COUNTY OF ALBANY
COST PROPOSAL FORM

PROPOSAL IDENTIFICATION:
Title: Medicare Advantage Plan
RFP #: 2023-087

This form is designed to provide information about each proposer's premium costs and any other administrative costs or fees associated with the provision of a Medicare Advantage Plan to the Medicare-Aged Retirees of the County of Albany. Due to the importance of the cost of this Plan to the County of Albany, any and all fees and/or reimbursements that will be charged to the County must be identified on this form. All the information contained on this form will be considered as your organization's full proposal and THE COUNTY OF ALBANY WILL NOT MAKE ANY FUTURE PAYMENTS TO YOUR ORGANIZATION IF THEY ARE NOT CLEARLY IDENTIFIED AND PROPPOSED IN THIS SECTION. For your Proposal to be accepted by The County of Albany, a Corporate Officer of your organization, who has pricing approval authority, must sign off on the fees and/or reimbursements proposed on this form.

1. Please list the medical and prescription drug premium per member below:

Medical Premium: $86.61 pmpm

Prescription Drug Premium: $234.07 pmpm

Total Premium: $320.68 pmpm

2. Please provide any other costs for all applicable Administrative, Consulting/Actuarial, Utilization Management, Cost Reporting, Network Access, or any other services related to the provision of the Medicare Advantage Plan you are quoting. As noted above, the County will not make any future payments to your organization if they are not clearly identified in this section.

There are no additional costs.

Name of Organization: Aetna Life Insurance Company

Principal Address: 151 Farmington Avenue

City: Hartford State: CT Zip Code: 06156-0001

Tel.#: 800-872-3862 Fax #: 860-273-3382 E-Mail: Aetnaplsproposals@aetna.com

Date: ____/____/____

Signature and Title: _____