

2020 Insured Middle Market and Public & Labor Medical Disclosure as of 08/01/2020

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This supplemental underwriting disclosure 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 Middle Market and Public & Labor Accounts Insured 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”.

Contract Period

Our policies provide for automatic 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

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during the continuance of the contract (that is, not just limited to termination occurring on the renewal date).

Eligibility

Employee Eligibility

Eligibility applies to:

- Permanent full-time employees working 25 hours or more per week, on a regularly scheduled basis or as mandated by legislative or regulatory requirements.
- Eligible dependents include an employee's spouse, domestic partner, and children up to the limiting age of the plan or as mandated by legislative or regulatory requirement. Individuals cannot be covered as an employee and dependent under the same plan.
- Children eligible for coverage through both parents cannot be covered by both under the same plan.

Dependent Eligibility

Eligible dependents include an employee's spouse and children up to the limiting age of the plan. Individuals cannot be covered as an employee and dependent under the same plan, nor may both under the same plan cover children eligible for coverage through both parents. Dependents must enroll in same benefit option as the employee. Domestic partners may be covered as eligible dependents if the employer elects this designation at contract effective date or renewal date. Coverage is available to eligible dependents who are same sex or opposite sex partners. If the plan sponsor elects to cover domestic partners, the plan sponsor is responsible for determining whether the domestic partner is eligible.

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 electronic

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reporting (ELR) segments whether associated with one transmission or by multiple methods. Costs associated with more than 4 electronic reporting 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.

Network Services

Primary Care Physician Referrals

Due to certain provider contractual arrangements with some Independent Provider Associations (IPAs) and medical groups, we will permit specific exemptions to the requirement that a member obtain a referral from their primary care physician (PCP) before receiving care from other providers.

California Primary Care Physician Referrals

Given the unique nature of the health care system in California, referral registration for members in California is generally not required *. The delegated model in place in the state already encourages providers to make appropriate referral decisions for our members. We believe this decision is in the best interests of plan sponsors, members and providers. * However, please note that referral registration is required in California in the event that the servicing provider is not in the same network area (e.g., Los Angeles, Northern California, San Diego and Central Valley) as the member or the member's PCP. In addition, PCP selection is required. Par provider claims for members that do not select a PCP will be processed at the par non-authorized level.

Relationship Advisor

At times, we secure the assistance of third parties in support of procuring business and responding to RFPs. Any payments to such third parties will be disclosed to you in case you choose to include such information in your Schedule 5500.

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Claim and Member Services

Alternate Office Processing (AOP)

We regularly use both internal and external claim adjudication services to meet service requirements of our business. These services may be located inside or outside of the United States. Aetna quality standards and controls apply to all claims regardless of where they are processed. Standard pricing assumptions are in effect based on type of product, auto-adjudication, plan design, and customer specific requirements. We may adjust rates based on the above factors and/or where plan sponsors wish to limit use of Alternative Office Processing (AOP).

Medical Explanation of Benefits (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.

Utah Provider Network

Effective January 1, 2017, changes will be made to the Utah provider network. Please contact your account manager for details on the changes and information on how to check provider status.

Federal Mandates

Federal Mental Health Parity

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The Federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) applies to fully-insured Traditional and HMO Middle Market (MM), Public and Labor (P&L) & National Accounts (NA) commercial plans for plan years beginning on or after October 3, 2009. Please speak to your Account Manager if you would like additional information.

European Union: General Data Protection Regulations (GDPR)

Aetna International has implemented a framework to follow the General Data Protection Regulation (GDPR), which became law in all European Union (EU) and European Economic Area (EEA) countries on May 25, 2018. This law gives people greater protection over their personal data, with the potential for significant fines for privacy breaches. GDPR includes requirements related to data collection, storage and usage among the companies and organizations that process personal data of individuals in the European Union.

Our domestic plans are not in scope. To help support operational requirements of GDPR, members based in the EU and EEA must be enrolled in Aetna International plans.

Health Care Reform

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

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 ("ACA") 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. Plan Sponsors or their designees must also annually certify grandfathered status by accessing the online tool at www.aetna.com/GF and completing a grandfathering certification in a few simple steps prior to each plan's effective date.

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If a plan's grand-fathered 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, please contact us for further instructions. We reserve the right to treat an insured plan as non-grandfathered.

For Customers with Non-Grandfathered Plans

As a non-grandfathered plan, the plan will include preventive care as defined by regulation, without cost sharing on In-Network services. This policy includes the women's preventive care coverage requirements, e.g., coverage for contraceptive methods and counseling, breastfeeding support and equipment, and prenatal care.

For Customers Claiming Religious Exemption

Certain religious employers and organizations may be exempt from including ACA contraceptive benefits in their plan or may be eligible for a religious accommodation. If your company qualifies for an exemption or an accommodation 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.

Retiree Only Plan Status Certification

Retiree only plans are exempt from the benefit mandates under the ACA including Medical Loss Ratio ("MLR") and rebate requirements for insured plans. However, 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 provide the required documentation to us. We have the right to treat insured plans as subject to ACA without an executed certification document.

Waiting Period Requirement

When renewing your plan(s) with us, you represent that:

- You will give us effective dates for your employees and their dependents that take into account all state and federal eligibility conditions and waiting period requirements, including a reasonable and bona fide orientation period.
- If this information changes, you will inform us immediately.

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Summaries of Benefits and Coverage (SBC)

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), MV and MEC determinations are associated with the employer shared responsibility provisions. We will review the MV standard for each plan based on the MV calculator criteria provided by the Department of Health and Human Services (HHS) and will indicate within the SBC whether the plan meets or does not meet the MV standard based on this review. We do not provide legal or tax advice and recommend that

plan sponsors consult with their own legal and tax counselors when reviewing MEC and MV determinations. We have no responsibility or liability regarding the MV or MEC evaluation, regardless of the role we may have played in reviewing/producing the SBC documents. To the extent you disagree with our evaluation, we will make changes to reflect your determination, as you are responsible for the final determination of these SBC elements.

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.

For insured group health plans, the reporting obligation under Section 6055 is our responsibility. We will report the required information to the IRS about the type and period of coverage provided to each individual member enrolled in our insured plans and will furnish the required statements to subscribers.

IRC Section 6056 requires applicable 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 furnish applicable statements to employees. The purpose is to allow the IRS to enforce the employer responsibility provisions.

To satisfy the 6056 employer reporting requirements, an applicable large employer must file the required returns with the IRS by no later than February 28 of the year following coverage (if filing on paper) or March 31 (if filing electronically), and furnish a statement to all full-time employees by January 31st of the year following the calendar year to which the return relates.

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State Mandates

California HMO Outpatient Behavioral Health

Based upon guidance provided by the California Department of Managed Health Care in conjunction with a regulatory filing pertaining to CA HMO plans, certain outpatient benefits, including outpatient medical, behavioral health, and substance use disorder benefits, were re-classified for purposes of federal mental health parity law. As a result, the cost share for certain outpatient medical and surgical benefits require a revision. Please refer to the Rate Exhibit bullet for the specifics. The cost shares for outpatient

medical and surgical benefits did not change as a result of this outpatient behavioral health reclassification. Outpatient behavioral health and substance use disorder benefits include the following: Mental Health/Substance Abuse Office Visits, psychological testing; medication therapy monitoring, partial hospitalization, intensive outpatient programs, substance abuse day treatment, medical treatment for withdrawal symptoms, autism behavioral therapy/Applied Behavior Analysis (ABA), Home health care for behavioral health or substance abuse disorders. As a result, the cost share for all outpatient behavioral health and substance use disorder benefits changed from \$ Copay to Covered at 100%, no deductible, no copay. The cost share for outpatient behavioral health and substance use disorder benefits did not change as a result of this outpatient behavioral health reclassification.

California Traditional Products Outpatient Behavioral Health

Based upon guidance provided by the California Department of Insurance in conjunction with a regulatory filing pertaining to CA PPO based plans, certain outpatient behavioral health benefits were re-classified for purposes of federal mental health parity law. As a result of mental health parity testing, the cost share for certain outpatient medical and surgical benefits require a revision. Please refer to the Rate Exhibit bullet for the specifics. The cost shares for outpatient medical and surgical benefits did not change as a result of this outpatient behavioral health reclassification. Outpatient behavioral health all other benefits include the following: Electroconvulsive therapy (ECT), Outpatient monitoring of injectable therapy, partial hospitalization, transcranial magnetic stimulation, neuropsychological testing, psychological testing, intensive outpatient programs, outpatient detoxification, ambulatory detoxification, medical treatment for withdrawal symptoms, behavioral health treatment for pervasive development disorder/autism, Home health care for behavioral health or substance abuse disorders. As a result, the cost

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share for Behavioral Health - All Other benefits requires a revision to be covered at plan coinsurance after deductible. As a result, the cost share for all outpatient behavioral health and substance use disorder benefits changed from \$ Copay to Covered at 100%, no deductible, no copay. The cost share for outpatient behavioral health and substance use disorder benefits did not change as a result of this outpatient behavioral health reclassification.

Connecticut Premium Refund (HB 5669)

CT HB 5669 allows employers to elect to stop paying group premiums for employees and their dependents if: 1) the employee was voluntarily terminated from employment or is terminated for any other reason, but layoff, and;2) the employer elects to stop payment

within 72 hours of the termination by notifying both the carrier and the employee. In order to make this election, notify your Aetna billing area.

Connecticut Copayment and Benefit Category Requirements

Please be advised that your renewal plan will meet the Connecticut Insurance Department's (CID) copayment and benefit category requirements. These requirements are explained in CID Bulletin HC-109 issued on February 5, 2016. The bulletin can be found in this URL: <http://www.ct.gov/cid/lib/cid/HC-109-MaximumCostSharing.pdf>

Delaware Plans

We will provide coverage for expenses for a scalp hair prosthesis worn for hair loss suffered as a result of alopecia areata, resulting from an autoimmune disease. The same limitations and guidelines that apply to other prosthesis as outlined in your Benefit Plan will apply but coverage for scalp hair prosthesis as a result of alopecia areata will not exceed \$500 per year.

Florida Plans

The rates assume that all lives residing in FL and within the HNOonly or HNOption service area will be provided HNOonly or HNOption plans only and any lives residing outside of the FL or outside the HNOonly/ HNOption service area will be provided another plan option. Plan designs will be provided at point of sale.

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Illinois Registration of Business Entities

If awarded your business, we will comply with Section 20-160 of the Illinois Procurement Code. If Aetna fails to comply with Section 20-160 of the Illinois Procurement Code, any contract between us shall be voidable under Section 50-60 of the Illinois Procurement Code. We have registered as a business entity with the State Board of Elections and our registration certificate is enclosed. We acknowledge that we have a continuing duty to update the registration in compliance with applicable Illinois law.

Kentucky Dependent Age Offer

If you have plans situated in Kentucky that do not have to follow Federal dependent age law, please let us know as the Kentucky dependent age offer may apply.

Louisiana Balance Billing

Health care services may be provided to you at a network health care facility by facility-based physicians who are not in your health plan. You may be responsible for payment of all or part of the fees for those out-of-network services, in addition to applicable amounts due for co-payments, coinsurance, deductibles, and non-covered services. Specific information about in-network and out of – network facility-based physicians can be found at the website address of your health plan or by calling the customer service telephone number of your health plan.

Massachusetts Health Care Reform Law

Massachusetts Health Care Reform Law requires that, a Massachusetts resident age 18 and older must have health coverage that satisfies certain minimum creditable coverage (MCC) requirements or be subject to personal income tax penalties. We must disclose to insured plan sponsors and subscribers with Massachusetts contracts whether their medical plan meets these MCC requirements.

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Massachusetts Premium Contribution Non-Discrimination Requirement

Massachusetts laws and regulations as further specified in Massachusetts Bulletin 2007-04 require that a health insurance carrier may only enter into a contract with an employer if: a) the employer offers the same health benefits plan(s) to all of its full-time subscribers living in Massachusetts in the carrier's approved network service area; and b) for each benefits plan, the employer does not make a smaller premium contribution percentage to a full-time subscriber residing in Massachusetts than the employer makes to any other full-time subscriber who resides in Massachusetts and receives an equal or greater total hourly or annual salary. This does not apply to contribution percentages established in a collective bargaining agreement. For information on how you can satisfy these statutory requirements, please refer to Massachusetts Bulletin 2007-04.

Maine Religious Employer

Maine law allows religious employers to exclude coverage for abortions that are not necessary to preserve the health or life of the mother. Contact your account representative for details on the process for excluding this coverage.

Missouri Groups Offering an EPO Medical Plan

If your group has selected an EPO Plan, a plan offering out-of-network coverage must also be included as a dual option. Enrollees must be given the option to select or reject a plan with out-of-network coverage. Upon request, you must provide to Aetna evidence of the enrollee's election.

New York Religious Opt Out Requirements for Medically Necessary Abortion, Contraceptive drugs and devices

New York Law requires that insurers provide you with the following option: verified religious employers may choose to exclude coverage for medically necessary abortion, contraceptive drugs and devices, as well as tubal ligation. To be a religious employer groups must meet the criteria for being a religious employer as defined in NY State Insurance Law. Contact your account representative for details to learn if you qualify for the exemption processes for medically necessary abortions (including the annual certification requirement) and contraceptive drugs and devices and tubal ligation surgery.

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New York Dependent Age 30

New York law requires that we offer you the option to provide dependent coverage to age 30 or to allow dependents who reach the maximum age to continue his or her coverage to age 30 under certain conditions. The offer letter is enclosed.

New York Out-of-Network Ambulatory Surgical Coverage

New York law requires an insurer to make available, upon your request, a plan that covers Out of Network Ambulatory Services versus our standard plan setup of Not applicable or not covered benefit Out of Network. If you are interested, please contact your Account Representative regarding quotation.

National Medical Support Notice

A National Medical Support Notice (“Notice”) issued by the New York State Division of Child Support Enforcement pursuant to a court order requires a non-custodial parent to provide health insurance for a dependent child. If we receive a Notice, we must enroll the dependent child and, if necessary, the parent. This applies even if a non-custodial parent fails to sign the required enrollment form. Importantly, if a party fails to comply with the court order, that party will be responsible for any health care costs incurred due to that failure. Once the child is enrolled, we will forward ID cards and any other coverage documents either to the custodial parent or, if that parent’s name and address is not on the enrollment form, to the issuing agency listed on the Notice. We may include a letter in those materials requesting that the custodial parent contact us regarding a HIPAA authorization form.

New York Out-Of-Network Fair Health

New York law requires an insurer to make available, upon your request, a plan that covers at least 80% of the usual and customary cost of each out-of-network health care service after you meet your deductible or any out of pocket benefit maximum. If you are interested, please contact your Account Representative regarding quotation.

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NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

Oregon Religious Opt Out for Abortion and Contraceptive drugs and devices

Oregon law requires health benefit plans to include coverage for abortion procedures and contraceptive drugs, devices and products. Religious employers may choose to exclude coverage for abortion and contraceptives from the health benefit plan. Contact your account representative for details on the exemption process.

Tennessee Physical Therapy, Occupational Therapy, and Chiropractic Care

Tennessee law requires that we offer a plan option in which Physical Therapy, Occupational Therapy and Chiropractic Care benefits have member cost share (copayments and coinsurance) that is the same as for Primary Care Physicians. If your

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current benefit plan offering does not include this feature and you would like to make a plan change, please contact your Account Manager.

Texas Optional Benefits Mandate

Texas state law requires insurers to offer plan sponsors the option of covering the following: • In vitro fertilization • Speech and hearing impairment • Certain therapies for children with developmental delays • Home health care • Non-serious mental illness
Should a plan sponsor decline to cover all or some of these benefits, they must notify Aetna in writing by using the TX Rejection Form.

Texas Elective Abortion

For groups renewing a Texas contract on or after April 1, 2018, Aetna will no longer offer an elective abortion benefit as part of a broader set of health benefits. These changes were made to comply with Tex. Ins. Code Chapter 1218. Note that abortions performed when a pregnancy places a woman's life in serious danger or poses a serious risk of substantial impairment of a major bodily function are not considered elective.

Utah Mental Health Reimbursement

Utah state legislation (UT Code Sec. 31A-22-625) requires insurers to offer certain mental health coverage for the evaluation and treatment of a mental health condition at parity with evaluation and treatment of physical health conditions. This legislation applies to Mental/Nervous and Substance Abuse coverage, for all Plan Sponsors with a Utah contract and for covered Utah residents of a non-Utah contract, where UT residents are equal to 25% or more of the enrolled members. Please contact your Account Manager if you would like information on the pricing impact to change your current coverage to meet the Mental Health Parity criteria.

Notice to large group employers located outside the state of Vermont

This quote is based on the [representation/census] that your plan covers fewer than 25 certificate holders in Vermont. Aetna cannot quote or renew cases that cover 25 or more Vermont residents who work at an employer location in Vermont.

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Notice to large group employers located inside and outside the state of Vermont

Health insurers who offer coverage in the state of Vermont must offer employers the option to cover all part-time employees who are Vermont residents and work 17.5 hours or more. Please note, however, that we are not filed and approved to sell medical coverage to employers located in the state of Vermont and must offer coverage to out of state coverage as noted above. Please contact your Account Manager for details.

*If you are a person with a disability who needs assistance using our websites (or mobile apps), our Customer Service Representatives can assist you. Please call them at the number on your member ID Card or at 1-855-401-5713 from 9 a.m.-5 p.m. ET Mon-Fri. Persons with a hearing or speech disability can use 711 for Telecommunications Relay Service (TRS). Additional information can be found on the following URL:
<https://www.aetna.com/accessibility/accessibility-services.html>.*