

2020 Middle Market and Public & Labor Self-Funded Medical Underwriting (UW) Disclosures as of 10/01/2020

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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 Middle Market Accounts self-funded 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’.

Billing of Fees

Claim Wire Billing

Claim wire billing fees refers to the portion of the total administrative expenses charged through the claim wire as the services are rendered and are subject to any future fee increases independent of any changes to the base per-employee, per-month (PEPM). Fees charged through the claim wire include those described on the financial exhibit as well as those fees that the parties may subsequently agree to add to the claim wire from time to time. Programs or services charged through the claim wire are excluded from the monthly Guaranteed Fees as outlined in the financial exhibit and will not appear on the monthly billing statement. Claim wire charges will appear in the claim detail report separated by unique Claim Reporting System (CRS) draft accounts and other monthly reports.

Eligibility Transmission

Customers Who Provide Weekly or Biweekly Eligibility Information

Aetna assumes the customer will submit eligibility information weekly or biweekly, from the customer’s location(s) and/or by the customer’s designated vendor. The preferred method of submission is via electronic connectivity. Aetna doesn’t charge for the first four Electronic Reporting (ELRs)/segments whether associated with one transmission or by multiple methods. Costs associated with more than four ELRs/segments or with any custom programming necessary to accept the customer’s eligibility information and/or information coming from a designated vendor aren’t included in this proposal/renewal

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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 customer's needs or the needs of the customer's designated vendor.

Customers Who Provide Monthly, or More Frequently, Eligibility Information

Aetna will receive eligibility information monthly, or more frequently, from one location by electronic connectivity. Submission of eligibility information by more than one location or via multiple methods will result in additional charges. Costs associated with any custom programming necessary to accept eligibility information are excluded. During this installation, we will review all available methods of submitting eligibility information and identify the approach that best meets the customer's needs or the needs of the customer's designated vendor.

Producer Compensation

Aetna will honor "Agent of Record" or "Broker of Record" letters when an agent, broker or consultant sells new business or takes over one of its customers from another agent, broker or consultant. Please have an appropriate representative from your company sign such a letter using your company's letterhead. The change will become effective on the first day of the month following the date the payment unit receives the "Agent of Record" or "Broker of Record" letter unless another future date is designated in the letter. Aetna has various programs for compensating agents, brokers and consultants. If your company would like information regarding commission and additional bonus programs for which your agent, broker, or consultant may be eligible for, payments (if any) which Aetna has made to your agent, broker, or consultant (including commission and applicable bonus payments), or other material relationships your agent, broker, or consultant may have with Aetna, you may contact your agent, broker, or consultant, or your Aetna Account Executive. Information about Aetna's programs for compensating agents, brokers and consultants is also available at www.aetna.com.

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Claim and Member Services

Alternate Office Processing (AOP)

Aetna 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's quality standards and controls apply to all claims regardless of where they're processed. Standard pricing assumptions are in effect based on type of product, auto-adjudication, plan design and customer specific requirements. Aetna may adjust service fees based on the above factors and/or where you wish to limit use of Alternate Office Processing (AOP).

Medical Explanation of Benefits (EOB) Suppression

Aetna doesn't produce paper EOBs for members registered through our member website. Aetna doesn't produce EOBs for claims when there is no member liability. EOBs are always available electronically through our secure member website. Members can visit www.aetna.com to register and sign in to their account.

Network Services

Network Provider Arrangements

Certain network providers require payment of claims that might otherwise be denied, such as those not medically necessary or experimental or investigational (but does not require payment for services you expressly exclude from coverage, such as for cosmetic surgery). We will charge you for these claims in order to be able to continue providing members with access to services on an in-network basis. You agree to comply with such applicable provisions of our network provider contracts.

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.

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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 customer's financial responsibility under many VBC arrangements 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.

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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.

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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.

General

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.

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Subcontractors

The work to be performed by Aetna under the Services Agreement may, at Aetna's discretion, be performed directly by us or wholly or in any part through a subsidiary, an affiliate, or under a contract with an organization of our choosing. Aetna will remain liable for Services under the Services Agreement.

Claims Subrogation

Aetna has an agreement with Rawlings & Associates to provide comprehensive subrogation services. A flat charge will be billed for a setup of any data feeds and for all subsequent data that we provide to the customer or the customer's external subrogation vendor. An additional hourly charge will be billed to the customer's claim wire for that work our claim offices need to do to support vendors other than Rawlings.

Contracted Services

Aetna utilizes external vendors for claim recovery on:

- Coordination of benefits (primary and secondary review)
- Retroactive terminations
- Medical bill and hospital bill audits
- Workers compensation (California, Florida, New York, Ohio and Texas)
- DRG and implant audits

These overpayment recovery services may be performed by Aetna or its affiliates, by an external vendor or by Aetna or its affiliates in conjunction with an external vendor. A contingency fee is charged for the claim recoveries. These fees are primarily to support vendor costs and/or internal administrative costs of Aetna or its affiliates associated with these programs. The contingency fee is outlined in the customer's Fee Schedule.

Third Party Claim and Code Review Program

Aetna performs claim review on:

- Coding compliance (e.g. payment policy adherence, duplicate claims)
- Clinical appropriateness (e.g. clinical feasibility and appropriateness of claim, chart review verification of claim)

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These claim review services may be performed by Aetna or its affiliates, by an external vendor or by Aetna or its affiliates in conjunction with an external vendor. A contingency fee is charged for the claim recoveries. These fees are primarily to support vendor costs and/or internal administrative costs of Aetna or its affiliates associated with these programs. The contingency fee is outlined in the customer's Fee Schedule.

Out-of-Network Benefits and National Advantage™ Program Description

Aetna networks help save money for you and your employees. However, we know that sometimes members receive care out-of-network. Not all out-of-network claims are the same. Sometimes members need care when an in-network provider is not available and sometimes they go out-of-network voluntarily if they have a plan that is not limited to in-network only options.

- **Involuntary:**
 - Emergency services: This often happens when a member gets care outside of our network for emergency care.
 - Out-of-network specialists: This can also happen when members get care in a network hospital from out-of-network specialists like radiologists or anesthesiologists.

Aetna always covers involuntary out-of-network claims and make sure the member pays at their in-network benefit level.

- **Voluntary:**
 - This is when a member chooses to get treatment from outside of our network. An example would be when a member could have reasonably utilized a participating surgeon but instead elected to go to a non-participating surgeon. This can also happen when members seek a second opinion consult with an out-of-network specialist. In these situations, the member's contractual plan benefits apply.

National Advantage™ Program (NAP)

NAP includes a Contracted Rates component and two optional components: Facility Charge Review (FCR) and Itemized Bill Review (IBR). In addition, some plans also have Data iSight (DiS) if warranted based on their out-of-network plan rate. NAP's Contracted Rates component offers access to contracted rates for many medical claims from non-network providers (including claims for emergency services and claims by hospital-based

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specialists such as anesthesiologists and radiologists who do not contract with insurers) and ad hoc negotiations (when a contracted rate is not available). We retain a percent of savings achieved through NAP, including savings achieved through FCR and IBR, if elected, and DiS, if applicable. This NAP Fee is in addition to the per-employee, per-month administrative service fees.

Facility Charge Review (FCR)

FCR is an optional NAP component. FCR applies to inpatient and outpatient facility claims for which a contracted rate is not available and for which the claim amount exceeds a certain threshold as determined by Aetna. Through the FCR component, Aetna establishes a reasonable charge for a plan benefit in the geographic area where such benefit was provided to the member (“**Recognized Charge**”). The Recognized Charge is based on the provider’s estimated cost, including an anticipated profit margin. The claim will be paid based on the Recognized Charge. Even with FCR, if a provider refuses to agree to a negotiated rate, claims may be paid at billed charges in certain circumstances.

There are three different types of FCR – Standard, Modified Balance Bill and Fixed Determination.

Standard FCR

In the event that a member is balance billed, we have a review process and will start negotiations with the facility to try to come to a mutually agreeable payment amount. For claims that are to be paid at the preferred/in-network level under the terms of the member’s plan of benefits (e.g., emergency services), we’ll negotiate with the facility so that the member isn’t responsible for charges in excess of any applicable deductible and coinsurance/copayments. However, for non-emergency out-of-network services, if we can’t negotiate a mutually acceptable rate, the member may be responsible for charges in excess of the Recognized Charge.

Modified Balance Bill FCR

In the event that a member is balance billed, we have a review process and will start negotiations with the facility to try to come to a mutually agreeable payment amount. We’ll negotiate with the facility so that the member is not responsible for any charges in excess of any applicable deductible and coinsurance/copayments.

Fixed Determination FCR

In the event that a member is balance billed or the facility appeals, the member is responsible for charges in excess of the Recognized Charge for voluntary out-of-network claims. For emergencies and other claims that are to be paid at the preferred/in-network

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level, we will negotiate with the facility so that the member isn't responsible for charges in excess of any applicable deductible and coinsurance/copayments.

Itemized Bill Review (IBR)

IBR is an optional NAP component. IBR applies to inpatient facility claims submitted by Aetna network providers (directly contracted) if (a) the submitted claim amount exceeds a certain threshold as determined by Aetna; and (b) Aetna's contracted rate with the provider uses a "percentage of billed charges" methodology. We refer to these as "IBR Claims."

Aetna will forward IBR Claims to a vendor to review and identify any billing inconsistencies and errors. The vendor reports back the amount of eligible charges after adjusting for any identified inconsistencies and errors. Aetna then pays the claim based on the adjusted bill.

Data iSight (DiS)

DiS applies to plans with certain out-of-network rates. MultiPlan, one of Aetna's external pricing vendors under NAP, uses the DiS patented methodology to price out-of-network professional claims under a certain threshold, as determined by Aetna, based on typical competitive charges and/or payments for a service, adjusted for the geography in which the service was provided. In the event a member receives a balance bill from a provider for an out-of-network service, patient advocacy services may be available to assist the member in certain circumstances. The DiS patient advocacy program gives members the ability to have an advocate from the vendor negotiate with providers on their behalf.

DiS will contact the provider to start negotiations on a mutually agreeable payment amount with no member balance billing. For claims that are to be paid at the preferred/in-network level under the terms of the member's plan of benefits (e.g., emergency services), DiS will negotiate with the provider so that the member is not responsible for charges in excess of any applicable deductible and coinsurance/copayments. However, for voluntary out-of-network services, if DiS can't negotiate a mutually acceptable rate, the member may be responsible for charges in excess of the DiS out-of-network plan rate.

Primary Care Physician Referrals for Gated Products

Because of certain provider contractual arrangements with some Independent Provider Associations (IPAs) and medical groups, Aetna 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.

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Primary Care Physician Referrals for Gated Products with membership in California

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. Aetna believes this decision is in the best interests of customers, 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.

Other Payments

Rebates for Specialty Products that are administered and paid through the Plan Participant's medical benefit rather than the Plan Participant's pharmacy benefit will be retained by Aetna as compensation for Aetna's efforts in administering the preferred Specialty Products program.

Reporting

States' All payer Claims database (APCD) reporting

Certain state regulations require insurance carriers to supply data relating to their fully insured products to that state's all payer claims database (APCD). As a result of a recent US Supreme Court ruling, and as a TPA for your self-funded plan, Aetna is no longer required to submit self-funded plan health care claims data to states with APCDs.

However, in some states, the law indicates that providing the data for self-funded plans is voluntary. In these circumstances, Aetna won't provide your self-funded plan data to these states unless you inform us in writing that you wish us to do so.

New Hampshire (for customers with a business or branch location in New Hampshire)

Many states have passed laws requiring disclosure of health care claims data to all payer claims databases (APCDs). The data is used by the states for a variety of analytical purposes. You can find more information on APCDs at the APCD Council website at <http://www.apcdouncil.org/>

In 2016, the U.S. Supreme Court ruled in *Gobeille v. Liberty Mutual Insurance Co.*, that the Employee Retirement Income Security Act of 1974 (ERISA) prevents states from requiring

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self-insured plan sponsors to submit data to APCDs. As a result of this ruling, Aetna will not automatically submit your self-funded plan data to any state APCDs. If you wish to have your plan's data submitted to state APCDs, you will need to affirmatively opt in to this process by notifying your account manager. Please read the New Hampshire Department of Insurance specific message to companies with a business location including a branch location in New Hampshire.

NHID Opt-In Form

All-Payer Claims Database Indication of Intent for Private employers Offering Self-Funded Health Coverage in New Hampshire

You are receiving this form under a 2016 New Hampshire law allowing a self-funded private employer to direct its claims administrator to include the health care claims data of its employees and covered dependents in the state's All-Payer Claims Database (APCD) (NH RSA 420-G:11, V).

- In response to rising health care costs, the New Hampshire Insurance Department has, since 2003, collected health care claims data from insurers and third-party administrators in an APCD. To protect privacy, under state law the database "shall not include or disclose any data that contains direct personal identifiers". (NH RSA 420-G:11-a, I).
- The APCD enhances transparency, providing employers, policymakers, payers, and health care providers with vital information about the factors contributing to rising health care costs in New Hampshire. In addition, the Insurance Department uses the database to provide health cost information to the public, including employers and their employees, through the NH HealthCost website: <http://nhhealthcost.nh.gov/>.
- New Hampshire's database has always included data from self-funded employers, because the accuracy of information derived from the database increases when more claims are included. In 2016, the U.S. Supreme Court ruled that Vermont could not require self-funded private employers to submit data to the state's APCD. To clarify New Hampshire law after that ruling, the legislature required the creation of this form to allow self-funded private employers to direct their claims administrators to include their data.

If you elect to participate, please contact your claims administrator. If you have questions about New Hampshire's APCD or the department's efforts to improve health care cost transparency, contact the NH Insurance Department at 603.271.2261 or requests@ins.nh.gov, or visit <http://www.nh.gov/insurance/>.

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Utah (for customers with a business or branch location in Utah)

VALUE OF PARTICIPATING IN THE UTAH APCD

- Data in the Utah APCD has supported a statewide coordination of benefits effort to reduce double payment and ensure that the responsible party is the one that pays.
- Patient privacy is taken very seriously and is protected by Utah and federal law.
- This initiative was created by the Utah State Legislature and is supported by the Governor's Office and key members of the business and health care communities.
- Prior to 2016, the APCD was receiving data for over 90% of Utah's population with private health care coverage. If employers do not opt in, that number could fall by as much as 40%, greatly affecting the ability to monitor trends and identify cost drivers.

Federal Mandates

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 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.

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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.

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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 26/26 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.

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,

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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

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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.

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.

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.

State Mandates

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.

Minnesota (for customers with membership in Minnesota)

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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.

Example:

- Member claim for \$100 at care clinic system with "two-step" reimbursement
- Our negotiated amount for this claim = \$80
- Our reimbursement to the provider via standard adjudication process = \$76
- At the end of the quarter, we will collect and reimburse the second provider entity = \$4
- Collection will be done via claims wire
- At the end of the year, we will account for the total allowed charges to report out Aetna's actual discount = $\$80/\100 ; discount = 20%

New Jersey Out-Of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act

Important information for Plan Sponsors that have voluntarily elected to participate in the New Jersey Out-Of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act (The Act). The Act requires employers sponsoring self-funded health benefits plans to make a voluntary election annually to participate in the Act's arbitration program for inadvertent and emergency or urgent care claims involving New Jersey providers. The plan sponsor is required to annually send its election to the New Jersey Department of Banking and Insurance at least 15 days prior to renewal. Contact your account manager if you have questions.

New York Dependent Age 30

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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. Please reach out to your Account Representative for the offer letter.

*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>.*