TALL TREE
ADMINISTRATORS

2022 MEC/MVP BENEFIT PLAN PROPOSAL

Prepared for: Sample Company

Prepared by: Jammie Walker

Date: Sample

Proposal Number:

Policy Period:

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EXPERIENCE YOU CAN COUNT ON

Take control of your healthcare with our friendly and accessible team who are available to answer your questions and provide you with solutions!

Tall Tree Administrators is a Utah-based, privately owned third-party administrator with a regional office in Dallas, Texas.

Claims Processing
Customer Service

- 65+ combined years claims processing experience, combined with 25+ years creating and administrating Health Plans.
- Your own dedicated Account Executive, in-house customer service, and in-house processing. Our team is here for you.
- Online enrollment, provider search functions, web access with claim data, and robust reporting packages.
- We offer administration for dental, vision, HRA, and Flex (FSA and DCA) programs in addition to medical plans.

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TPA SERVICES

IMPLEMENTATION
- Customized Explanation of Benefits
- Customized Schedules of Benefits
- Website Access
- Online Reporting

CUSTOMER SERVICE
- No Phone Tree - Live CSR Every Call
- Bilingual Service Available

ENROLLMENT
- Interface With Payroll Companies
- Online, Paper, or Electronic Enrollment
- Interface Eligibility to Multiple Vendors

UTILIZATION REVIEW
- Comprehensive Programs Included in Reporting
- Personalized Case Management
- Stop Loss Prognosis

PHARMACY BENEFIT MANAGER (PBM)
- Local or National Options
- Rx data included in reporting
- Customer Support
- Mail Order, Retail, or Specialty

PPO NETWORKS
- Regional and National Networks

All services are included in the TPA fee.

OTHER SERVICES
- Subrogation
- Appeal Facilitation
- ID Cards
- Open Enrollment Assistance

ALL PRODUCT INCLUDE:
- Administration Fees, PPO Network Fees, Stop Loss Insurance Fees, Broker Fees, Distribution Fees.
- Data iSight pricing at 150% of Medicare for inpatient hospitalization -- however, balance billing may apply.
- ID Cards indicate facility agrees to accept 150% of Medicare upon admission to help the member communicate up front.
- IRS-required data (in Excel format) for W-2s, 1094/1095s, and PCORI fees. *(Please note: TTA does not file on the client's behalf.)*
- Schedule A is available upon request.

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SERVICES COVERED UNDER MEC

Minimum Essential Coverage

All Marketplace health plans, and many other plans, must cover this list of preventative services without charging you a copayment or coinsurance. This is true even if you haven't met your yearly deductible. This applies only when these services are delivered by an in-network provider.

Preventive Care for Adults

- **Annual Physical**
- **Abdominal Aortic Aneurism**
- **Alcohol Misuse Screening**
- **Aspirin Use for Men & Women**
- **Blood Pressure Screening**
- **Cholesterol Screening**
- **Colorectal Cancer Screening**
- **Depression Screening**
- **Type 2 Diabetes Screening**
- **Diet Counseling**
- **Hepatitis B Screening**
- **Hepatitis C Screening**
- **HIV Screening**
- **Immunizations**
- **Latent Tuberculosis Infection**
- **Lung Cancer Screening**
- **Obesity Screening**
- **STI Screening and Counseling**
- **Statin**
- **Syphilis Screening**
- **Tobacco Use Screening**

Preventive Care for Women

Pregnant or Will Become Pregnant

- Breastfeeding Support & Counseling
- Birth Control
- Folic Acid
- Gestational Diabetes Screening
- Gonorrhea Screening
- Hepatitis B Screening
- Maternal Depression Screening
- Preeclampsia Prevention
- Rh Incompatibility Screening
- Syphilis Screening
- Expanded Tobacco Intervention
- Urinary Tract Infection Screening

Other Covered Services for Women

- Annual Well-Women Visit
- Bone Density Screening
- Breast Cancer Genetic Test Counseling
- Breast Cancer Mammography
- Breast Cancer Chemoprevention
- Cervical Cancer Screening
- Chlamydia Infection Screening
- Diabetes Screening
- Domestic & Interpersonal Violence Screening & Counseling
- Gonorrhea Screening
- HIV Screening
- PrEP HIV Prevention Medication
- STI Counseling
- Tobacco Use Screening & Intervention
- Urinary Incontinence Screening

Preventive Care for Children

- Well Baby and Child Exams
- Alcohol and Drug Use Assessment
- Autism Screening
- Behavioral Assessment
- Blood Pressure Screening
- Cervical Dysplasia Screening
- Congential Hypothyroidism Screening
- Contraception
- Depression Screening
- Developmental Screening
- Dyslipidemia Screening
- Fluoride Chemoprevention Supplements
- Gonorrhea Preventive Medication
- Hearing Screenings
- Height, Weight, and BMI
- Hematocrit or Hemoglobin Screening
- Hemoglobinopathies or Sickle Cell Screenings
- Hepatitis B Screenings
- HIV Screenings
- Hypothyroidism Screenings
- PrEP HIV Prevention Medication
- Immunizations
- Lead Screenings
- Obesity Screenings
- Oral Health Risk Assessment
- PKU Screenings
- STI Prevention
- Tuberculin Testing
- Vision Screenings

For more information on covered preventive services, visit https://www.healthcare.gov/coverage/preventive-care-benefits/

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FULFILLING BOTH PPACA REQUIREMENTS

100% COMPLIANT WITH THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

1 **Minimum Essential Coverage**

+

2 **Minimum Value Plan**

COMPANIES USING OUR PLANS ACHIEVE 100% ACA COMPLIANCE

MINIMUM ESSENTIAL COVERAGE

The first Affordable Care Act requirement is that all companies with more than 50 full-time employees must provide coverage for the ACA recommended wellness and preventative services.

MINIMUM VALUE PLANS

The second Affordable Care Act requirement is that employers must offer a Minimum Value Plan (MVP). MVP plans provide most of the benefits that people generally associate with health insurance, such as doctor visits and prescription drug benefits.

TAX 1 The "TAX 1" is a $2,570 per employee per year penalty which will be assessed against any company that fails to offer an ACA-compliant plan to at least 95% of its full-time employees.

TAX 2 The "TAX 2" is a $3,860 per employee per year penalty which will be assessed whenever a company fails to offer a compliant plan and one of its full-time employees instead receives a subsidized plan through a government exchange.

MEC BENEFIT OPTIONS

Network Provider Benefits Shown

Lifetime Max: None	MEC	Enhanced MEC	Enhanced MEC+	Benefit Limits Per Plan Year
Annual Deductible - Individual/Family (Does not include Copays)	None	None	None	All limits and accumulations are per person per plan year.
Annual Out of Pocket Maximum - Ind/Fam (Includes Medical and Rx Copays)	None	$6,500 / $13,000	$6,500 / $13,000	
Covered Preventive Services (Adults, Women, and Children)	Plan pays 100%	Plan pays 100%	Plan pays 100%	
Office Visits - Primary Care	No Benefit	$20 Copay, Plan pays 100%	$20 Copay, Plan pays 100%	
Office Visits - Specialist	No Benefit	$40 Copay, Plan pays 100%	$40 Copay, Plan pays 100%	
Telemedicine	No Benefit	Plan pays 100%	Plan pays 100%	Physicians available 24 hours a day, seven days a week.
Diagnostic Services - Basic labs/x-rays (related to office visit, LabCorp, etc.)	No Benefit	$50 Copay, Plan pays 100%	$50 Copay, Plan pays 100%	
Diagnostic Services - Major (Facility&Phys) (MRI, CT, PET, Nuclear Medicine, etc.)	No Benefit	$400 Copay, Plan pays 100%	$500 Copay, Plan pays 100%	**Patient may be balance billed if provider does not accept 150% of Medicare Allowable payment.
Diagnostic Services - Minor (ultrasounds, bone density, echogropahy, etc.)	No Benefit	$50 Copay, Plan pays 100%	$50 Copay, Plan pays 100%	
Emergency Room Facilities	No Benefit	No Benefit	$500 Copay, Plan pays 100%	**Patient may be balance billed if provider does not accept 150% of Medicare Allowable payment.
Emergency Room All covered services other than facility charges	No Benefit	No Benefit	Plan pays 100%	
*Hospital Facility and Inpatient Services	No Benefit	No Benefit	$500 Copay, Plan pays 100%	**Patient may be balance billed if provider does not accept 150% of Medicare Allowable payment.
Hospital attending physician, surgeon, and anesthesiologist charges during an inpatient hospital confinement	No Benefit	No Benefit	Plan pays 100%	Inpatient Benefit limited to 5 days per Plan Year.
Urgent Care & 24-Hour Clinics	No Benefit	$50 Copay, Plan pays 100%	$50 Copay, Plan pays 100%	
PRESCRIPTION BENEFITS				
Covered Prescription Drugs	Generic Birth Control Pills and select prescriptions as identified by CMS Preventive Services. $0 Copay	Generic: $10 Copay Formulary: No Benefit Non-Formulary: No Benefit Specialty: No Benefit	Generic: $10 Copay Formulary: $40 Copay Non-Formulary: $80 Copay Specialty: No Benefit	No Specialty medications are covered

*Pre Certification Required. Failure to obtain Pre Certification may result in a reduction of $250 or denial of benefits.

**All payments will be based off of the in-network allowed amount or will be capped at 150% of the Medicare Allowable Payment. If provider does not accept the Medicare Allowable Amount, patient may be balance billed.

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MVP BENEFIT OPTIONS

Network Provider Benefits Shown

Lifetime Max: None	Basic MVP	MVP	MVP+	MVP++	Benefit Limits Per Plan Year
Annual Deductible - Individual/Family (Does not include Copays)	$6,500 / $13,700	None	None	None	All limits and accumulations are per person per plan year.
Annual Out of Pocket Maximum - Ind/Fam (Includes Medical and Rx Copays)	$6,500 / $13,700	$2,000 / $13,200	$2,000 / $13,200	$2,000 / $13,200	
Covered Preventive Services (Adults, Women, and Children)	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	
Office Visits - Primary Care	$50 Copay, Plan pays 60%	$20 Copay, plan pays 100%	$20 Copay, Plan pays 100%	$20 Copay, plan pays 100%	
Office Visits - Specialist	$70 Copay, Plan pays 60%	$40 Copay, plan pays 100%	$40 Copay, Plan pays 100%	$40 Copay, plan pays 100%	
Office Services - basic services with exam. (Does not include pain management, chemo, or surgery)	Plan pays 60%	Plan pays 100%	Plan pays 100%	Plan pays 100%	
Telemedicine	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	
Ambulance (Ground Service Only)	No Benefit	No Benefit	No Benefit		**Patient may be balance billed if provider does not accept 150% of Medicare Allowable payment.
Birth Control / IUD	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	
Breast Pumps	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Limit $250. One per delivery. Purchase pump at local store and submit the receipt for reimbursement.
Chemical Dependency - Inpatient	Deductible, then Plan pays 100%	No Benefit	No Benefit	No Benefit	**Patient may be balance billed if provider does not accept 150% of Medicare Allowable payment.
Chemical Dependency - Outpatient	$70 Copay, Plan pays 60%	No Benefit	No Benefit	No Benefit	
Chemotherapy / Radiation Therapy	No Benefit	No Benefit	No Benefit	$400 Copay, Plan pays 100%	**Patient may be balance billed if provider does not accept 150% of Medicare Allowable payment.
Chiropractice Services	No Benefit	No Benefit	No Benefit	No Benefit	
Colonoscopy (For Medical Reasons) - Facility	No Benefit	No Benefit	$400 Copay, Plan pays 100%	$400 Copay, Plan pays 100%	**Patient may be balance billed if provider does not accept 150% of Medicare Allowable payment.
Colonoscopy (For Medical Reasons) - Physician	No Benefit	No Benefit	Plan pays 100%	Plan pays 100%	
Diagnostic Services - Basic labs/x-rays (related to office visit, LabCorp, etc.)	Deductible, then Plan pays 100%	$50 Copay, plan pays 100%	$50 Copay, Plan pays 100%	$50 Copay, plan pays 100%	
Diagnostic Services - Major (Facility) (MRI, CT, PET, Nuclear Medicine, etc.)	Deductible, then Plan pays 100%	No Benefit	$400 Copay, Plan pays 100%	$400 Copay, Plan pays 100%	**Patient may be balance billed if provider does not accept 150% of Medicare Allowable payment.
Diagnostic Services - Major (Physician) (MRI, CT, PET, Nuclear Medicine, etc.)	Deductible, then Plan pays 100%	No Benefit	Plan pays 100%	Plan pays 100%	

MVP BENEFIT OPTIONS

Network Provider Benefits Shown

Lifetime Max: None	Basic MVP	MVP	MVP+	MVP++	Benefit Limits Per Plan Year
Diagnostic Services - Minor (Ultrasounds, Bone Density, Echography, etc.)	No Benefit	No Benefit	$50 Copay, Plan pays 100%	$50 Copay, plan pays 100%	
Diabetic Education	No Benefit	No Benefit	No Benefit	No Benefit	
Dialysis	No Benefit	No Benefit	No Benefit	$400 Copay, Plan pays 100%	**Patient may be balance billed if provider does not accept 150% of Medicare Allowable payment.
Durable Medical Equipment (includes orthotics & prosthetics)	No Benefit	No Benefit	No Benefit	$400 Copay, Plan pays 100%	**Patient may be balance billed if provider does not accept 150% of Medicare Allowable payment.
Emergency Room - Facilities	Deductible, then Plan pays 100%	$400 Copay, Plan pays 100%	$400 Copay, Plan pays 100%	$400 Copay, Plan pays 100%	**Patient may be balance billed if provider does not accept 150% of Medicare Allowable payment.
Emergency Room All covered services other than facility charges	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	
Gastric Bypass Surgery / Lap Banding	No Benefit	No Benefit	No Benefit	No Benefit	
Home Health Care	No Benefit	No Benefit	No Benefit	No Benefit	
Hospice Care	No Benefit	No Benefit	No Benefit	$400 Copay, Plan pays 100%	
*Hospital Facility and Inpatient Services	Deductible, then Plan pays 100%	$400 Copay, Plan pays 100%	$400 Copay, Plan pays 100%	$400 Copay, Plan pays 100%	**Patient may be balance billed if provider does not accept 150% of Medicare Allowable payment.
Hospital attending physician, surgeon, and anesthesiologist charges during an inpatient hospital confinement	Deductible, then Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	
Hospital - Outpatient Surgery Facility	No Benefit	No Benefit	$400 Copay, Plan pays 100%	$400 Copay, Plan pays 100%	**Patient may be balance billed if provider does not accept 150% of Medicare Allowable payment.
Hospital attending physician, surgeon, and anesthesiologist charges during an outpatient hospital confinement	No Benefit	No Benefit	Plan pays 100%	Plan pays 100%	
Infertility Services	No Benefit	No Benefit	No Benefit	No Benefit	
Maternity - Prenatal Office Visits Only (billed separately from total delivery)	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Prenatal office visits are covered for all females covered under the plan
Maternity - (Labs, x-rays, ultrasounds, etc)	Deductible, then Plan pays 100%	No Benefit	$50 Copay, Plan pays 100%	$50 Copay, plan pays 100%	Diagnostics and Delivery coverage is limited to Employee and Spouse only
*Maternity - Facility and Inpatient Services	Deductible, then Plan pays 100%	$400 Copay, Plan pays 100%	$400 Copay, Plan pays 100%	$400 Copay, Plan pays 100%	**Patient may be balance billed if provider does not accept 150% of Medicare Allowable payment.
Maternity attending physician, surgeon, and anesthesiologist charges during an inpatient hospital confinement	Deductible, then Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	*Precertification required if stay is in excess of 48 hours (or 96 hours).

MVP BENEFIT OPTIONS

Network Provider Benefits Shown

Lifetime Max: None	Basic MVP	MVP	MVP+	MVP++	Benefit Limits Per Plan Year
Medical Supplies (Insulin, Diabetic test strips, Insulin pumps, etc.) These may be covered under Rx.	No Benefit	No Benefit	$50 Copay, Plan pays 100%	$50 Copay, plan pays 100%	
Mental Health - Inpatient	Deductible, then Plan pays 100%	No Benefit	No Benefit	No Benefit	**Patient may be balance billed if provider does not accept 150% of Medicare Allowable payment.
Mental Health - Outpatient	$70 Copay, Plan pays 60%	No Benefit	No Benefit	No Benefit	
Outpatient Therapy Physical, Speech, and Occupational	No Benefit	No Benefit	No Benefit	$400 Copay, Plan pays 100%	Limit: 20 Visits** Patient may be balance billed if provider does not accept 150% of Medicare Allowable payment.
Outpatient Surgery - Performed in an office or Urgent Care	Included with office visit copay	Included with office visit copay	Included with office visit copay	Included with office visit copay	Coverage Limited to $300 per visit
*Skilled Nursing	No Benefit	No Benefit	No Benefit	No Benefit	
Sleep Studies	No Benefit	No Benefit	No Benefit	No Benefit	
Sterilization for Women	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	
Sterilization for Men	No Benefit	No Benefit	No Benefit	$400 Copay, Plan pays 100%	
TMJ and Orthognathic	No Benefit	No Benefit	No Benefit	No Benefit	
Transplant - Facility	Deductible, then Plan pays 100%	$400 Copay, Plan pays 100%	$400 Copay, Plan pays 100%	$400 Copay, Plan pays 100%	**Patient may be balance billed if provider does not accept 150% of Medicare Allowable payment.
Transplant attending physician, surgeon, and anesthesiologist charges during an inpatient hospital confinement	Deductible, then Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	
Urgent Care & 24 Hour Clinics	$70 Copay, Plan pays 60%	$50 Copay, Plan pays 100%	$50 Copay, Plan pays 100%	$50 Copay, Plan pays 100%	
PRESCRIPTION BENEFITS					
Covered Prescription Drugs	Generic & Preferred Brand: Deductible, then Plan pays 100%	Generic: $10 Copay Formulary: No Benefit Non-Formulary: No Benefit Specialty: No Benefit	Generic: $10 Copay Formulary: $40 Copay Non-Formulary: $80 Copay Specialty: No Benefit	Generic: $10 Copay Formulary: $40 Copay Non-Formulary: $80 Copay Specialty: No Benefit	No Specialty medications are covered All prescriptions limited to a 31-day supply

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SAMPLE PLAN COST

MEC

COVERAGE TYPE	LIVES	CLAIM FUNDING	EMPLOYER CONTRIBUTION	PREMIUM
EMPLOYEE ONLY	52	$ 11.67	$ 97.11	$ 97.11
EMPLOYEE + SPOUSE		$ 24.03	$ 97.11	$ 113.47
EMPLOYEE+Child(ren)		$ 25.90	$ 97.11	$ 115.34
EMPLOYEE + FAMILY		$ 36.75	$ 97.11	$ 126.19

Enhanced MEC

COVERAGE TYPE	CLAIM FUNDING	PREMIUM
EMPLOYEE ONLY	$ 122.85	$ 241.63
EMPLOYEE + SPOUSE	$ 253.07	$ 376.85
EMPLOYEE+Child(ren)	$ 272.73	$ 396.51
EMPLOYEE + FAMILY	$ 386.98	$ 510.76

Enhanced MEC+

COVERAGE TYPE	CLAIM FUNDING	PREMIUM
EMPLOYEE ONLY	$ 192.96	$ 481.27
EMPLOYEE + SPOUSE	$ 397.50	$ 900.72
EMPLOYEE+Child(ren)	$ 337.69	$ 785.37
EMPLOYEE + FAMILY	$ 549.95	$ 1,194.71

Basic MVP

COVERAGE TYPE	CLAIM FUNDING	PREMIUM
EMPLOYEE ONLY	$ 226.35	$ 547.09
EMPLOYEE + SPOUSE	$ 466.28	$ 1,026.91
EMPLOYEE+Child(ren)	$ 396.11	$ 888.04
EMPLOYEE + FAMILY	$ 645.09	$ 1,380.77

MVP

COVERAGE TYPE	CLAIM FUNDING	PREMIUM
EMPLOYEE ONLY	$ 245.97	$ 602.26
EMPLOYEE + SPOUSE	$ 506.70	$ 1,144.67
EMPLOYEE+Child(ren)	$ 430.45	$ 993.35
EMPLOYEE + FAMILY	$ 701.01	$ 1,530.27

MVP+

COVERAGE TYPE	CLAIM FUNDING	PREMIUM
EMPLOYEE ONLY	$ 363.82	$ 779.64
EMPLOYEE + SPOUSE	$ 749.48	$ 1,510.06
EMPLOYEE+Child(ren)	$ 363.96	$ 1,303.76
EMPLOYEE + FAMILY	$ 1,036.90	$ 2,035.80

MVP++

COVERAGE TYPE	CLAIM FUNDING	PREMIUM
EMPLOYEE ONLY	$ 537.95	$ 1,166.26
EMPLOYEE + SPOUSE	$ 1,108.18	$ 2,306.50
EMPLOYEE+Child(ren)	$ 941.41	$ 1,980.34
EMPLOYEE + FAMILY	$ 1,533.16	$ 3,137.66

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PLAN REQUIREMENTS

- The rates contained in this proposal are based on **100%** participation in the MEC plan and allow for the buy-up of the MVP. Any deviation from the quoted census by more than 10% may require a re-rate due to the required stop loss premium.
- The reinsurance contract requires $14,000 in Minimum Annual Premium. If this is not met at the end of the contract, TTA will use any funds remaining in the account to pay Excess Reinsurance the Minimum Annual Premium.
- Minimum number of enrolled lives must be 50 or more, combined between MEC and MVP. If a group falls below 50 enrolled lives, they will be subject to paying the Minimum Participation Rate Adjustment (MPRA) rate for the difference between enrolled members and the minimum requirement of 50.
- The MPRA rate is paid by the employer for all employees who do not provide valid waivers or agree to purchase the MEC.
- $1,000 binder check will be required to start implementation. This will show as a credit to the account. If for some reason the group decides not to move forward before implementation this will be refunded. If the group chooses to not move forward or does not meet the requirements after implementation has begun, the binder check is nonrefundable.
- $30.00 monthly banking fee. This fee will cover any fees associated with the bank account and will be billed on the monthly invoice.
- Untimely notice of an employee's entry onto the health plan will result in a retroactive charge based on the number of months of coverage for that member that have not previously been charged to or paid by the Employer. When TTA receives untimely notice that a member's eligibility should have been terminated, a retroactive credit will be added to the invoice up to a maximum of three months -- unless the member incurred charges during that time, in which case the Employer shall pay the charges as if the member had been covered. For TTA to send out billing invoices in a timely manner, we ask that all enrollment changes be received by email or in RGM by the 20th of each month.
- TTA views all funds in client reserve accounts as belonging to the clients. Any funds not used to cover medical claims or other specific obligations (additional stop loss insurance, future invoice payments, etc.) authorized by the client will be returned when it is feasible to do so. Requests for refunds will not usually be considered until at least 6 months after the end of the plan year in question. Full refunds will only be offered when there are no more than three months remaining in the obligated run-out period and the likelihood of further claims having to be paid from the previous year's reserve is determined to be low.

DATA iSIGHT/MULTIPLAN

A rational, transparent way to value facility bills, paying claims at 150% of Medicare

EFFECTIVE Complete modules for inpatient, outpatient and practitioner claims

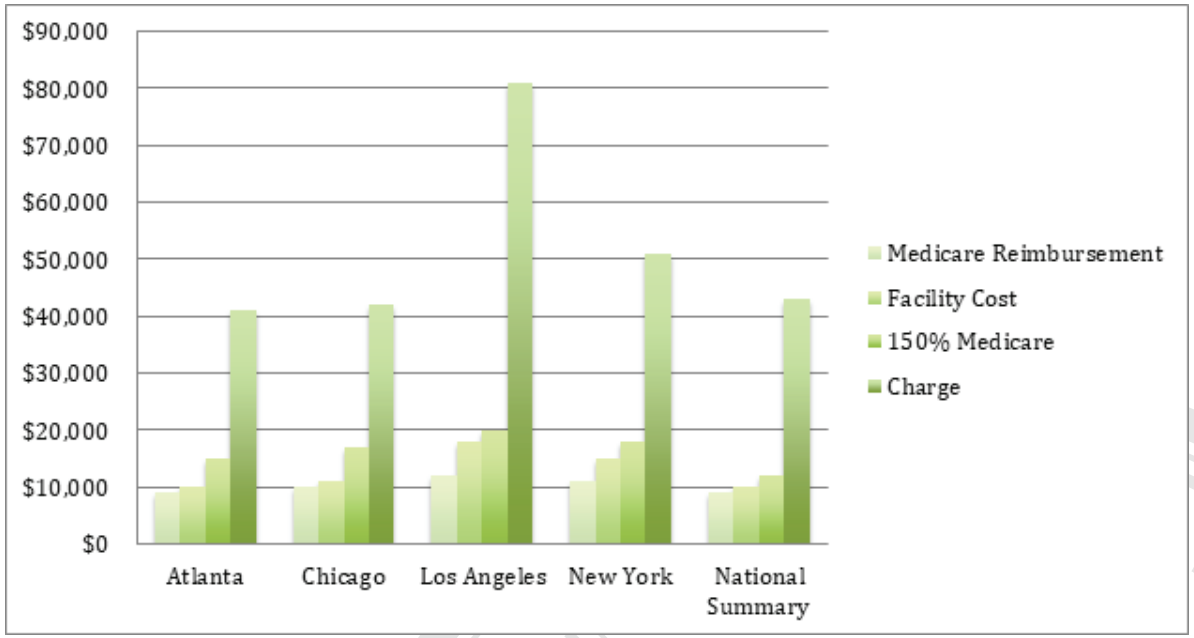
- Patented methodology
- Transparent to payer, practitioner and patient – no black boxes
- Saves more than 55% on inpatient claims and nearly 75% on outpatient claims
- Patient advocacy lends support when balance billing occurs

DEFENSIBLE

- Cost-based for facilities; median reimbursement-based for practitioners
- Derived from publicly available, industry-accepted data, process and rules
- National benchmarking
- Incorporates appropriate margins for providers

PLAN COVERAGE

- Plan is capped at 150% of Medicare.
- Other plans in the market capped below 150% will fall below a facility's procedural cost and create significant conflict and employee balance billing issues.



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