The following FAQ was prepared to include the questions that were sent to WellNet as a follow up to our recent webinar on reference based plan designs.

Plan-Design

- **What support is there is developing plan designs initially?**
  Groups may build plan designs however they want, whether that be duplicating their current plan or using one of WellNet's canned plans.

- **You mentioned two plan designs though I only saw one and for companies that could support enrollment of 25+. Is there an option for smaller companies with less than 25 enrolled?**
  Typically reference based pricing is reserved for groups with 75 or more enrolled. WellNet was able to make arrangements to offer our reference based plan design to groups with as few as 25 enrolled. WellNet does not work with groups with less than 25 enrolled in any capacity. The other plan design as part of a dual option is able to be whatever you want it to be. It could be another reference based plan design or it could be a standard PPO based plan design. During the webinar we positioned the second plan design as a standard PPO based plan using the Cigna network with the exact same benefits as the group's current plan so that the employer could not give the objection that they didn't want to offer reference based pricing as a full replacement.

- **Do you use plan language to incentivize high quality provider utilization?** Yes. While incentive design is able to be customized based on the wants and needs of the group, we suggest waiving the deductible and coinsurance for any members that utilize high value providers, (high quality and fair price,) as part of the precertification process.

- **Where does Cigna or Aetna come into play with regard to reference based pricing?** They don't. For WellNet's reference based pricing plan design, the network that employees would use to access primary care doctors, specialists, and labs would be a regional network, for example Multiplan. Only services that require pre-certification would be subject to reference based pricing. The Cigna network can be used within a dual option as a separate plan design that has nothing to do with reference based pricing. WellNet can also offer the Aetna network but we cannot offer a reference based plan design in conjunction with the Aetna network. We can only offer dual options using Cigna as the other plan design.

- **Can you offer a dual option whereby an employee can get a "Cigna network" plan or an "RBP plan" (employee just pays more for the Cigna plan?)** Yes. This is the strategy that was highlighted on the webinar. In the case of a dual option, we would need at least 25 enrolled employees in the Cigna plan design and at least 25 enrolled employees in our reference based plan design.

- **Can you waive the deductible and out of pocket if the employer has a HDHP (High Deductible Health Plan)?**
  Yes. We are suggesting that the deductible and coinsurance are waived when members choose high value facilities and surgeons that have already agreed to fair pricing, as a reward for smarter healthcare consumption. In the case of a *Qualified* High Deductible Health Plan however, we cannot waive the deductible. As an alternative, the employer could potentially have monies deposited into the employee's H.S.A. account for being a smart consumer.

Stop-Loss

- **Are these plans guaranteed issue? If not, what existing condition might exclude someone? If so, would there be a pre-ex waiting period. What about pregnancy?** Self-funded plans are not guaranteed issue as they need to be underwritten. Stop-loss vendors review either historic claims information or individual medical questionnaires from which they set appropriate stop loss rates and terms. Risk is all relative, so the smaller the group is the less risk the stop loss carrier will tolerate before they are either uncompetitive from a rate and claims exposure perspective or they

decline to offer a quote altogether. If a case is approved, there is no pre-existing conditions clause. A group is either approved and everyone has the same coverage or they are not approved. Pregnancy is treated like any other claim in that the stop-loss partners evaluate the potential claims risk involved with pregnancy and issue stop-loss rates and terms that are appropriate for the whole group based on the entire risk profile of that group.

- **How many different stop loss carriers are in the mix?** WellNet shops each case with at least 3 different stop-loss partners. Our consultants and clients are also free to shop and place their own stop-loss coverage when working with WellNet. WellNet's administrative fees do not change when our partners place their own stop-loss.

- **What is your target market and funding options?** Our pricing does not change whether a group chooses to level fund their plan or pay claims as they are incurred. Groups must have a minimum of 25 enrolled employees. If we had to pick a target market, we would say 100-2000 enrolled, although we have plenty of groups that have less than 50 enrolled on the plan.

- **Can you do fully insured/guaranteed cost models as well as self-funded?** WellNet offers both level and self-funded health plans. We do not offer a fully insured plan at this time.

- **What do we do in CA with SB161?** WellNet and our stop-loss partners will issue policies and plans that adhere to all state stop-loss requirements, including California's.

Quoting

- **What information is needed form the company and its employees on the front end?** In addition to the usual quoting items like a census in Excel and a copy of the renewal, WellNet's stop-loss partners require either historic claims information or individual medical questionnaires to generate proposals. WellNet does not offer purely illustrative quotes.

- **Is there a health questionnaire necessary for your smallest 25 person participating group?** Yes, if historic claims data cannot be provided, then WellNet's stop loss partners require the submission of individual medical questionnaires. WellNet offers our own free, online medical questionnaire portal and we also participate with Form Fire or Easy Apps Online.

- **What is WellNet's minimum group size?** 25 enrolled employees.

- **What is WellNet's minimum participation rate?** Generally speaking, our stop-loss partners require 75% of eligible employees to enroll, (valid waivers do not count toward this calculation,) but no less than 50% of all full time employees. This requirement is somewhat flexible.

- **Can you provide a contact to speak to in order to secure a quote?** Please send all quote requests to either Jill Fallon or John Augustine. Here is their contact information:

  Jill Fallon
  jfallon@wellnet.com
  Mobile: 713-303-5657

  John Augustine
  jaugustine@wellnet.com
  Mobile: 610-348-6804

Rx

- **Can we use Script Sourcing for our current WellNet groups?**

Yes, we will start by running a report of Rx utilization and then cross reference that report with the drugs that are capable of being filled internationally. From there, if the employer wishes to implement the program, Scriptsourcing typically charges 25% of the savings. It is also possible to add agent compensation. This is a purely voluntary program for employees so if the group wants to move forward, we can then discuss how to roll it out.

- **Do you use CVS/Caremark for the Rx? How is Rx impacted by RBP?** Yes, WellNet has had a long-standing relationship with CVS/Caremark. RBP has no impact on the pharmacy portion of the plan design. WellNet does however have other cost saving strategies that we can discuss regarding the pharmacy portion of the plan.

Marketing/ Messaging

- **How are RBP plans marketed to employers currently to start the conversations?**
  I suggest using the first few slides of the slide deck that we provided as a follow up to the webinar along with the WellNet 1 pager on RBP:

    - WellNet 1 Pager on RBP (live link)
    - WellNet RBP Presentation (live link)

- **Do you have a short intro approach to a business who currently has a traditional (not self-funded) plan?** Yes. We are happy to spend time with you and your clients educating them on why self-funded plans can be a great way to pay for healthcare. Once groups understand the true value of self-funding and how it works, the natural progression is to then consider approaches like reference based pricing due to the rational basis for claim payments, versus the irrational traditional model of applying a network discount to an artificially high billed charge. In addition to the 2 links in the previous question, located within WellNet's Broker Marketing Center, (live link) there are a variety of useful documents that speak to the benefits of self-funding.

- **What size group and or industry is the best to market to?** Smaller groups must be healthier while larger "experience rated groups" are potentially a great fit. The idea of reference based pricing will work very well for employers that are willing to think outside the box to offer a higher level of care at a lower price point. To pay less for healthcare, we all must collectively begin paying less for healthcare. Nearly all industries are a good fit, though specifically privately-held, entrepreneurial run firms tend to be more open-minded to proactive solutions such as RBP.

- **What are the objections when approaching a new group and suggesting they change before they have heard the ins and outs of a presentation?** Groups need to understand the negative implications of the healthcare world they are current operating in, which include: PPO discounts applied to an artificially high billed charge, the fact that every provider charges something different, and the fact that currently most employees have no way of assessing the quality of the providers they are seeing. Once employers understand that the traditional health insurance model always favors the insurance company / PPO and not the employer, they will be open to alternative approaches. The employer must first understand the failures of the traditional system before they will fully embrace the solutions provided by modern and innovative strategies.

Commission

- **What is the commission schedule for a writing agent?** Historically, WellNet has included a 6% commission on level funded plans, though our agents tell us at the time of quoting how much in commission or fees they would like us to build into our quote.

Operational

- **Can you show how many providers are willing to accept RBP who are in close proximity to a prospective group before they decide to move to WellNet?**
  Yes, though we generally reserve this analysis until the group is very close to choosing WellNet as their partner since list can change at any time depending on availability of beds, surgeons, etc. Remember that WellNet's RBP plans are only for services that are subject to pre-certification, not for things like primary care doctors, specialists, labs, or pharmacy. Generally speaking, each metropolitan area has between 10-30 ambulatory surgical centers that have already agreed to fair pricing.

- **What are the quality metrics based on?** Our pre-certification partner, Medical Advocate Program (map-health.com) uses 36 different data collection points from within over 1 billion claims to asses the quality and performance of providers.

- **Critics of reference based pricing speak about savings being diluted by two primary factors:**

  - **Less than stellar discounts on low-acuity professional claims which eats into a portion of the surgical/facility savings.** We have also heard this. Supporters of the status quo, (people that want to keep things the same as they are now,) would have you focus on this rather than focusing on the fact that even with the potentially lower discounts that a network like Multiplan might offer on professional claims, the claim savings is huge on the claims that require pre-certification, (the very expensive items). The claims savings from the pre-certification items more than outweighs the potentially lesser discounts received on professional claims. Professional claims are claims that cost hundreds of dollars. Pre-certified claims are claims that cost thousands, if not tens of thousands of dollars. Reference based pricing clients must avoid being penny wise and pound foolish.

  - **Administrator fees for RBP, (i.e. setting fees on charge amounts vs. allowed amounts). Is WellNet willing to go on a fee basis arrangement vs. a % of claim?** Even with the fees associated with reference based pricing, the claim savings to the client is potentially vast. Remember that today in traditional PPO based plans, the client is paying claims based on a percentage discount off of billed charges with no ability to audit claims. In addition, every surgeon and hospital charges something different and so your clients using the traditional PPO discount model have no idea what their paid claim amounts will be until after the claim is incurred, leaving them helpless.

    Reference based pricing eliminates this pricing volatility within the area of the plan where most dollars are spent, the high ticket items. A key partner that WellNet chose to support our reference based pricing platform is AMPS http://advancedpricing.com/. AMPS offers both a PEPM and % based fee structure. AMPS also offers balance bill indemnity protection for members, but only if the employer chooses their % based fee model. WellNet felt it was extremely important for us to be able to guarantee that members would not be responsible for balance bills, at least in the first year or until the client realizes that this indemnity protection is not actually necessary. The indemnity protection mostly provides peace of mind, but valuable peace of mind in the first year of a reference based plan. The PEPM fee is approximately $25 and the % model is 9% of billed charges for claims that are paid to facilities and surgeons that are not in the AMPS *Connex* network. For claims that are incurred within the *Connex* network, their fee is 5% of billed charges. The maximum fee amount per claim in either scenario is $20,000. In just about all cases, the final paid claim amount under a reference based pricing arrangement will still be less than a PPO negotiated discount for high cost items. Lower stop-loss rates and claims projections will prove that point.

- **Who negotiates on behalf of members?? Do you use a firm like ELAP? If not do you have attorneys on staff that do this?** As part of the pre-certification process, our pre-certification partner, Medical Advocate Program (map-health.com,) uses 36 different metrics to determine provider and facility quality. Our Medical Advocate Program will inform members that they can receive free care for items that require pre-certification if they go to one of the recommended providers or facilities. These recommended providers are already part of the AMPS *Connex* network. AMPS already has pre-negotiated rates with these providers which is why we recommend making these providers free to the members since the cost will be lower to the plan and there will be no chance of balance billing. Member are still free to go to whatever providers they want but if they do, we recommend that the usual deductible and coinsurance apply and we will also notify the member at the time of pre-certification that if they go wherever they want instead of following our recommendations, then they could get balance billed. Waiving the deductible and coinsurance so members go where we want them to go will result in WAY less balance bills. When a member does receive a balance bill, they will call their claims advocate, who will assist them and even indemnify them of any balance bill liability if they follow the instructions we provide them. Behind the scenes, AMPS has attorney's that assist in defending the members from balance billing if it gets to that point.

- **Can you provide the document that indemnifies the employee?** Enclosed is the language within the reference based pricing contract that your client, WellNet, and our stop-loss partner would sign as part of the implementation process:

  Balance Billing Defense. Except as otherwise specifically set forth in this Agreement, AMPS will defend the Billed Participant from being forced to pay such portion of an Improper Balance that, if taken together with the Benefits and Properly Balance Billed Amounts actually paid for the Claim at issue, would exceed the Improper Balance amount for Proactive or Reactive Advocacy set forth above for the Medical Care covered by the Plan in question. The Parties understand and acknowledge that the effectiveness of Protective Efforts is highly dependent on AMPS receiving timely notice of all Demands for Payment. The Plan Parties and TPA agree to ensure that every Participant is given clear notice and periodic reminders that effective Advocacy and the availability of Balance Billing Defense requires that the Participant must notify AMPS of any Demand for Payment (and, for any demand made in writing, by facsimile, email or other digital or electronic means, provide a copy to AMPS) within 15 days of the date of the Demand for Payment.

- **Do you also share in fiduciary risk if employee sues the plan over a claim related to this?** For all claims subject to pre-certification, AMPS and WellNet act as the co-fiduciary in conjunction with our clients.