

Large Group, National, Public & Labor Self-Funded Medical Underwriting (UW) Disclosures as of 07-01-2026

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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 Large Group and Public & Labor self-funded medical relationships administered by Aetna Life Insurance Company and its affiliates, including Banner Health and Aetna Health Insurance Company and Allina Health and Aetna Insurance Company. 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

Monthly Self-Funded billing

Aetna will reconcile the collected fees at the end of the Guarantee Period. Any surplus or shortfall due, will be payable within the timeframe specified in the Agreement for the payment of service 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



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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.

Subrogation

This recovery program involves analyzing trauma-related claim data when the health plan has incurred medical expenses on behalf of a plan participant associated with an accident, injury, or medical condition (typically due to some form of third-party liability, such as a motor vehicle accident, slip and fall on another person's property, etc.). Proprietary algorithms are applied to adjudicated claim data to identify a potential recoverable opportunity. Identified opportunities are investigated and negotiated for potential recovery.

Calculation of Shared Savings

We calculate savings as the actual amount recovered. We will retain the percentage of savings specified in your service and fee schedule as compensation for the services provided under the program. These fees are primarily to support vendor costs and/or internal administrative costs of Aetna or its affiliates associated with the program. The following is an example of a savings calculation (using a 30% fee for illustrative purposes only):

Calculation Example	
Total amount paid by Plan for participant's case	\$ 57,000
Total subrogation lien settlement	\$ 8,333
Total Administrative Fee (30%)	\$ 2,500
Total Net Credit to Customer	\$ 5,833

Out of the subrogation lien settlement, the customer will receive a total net credit of \$5,833 and Aetna will retain \$2,500 (30%) as compensation for the services provided by Aetna, its affiliates and/or a vendor with respect to the program. These amounts will be charged and credited to the customer on a quarterly basis and disclosed in the claim detail report.

Third-Party Subrogation Vendor

For plan sponsors utilizing an external subrogation vendor, a flat charge will be billed for setup of any data feeds and for all subsequent data that we provide to the plan sponsor or the plan sponsor's external subrogation vendor. An additional hourly charge will be billed to the plan sponsor's claim wire for work our claim offices need to do support an external subrogation vendor.

Contracted Services

This recovery program is intended to locate overpayments that might not have otherwise been discovered utilizing specialized methods and applications. The following reviews are conducted on certain inpatient, outpatient, and professional claims submitted by in-



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network and out-of-network providers:

- **Coordination of Benefits (COB).** This review Identifies other primary insurance in situations in which Aetna has already paid as primary, assigns the correct COB order of primacy, updates our COB data stores to reflect the determination and recovers overpayments.
- **Retroactive Terminations.** This review identifies overpayments that occur where the claim was processed after the member's termination date.
- **Hospital and outpatient bill review** A hospital bill onsite chart review is conducted for eligible claims over \$10,000. This review compares the patient medical records to the itemized bill to determine the integrity of the billed charges and the actual paid amount for claims paid using a fee for service reimbursement methodology.
- **Outpatient Coding Audits.** These audits are performed by clinical coders to verify the code assignment and reimbursement using medical records.
- **Workers Compensation.** This review includes a comparison member data to the state workers compensation database. The benefits are coordinated, and funds are recovered from Workers Compensation carriers.
- **DRG (Diagnosis Related Grouper) and Implant Audits.** DRG audits identify claims with DRG payment methodology which have a high recovery potential to ensure that diagnosis and procedure codes are assigned accurately. A short stay DRG audit is a post service, post payment review of participating and non-participating Medicare Risk inpatient claims paid under a DRG methodology to validate that it was medically appropriate for the patient to be treated and billed as inpatient rather than outpatient. This program also identifies potential implant and high-cost drug overpayments to ensure providers are complying with the contract cost limitation language on implant and high-cost drug reimbursement. Both medical chart audits are based on a comprehensive review of physician documentation within the medical chart.

These services may be performed by Aetna and/or its affiliates and/or an external vendor. Overpayments identified through this program are pursued for reimbursement from the provider and/or member.

Calculation of Shared Savings

We calculate the savings achieved through the program as the actual amount recovered. We will retain the percentage of savings specified in your service and fee schedule as compensation for the services provided under the program. These fees are primarily to support vendor costs and/or internal administrative costs of Aetna or its affiliates associated with these programs. The following is an example of a savings calculation (using a 30% fee for illustrative purposes only):



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Calculation Example	
Amount paid on claim	\$ 1,500
Amount recovered (via pursuit of other primary coverage)	\$ 1,000
Total Administrative Fee (30%)	\$ 300
Total Net Credit to Customer	\$ 700

Out of the amount recovered, the customer will receive a total net credit of \$700 and Aetna will retain a fee of \$300 (30%) as compensation for the services provided by Aetna, its affiliates and/or a vendor with respect to the program. These amounts will be credited and charged to the customer on a daily basis and are disclosed in the claim detail report.

PrudentMed®

The PrudentMed® program, offered by PrudentRx, assists your plan's members in securing available third-party copayment assistance for certain specialty drugs through the various programs funded by pharmaceutical companies.

Calculation of Shared Savings

We calculate savings as the dollar amount of financial assistance your eligible members receive through programs sponsored by pharmaceutical companies that provide financial assistance for payment of the member's cost share. In addition to benefiting your members, the plan will realize savings by increasing the member cost share (which increase in member cost share is offset by the manufacturer programs). A percentage of the savings generated will be charged as compensation for the services provided under the PrudentMed® program, as specified in your service and fee schedule. The following is an example of a savings calculation (using a 25% fee for illustrative purposes only):

Calculation Example	
Generated Savings from Pharma Copayment Assistance Programs	\$ 10,000
Less Discount Factor (1%)	\$ 9,900
Total Administrative Fee (25%)	\$ 2,475
Net Savings	\$ 7,425

In this example, PrudentMed® was able to generate savings by utilizing \$10,000 in manufacturer funds. PrudentRx will receive \$2,475 (25%) as compensation for the services provided under the PrudentMed® program. PrudentRx may share a portion of the service fee with third parties, including Aetna and/or its affiliates for services rendered in connection with the PrudentMed® program. This service fee will be charged to the customer on a monthly basis through claim wire billing.



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Claim and Code Review Program

This program includes several components that apply additional layers of review to certain inpatient, outpatient, and professional claims submitted by in-network and out-of-network providers using claim editing and clinical coding validation capabilities that are integrated with our claims processing systems. Utilizing proprietary algorithms and claim editing solutions, these reviews ensure claims are properly coded and validated, compliant with Aetna's policies and provider contracts and clinically appropriate and consistent. These additional reviews may include:

- Edits to enhance accuracy and consistency of claims payments in accordance with Aetna's clinical, payment and coding policies identify claims subject to the Clinical Review Program and manage policies targeting billing errors as well as waste and abuse scenarios
- Evaluation of the clinical accuracy of claims
- Identification of inappropriate billing and procedures on certain medical, diagnostic and surgical claims
- Management of complex billing scenarios for medical injectables, which includes authorization support as well as compliance of FDA-recognized dose and frequency limits
- Reviews performed by specialized nurse coders to ensure accuracy of certain complex claims at risk of improper payment
- Enhanced claim editing for certain services
- Medical record reviews for claims meeting certain criteria that includes requesting medical records as needed

These reviews are applied to submitted claims and adjustments or denials are made for charges that are determined not authorized or not allowed. Examples of adjustments include: unbundling or mutually exclusive coding scenarios, experimental & investigational or cosmetic services, billing errors involving excessive number of units or billable thresholds, duplicate claims, multiple charges for the same procedure, billing errors, insufficient information regarding a service, non-covered services or supplies, services determined not medically necessary or not pre-authorized. Also included are services that may require clinical review such as level of care and DRG audits. The provider is paid the allowed amount, after application of any appropriate adjustments identified through the program.

These services may be performed by Aetna and/or its affiliates and/or an external vendor.



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Calculation of Shared Savings

We calculate the savings achieved through the program as the difference in the paid amount. Savings is the difference between the amount that would have paid before review under the program and the amount paid after the claim was reviewed and adjusted. We will retain the percentage specified in your service and fee schedule as compensation for the services provided under the program.

The following is an example of a savings calculation (using a 30% fee for illustrative purposes only):

Calculation Example	
Program Adjustments/Denials	
Denied for specialty drug quantity limit	\$ 500.00
Denied per specialized nurse coders	\$ 500.00
Total disallowed charges	\$1000.00
Shared Savings Retained by Aetna (30%)	\$ 300.00
Net Plan Sponsor Savings	\$ 700.00

Aetna will receive \$300 (30%) of the total savings as compensation for the services provided by Aetna, its affiliates and/or a vendor with respect to the program and the customer received a net savings of \$700 on these claims. The charge will be applied on a quarterly basis and disclosed in the customer's Claim and Code Review Report, which details savings on a claim-by-claim basis.

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 uses 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)

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 into their account.

Eligibility Transmission

Aetna assumes the customer will submit eligibility information once a week, twice a week or every two weeks 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 and will be assessed separately. Customers who elect to send eligibility less frequently than every two weeks may incur additional charges due to the increase in retroactive activity. Customers who elect to send eligibility information more than twice a week may incur additional charges due to additional time and resources necessary to manage files. 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.

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:



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- Key Benefit Plan Changes
- New Hires/Rehires
- Member elects a different benefit plan option
- Member calls to request a replacement/additional ID card

Customer requests to issue individual ID cards (one card to each member versus family style) may also result in additional fees (except where mandated by state law). ID cards and member plan details which include plan deductibles and out of pocket limits are always available electronically through our secure member website. Members can visit www.aetna.com to register and sign into their account.

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.

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



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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.

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



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providers to advance the goals of improving the quality of patient care and health outcomes, while controlling costs.

Example Calculations

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

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

Examples

A. P4P. Percentage of allowed claims dollars:

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

- i. Provider earns \$100,000 performance-based compensation for the 12-month period January to December;
- ii. All Customers combined, incurred \$8,500,000 in claims with the provider for the 12-month period January to December;
- iii. Customer incurred \$150,000 in claims with the provider for the 12-month period January to December;
- iv. Customer's share of claims costs is $(\$150,000/\$8,500,000) = 1.7647\%$.
Formula: (Customer incurred claims/All Customers incurred claims);
- v. Customer'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 Customers combined, had 100,500 member months with the provider for the 12-month period January to December;
- iii. Customer had 9,500 member months (for 850 unique members) attributed to the provider for the 12-month period January to December;
- iv. Customer's share of the member months is $(9,500/100,500) = 9.4527\%$.
Formula: (Customer member months/All Customers member months)



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

The Commercial Incentive Attribution's (CIA's) three options, Basic, Plus and Enhanced, offer the continuity and consistency of a single model but the flexibility to engage providers wherever they're at in their value-based progression. Our next generation model gives providers line of sight for long-term planning and strategic investment in value-based solutions. As providers implement strategies for managing risk and population health, the CIA model evolves with them.

CIA Basic, Plus and Enhanced

We collaborate with CIA providers to develop a care transformation roadmap. We emphasize prevention and annual wellness visits, chronic condition management, transition of care, medication management and closing gaps in care. Delivering advanced clinical care requires interdisciplinary care team collaboration and coordinated navigation across the care spectrum. It also relies on relationship-based member engagement and omnichannel access to clinical and community resources.

We start by using the provider's own baseline performance to set targets, and then we reset performance levels annually, building on the previous year's achievements. CIA performance metrics serve as a blueprint for managing financial trend and population health.



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All CIA include a performance measure incentive (PMI). The incentive is contingent on meeting quality and clinical efficiency targets. Quality metrics reflect evidence-based best practices aligned with chronic care, diabetes, cardiovascular disease, blood pressure, preventive care, cancer screenings and pediatric well care.

Clinical efficiency metrics include:

- 30-day readmission rate
- Sub-acute days
- CT scan and MRI visits
- Avoidable emergency room visits
- Preferred sites for outpatient, lab and radiology
- Potentially impactable admissions or total acute admissions
- Generic pharmacy prescribing rate or therapeutic equivalents

While CIAs have some flexibility when selecting performance measures, the menu of available metrics is the same across all CIA collaborations. We typically allocate the PMI following annual reconciliation. Upon request, we can distribute a portion of the PMI as an operating advance, which is capped at \$1.50 per member per month (PMPM) in CIA Basic, \$2.50 PMPM in CIA Plus and \$3.00 in CIA Enhanced. The quarterly operating advance is at risk, meaning the CIA must refund PMI advances if it doesn't meet quality scorecard targets.

CIA Plus

In addition to the PMI, CIA Plus includes a gainshare incentive. CIAs must meet quality scorecard and financial trend targets. Instead of relying on market-based trend, we use the CIA's own baseline performance. Trend targets, evaluated annually, can be set to improve performance or to sustain high-level achievement. The maximum allowable gainshare in CIA Plus is 30 percent of the CIA's PMPM savings, which is capped at 8 percent of the baseline PMPM. We distribute gainshare payments retrospectively following annual reconciliation.

CIA Enhanced

CIA Enhanced includes also includes PMI and gainshare. However, CIA Enhanced offers a higher level of gainshare. The gainshare maximum in CIA Enhanced is 50 percent of PMPM savings, which is capped at 6 percent of the CIA's baseline PMPM. CIA Enhanced also includes unit cost discounts and additional downside risk. Under CIA Enhanced, providers must pay an out-of-pocket penalty, not to exceed the cap, if they're unable to meet the financial trend target.

Accessing CIAs in the broad network

Members enrolled in our broad network plans can access care seamlessly from available CIA providers by scheduling appointments or tapping into on-demand care. When they do, our



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algorithm connects the dots and “attributes” them to the CIA. The minimum membership requirement is 2,500 for CIA Basic and 5,000 for CIA Plus and CIA Enhanced. By focusing on health outcomes instead of service volume, CIA incentivizes improvements to the quality, coordination and cost of care.

General

Aetna will process any payments in accordance with the terms of each VBC arrangement. In each of the VBC models, self-funded Customers 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 customer’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 Customer will be available on a quarterly basis. Upon request, Aetna will provide additional information regarding our VBC arrangements.

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.

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



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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 elect Professional Claims Repricing Service (PCRS) as their out-of-network plan rate for professional services. 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 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, and PCRS, 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 out-of-network facility claims for which a contracted rate or facility plan rate is not applicable 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.



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Out-of-network facilities may balance bill the member for any amount above the Recognized Charge. We offer three different types of FCR – Standard, Modified Balance Bill and Fixed Determination, which provide a range of options regarding how member balance billing will be handled through negotiations with the facility. Even with FCR, if a provider refuses to agree to a negotiated rate, claims may be paid at billed charges in certain circumstances. For claims eligible under the No Surprises Act (NSA), FCR pricing will not apply.

Standard FCR

In the event a member is balance billed, we have a Patient Advocacy reconsideration process which will attempt to negotiate with the facility to try to come to a mutually agreeable settlement amount. For claims that are to be paid at the preferred/in-network level under the terms of the member's plan of benefits, we'll negotiate with the facility so that the member isn't responsible for any covered charges in excess of any applicable deductible and coinsurance/copayments. However, for non-preferred 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 a member is balance billed or the facility requests a reconsideration, we have a Patient Advocacy reconsideration process which will attempt to negotiate with the facility to try to come to a mutually agreeable settlement amount. We'll negotiate with the facility so that the member is not responsible for any covered charges in excess of any applicable deductible and coinsurance/copayments.

Fixed Determination FCR

In the event a member is balance billed, there is no Patient Advocacy reconsideration process for voluntary out-of-network claims. The member is responsible for charges in excess of the Recognized Charge for voluntary out-of-network claims. For claims that are to be paid at the preferred/in-network level, we will negotiate with the facility so that the member isn't responsible for any covered 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.



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Professional Claims Repricing Service (PCRS)

PCRS applies to plans with certain out-of-network rates. Aetna, directly or through a vendor, employs a methodology to price certain out-of-network claims, 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 are available to assist the member. The Patient Advocacy program gives members the ability to have an advocate negotiate with providers on their behalf.

When initiated by a member, the provider will be contacted by an advocate 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, the member is not responsible for charges in excess of any applicable deductible and coinsurance/copayments. However, for voluntary out-of-network services, if a mutually acceptable rate is not achieved, the member may be responsible for charges in excess of the PCRS out-of-network plan rate. PCRS does not apply to NSA eligible claims.

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.

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

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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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

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.

Minnesota (Self-Insured Customers with Members Residing in Minnesota)

Minnesota Statutes, chapter 62, section 62U.04, subdivision 5a, requires third-party administrators (TPAs) to notify their self-insured employer clients annually of their **right to elect to have the TPA submit data to the MN APCD on their behalf for the upcoming plan year**. Under this law, TPAs must report summary data to the Minnesota Department of Health (MDH), including the total number of clients, covered lives, and claim volumes for clients who both opt in and opt out of the MN APCD.

Participation in the MN APCD is at the employer's sole discretion. While the opt-in process typically begins during annual registration, employers may elect to participate at any time during the year.

There are two simple options:

- 1. Opt-In to Submit Data to the MN APCD** – Notify your TPA of your decision to voluntarily submit data. Your TPA will then update its existing data submission to transmit de-identified data monthly to the MN APCD on your behalf. If you have already opted to participate, no action is required to continue voluntarily submitting data.
- 2. Do Not Opt-In to Submit Data to the MN APCD** – Your TPA is responsible for completing the annual MN APCD registration process and anonymously including your decision in the summary report. You will receive another notice next year about the opportunity to participate.

For more information, see the following documents:

- Notice to Opt-In to the MN APCD:
<https://www.aetna.com/content/dam/aetna/pdfs/aetnacom/employers-organizations/notice-to-opt-in-to-minnesota-apcd.pdf>



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- A New Tool to Help MN Employers Control Their Health Care Costs:
<https://www.aetna.com/content/dam/aetna/pdfs/aetnacom/employers-organizations/minnesota-all-payer-claims-database.pdf>

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.apcdcouncil.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 self-insured customers 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 into 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/>.



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- 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/>.

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 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



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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 26/26 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 (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



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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 Customer 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 customers 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 customers 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 Human 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



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information is used by the IRS to administer the individual shared responsibility provision and by individuals to show compliance with the individual shared responsibility provision.

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

Federal Mental Health Parity

For self-funded plans, it is the customer'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 Customer 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 Customer 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. 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.

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.



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Illinois TMJ and Craniomandibular Disorder Mandated Offer

Illinois law requires that we offer you optional coverage for the treatment of temporomandibular joint disorder and craniomandibular disorder for an additional premium and subject to standards of insurability. The maximum lifetime benefit for treatment of these disorders must be no less than \$2,500. If you'd like to know more about adding this optional coverage to your plan, please contact your sales representative. Please note that continuing of your plan without adding this optional coverage constitutes a declination of this offer.

New Jersey A-4 Surcharge

Chapter 8, Public Law 1993, requires health plans of school districts that do not participate in the State Health Benefits Program (SHBP) to pay an annual surcharge to the program. Referred to as A-4, the surcharge is determined by the State Treasurer and is based on a percentage of the total claims paid for the coverage of employees of the nonparticipating school districts. Plan Sponsors subject to the surcharge are responsible for compliance and payment in accordance with applicable law. To assist Plan Sponsors in meeting their obligation, on an annual basis, Aetna will remit payment of the A-4 surcharge on behalf of the Plan Sponsor. Aetna will collect payment from the Plan Sponsor through the claim wire on an annual basis. The surcharge will appear as a separate line item in the claim wire. Once an annual reconciliation has been completed, any adjustments required to equal the actual A-4 payment to the State will be submitted through the claim wire.

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.

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. 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



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*Service (TRS). Additional information can be found on the following URL:
<https://www.aetna.com/accessibility/accessibility-services.html>.*

