

**STATE OF NORTH CAROLINA
COUNTY OF WAKE**

**AMENDMENT NUMBER THREE
TO THE
THIRD-PARTY ADMINISTRATIVE SERVICES CONTRACT**

THIS AMENDMENT (“Amendment”) to the Third-Party Administrative Services Contract (“TPA Contract” or “Contract”), executed the 14th day of December, 2022, is between the North Carolina State Health Plan for Teachers and State Employees (“Plan”) and Aetna Life Insurance Company (“Aetna” or “Vendor”), each, a “Party” and collectively, the “Parties,” and is effective January 1, 2025, after signature of both Parties.

Background

The Plan awarded Request for Proposals # 270-20220830TPAS – Third-Party Administrative Services to Aetna on December 14, 2022, with an initial Contract term of 60 months, including 24 months for implementation, beginning January 1, 2023, through December 31, 2024, and 36 months for services beginning January 1, 2025, through December 31, 2027. At the end of the Contract’s current term, the State shall have the option, in its sole discretion, to extend the Contract on the same terms and conditions for up to two (2) additional one-year terms beginning January 1, 2028, through December 31, 2028, and January 1, 2029, through December 31, 2029.

The Parties executed Amendment Number One to the TPA Contract on February 2, 2024, which provided an Aetna dedicated Business Analyst to work onsite at the Plan two or three days a week to support the Plan Integration Team’s oversight of the Contract.

The Parties executed Amendment Number Two to the TPA Contract on December 18, 2024, to document Aetna’s acceptance and processing of the prior claim administrator’s precertification determinations.

Since the execution of Amendment Number Two, the Plan has elected to implement the following two additional optional services and to reimburse Aetna per subscriber per month (PSPM) fees for the services as set forth in this Amendment:



Also, during the implementation of the TPA Contract, the Plan and Aetna refined some of the Standard Reports resulting in the removal of 18 reports from “Exhibit 11 Standard Reports.”

Therefore, the purpose of this Amendment to the TPA Contract is to memorialize the (1) addition of the two optional services and costs described above; and (2) remove 18 reports from “Exhibit 11 Standard Reports.”

Amendment

In accordance with the foregoing Background, the Parties agree as follows:

A. Reference Contract Section 5.2.8.2. “Services.”

Item b. in Section 5.2.8.2 “Services” is amended to add the [REDACTED] as b.xvii. and [REDACTED] s b.xviii. The amended Contract Section 5.2.8.2 “Services” restates its contents as follows:

5.2.8.2 Services

a. Vendor confirmed the following in the Minimum Requirements:

- i. Vendor will comply with all requirements set forth in Article 29B of Chapter 90 of the North Carolina General Statutes. As required, Vendor will validate provider enrollment in North Carolina’s Health Information Exchange (NC HealthConnex) prior to paying Plan Member claims. If prohibited by the Statewide Health Information Exchange Act, Vendor must deny any claims received from providers that are not in compliance on the date of service.
- ii. Vendor will process all claims, including claims that are Medicare primary and Medicare secondary, from the same claims processing platform.
- iii. Vendor will administer the appeals process required by Chapters 58 and 135 of the North Carolina General Statutes, including appeals for the Plan’s PBM. Refer to Benefits Booklets and N.C.G.S. § 135-48.24.
- iv. Vendor will customize any appeals letters, as requested by the Plan.
- v. Vendor will work with the Plan to resolve and respond to any inquiries from the North Carolina Department of Insurance’s Smart NC Program.
- vi. Vendor will support the Plan’s methodology for coordinating with Medicare Members who have not elected Medicare Part A and/or B. As required by state law, the Plan coordinates claims for Members who do not elect Medicare Parts A and/or B as if they had elected them. (a.k.a. Phantom Processing) See Exhibit 9, “Claims Processing Phantom Plan – Medicare Part B.”
- vii. Vendor will reimburse the Plan on a weekly basis for any prompt pay penalties included in the weekly claims disbursement for that week as the Plan will pay no prompt-pay penalties for claims that are paid outside of the prompt-pay guidelines as a result of Vendor’s action, inaction, or system failure.
- viii. Vendor will customize EOBs with the Plan’s logo and if applicable, custom network and other information as illustrated in Exhibit 8, “Sample EOB.”

- b. Vendor shall additionally confirm each of the following:
- i. Vendor will maintain and make accessible to the Plan at least 10 years of claims history.
 - ii. Vendor will work with the Plan's internal legal counsel and the North Carolina Attorney General's Office, as appropriate, throughout the appeals process; and Vendor will make available its subject matter experts to testify during hearings when requested.
 - iii. Vendor will process all claims in accordance with state and federal laws including the Plan's 18 month timely filing rules set forth in N.C.G.S. § 135-48.52(6).
 - iv. Vendor will provide the Plan with any information requested regarding its pre-pay claims edits and will add edits at the Plan's request.
 - v. Upon request, Vendor will pay all claims, including non-network claims, based on assignment of benefits.
 - vi. Vendor will provide a weekly summary of any claims totaling \geq \$100,000.00 to the Plan's Contract Administrator for day to day activities. The summary shall include the total charge, total allowed amount, Member cost share, and a short description of circumstance of the claim, including a status of the Member's condition.
 - vii. Vendor will support Medicare direct claims by interfacing with Medicare crossover vendors and CMS.
 - viii. Vendor will coordinate benefits with other commercial payors.
 - ix. Vendor will support all future state and federal requirements at no additional cost to the Plan.
 - x. Vendor will produce EOBs that meet all Federal requirements.
 - xi. Vendor will prevent Subscribers from having access to the Dependents EOBs when the Subscriber does not have custodial rights.
 - xii. Vendor will mail EOBs directly to Dependents 18 years of age or older without a copy to the Subscriber.
 - xiii. Vendors will mail a Dependent's EOB to a different address if a different address exists in the Dependent's demographic record.
 - xiv. Vendor will support Members' election of electronic EOBs in lieu of paper EOBs.
 - xv. Vendor will provide a single, combined Medical and HRA EOB, as requested by the Plan.
 - xvi. Vendor will implement PCP "gate-keeper" rules, as requested by the Plan.

xvii. Vendor will utilize its [REDACTED] to apply contracted and negotiated rates to out-of-network claims [REDACTED] as well as Facility Charge Review (FCR) and Itemized Bill Review (IBR).

xviii. Vendor will utilize its [REDACTED] to implement an advanced suite of technology-based solutions, developed through CVS Health, its subsidiaries or affiliates (including Aetna) or its third-party vendors to ensure claims are properly coded and compliant with Vendor's policies and provider contracts.

B. Reference "Exhibit 11 Standard Reports."

Exhibit 11 Standard Reports is amended to remove the 18 following reports, is restated in its entirety, and attached to this Amendment as the "First Amended and Restated Exhibit 11 Standard Reports."

1. CLM007 - Monthly Pharmacy Appeals Detail Report
2. FIN001 - Accounts Receivable Aging Report
3. FIN003 - Prepaid Premiums Report
4. FP007 - Open Invoice Report
5. MAT001 - Change Summary Paid Report
6. MAT002 - Change Summary Incurred Report
7. MAT003 - Change Summary Trend Paid Report
8. MAT005 - Coinsurance & Deductible, Full Population-Paid Report
9. MAT007 - Coinsurance & Deductible, Closed Population-Paid Report
10. MAT008 - Coinsurance & Deductible, Closed Population-Incurred Report
11. MAT009 - Copay Incurred Report
12. MAT010 - Copay Paid Report
13. MAT012 - Claims Experience Summary by Age and Sex Paid Report
14. MAT014 - Financial Summary Paid Report
15. MAT015 - Financial Summary Incurred Report
16. MAT016 - Financial Reconciliation Paid Report
17. MAT018 - Member Utilization and Cost Share by Type of Service Report
18. MM006 - Clinical Quality Improvement



Note: The remaining MAT Reports 004, 006, 011, 013, and 017 were renumbered as MAT001 through MAT005.

[Continued on next page.]

C. Reference “Attachment A-7: Administrative Fees - BAFO #1.”

1. ATTACHMENT A-7: Administrative Fees - BAFO #1 is amended to incorporate the “per subscriber per month” (PSPM) fees for the following additional optional services and is restated in its entirety and attached to this Amendment as the “First Amended and Restated ATTACHMENT A-7: Administrative Fees - BAFO #1.”

Additional Services	PSPM Fee

2. Aetna shall begin providing th  services effective January 1, 2025.
3. Other than  Aetna (A) shall not charge the Plan separately for savings programs that are included in the “Standard Services” administrative fee under the Contract and (B) is contractually bound not to charge the Plan any fee for the identification, recovery, or adjustment of overpayments, duplicate payments, or other processing errors.


D. Unchanged Provisions.

The Parties acknowledge that the terms and conditions of this Amendment are incorporated by reference into the terms and conditions of the TPA Contract as though originally a part thereof, and to the extent that the terms and conditions of the Contract are not negated or otherwise modified by this Amendment, such terms and conditions shall remain in full force and effect.

[Signatures on next page.]

Each party is signing this agreement on the date set forth beneath the signature line and title.


State Health Plan for Teachers and State Employees

Signed by:

By: 98C543FB82864F3...
Samuel W. Watts

Title: Executive Administrator

Date: 12/30/2024

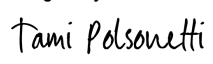
Office of the State Treasurer


By: D9B80AAB6C4B428... WT Brinn, Chief of Staff
Dale R. Folwell, CPA

Title: State Treasurer of North Carolina

Date: 12/31/2024

Aetna Life Insurance Company

Signed by:

By: 0DBF4CDBAB98477...
Tami Polsonetti

Title: Assistant Vice President

12/31/2024
Date: _____

First Amended and Restated Exhibit 11 Standard Reports			
Number	Name	Frequency	Notes
Claims Reports			
CLM001	Processed Claims Report	Monthly-20 th	
CLM002	Deductible & Out of Pocket Maximums by Plan and Month	Quarterly-due forty five (45) days after the end of each quarter	
CLM003	Monthly COB Report	Monthly - 20 th	
CLM004	Quarterly Summary of Denied Claims Report	Quarterly-due forty five (45) days after the end of each quarter	
CLM005	High Claimant Report	Quarterly-due forty five (45) days after the end of each quarter	
CLM006	Appeals Reports	Monthly-20 th	
Customer Experience Reports			
CUS001	Operations Dashboard	Weekly-Thursday-End of Day	
CUS002	Web Trends Report	Quarterly-due forty five (45) days after the end of each quarter	
Finance Reports			
FIN002	Uncollectible Accounts Report	Quarterly-due forty five (45) days after the end of each quarter	
FIN004	Daily Deposit Report	Daily-Receive by 10:00 a.m.	
FIN005	Not Sufficient Funds Report	Daily-5:00 p.m.	
FIN006	Misapplied Deposits and/or Collections Report	Monthly-20 th	
FIN007	Net Disbursement Reporting Package	Weekly-due by 9:30 a.m.-1st State Business day of week	
FIN008	Deposit Reconciliation Report	Monthly-5 th	
FIN009	Reconciliation of Claims and Other Disbursements Report	Monthly-13 th	
FIN010	Escheats	Annually and as Otherwise Needed- no less than 20 calendar days prior to Vendor's planned date for escheating funds to the state based on the State's required deadline	
FIN011	PPO Summary of Billed Charges by State Fiscal Year Report	Monthly-20 th	
FIN012	Statement of Account (SOA) by State Fiscal Year Report	Monthly-20 th	
Financial Performance Reports			
FP001	Performance Guarantee Report	Monthly-20 th	
FP002	Performance Guarantee Report	Quarterly-due forty five (45) days after the end of each quarter	
FP003	Performance Guarantee Report	Annually - due forty five (45) days after the end of the calendar year	
FP004	Triangulation Report by Plan Option	Monthly-20 th - Except the fiscal year end report (June) which must be received by July 12th	
FP005	Triangulation Report by Service	Monthly-20 th - Except the fiscal year end report (June) which must be received by July 12th	
FP006	Prompt Pay Interest Report	Monthly-20 th	
Matrix Reports			
MAT001	Charge Summary Trend Incurred Report	Monthly-20 th - Except the fiscal year end report (June) which must be received by July 12th	
MAT002	Coinurance & Deductible, Full Population-Incurred Report	Monthly-20 th - Except the fiscal year end report (June) which must be received by July 12th	
MAT003	Copay--Incurred (Claims Runout) Report	Monthly-20 th - Except the fiscal year end report (June) which must be received by July 12th	
MAT004	Claims Experience Summary by Age and Sex-Incurred Report	Monthly-20 th - Except the fiscal year end report (June) which must be received by July 12th	
MAT005	Financial Reconciliation-Incurred Report	Monthly-20 th - Except the fiscal year end report (June) which must be received by July 12th	
Membership Reports			
MEM001	Monthly Member Reporting Package	Monthly-15 th	
Operations Reports			
OPS001	Weekly Membership report	Weekly-due by 10:00 a.m.-1st State Business day of week	
OPS002	PCP Election Report	Monthly-20 th	
Network Management Reports			
NM001	GeoAccess Report	Quarterly-due forty five (45) days after the end of each quarter	
Pharmacy Reports			

First Amended and Restated Exhibit 11 Standard Reports			
Number	Name	Frequency	Notes
PHM001	Specialty Pharmacy Rebates Report	Quarterly-due forty five (45) days after the end of each quarter	
Medical Management Reports			
MM001	Medical Costs and Clinical Outcomes	Quarterly-to coincide with the Program Performance Meeting	
MM002	Case Management Clinical Outcomes	Quarterly-to coincide with the Program Performance Meeting	
MM003	Preventive Care Services Utilization	Quarterly-to coincide with the Program Performance Meeting	
MM004	Utilization Management	Quarterly-to coincide with the Program Performance Meeting	
MM005	Utilization Management	Quarterly-to coincide with the Program Performance Meeting	
MM007	Annual Medical Policy Change Review Report	Annually - Due in October for Plan's review and approval for January 1 implementation	
Recovery and SIU Reports			
REC001	Recovery Reporting Package	Monthly-20th	
REC006	Special Investigation Reporting Package	Monthly-20th	
REC007	Audit Repayment Reporting Package	Thirty (30) days after the final medical claims audit report is issued	

First Amended and Restated ATTACHMENT A-7: Administrative Fees - BAFO #1

Provide the monthly administrative fee per Subscriber (PSPM) broken out by service item. Do not leave the data field blank for any service item line. If there is not a separate allocation for the service item indicate such by inserting "included" in the field. The total PSPM fee should include all administrative fees for all services proposed and for all covered Subscribers. **Approximate number of total Plan Non-Medicare Members: 528,648**
approximate number of total Plan Subscribers: 333,446, approximate number of total Plan Medicare Members: 50,177; approximate number of Subscribers: 47,825. Based on June 2022 enrollment (Fees will exclude actual claims payments).

All costs, except actual claim payments for covered Members, must be included below. Unspecified fees and other expenses will not be paid by the Plan.

*Offerors are encouraged to quote additional services not included in the pre-populated list. Additionally, if there are services which if selected by the Plan reduce the monthly administrative fee per Subscriber, list those services and the applicable reduction to the monthly administrative fee. For example, list any savings if electronic EOBs are selected vs. paper EOBs. Include additional documentation for any additional services or discounts as appropriate.

TABLE A-7.1: Monthly TPA Fees					
Service Item Per Subscriber Administrative Fee Based on Total Subscribers					
	Initial Contract Term			1st Renewal Period	2nd Renewal Period
	01/01/25 -12/31/25	01/01/26 - 12/31/26	01/01/27 - 12/31/27	01/01/28 -12/31/28	01/01/29 - 12/31/29
Standard Services PSPM					
Claims Administration	\$ 22.75	\$ 22.75	\$ 22.75	\$ 23.43	\$ 24.14
Customer Service	Included	Included	Included	Included	Included
ID Cards	Included	Included	Included	Included	Included
Utilization Review	Included	Included	Included	Included	Included
Medical Management	Included	Included	Included	Included	Included
Network Access	Included	Included	Included	Included	Included
Appeals	Included	Included	Included	Included	Included
Enrollment/EDI Reconciliation	Included	Included	Included	Included	Included
Outbound Data Files	Included	Included	Included	Included	Included
Secure Member Portal	Included	Included	Included	Included	Included
Audits	Included	Included	Included	Included	Included
Standard Reporting	Included	Included	Included	Included	Included
Custom Reporting	Included	Included	Included	Included	Included
Ad Hoc Reporting	Included	Included	Included	Included	Included
Other (list and describe as needed)	Included	Included	Included	Included	Included
Aetna Concierge (Dedicated Customer Service/Claims)	Included	Included	Included	Included	Included

24 Hour Dedicated Nurse Line	Included	Included	Included	Included	Included
Individual ID Cards (custom)	Included	Included	Included	Included	Included
Management	Included	Included	Included	Included	Included
Dedicated Account Manager	Included	Included	Included	Included	Included
Dedicated Account Executive	Included	Included	Included	Included	Included
Dedicated Implementation Manager	Included	Included	Included	Included	Included
Dedicated Provider Call Center	Included	Included	Included	Included	Included
Dedicated Member Services Team	Included	Included	Included	Included	Included
Integration with Stop Loss Vendor	Included	Included	Included	Included	Included
Wellness Allowance (Annual) \$1,000,000	Included	Included	Included	Included	Included
Communication Allowance (Annual) \$1,000,000	Included	Included	Included	Included	Included
Standard Services Fees - Subtotal	\$ 22.75	\$ 22.75	\$ 22.75	\$ 23.43	\$ 24.14

TABLE A-7.1 (continued): Monthly TPA Fees

Service Item Per Subscriber Administrative Fee Based on Total Subscribers

Additional Services PSPM					
Health Savings Accounts (HSA)	\$ 1.25	\$ 1.25	\$ 1.25	\$ 1.29	\$ 1.33
Health Reimbursement Accounts (HRA)	\$ 2.45	\$ 2.45	\$ 2.45	\$ 2.52	\$ 2.60
Assume Claims Fiduciary Liability	Included	Included	Included	Included	Included
Exception processing	Included	Included	Included	Included	Included
1095 Reporting	Included	Included	Included	Included	Included
Various required filings (including New York and Massachusetts surcharge filing, and Michigan Public Act 142 filing)	Included	Included	Included	Included	Included
Telehealth services	Included	Included	Included	Included	Included

ther list and describe as needed					
Subrogation (Optional)	\$ 0.95	\$ 0.95	\$ 0.95	\$ 0.98	\$ 1.01
Additional Services Fees - Subtotal	\$ 9.55	\$ 9.55	\$ 9.55	\$ 9.69	\$ 9.83

Credit/Savings					
Electronic EOB Adoption	Included	Included	Included	Included	Included
Other					
Subtotal Credits/Savings	Included	Included	Included	Included	Included

Total Cost (PSPM) excludes additional Service Fees outlined for HSA, HRA, Subrogation	\$ 22.75	\$ 22.75	\$ 22.75	\$ 23.43	\$ 24.14

Monthly Administrative Fees Based on Non-Medicare Lives (Excludes Medicare Primary)

TABLE A-7.1: (continued) Monthly TPA Fees					
Service Item Per Subscriber Administrative Fee Based on Total Non-Medicare Primary Members					
	Initial Contract Term			1st Renewal Period	2nd Renewal Period
	01/01/25 -12/31/25	01/01/26 - 12/31/26	01/01/27 - 12/31/27	01/01/28 -12/31/28	01/01/29 - 12/31/29
Service Item					
Disease Management	Included	Included	Included	Included	Included
Care Coordination	Included	Included	Included	Included	Included
Lifestyle Coaching	Included	Included	Included	Included	Included
Transition of Care	Included	Included	Included	Included	Included
High Utilizer Programs	Included	Included	Included	Included	Included
Complex Case Management	Included	Included	Included	Included	Included
PHM Services via Secure Member Portal	Included	Included	Included	Included	Included
Digital Coaching	Included	Included	Included	Included	Included
Health Risk Assessment	Included	Included	Included	Included	Included
Other (list and describe as needed)					
Behavioral Health Wellbeing	Included	Included	Included	Included	Included
Medication Therapy Management	Included	Included	Included	Included	Included
Opioid Case Management	Included	Included	Included	Included	Included
24/7Nurse Hotline	Included	Included	Included	Included	Included
Total PSPM Additional Services Fee	\$ -	\$ -	\$ -	\$ -	\$ -

One-time Administration Fees/Credits - TPA Standard Products & Population Health Management

Provide and describe any applicable one-time administrative fees or credits including any applicable conditions, requirements or restrictions related to the charge or credit. Do not leave any data field blank. If there is not a separate one-time charge or credit for the item indicate the fee/credit is not applicable by inserting "N/A" in the field. The total should include all onetime administrative fees and credits for all services proposed and for all covered Subscribers/Members.

Specify the expected timing of invoicing for payment of one-time fees and the application of onetime credits, including whether fees will be payable and credits applied in installments .

Offerors may quote additional one-time fees and credits not included in the pre-populated list.

TABLE A-7.2: Onetime Fees/Credits, TPA Standard Products & Population Health Management

Onetime Fees	Amount		Invoice timing and frequency
Initial TPA Implementation Credit	\$1,000,000		Year 1 only
Single Sign-on Implementations	Included		
Termination Fee 18 month claims run-out	Included		
New Vendor Data Files	Included		
Web customization to support Plan Programs	Included		
Expanded call center hours during OE	Included		
Other (list and describe as needed)			
Total Onetime Credits/Fees	\$1,000,000		

TABLE A-7.3: Per Participant Fees, Biometric Screenings

Per Participant Fee for each type of screening performed

	Initial Contract Term			1st Renewal Period	2nd Renewal Period
	01/01/25 -12/31/25	01/01/26 - 12/31/26	01/01/27 - 12/31/27	01/01/28 -12/31/28	01/01/29 - 12/31/29
Screening Type					
Onsite Biometric Screening 1: Finger Stick, Full Lipid Panel, Blood Glucose or A1c (for diabetics only), Blood Pressure, Height, Weight, BMI Calculation, Waist Circumference, and Counseling	\$ 46.40	\$ 46.40	\$ 46.40	\$ 46.40	\$ 46.40
Onsite Biometric Screening 2: Finger Stick, Full Lipid Panel, A1c (all), Prediabetes Paper Test (for non-diabetics), Blood Pressure, Height, Weight, BMI Calculation, Body Composition including Waist Circumference or Waist-to-Hip Ratio and other methods, and Counseling	\$ 46.40	\$ 46.40	\$ 46.40	\$ 46.40	\$ 46.40
Other (list and describe as needed)					
Biometric Screenings Fees - Total					

Is Contractor willing to offer a multi-year fee rate cap for TPA Services?

Yes

If yes, provide cap and explain.

Aetna has offered 3 Year flat fees with 3% escalators in Years 4 and 5.