Large Group Aetna Funding Advantage Medical Underwriting (UW) Disclosures as of 01-01-2024

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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 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'.

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.

Member ID Cards

Our standard is to provide new customers with physical ID cards for the family ("family style") except where individual ID cards are mandated by state law. The number of cards mailed is dependent on the type of coverage and state laws. For existing customers at renewal, digital ID cards are issued to members with an email address on file when changes are minor. Customers requesting a reissue of ID cards without a business reason may incur an additional charge. Examples of a business reason for reissuing physical ID cards where charges will be waived include, but are not limited to:

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**.

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.

ERISA

To be eligible for AFA, the health plan must be governed by the Employee Retirement Income Security Act of 1974 (ERISA). In general, ERISA does not cover group health plans established or maintained by governmental entities, churches for their employees, or plans which are maintained solely to comply with applicable workers compensation, unemployment, or disability laws, ERISA also does not cover plans maintained outside the United States primarily for the benefit of nonresidential aliens or unfunded excess benefit plans.

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Network Services

Delegated Relationships

In some circumstances, we engage third parties to perform certain operations. A few examples of functions that are "delegated" in this manner include claims management, utilization management, credentialing and call center. We are ultimately responsible for these functions and exercise oversight over the delegated activities. In some cases, we enter into these delegated arrangements with participating providers and provider organizations, including ACOs, network vendors, specialty groups and medical service organizations.

Under some of these arrangements, the vendor bills us for the health care services performed by the vendor's network of providers, as well as for the other administrative/delegated services performed by the vendor. In those situations, we determine the allowed amount, based on the vendor's contracted rate with Aetna, which may include fees supporting the administrative/delegated services. For claims that are billed through these arrangements, the amount charged by or paid to the underlying provider who rendered the health care services may be higher or lower than the allowed amount used to determine what the plan and plan participant owes because the allowed amount under the plan will be our contracted rate with the vendor, and not the contracted amount between the vendor and the underlying provider who rendered the health care services. Accordingly, in this scenario, the allowed amount under the plan for purposes of determining what the plan and participant owes will include fees paid to the vendor for administrative or delegated services (or both) and will not be limited to amounts related to medical 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).

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 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.

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.

Other Payments

Specialty Pharmaceuticals Program

Rebates for specialty pharmaceuticals 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 pharmaceuticals program.

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.

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. It is your responsibility to inform us whether changes to your plan have resulted in a loss of grandfathered status. We recommend that you seek the advice of legal counsel in making this determination and/or before making changes to your medical plan or your business that might defeat grandfathered status.

You are also required to notify us if your contribution rate changes for a grandfathered plan at any point during the plan year. By accepting your renewal, you represent that your contribution rate towards the cost of coverage for the upcoming plan year has not decreased by more than 5 percentage points below the contribution rate that was in effect on March 23, 2010.

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 employers and organizations with a religious or moral objection, may claim an exemption from ACA contraceptive services coverage requirements, or request an accommodation. If you qualify and want to claim an exemption or request an accommodation, please work with your Aetna Account Executive to submit the required. Certification so Aetna can handle accordingly. Aetna will treat your plan as subject to the ACA contraceptive services coverage requirements without an executed Certification on file.

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 (though 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 your company has a retiree-only plan, and wants to be considered exempt, you may be asked

to submit a retiree-only certification form and required documentation by your Aetna Account Executive. The benefits and fees within the new business proposal or renewal letter are subject to change pending any required approvals or future guidance from state or federal regulatory agencies. If you have questions, please contact your Aetna 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 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 will 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.

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Stop Loss State Mandates

Notice for Arkansas Groups

Plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

Maine Continuity Law

In accordance with 24-A M.R.S.A. §2849, Continuity of Health Insurance Coverage, you confirm that your health benefit plan(s) comply with Maine's continuity law.

Maine Tail Coverage Offer

Maine requires that an extended reporting period “tail coverage” of at least 6 months be offered on all Stop Loss policies. Tail coverage provides Stop Loss coverage for claims incurred during the policy period but paid within a specific period immediately following policy termination. It protects you from potential gaps in coverage during which you may be liable for catastrophic claim expenses. This quotation includes 6 or more months of tail coverage.

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

Important information for Customers 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 New Jersey residents’ inadvertent and emergency care claims involving New Jersey out of network providers. Contact your account manager if you have questions.