State of Connecticut Partnership Plan 2.0 for Healthcare Benefits
Nonstate Public Employer Participation Agreement

This Participation Agreement ("Agreement") is made on [effective date] by and between the Office of the State Comptroller ("Comptroller") and [insert name], a nonstate public employer located within the State of Connecticut (the "State").

RECITALS

WHEREAS, the Comptroller has entered into contracts to obtain group medical benefits; pharmacy benefit management services; dental benefits; and Medicare Advantage benefits for State employees, retirees, and other groups pursuant to Connecticut General Statutes ("C.G.S.") § 5-259;

WHEREAS, the Comptroller is authorized to offer nonstate public employers healthcare benefit coverage pursuant to C.G.S. § 3-123aaa *et seq*. through its the Partnership Plan 2.0 which is based upon the State's healthcare benefit plans procured under C.G.S. § 5-259;

WHEREAS, [insert name] has applied to obtain healthcare benefit coverage for its employees, retirees, and eligible dependents under the Partnership Plan 2.0;

WHEREAS, Comptroller has provided [insert name] with a premium equivalent rate for group medical and pharmacy benefits based on the experience of the State's self-insured health plans;

WHEREAS, Comptroller has provided [insert name] with the opportunity of enrolling its employees, retirees, and eligible dependents in a fully insured dental care plan and optional vision rider offered by the State's dental carrier; and

WHEREAS, Comptroller has provided [insert name] with the opportunity of enrolling its eligible retirees with a fully insured premium for coverage under the State's Medicare Advantage Plan.

NOW THEREFORE, intending to be legally bound, the parties to this Participation Agreement agree as follows:

Upon execution of this Agreement, [insert name] shall become and be known as a Participating Employer and shall be entitled to obtain healthcare coverage for its eligible employees, retirees, and dependents under the Partnership Plan 2.0 as of the effective date shown above.

I. TERM and TERMINATION

A. Participating Employer shall participate in Partnership Plan 2.0 for an initial three (3) year enrollment period beginning on [insert date]. Participating Employer may not terminate its participation before [insert date]. Should Participating Employer exit Partnership Plan 2.0 before the termination date set forth above, it may be subject to assessment of exit fees for early termination, as set forth in subsections E and F below.

B. Upon expiration of the initial three (3) year term, the Agreement shall be automatically renewed for an additional three (3) years unless the Participating Employer provides written notice of its election to not renew at least thirty (30) days before the expiration date.

C. After completion of the initial three (3) year term, Participating Employer may terminate its participation in Partnership Plan 2.0 upon ninety (90) days' notice to Comptroller without assessment of exit fees for termination.

D. Participating Employer acknowledges that Partnership Plan 2.0 may be modified as a result of changes in State law or in the State's collective bargaining agreement(s). If Plan benefit design or rate calculations are modified as a result of such change(s), Participating Employer may terminate its participation in the Plan upon 90 days' notice without assessment of the exit fees for early termination as set forth in in subsections E and F below.

E. Early Termination. If Participating Employer chooses to leave the Plan before the initial required three (3) year enrollment period is completed, it must be current on all premiums and any interest assessed and may be subject to an assessment as set forth below. Participating Employer shall not be entitled to a refund of premium payments due to differences in premiums paid and claims experience.

F. Early Termination Fees. If Participating Employer's actual experience since inception has been worse than the Partnership Plan 2.0 rates that have been established for that group, the group will be assessed a fee as follows:

1. Exit after completion of one (1) year: Lesser of the excess of the group's total costs over the rates they were charged since joining the Plan or five per cent (5%) of the total premium paid by the group in the most recent Plan year.

2. Exit after completion of two (2) years: Lesser of the excess of the group's total costs over the rates charged since joining the Plan or three per cent (3%) of the total premium paid by the group in the most recent Plan year.

3. Exit after completion of three (3) years or later: no assessment.

II. DEFINITIONS — Capitalized terms used in the Agreement shall have the meaning provided in this section:

Carrier means a vendor that has a current contract with the State of Connecticut to provide healthcare benefit services ("the Services") and that has been designated as an eligible provider for purposes of Partnership Plan 2.0.

Eligibility Structure means the structure determined by the Participating Employer to classify as either active or retired (pre-age 65).

Health Enhancement Program (or HEP) means a component of the pricing structure for Partnership Plan 2.0 where Members pay a discounted rate for coverage if they complete certain preventive and wellness activities on an annual basis.

Member means each individual identified by a Participating Employer as eligible for healthcare benefits under the Plan.

Partnership Plan 2.0 (or Plan) means the health benefit programs(s) sponsored by Participating Employers that include prescription drug and medical benefits.

State means the State of Connecticut, including the Office of the State Comptroller, and any office, department, board, council, commission, institution or other agency or entity of the State.

III. NOTICES

Unless otherwise expressly provided to the contrary, any notices provided for hereunder shall be in writing and may be delivered personally, by email, by U.S. mail, or by overnight mail delivery service. The parties may change their respective addresses for notices under this paragraph upon prior written notification to the other. Notices will be effective if delivered personally, by email, by U.S. mail, or by overnight delivery carrier to the following addresses:

OFFICE OF THE STATE COMPTROLLER
Joshua Wojcik
165 Capitol Avenue
Hartford, CT 06106
Joshua.Wojcik@ct.gov

[PARTICIPATING EMPLOYER]
Main Contact Name
Address
City, State ZIP
Email

IV. RATES

A. Annual Rates. Participating Employer shall be charged the rates set forth in Exhibit A of this Agreement for medical and pharmacy benefits, dental and vision benefits, and Medicare Advantage coverage, as applicable. Rates to be charged to Participating Employer for its active employees and non-Medicare retirees are subject to annual revision based on the State's annual renewal on [insert date] and each July 1st thereafter, taking into account any applicable regional adjustment.

B. HEP Charges. Rates charged to Participating Employer shall be increased for each Member who fails to qualify for the financial benefits of the Health Enhancement Program (HEP) as described in Section VI.F. of the Agreement.

C. Premium Rate Development – Active & Non-Medicare Retiree Plans

1. Partnership Plan 2.0 base rates are developed using a combination of the State's overall claims experience and Partnership Plan 2.0 claims experience. The base rate is combined with a regional rate adjustment based on the county in which the majority of the nonstate public employer's employees work. The rates are established as follows.

2. The medical and pharmacy claims experience are evaluated separately for Actives and Non-Medicare Retirees. The claims include all plans consisting of State and Partnership Plan 2.0 employees and Non-Medicare Retirees to produce the experience-based total incurred claim amount for the experience period.

3. The experience-based total incurred claim amount is trended forward to the plan year. ASO fees, fees required by the Affordable Care Act, and administrative fees are added to the claims cost. Pharmacy rebates are included with the prescription claims cost. This amount is divided by the average number of employees by tier during the experience period in which the claims were extracted.

    a. The formula for Actives is:
    Single Employees + 2.2 x (Employee + 1 family) + 2.7 x Family Employees

    b. The formula for Non-Medicare Retirees is:
    Single Employees + 2.2 x (Employee + 1 family) + 2.7 x Family Employees

4. Post-65 Retirees Not Eligible for Medicare rates are based on (pre-65) Non-Medicare Retiree rate actions for medical claims, pharmacy claims, ASO fees, fees required by the Affordable Care Act, and administrative fees.

5. The result of this calculation is a premium amount for each tier (i.e. active employees, Non-Medicare Retirees under 65 and Non-Medicare Retirees over 65). The premium rates to be charged for each tier were then established by the Comptroller to comply with the SEBAC (State Employees Bargaining Agent Coalition) agreement.

6. Regional adjustments are made to the rates based on a review of ASO factors by county as well as the State and Partnership Plan 2.0 per member per month costs by county.

7. Premium rates for nonstate public employers are reset on July 1 and will be based on the entire pool's experience combined with the regional rate adjustment by county. The monthly premium

rates are posted by county and are guaranteed from the original date of coverage to the end of the current fiscal year. Quarterly rates are posted for new groups to accommodate effective dates other than July 1st. Nonstate public employers pay the same calculated premium by county regardless of the employer's specific experience.[1]

D. Premium Rate Development – Medicare Retiree Plans

1. Medicare Retirees enrolled in Partnership 2.0 are offered a fully insured Medicare Advantage plan with prescription drug plan (MAPD). The Carrier develops rates for each calendar year on a per member basis.

2. If a nonstate public employer elects to exit the Partnership 2.0 Plan with respect to its active employees and Non-Medicare Retirees, coverage for its Medicare-Eligible Retirees in the Medicare Advantage Prescription Drug Plan will be terminated effective the last day of the calendar year.

E. Considerations for Enrollment Acceptance

1. If Participating Employer's application to the Comptroller indicates the entire group shall be enrolled, the Employer may join the State pool in accordance with the current premium rate and benefit offering. The application is not subject to traditional underwriting procedures whereby the premium rates are adjusted based on the characteristics of the group.

2. If the Participating Employer's application to the Comptroller indicates that a portion of the group will be enrolled (less than the entire board, town or other nonstate public employer's covered employees or retirees) the application will be forwarded to the Health Care Cost Containment Committee (HC4) for review. The following are considerations in the HC4 review, but are not exhaustive:

a. If the intention is to shift a high risk or high-cost population to Partnership Plan 2.0 for budget purposes, Participating Employer's application will be denied.

b. If Partnership Plan 2.0 is offered in conjunction with plans offering less generous benefits and lower costs, Participating Employer's application will generally be denied due to the likelihood that Partnership Plan 2.0 would attract a higher risk population than the competing option.

c. If the population is segmented by division, HC4 may review the application to determine whether the segmentation will shift a significant portion of the high cost claims to the State while leaving more favorable populations in the Participating Employer's control. The Comptroller will supply any required analysis and a recommendation for the HC4 to consider.

3. Once the application has been accepted, the Participating Employer shall work with the State's third-party administrator to enroll.

[1] Premium rates do not include the excise tax, which will apply to certain health plans under the Affordable Care Act, in its current form, beginning in 2022. To the extent that the excise tax applies to premiums for non-state public employers under the Partnership Plan 2.0, the non-state public employer will be responsible for paying such costs. Rates will be developed annually based on actual experience. Applicants may request information regarding the state historical trends to assist in determining the potential impact, if any, of the excise tax provision on the Partnership Plan 2.0. The HCCCC is continually working to constrain health care costs through our HEP program, and other initiatives. The excise tax is assessed on only the premium amounts in excess of the statutory thresholds. (Please note that final regulations concerning the excise tax are not complete; some of the proposed regulations provide for higher thresholds for certain plans based upon occupation, age and/or gender, and rules for combining different plans for purposes of calculating the tax have not been finalized.)

F. Benefit Plan Offerings

1. The State's current benefit plans for nonstate public employers are[2]:

   - Anthem POS Plan
   - CVS/Caremark Pharmacy Plan
   - Aetna MA-PD Plan for Medicare Retirees
   - Cigna Dental Plan (Separate fully insured plan with varying premium rates)
   - Cigna Vision (Separate rider, not included in the calculated premium rates)

2. The medical plan will be administered according to the POS benefit design, including medical management and case management administration. Participating Employers must enroll in both the medical and pharmacy plans in order to participate in Partnership Plan 2.0. Participation in the dental plan or the vision rider is not required; however, selecting one of the dental plans offered may facilitate compliance monitoring of the HEP requirement for annual dental cleanings by Members. Complete HEP requirements are described in Section VI.F. of the Agreement.

3. Catastrophic Claims. Premium rates are developed using all claims experience, including large claims. High cost claims are pooled into the entire Plan experience. There will be no premium rate adjustments for any individual nonstate public employers based on the existence or absence of high cost claims experience. Premium rate increases will be based upon the experience of the entire population covered under the State Plan and Partnership Plan 2.0. Stop loss insurance is not necessary for Plan participants.

4. Group Size. All nonstate public employers shall receive the same premium rates by county regardless of group size.

V. COVERAGE

A. Review of Partnership Plan 2.0 Documents. Participating Employer represents and warrants that it has reviewed the healthcare benefits available under Partnership Plan 2.0 and understands that the benefits to be provided to Members are limited to those services authorized under the terms of the operative Partnership Plan 2.0 documents consistent with the Carriers' medical necessity guidelines.

Medical Plan Document:
https://osc.ct.gov/ctpartner/docs/State%20of%20CT%202023%20Partnership%20Medical-Plan-Document-Rev.03.2024.pdf

Prescription Benefit / Pharmacy Plan Document:
https://carecompass.ct.gov/wp-content/uploads/2023/09/State-of-CT-2023-Partnership-Pharmacy-Plan-Document.pdf

Dental Program:
https://carecompass.ct.gov/ctpartner/dental/

Vision Rider Coverage:
https://carecompass.ct.gov/ctpartner/vision/

[2] Carriers are subject to change; the State engages in a competitive bidding process on a regular basis to ensure the best possible price and service from vendors.

Medicare Advantage (MAPD):
https://ct.aetnamedicare.com/coverage-and-benefits/plan-benefits-and-forms

B. Carriers' Right to Rely. Participating Employer agrees that Carriers under contract with the State shall be entitled to rely upon and enforce the promises and agreements made by Participating Employer to the Comptroller under this Agreement as if the Carrier were a party to this Agreement.

C. Disclosure of Coverage Exceptions. Participating Employer represents and warrants that it has disclosed to Comptroller all instances where its current medical or pharmacy plan was directed to provide coverage for services or medications that are exceptions to or in excess of benefits covered by the terms of the plan document(s) in effect prior to its entry into Partnership Plan 2.0.

D. Liability for Non-Covered Benefits. Participating Employer acknowledges and agrees that Partnership Plan 2.0 is not obligated to continue providing coverage to Members for healthcare benefits or medical or pharmacy coverage exceptions authorized prior to its entry into Partnership Plan 2.0 that are not eligible for coverage under Partnership Plan 2.0. If Participating Employer requests continuation of any coverage exceptions, Participating Employer understands and agrees that it will be responsible for payment of the full cost of all excepted benefits and that such costs will be invoiced to it by the Carrier(s) as a line item captioned "Supplemental Claims Charges" and are subject to payment in accordance with Section VI.D. of the Agreement.

VI. INVOICING AND PAYMENT

A. Eligibility

1. Thirty (30) days prior to the effective date, Participating Employer shall provide the State's current Carriers with an electronic file providing a snapshot of all current live enrollment data (known as the "Full File"). After receipt of the Full File the Carrier(s) shall reconcile all enrollment data and report any discrepancies to the Participating Employer. The Carrier(s) shall forward the Participating Employer's eligibility data to the State's current Pharmacy Benefits Manager ("PBM") on a mutually agreeable schedule and the PBM may rely on the accuracy of such data.

2. The Carrier(s) shall accept the Eligibility Structure as defined by the Participating Employer. Participating Employer shall provide the Carrier(s) of any changes within its enrollments, including additions, terminations, coverage class changes, or dependent eligibility modifications. the medical and pharmacy carrier shall forward Participating Employer's eligibility data to the PBM on a on a mutually agreeable schedule.

3. Participating Employer is responsible for ongoing verification of continuing eligibility of its Members. Comptroller shall not reimburse, or refund premiums or other payments made for a Member who is later determined by Participating Employer to no longer be eligible to receive healthcare services.

B. Invoicing

1. Carrier(s) shall invoice Participating Employer monthly in advance for the premium equivalent amounts set by the Comptroller for payment of premiums and any applicable fees based on current eligibility as reflected in its Full File.

2. Carrier(s) shall invoice Participating Employer monthly for any Supplemental Claims Charges.

C. Payment

1. Participating Employer shall pay all invoiced amounts to the Carrier(s) by the first (1st) day of the month following the date of the invoice. If any payment due from a Participating Employer is not received by the tenth (10th) day after the date such payment is due, interest shall be added to the outstanding invoice retroactive to the date such payment was due, at the rate of eight (8%) per cent per annum. Carrier(s) shall forward all Partnership Plan 2.0 payment amounts received from Participating Employer to Comptroller.

D. Non-Payment of Invoices

1. If Participating Employer fails to make payments for healthcare benefits as required under the Agreement, the Comptroller may direct the State Treasurer, or any other officer of the State who is the custodian of any moneys made available by grant, allocation or appropriation payable to such Participating Employer, to withhold the payment of such moneys until the amount due, including interest, has been paid to the Comptroller, or until the State Treasurer or such custodial officer determines that arrangements have been made, to the satisfaction of the State Treasurer, for the payment of such amounts and interest. Such moneys shall not be withheld if such withholding will adversely affect the receipt of any federal grant or aid in connection with such moneys.

2. If no grant, allocation or appropriation is payable to such Participating Employer or is not withheld, pursuant to subparagraph (1) of this section, the Comptroller may terminate Participating Employer's participation in the Partnership Plan 2.0 on the basis of nonpayment of amounts due, provided at least ten (10) days' advance notice is given to Participating Employer, which may continue the coverage and avoid the effect of the termination by remitting payment in full at any time prior to the effective date of termination.

3. The Comptroller may request the Attorney General to bring an action in the superior court for the judicial district of Hartford to recover any premium or premium equivalent, administrative fees, interest costs, paid claim expenses or equitable relief from a terminated Participating Employer, including any amounts assessed for premature termination or any claims paid on behalf of Participating Employer's Members after the date of termination.

4. If Participating Employer fails to make payments as required under the Agreement, the Comptroller, in addition to the other remedies above, may direct the Carrier(s) to implement a temporary hold on payment of claims for the Participating Employer's Members until such time as the outstanding invoices and any accrued interest are paid in full.

5. If Participating Employer fails to make payments to the Carrier for Supplemental Claims Charges when due the Carrier may, upon notice to Comptroller and Participating Employer, discontinue coverage of Excepted Services to the Participating Employer's Member(s) until outstanding charges are paid in full.

E. Payment of Claims and Premiums

1. Comptroller shall pay claims for medical and pharmacy benefits allocable to a Participating Employer's Active Members and any non-Medicare-Eligible Retirees and their eligible dependents on a self-insured basis. Any rebates or payments for missed pricing guarantees on pharmacy claims attributable to Participating Employer's Members shall be included in the State's claims experience for the purpose of determining annual renewal rates. The rates for Partnership Plan 2.0, as set forth in Exhibit A are set to cover the claims incurred during the contract period, regardless of their payment date.

2. If the Participating Employer was self-insured immediately prior to joining the Partnership Plan 2.0, it shall be responsible for funding claims incurred by Participating Employer's Members before the effective date of coverage under this Plan.

3. If the Participating Employer exits Partnership Plan 2.0, the Plan shall fund the run-out claims. Comptroller shall invoice Participating Employer for any administrative fees that are assessed by the Carrier(s) for processing its run-out claims, and Participating Employer agrees to pay such invoice(s) within thirty (30) days of receipt.

F. Payment of HEP Noncompliance Fees by Employee or Retiree

If a Participating Employer's Member fails to meet the requirements of the Health Enhancement Program (HEP) the Plan shall invoice the Participating Employer an additional fee for each month of noncompliance for each employee or retiree. Those fees may initially be paid by the Participating Employer but the individual employee or retiree, as applicable, must reimbursed the Participating Employer.

The following table describes the HEP Requirements as of 1/1/2025. These requirements are subject to change. Please contact partnershipplan@ct.gov to confirm the most up-to-date information.

[This section intentionally left blank]

HEALTH ENHANCEMENT PROGRAM (HEP)

BY THE STATE OF CONNECTICUT. ADMINISTERED BY QUANTUM HEALTH.

The Health Enhancement Program (HEP) encourages regular check-ups and screenings to help health plan members find health issues early and get the care they need. By completing your age-related screenings and any required education for chronic conditions each year, you save on healthcare costs. If everyone covered under your plan does not meet these requirements, you will have an in-network deductible of up to $1,400 and your monthly premiums will increase by $100 per month.

<table>
<tr><th rowspan="2">PREVENTIVE SCREENINGS</th><th>Dependent Requirements</th><th colspan="5">Employee and Spouse Requirements</th></tr>
<tr><th>6-25 years</th><th>18-29 years</th><th>30-39 years</th><th>40-49 years</th><th>50-64 years</th><th>65+ years</th></tr>
<tr><td>Preventive Visit</td><td></td><td colspan="5">Every 2 years</td></tr>
<tr><td>Dental Cleaning</td><td>At least 1 per year</td><td colspan="5">At least 1 per year</td></tr>
<tr><td>Cholesterol Screening</td><td rowspan="4"></td><td colspan="5">Every 5 years (age 20+)</td></tr>
<tr><td>Breast Cancer Screening (for women)</td><td colspan="2">N/A</td><td colspan="3">Mammogram every 2 years to age 75</td></tr>
<tr><td>Cervical Cancer Screening (for women)</td><td>Pap every 3 years (age 21+)</td><td colspan="3">Pap only every 3 years or Pap/HPV combo every 5 years</td><td>N/A</td></tr>
<tr><td>Colorectal Cancer Screening</td><td colspan="2">N/A</td><td colspan="3">Colonoscopy every 10 years (45+), Cologuard screening every 3 years, or Annual FIT/FOBT to age 75</td></tr>
</table>

The requirements are based on your age as of January 1 each year. As Quantum Health receives your claims, your preventive care will be marked complete in your online account.

ADDITIONAL STEPS REQUIRED IF YOU HAVE A CHRONIC CONDITION

Covered adults (18+) diagnosed with any of the following chronic conditions, must complete one education for each condition.

- Diabetes (type 1 or 2)
- Asthma or COPD
- Heart disease/heart failure
- Hyperlipidemia (high cholesterol)
- Hypertension (high blood pressure)

CONFIRM HEP COMPLIANCE AND LEARN MORE

- Go to **carecompass.ct.gov**, log in to Quantum Health, and click the **My Health** tab
- Call your Quantum Health Care Coordinators at (833) 740-3258

Download on the App Store | GET IT ON Google Play

carecompass.ct.gov

(833) 740-3258
(Monday-Friday, 8:30 a.m.-10 p.m. ET)

CARE COMPASS | Quantum HEALTH

VII. OBLIGATIONS OF PARTICIPATING EMPLOYER

A. Plan Member Authorizations. Participating Employer represents and warrants that it has obtained from its Members all consents and/or authorizations required, if any, to enable the State's Carriers, if applicable, to perform the Services and for the use and disclosure of information, including private health information (PHI), as permitted under this Agreement.

B. Claims Reporting. Participating Employer authorizes the Comptroller to obtain reporting of claims data for its Members from the Carrier(s) as necessary in the same format and on the same schedule as is employed for reporting of the State's claims. As applicable, the Carrier(s) shall provide claims, administration services, and enrollment data for Participating Employer's Members to the State's healthcare consultant (Segal) for analysis and inclusion in the claims database. Comptroller shall direct Segal to provide Participating Employer with de-identified claims data pertaining to its Members.

C. Control of Plan. Participating Employer retains the sole and absolute authority to modify provisions pertaining to applicable premium or cost shares to be paid by its employees or retirees, and the rules concerning eligibility for coverage of active and retired employees and their eligible dependents, subject to the right of Comptroller to ensure the Participating Employer's compliance with the conditions under which its participation in Partnership Plan 2.0 was accepted. Participating Employer shall accept the State's Plan design without modification.

D. Administration of Eligibility. Participating Employer shall have complete discretionary, binding and final authority to construe eligibility rules affecting its Members. Provided however, each Participating Employer is responsible for maintaining compliance with the requirements of the Internal Revenue Code Section 125 with regard to deduction of health care premiums from employee wages and any necessary tax reporting.

E. Communications with Members. In order to increase awareness of the wide range of healthcare services available to Members and to facilitate compliance with the Health Enhancement Program (HEP), Participating Employer shall share a file of membership's contact information to partnershipplan@ct.gov on an annual basis. The Comptroller and Quantum Health (administrator of HEP) shall use the contact information solely to communicate about healthcare services available through the Plan and HEP requirements and deadlines. The following fields are required to be included in the data file: Employment Status; First Name; Middle Name; Last Name; Gender; Birthdate; Mailing Address; Home Phone; and Email.

F. Affordable Care Act (ACA) Compliance

1. Fees for the Patient-Centered Outcomes Research Institute ("PCORI") under the ACA are included in the rates, and Partnership Plan 2.0 's members shall be included in the State's reporting for this purpose. These fees are built into the premium calculations based on Segal's understanding of the ACA laws as they exist in May 2020.

2. As an entity sponsoring a self-funded health plan, the State of Connecticut reports to the Internal Revenue Service (IRS) healthcare benefit coverage that it provides to its employees and some non-employee individuals covered under its plan. The size of the Partnership Plan 2.0 group determines whether the reporting will be done by the State or will be the responsibility of the Participating Employer.

3. Employer Groups with Fewer than Fifty Full-Time Employees. For Partnership Plan 2.0 Participating Employers with fewer than fifty (50) full-time employees, the State shall complete and mail the 1095- C forms directly to the Employer Groups' Members, using enrollment data obtained from the

Carrier(s).

4. Employer Groups with More than Fifty Full-Time Employees. Partnership Plan 2.0 groups with fifty (50) or more full-time employees are obligated to provide the IRS Form 1095-C, Employer-Provided Health Insurance Offer and Coverage to covered individuals and to file Form 1094-C Transmittal of Employer-Provided Health Insurance Offer with the IRS.

5. Participating Employer may consult with Partnership Plan 2.0 administrators for alternatives to assist it in meeting its ACA compliance requirements. However, any fees or penalties assessed by the IRS against a Participating Employer for failure to make affordable healthcare coverage available to its employees are to be paid by the Participating Employer.

VIII. INTERPRETATION OF PLAN

Comptroller shall have complete discretionary, binding and final authority to interpret the Partnership Plan 2.0 documents, to make factual determinations regarding the payment of claims or provision of benefits, to review denied claims and to resolve complaints by Members under the self-insured medical and pharmacy plan, the fully insured MAPD plan, and the fully insured dental plan with optional vision benefits rider. Such authority is delegated to the respective Carriers for the sole purpose of initial claims determinations and appeals adjudication.

IX. DATA

Participating Employer authorizes Comptroller to obtain reporting of claims data for its Members from the Carrier(s), if applicable, in the same format and on the same schedule as is employed for reporting the State Plan's claims. As applicable, the Carrier(s), shall provide claims, capitated services, and enrollment data for Participating Employer's Members to the State's healthcare consultant for analysis and inclusion in the claims database. Comptroller shall direct its healthcare consultant to provide Participating Employer with de-identified claims data pertaining to its Members.

X. FREEDOM OF INFORMATION

Participating Employer acknowledges that the Comptroller must comply with the Freedom of Information Act pursuant to C.G.S. §§1-200 *et seq*. which requires the disclosure of documents in the possession of the State upon request of any citizen, unless the content of the document falls within certain categories of exemption, as defined by C.G.S. §1-210(b).

XI. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")

The Carrier(s) are "Business Associates", and the Comptroller is a "Covered Entity", as defined in 45 C.F.R § 160.163. "Business Associates" of the Comptroller, may make claims disclosures directly to Comptroller as a "Covered Entity" (or to its healthcare consultant) for plan administration purposes. The Carrier(s) are bound by the provisions of their respective Business Associate Agreements with the Comptroller.

XII. SIGNATURES AND APPROVAL

IN WITNESS WHEREOF, the parties execute this Agreement.

OFFICE OF THE STATE COMPTROLLER	Insert name [PART. EMPLOYER]
By: _____	By: _____
Tara Downes	Name
Deputy State Comptroller	Title
Date: _____	Date: _____

EXHIBIT A.

Premium Rates for Select Healthcare Coverage

Rates for medical and pharmacy benefits

Rates for dental benefits and vision rider, if applicable

Rates for Medicare Advantage benefits, if applicable

Insert Rate Sheet(s) here