize different amounts of MA Premium for different classes of Members and their dependents, 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 vs. hourly).
- MA Premium contribution levels cannot vary for Members within a given class.
- Direct subsidy payments from CMS to Contractor must be passed through to reduce the amount of any required MA Premium payment by the Member.

1.2 **Part D – Premium and Low Income Subsidy Requirements**. This Section 1.2 applies only if Contractor is offering to Members a Medicare Advantage PPO plan with Medicare prescription drug plan benefits and/or a standalone Medicare prescription drug plan.

The City will comply with the following conditions with respect to any subsidization of that portion of Premiums paid by the City for the Medicare Prescription Drug benefit ("PD Premium") and any required PD Premium contribution by the Member:

- The City may subsidize different amounts of PD Premium for different classes of Members and their dependents, 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 vs. hourly). Classes of Members and their dependents cannot be based on eligibility for the Low Income Subsidy ("LIS").
- PD Premium contribution levels cannot vary for Members within a given class.
- Direct subsidy payments from CMS to Contractor must be passed through to reduce the amount of any required PD Premium payment by the Member ("Member Contribution") so the Member in no event shall be required to pay more than the sum of: a) the standard Medicare Part D premium, net of the direct subsidy payment from CMS, and b) one hundred percent (100%) for any supplemental coverage selected by the Member.

The City shall comply with the following conditions with respect to any LIS payment received from CMS for any LIS-eligible Member:

- Any monthly LIS payment received from CMS for a LIS-eligible Member shall be used to reduce any Member Contribution. Any remainder may then be used to reduce the amount of

the City's PD Premium contribution. However, if the sum of the Member Contribution and the City's PD Premium is less than the LIS payment, any portion of the LIS payment will be returned to CMS by Contractor.

- If the LIS payment for any LIS-eligible Member is less than the Member Contribution required by such individual (including the Member Contribution for supplemental benefits, if any), the City shall communicate with the LIS-eligible Member about the cost of remaining enrolled in the City's Plan versus obtaining coverage as an individual under another Medicare Part D Prescription Drug plan.
- In the event that the LIS-eligible Member is due a refund of the LIS payment (i.e., there was no upfront reduction of the PD Premium by the LIS amount), such refund shall be completed by Contractor or the City, as applicable, within 45 days of the date Contractor receives the LIS payment for that Member from CMS.

Section 2.0 Records.

2.1 **Maintenance of Information & Records**. The City agrees to maintain Information and Records (as those terms are defined in Section 2.2 below) in a current, detailed, organized and comprehensive manner and in accordance with Mandates, and to maintain such Information and Records for the longer of: (i) a period of ten (10) years from the end of the final contract period for the Plan(s), (ii) the date the U.S. Department of Health and Human Services, the Comptroller General or their designees complete an audit, or (iii) the period required by Mandates.

2.2 **Access to Information and Records**. The City will provide Contractor and federal, state and local governmental authorities having jurisdiction, directly or through their designated agents (collectively "Government Officials"), upon request, access to all books, records and other papers, documents, materials and other information (including, but not limited to, contracts and financial records), whether in paper or electronic format, relating to the arrangement described in this Contract ('Information and Records"). The City agrees to provide Contractor and Government Officials with access to Information and Records for as long as it is maintained as provided in Section 2.1 above. Access to Information and Records will be provided within 14 calendar days of receipt of an applicable request, where practicable, and in no event later than the date required by an applicable law or regulatory authority.

2.3 **Survival**. The preceding provisions of this Section 2.3 shall survive termination of this Contract regardless of the cause of termination.

Section 3.0 Medicare Secondary Payer Requirements.

3.1 **Generally**. Contractor and the City agree to comply with all Medicare Secondary Payer ("MSP") Mandates that apply to the City, the Plan and Contractor ("MSP Requirements").

3.2 **MSP Requirements Applicable to Medicare Beneficiaries Diagnosed with End Stage Renal Disease ("ESRD**"). Contractor and the City agree to comply with all MSP Requirements applicable to the City's active employees and retirees and their dependents who are Medicare beneficiaries diagnosed with ESRD ("ESRD Beneficiaries" or "ESRD Beneficiary"), including, without limitation, those MSP Requirements set forth in 42 U.S.C. § 1395y (b)(1)(C), 42 C.F.R. §§ 411.102(a), 411.161, and 411.162 and 42 C.F.R. §§ 422.106 and 422.108 ("ESRD MSP Requirements").

3.3 The City acknowledges and agrees that if an ESRD Beneficiary is eligible for or entitled to Medicare based on ESRD, the MSP Requirements require the commercial group health plan offered by the City ("GHP") to be the primary payer for the first 30 months of the ESRD Beneficiary's Medicare

eligibility or entitlement ("30-month coordination period"), regardless of the number of employees employed by the City and regardless of whether the ESRD Beneficiary is a current employee or retiree.

3.4 To ensure Contractor's and the City's compliance with ESRD MSP Requirements, the City agrees to confirm to Contractor whether ESRD Beneficiaries are in their 30-month coordination period, and not seek to enroll ESRD Beneficiaries in the Plan(s) during their 30-month coordination period unless coverage under the GHP is maintained for such ESRD Beneficiaries for that period. If the City seeks to enroll an ESRD Beneficiary in a Plan, the City agrees to provide Contractor, upon request, with information or documentation to verify compliance with ESRD MSP Requirements, including any MSP reporting or other requirements established by CMS.

Section 4.0 Office of Foreign Asset Control. If coverage provided by the Contract violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, Contractor cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a written Office of Foreign Asset Control (OFAC) license.

Section 5.0 CMS Enrollment & Disenrollment Requirements.

5.1 To the extent that the City directly accepts enrollment and/or disenrollment requests from potential Members or Members that the City forwards to Contractor for processing and submission to CMS, the City will comply with all Mandates that relate to the handling and processing of enrollment and disenrollment requests that apply to the Plan(s). A Member's signature on an enrollment/disenrollment form must be dated prior to the requested enrollment/disenrollment effective date.

If requesting retroactive enrollment or disenrollment, the City will forward enrollment and disenrollment forms completed by potential Members or Members to Contractor no later than 90 days after the Member's enrollment or termination effective date. If there is a delay between the time a Member submits an enrollment/disenrollment request to the City and when the enrollment/disenrollment request is received by Contractor, the enrollment/disenrollment transaction may not be processed by CMS, unless Contractor requests and CMS approves a retroactive enrollment/disenrollment transaction for the Member. Contractor will determine whether to submit retroactive enrollment and disenrollment transaction requests to CMS and will make such determinations in accordance with Mandates.

All Members must be notified that they will be enrolled in a Plan. CMS requires that this notice be provided by Contractor or the City not less than 21 calendar days prior to the effective date of the Member's enrollment in the Plan to allow Members the opportunity to evaluate other available health plan options.

5.2 The effective date of enrollments and disenrollments in the Plan(s) cannot be earlier than the date the enrollment or disenrollment request was completed by a Member. If approved by CMS, the effective date of an enrollment or disenrollment may be retroactive up to, but may not exceed, 90 days from the date that Contractor received the enrollment or disenrollment request from the City, and the enrollment or disenrollment form must be completed and signed by the Member prior to the requested enrollment or disenrollment effective date.

5.3 CMS does not permit retroactive termination of a Member's coverage under the Plan(s) if the Member no longer meets the City's eligibility criteria to remain enrolled in the Plan(s). To meet this CMS requirement, the City will provide Contractor with advanced written notice if The City chooses to terminate a Member's coverage under the Plan based on loss of eligibility, and the City acknowledges that the Member's prospective coverage termination effective date will be determined in accordance with Mandates.

5.4 If the City elects to change Plan coverage offered to Members or to terminate a Member's coverage under the Plan(s), the City must provide written notice to such Member(s) at least 21 calendar days prior to the effective date of the change in the Member's coverage or disenrollment from the Plan(s), as applicable. This written notice must include a description of how the Member can contact Medicare to obtain information regarding other Medicare Advantage or Medicare Part D plan options that may be available to the Member. Contractor will assist the City with developing appropriate notices.

5.5 Contractor reserves the right to notify Members of the involuntary termination of their coverage under this Contract for any reason.

5.6 If eligible individuals are to be enrolled and/or disenrolled in the Plan(s) electronically, the electronic forms used for this process must be approved by CMS for use by the Plan(s) and conform to all Mandates applicable to format, data fields and other required information. Contractor will work with the City to develop appropriate electronic forms.

5.7 Electronic enrollments and disenrollments will be deemed effective on the first day of the month requested, subject to compliance with any applicable Mandates.

5.8 The City will produce, at Contractor's request, the original copy of any enrollment or disenrollment form or record received by the City.

5.9 The City shall limit enrollment in the Plans to retirees who are Medicare eligible individuals and are receiving Employment-Based Retiree Coverage under a Group Health Plan sponsored by the City. Employment-Based Retiree Coverage means coverage of health care costs under a Group Health Plan based on an individual's status as a retired participant in the plan, or as the spouse or dependent of a retired participant. A Group Health Plan means a plan defined in Section 607(1) of ERISA or any other plan described in 42 C.F.R. § 422.106(d).

Section 6.0 Notices to Members.

6.1 **Notice re Changes.** The City will provide Members with written notice describing any changes made to premiums, benefits or other terms of the Plan(s) if required under Mandates. If the City does not distribute notices as required under this Section 6.0 Contractor may, at its discretion, distribute such notices to Members.

6.2 **Notice re Termination of Coverage**. The City will notify Members of the termination of the Plan(s) in compliance with Mandates. However, Contractor reserves the right to notify Members of termination or suspension of the Plan(s) for any reason. The City will provide written notice to Members of their rights upon termination of coverage as required under Mandates.

Section 7.0 Service Area Extension & Network Adequacy for Plan. This Section 7.0 only applies if Contractor is offering a Medicare Advantage PPO Plan to Members who reside in an Extended Service Area (as defined below).

To enable employers/unions to offer group Medicare Advantage ("MA") plans to all of their Medicare-eligible

retirees/dependents wherever they reside, CMS has established a waiver of service area requirements ("Waiver") for organizations that are approved by CMS to offer MA plans ("MAOs"). Under this Waiver, MAOs offering a group MA plan in a given Service Area, can extend coverage to an employer/union sponsor's Medicare-eligible retirees/dependents residing outside of that Service Area, even if the MAO does not offer a provider network for the group MA plan ("Provider Network") that meets CMS network adequacy requirements in that Service Area ("Extended Service Area").

Contractor and the City agree that Contractor will use this Waiver to offer the Medicare Advantage PPO Plan to Members who reside in an Extended Service Area ("MA PPO Plan"). The Parties acknowledge that Contractor must meet certain CMS requirements to offer the MA PPO Plan in an Extended Service Area, and these requirements include, but are not limited to, the following:

(1) at least 51% of retirees/dependents who are currently enrolled in Contractor MA HMO or PPO plans offered by the City must be enrolled in an Contractor MA HMO or PPO plan that offers a Provider Network that meets CMS network adequacy requirements, and

(2) all Members who reside in an Extended Service Area must receive the same Covered Benefits at the preferred in-network cost-sharing for all Covered Benefits.

The Parties agree to comply with all Mandates that apply to use of this Waiver. Further, the City acknowledges and agrees that:

(1) Members who reside in an Extended Service Area do not have access to a Provider Network that meets CMS network adequacy requirements, and

(2) health care providers and suppliers that are not contracted with Contractor to participate in the Provider Network are not required to accept the Plan and furnish Covered Benefits to Members who reside inside or outside of an Extended Service Area, except as required under Mandates. Failure to meet CMS requirements of this Waiver may result in termination of the MA PPO Plan in Extended Service Areas.

Section 8.0 Retiree-Only Plan. The City represents that actively working employees and their dependents are not permitted to enroll in the Plan(s) and that by offering the Plan(s) it intends to create and maintain a retiree plan that is separate from its active plan.

Section 9.0 Public Records Acts. The Parties acknowledge that City is a public entity and subject to state laws governing disclosure of public records. The City agrees that the confidential and proprietary information of Contractor which is in writing and marked as confidential and proprietary, shall be afforded protection under applicable law. Prior to disclosing such confidential and proprietary information of Contractor, the City shall immediately notify Contractor of any requests for information made by a third party pursuant to applicable state statute or local ordinance and shall further provide Contractor sufficient time to claim applicable exemptions and/or designate those portions of this information that constitute proprietary information exempt from disclosure under applicable state statute or local ordinance. The City further acknowledges that it will not release any information identified by Contractor as exempt from disclosure without first providing notice to Contractor of such intent and allowing Contractor to seek judicial relief to prevent such disclosure. The City agrees not to oppose any action of Contractor to obtain a declaratory judgment or other appropriate remedy. If a court thereafter determines that the City is legally required to disclose such proprietary information, the City shall disclose the minimum required pursuant to the court order.

HIPAA Plan Sponsor Certification ("PSC") Addendum

The compliance requirements imposed by the HIPAA Privacy Rule vary based on whether or not the Fully Insured (FI) Plan Sponsor and/or Group Health Plan has access to plan member Protected Health Information ("PHI"). Please carefully review this form and confirm you need access to the member PHI for your plan operations and understand the HIPAA compliance implications of receiving that information.

Plan Sponsors Offering a Fully Insured (FI) Group Health Plan/ FI Group Health Plan - No Access to PHI

A FI Plan Sponsor/Group Health Plan is minimally impacted by the HIPAA Privacy Rule so long as its access to PHI is limited to the following functions:

- Assisting employees with claim disputes as permitted by the employees' written authorization;
- Receiving Summary Health Information ("SHI") for purposes of obtaining premium bids or modifying, amending, or terminating the plan; and
- Conducting enrollment and disenrollment activities.

If the above is adequate for your plan administration purposes, then no further action is required, and you do not need to complete this form.

Plan Sponsors Offering a Fully Insured (FI) Group Health Plan/FI Group Health Plan - With Access to PHI

FI Plan Sponsors or a FI Group Health Plan with access to PHI for plan administration purposes, either directly or through its third-party (i.e., vendors, agents, brokers, or consultants), must comply with the HIPAA Privacy Rule requirements in the same way that a health insurer would have to comply.

Aetna is a Covered Entity regulated by HIPAA. The HIPAA Privacy Rule controls the conditions under which Aetna can share PHI with the Plan Sponsor. See 45 CFR 164.504(f).

For Aetna to provide PHI to the Plan Sponsor of a Fully Insured Group Health Plan or a Fully Insured Group Health Plan, or its third-party vendor(s), the Plan Sponsor and/or the Group Health Plan must certify the following requirements are met:

A. Where applicable, Plan Sponsor represents that it has certified that the plan document of the Group Health Plan has been amended to comply with HIPAA as follows and agrees to comply with the following:

- Plan documents note the permitted and required uses and disclosures of PHI, consistent with HIPAA;
- Only use or disclose PHI as permitted by the plan documents, or as required by law;
- Establish a mechanism to require any agents or subcontractors to whom it provides PHI received from the group health plan agree to the same restrictions and conditions as the Plan Sponsor with respect to the PHI;
- Not use or disclose the PHI for employment-related actions or decisions in connection with any other benefit or employee benefit plan offered by the Plan Sponsor;
- Establish a policy and procedure to report any improper uses/disclosures to the Group Health Plan;
- Plan sponsor makes available PHI contained in a designated record set;
- Plan sponsor allows individuals to request amendments to PHI in their designated record set;
- Plan sponsor provides for an accounting of disclosure of PHI;
- Make its internal practices, books, and records relating to the use and disclosure of PHI available to the Department of Health and Human Services (HHS) for purposes of determining compliance with the HIPAA Privacy Rule;
- Return or destroy PHI provided by the group health plan that is still maintained by the Plan Sponsor when no longer needed for the purpose that the disclosure was made. If not feasible, limit the use and disclosure to those purposes that make the return/destruction of the information infeasible;
- Ensure that there is adequate separation between the employer (Plan Sponsor) and the health benefits administrator (Group Health Plan) that will have access to PHI;
- Describe who has access to the PHI to be disclosed; restrict the access to and use by those described; and provide an effective mechanism for issues of noncompliance;

B. Plan Sponsor and/or Group Health Plan represents that it complies with all applicable HIPAA requirements including but not limited to:

- Designating a privacy officer;
- Implementing policies and procedures that are designed to comply with the HIPAA Privacy Rule;
- Adopting appropriate administrative, technical, and physical safeguards to protect PHI, as required by the HIPAA Security Rule;
- Training and documenting completion by all members of its workforce on privacy policies and procedures;
- Adopting appropriate sanctions against its workforce who fail to comply with privacy policies and procedures;
- Enacting a confidential internal compliant process;
- Mitigating, to the extent possible, any harmful effects related to a use or disclosure of PHI; and

C. Plan Sponsor and/or Group Health Plan certifies that it will NOT use or disclose PHI for employment-related actions or decisions, or for other non-plan related purposes.

Please complete this form and return entire document to your Aetna representative

Group Information			
Group Name	New York City Employee Benefits Program		
Address	Street: 22 Cortlandt Street, 12th Floor		
	City: New York	State: NY	Zip: 10007
Privacy Officer Name and Contact Information	Nicole Andrade General Counsel Mayor's Office of Labor Relations 212.306.7238 nicole.andrade@olr.nyc.gov		
Third-Party Information *Complete this section if Group is requesting disclosure to its Business Associate or other Third Party*			
Third Party Name			
Address	Street:		
	City:	State:	Zip:
Relationship of Third Party	☐ Broker ☐ Vendor ☐ Other (describe):		
Reason for Disclosure			

Note that if Aetna's proprietary information is included in any report shared with a Group's vendor or other Third Party, a Non-Disclosure Agreement signed by recipient will be required prior to any disclosure. In addition, it is the responsibility of the Group to ensure that this disclosure is permitted by applicable law, and that all required contracts, such as a Business Associate Agreement (BAA), are in place between Group and Third Party prior to signing this form.

Signature

By signing below, the Group agrees: (1) that they satisfy all requirements under sections A, B, and C of this document; (2) that the Group and its agents will comply with all applicable HIPAA Privacy Regulations, including but not limited to the provisions above and minimum necessary requirements; and (3) that the Group and its agents will keep any Aetna proprietary information confidential and will not further use or disclose this information without the Aetna's advance written notice. Aetna shall not be liable for properly acting in reliance on your request to disclose PHI.

By: _____	Renee Campion	Commissioner	_____
Signature	Print Name	Title	Date