2020 3rd Quarter Aetna Funding Advantage Medical Underwriting (UW) Disclosures

Contents

This supplemental underwriting disclosures document (the "Supplement Document") provides additional information regarding your programs and services and is intended to be used in conjunction with your new business proposal or renewal letter. The Supplemental Document applies to our Large Group AFA medical relationships administered by Aetna Life Insurance Company and its affiliates, including Innovation Health Insurance Company, Texas Health + Aetna Health Insurance Company, Banner Health and Aetna Health Insurance Company, Allina Health and Aetna Insurance Company and Sutter Health and Aetna Administrative Services, LLC. For purposes of this document, Aetna may be referred to using 'we', 'our' or 'us' and your company may be referred to using 'you' or 'your'.

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Billing of Fees

Eligibility Transmission

We will receive eligibility information weekly or biweekly, from the Plan Sponsors location(s) and/or by the Plan Sponsor's designated vendor. Our preferred method of submission is via electronic connectivity. We do not charge for the first 4 ELRs/segments whether associated with one transmission or by multiple methods. Costs associated with more than 4 ELRs/segments or with any custom programming necessary to accept the Plan Sponsor's eligibility information and/or information coming from a designated vendor are not included in this proposal and will be assessed separately. During the installation, we will review all available methods of submitting eligibility information and identify the approach that best meets the Plan Sponsor's needs or the needs of their designated vendor.

Claim and Member Service

Medical EOBs

We make EOBs available through our secure Navigator website for subscribers who have registered to use Navigator and for whom we have a valid email address. We send members an email when a new EOB is available. All other members receive paper EOBs. If a member receiving EOBs electronically prefers paper EOBs, they can get them by telling us that is their preference. Please note that unless required by state law we do not produce EOBs for claims when there is no member liability.

Network Services

Contract Period

Our policies provide for renewal upon the completion of each contract period unless either party invokes the termination provision requiring 31 days advance written notice of termination to the other party. This provision may be invoked at any time during the continuance of the contract (that is, not just limited to termination occurring on the renewal date).

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Subrogation

We have entered into an agreement with the firm of Rawlings & Associates to provide comprehensive subrogation services. A contingency fee of 30% is retained upon recovery for AFA customers.

Value-Based Contracting

Introduction

Aetna has a variety of different value-based contracting (VBC) arrangements with many of our in-network providers. These arrangements compensate providers to improve indicators of value such as, effective population health management, efficiency and quality care.

Contracting Models

Aetna has VBC arrangements ranging from bundled payments and pay-for-performance approaches to more advanced forms of collaborative arrangements that include integrated technology and case management, aligned incentives and risk sharing. Our VBC models include:

(A) Pay for Performance (P4P). Under P4P programs, Aetna works together with providers (doctors and hospitals) to develop and agree to a set of quality and efficiency measures and their performance impacts their total compensation.

(B) Bundled Payments. In a Bundled Payment model, a single payment is made to doctors or health care facilities (or jointly to both) for all services associated with an episode-of-care. Bundled payment rates are determined based on the total expected costs for a particular treatment, including pre- and post-treatment services, and are set to incentivize efficient medical treatment.

(C) Patient Centered Medical Home (PCMH). In a PCMH, a primary care doctor leads a clinical team that oversees the care of each patient in a practice. The medical practice receives data about their patients' quality and costs of care in order to improve care delivery. Financial incentives can be earned based upon performance on specific quality and efficiency measures.

(D) Accountable Care Organizations (ACOs). In an ACO, Aetna teams up with systems of doctors, hospitals and other health care providers to help these organizations manage risk, improve clinical care management, and implement data and technology to connect providers, health plans and patients. The ACO arrangements include financial incentives for the

organization to improve the quality of patient care and health outcomes, while controlling costs.

Aetna will continue to evolve our value-based contracting arrangements over time. We employ a broad spectrum of different reimbursement arrangements with providers to advance the goals of improving the quality of patient care and health outcomes, while controlling costs.

Example Calculations

A customers' financial responsibility under many VBC arrangement is determined based on provider performance, using an allocation method appropriate for each particular performance program. These methods include:

A. Percentage of allowed claims dollars;
B. Percentage of member months;
C. Number of members.

Examples

A. **P4P.** Percentage of allowed claims dollars:
Achieving agreed upon clinical and efficiency performance goals by comparing performance year end to performance year baseline or an industry standard.

i. Provider earns $100,000 performance-based compensation for the 12-month period January to December;

ii. All plan sponsors combined, incurred $8,500,000 in claims with the provider for the 12-month period January to December;

iii. Plan sponsor incurred $150,000 in claims with the provider for the 12-month period January to December;

iv. Plan sponsor's share of claims costs is ($150,000/$8,500,000) = 1.7647 %. Formula: (Plan sponsor incurred claims/All plan sponsors incurred claims);

v. Plan sponsor's share of the $100,000 performance-based compensation is 1.7647 % * $100,000) = $1,764.70, which would be processed as a claim through ordinary self-funded banking channels.

B. **PCMH and ACO**. Percentage of member months:

Achieving agreed upon clinical and efficiency goals as measured by performance year end to performance year baseline or an industry standard.

i. Provider earns $100,000 performance-based compensation for the 12-month period January to December;
ii. All plan sponsors combined, had 100,500 member months with the provider for the 12-month period January to December;

iii. Plan sponsor had 9,500 member months (for 850 unique members) attributed to the provider for the 12-month period January to December;

iv. Plan sponsor's share of the member months is (9,500/100,500) = 9.4527%. Formula: (Plan sponsor member months/All plan sponsors member months);

v. Plan sponsor's share of the $100,000 performance-based compensation is (9.4527% * $100,000) = $9,452.73, which would be processed as a claim through ordinary self-funded banking channels.

C. **PCMH and ACO.** Number of Members:
In addition to Example B above, a quarterly Accountable Care Payment (ACP) may be made to the provider to fund activities necessary to meet the financial and clinical objectives. These are paid quarterly either during, or after the end of each quarter. The financial impact is considered in the total financial package negotiated with the provider.

i. We determine the attributed patients for the provider for the quarter April through June;

ii. Plan sponsor had 850 members attributed to the provider for the quarter April through June;

iii. ACP and FFS payments are incorporated into the final analysis of provider performance against the medical claims target;

iv. We apply the agreed upon rate to the attributed patients; i.e. $2.00 per-member, per-month (PMPM) = $6.00 per quarter per member, to determine funding to the provider;

v. Plan sponsor's calculated share is $5,100 ($6.00 * 850), which would be processed as a claim through ordinary self-funded banking channels.

<u>General</u>

Aetna will process any payments in accordance with the terms of each VBC arrangement. In each of the VBC models, self-funded plan sponsors reimburse Aetna for any payment attributable to their plan when the payments are made. Each customer's results will vary. It is possible that payments paid to a particular provider or health system may be required even if the plan sponsor's own population did not experience the same financial or qualitative improvements. It is also possible that payments will not be paid to a provider even if the customer's own population did experience financial and quality improvements. A report of VBC charges to a plan sponsor will be available on a quarterly basis.

Upon request, Aetna will provide additional information regarding our VBC arrangements.

Reporting

State' All Claims Database (APCD) Reporting

State all payer claims database regulations require insurance carriers and third party administrators (TPAs) for self funded plan to supply data to that state's all payers claims database (APCD). As a TPA for your self-funded plan, we are required to submit health care claims data to states with APCDs for all incurred and self-funded plans. However, in some states, the law indicates that providing the data for self-funded plans is voluntary. We will provide your self funded plan data to these states unless you inform us in writing that you do not wish us to do so.

Federal Mandates

Federal Mental Health Parity

For self-funded plans, it is the plan sponsor's responsibility to ensure its plan complies with Federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), including any and all regulations, amendments, and regulatory guidance. Aetna cannot provide a self-funded plan sponsor legal advice on the application of MHPAEA (or any other law) to its plan. Where appropriate, Aetna can share its determinations concerning the scope and applicability of MHPAEA to our fully-insured plans for illustrative and informational purposes only. Therefore, the plan sponsor should consult with its legal counsel to determine compliance with MHPAEA.

Healthcare Reform

Aetna believes this new business proposal or renewal letter is compliant with health care reform.

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For customers with a Grandfathered Plan

Under the federal health care reform legislation, health plans existing prior to the enactment of the Affordable Care Act may be "grandfathered" and not subject to **some** of the mandated benefits and reform provisions. Changes in your benefit design as well as your contribution strategy may affect grandfathering. You're required to notify us if your contribution rate changes for a grandfathered plan at any point during the plan year.

If your plan is currently certified as grandfathered, in order to retain grandfathered status, the plan must meet all grandfathering criteria and must have done nothing to cause the loss of grandfathered status in relation to the benefits in place on March 23, 2010. Your designees must also annually certify grandfathered status by submitting a grandfathering certification form prior to each plan's effective date. Please review the attached Plan Sponsor Certification of Grandfathered Status, and return a signed copy to your Account Executive.

Except for specific and limited scenarios described as transitional rules in the health care reform legislation, if a plan's grandfathered status has been lost, it cannot be regained. If, after reviewing the grandfathering rules with your benefit consultant or counsel, you determine that your coverage could be or is grandfathered, and you want to retain grandfathered status, you should contact your Account Executive for further instructions.

For customers changing from Grandfathered to Non-Grandfathered

This new business proposal or renewal letter offering assumes your plan is changing from grandfathered to non-grandfathered.

As a non-grandfathered plan, the plan will include Preventive care as defined by regulation without cost sharing on in-network services.

This new business proposal or renewal letter includes the women's preventive care coverage requirements, e.g., coverage for contraceptive methods and counseling, breastfeeding support and equipment, and prenatal care.

Except for specific and limited scenarios described as transitional rules in the health care reform legislation, if a plan's grandfathered status has been lost, it cannot be regained. If, after reviewing the grandfathering rules with your benefit consultant or counsel, you determine that your coverage could be or is grandfathered, and you want to retain grandfathered status, you should contact your Account Executive for further instructions.

For customers claiming religious exemption

Certain religious employers and organizations may be exempt from contraceptive services coverage requirements or may be eligible for a religious accommodation. If your company qualifies and wants to be exempt from including ACA contraceptive services benefits in your company's plan, please work with your Aetna Account Executive to provide the required documentation so Aetna can handle accordingly. Aetna will assume and treat your company's plan as subject to the ACA contraceptive services coverage requirements without an executed certification document.

For customers with Grandfathered and Non-Grandfathered plans

For your company's plans that are currently certified as grandfathered, in order to retain grandfathered status, the plan must meet all grandfathering criteria and must have done nothing to cause the loss of grandfathered status in relation to the benefits in place on March 23, 2010. Your company's designees must also annually certify grandfathered status by submitting a grandfathering certification form prior to each plan's effective date. Please review the Plan Sponsor Certification of Grandfathered Status and return a signed copy to your Aetna Account Executive.

Except for specific and limited scenarios described as transitional rules in the health care reform legislation, if a plan's grandfathered status has been lost, it cannot be regained. If, after reviewing the grandfathering rules with your benefit consultant or counsel, you determine that your coverage could be or is grandfathered, and you want to retain grandfathered status, you should contact your Account Executive for further instructions.

You do not need to complete anything on your non-grandfathered plans.

HCR Dependent to Age 26

Source documentation of the dependent limiting age is required for plan installation. In the absence of documentation from the current carrier(s), the fee and Stop Loss rates consider the dependent limiting age is up to age 26 student/non-student based on health care reform legislation. The expected claims and, if applicable, the resultant Stop Loss factors [and claim target factors] contemplate the change to a dependent limiting age of up to 26/26 student/non-student and may be amended upward upon receipt of the dependent eligibility documentation.

Customers with Retiree Only Plans

Guidance issued by the Internal Revenue Service (IRS), and the U.S. Department of Labor (DOL), and Department of Health and Human Services (HHS) has indicated that "retiree only" plans are exempt from the benefit mandates under the ACA (Retiree only plans are subject to certain ACA fees and assessments). In order to demonstrate the establishment of a retiree only plan, a plan

should maintain, separately from the plan for current (i.e., active) employees, a separate plan document and Summary Plan Description (SPD) and file a separate Form 5500. If you have a retiree only plan, and want to be considered exempt, please submit a retiree only certification form and required documentation to us.

The benefits and fees within this proposal/renewal are subject to change pending any required approvals or future guidance from state or federal regulatory agencies. If you have questions, please contact your Account Executive.

Support for summaries of benefits and coverage (SBC) draft documents

At the customer's request, we will provide assistance in connection with the preparation of draft Summary of Benefits and Coverage (SBCs), subject to the direction, review and final approval of the customer. The development of draft SBCs by us will be based on the benefits information the customer has provided and existing plan information from our benefit source system. We will include plan design information in the draft SBC relating to products or services administered under the system. We will include plan design information in the draft SBC relating to products or services administered under the Services Agreement as well as any additional pharmacy or behavioral health carve out information provided by the plan sponsor or its delegate. SBCs are not required for "retiree-only plans" as defined by the Affordable Care Act (ACA) and Aetna will not be supporting generation of SBCs for "retiree-only plans."

The customer has the responsibility to review and approve any SBCs and revisions hereto and to consult with their legal counsel, at their discretion, in connection with said review and approval, as well as to disseminate the final SBC to Plan participants. We have no responsibility or liability for the content or distribution of any of the customer's SBCs, regardless of the role we may have played in the preparation of the documents. The production of SBCs will not be subject to Service or Performance Guarantees.

For applicable plans and policies, the SBC must include statements about whether the plan or coverage provides minimum essential coverage (MEC) and if the coverage meets minimum value (MV) requirements. Under the Affordable Care Act (ACA), minimum value and minimum essential coverage determinations are associated with the employer's shared responsibility provisions. We will include the MV and MEC statements in SBCs that are produced for plans with effective dates of January 1, 2014, and later. However, we will not make the MV or MEC determinations. Although it will indicate whether the plans meet or do not meet the minimum value standard, we do not assume any responsibility regarding determination.

We will provide the SBC in editable format so plan sponsors for self-funded plans can update MV and MEC statements within the document to appropriately reflect their determination for each

respective plan. We do not provide legal or tax advice and recommend that plan sponsors consult with their own legal and tax counselors when making MEC and MV determinations. We have no responsibility or liability regarding the minimum value or minimum essential coverage evaluation, regardless of the role we may have played in reviewing/producing the SBC documents.

We will review the minimum value standard for the plans based on the minimum value calculator criteria provided by the Department of Health and Humans Services (HHS).

Employer Reporting Requirements

Under Internal Revenue Code (IRC) Section 6055 health insurance issuers, certain employers, government agencies and other entities that provide Minimum Essential Coverage (MEC) to individuals must report to the IRS information about the type and period of coverage and furnish related statements to covered individuals. This information is used by the IRS to administer the individual shared responsibility provision and by individuals to show compliance with the individual shared responsibility provision.

IRC Section 6056 requires large employers (those having employed an average of 50 or more full-time employees during the preceding calendar year) to report to the IRS information about the health care coverage they have offered and also furnish applicable statements to employees. The purpose is to allow the IRS to enforce the employer responsibility provisions. Self-funded employers are responsible for collecting and reporting the information to both the IRS and its employees pursuant to their obligations under both Sections 6055 and 6056. For the collection they may use a combined form for their 6055 and 6056 reporting. Entities must file returns under the 6055 and 6056 requirements with the no later than February 28 of the year following coverage (if filing on paper) or March 31 if filing electronically. A statement must be furnished to individuals by January 31 of the year succeeding the calendar year to which the return relates.

State Mandates

Massachusetts Credible Coverage

If the group has any Massachusetts employees, the plan would need to meet Massachusetts Credibility. IF the employee/group proceed a with a plan that does not meet Massachusetts Credibility, the MA employee(s) could be subject to fines/penalties associated with Massachusetts Credibility. The Employer is responsible for the attestation process and will receive an attestation form to complete and return to verify the plan meets Massachusetts Credibility. For more information or questions/concerns on Massachusetts Credibility, please contact your CPA or Financial Advisor.

Minnesota

Patient Choice Insights- Additional Claims Wire:

The local Minnesota market is unique in that some provider contracts split the reimbursement between two provider entities. To accommodate this, you will see a two-step reimbursement process. The first step is paid to the clinic at the time of adjudication and is the larger portion of the allowed amount. In the second step, a smaller portion of the allowed amount is then reimbursed separately to the provider's corresponding care clinic. We will collect this amount from applicable self-funded customers quarterly via a claims wire, and it will appear on the report typically sent with the wire amount. It will be based on the customer's specific experience with the clinic systems using this reimbursement mechanism. Our discounts, shown on the enclosed discount guarantee exhibit, include both steps as part of the allowed charges.