2022 Plan Administration Information

We provide this plan administration disclosure document to all our self-funded customers on an annual basis to provide a general description of our administrative practices and updates on how those practices may have changed in the past year. This document applies to self-funded 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. Unless otherwise noted, the terms "we", "us" and "our" refer to the applicable Aetna affiliate providing administrative services to your plan(s).

1. Payments to Providers and Negotiated Rates

We use several different payment methodologies in our contracts with participating providers for your plan. The following are some of the more common methodologies:

- Per individual service (specified fee for a particular service)
- Per diem (specified fee per hospital day)
- Case rate (specified fee for a full range of services for an injury or illness)
- Bundled payment (combined payment covering hospital/facility and physician services)
- Capitation (a prepaid amount per plan participant, per month or per employee per month, as applicable)
- Accountable care payments for Accountable Care Organizations (ACO), Patient Centered Medical Homes (PCMH), or similar provider groups (a prepaid amount per plan participant, per month)
- Gain share payments in ACOs, PCMH, and other value-based contracting arrangements (payments might be made to the provider for generating savings and making improvements in clinical measures)
- Performance incentive payments for improvements in clinical care for both physicians and hospitals
- Waiver of medical necessity or other standard claim and patient management functions, in exchange for a negotiated payment reduction

In certain circumstances, usually with case rates and per diems, a participating provider's billed charges may be less than the contracted rate. This can happen because we establish the case rates or per diems based on an average episode of care, whereas the billed charges are based on the actual services that were provided to the plan participant. For example, we may negotiate a fixed case rate with a hospital for all emergency room visits. We might pay the same amount under this arrangement for an emergency room visit requiring intensive services as we would for an emergency room visit requiring relatively routine services. These arrangements can produce savings for our customers over a broad range of services, but they might create inequities for individual plan participants who receive relatively fewer intensive services. In some cases, we calculate the plan participant's cost sharing (co-pay or coinsurance)

based on the lesser of the provider's billed charges or the contracted rate but in other cases based on the way we have contracted with the providers, the plan participants cost share will be based on the rate we pay for the bundled services. The customer will be obligated to fund the remainder of the contracted rate.

We have a variety of different Value-Based Contracting (VBC) arrangements with many of our participating providers. These arrangements compensate providers to improve indicators of value such as, effective population health management, efficiency and quality care. Our VBC models include: Pay-for-Performance (P4P), Bundled Payments, Patient Centered Medical Homes (PCMH), and Accountable Care Organizations (ACOs). We will continue to evolve our VBC 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. A customer's financial responsibility under each VBC arrangement is determined based on provider performance, using an allocation method appropriate for each particular program. These methods include: percentage of allowed claims dollars, percentage of plan participant member months, or specific savings for bundles payment cases.

We will process any payments in accordance with the terms of each VBC arrangement. In each of the VBC models, all self-funded customers reimburse us for any payment attributable to their plan when the payments are made, subject to "Issued" or "Cleared" basis funding arrangement. 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 that 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.

2. <u>Network Provider Arrangements</u>

Certain (very limited) network provider contracts require us to pay claims we otherwise may deny, including those that certain providers deem medically necessary or experimental or investigational regardless of the plan's determination (but does not require us to pay for services your plan expressly excludes from coverage, such as for cosmetic surgery). We will charge your plan for these claims in order to be able to continue providing your plan's participants with access to these services on an in-network basis. Consult your Summary Plan Description (SPD) text to ensure that the description of our services accommodates such arrangements.

Aetna is now part of the CVS Health family of companies. Other entities that are also part of the CVS Health family of companies may provide services covered by your plan and, as a result, Aetna may adjudicate benefit claims and remit payments to those entities. A listing of these entities is available on request or may be found on www.cvshealth.com.

3. <u>Gold Carding Programs</u>

Aetna or an Aetna vendor may use an abbreviated medical necessity review protocol for a select number of procedures. The protocol includes qualified providers that were chosen based on their consistent precertification approval rates and the regularity in which they follow Aetna clinical policy bulletins. Providers submit requests for authorization for the in-scope program procedure groups and requests go through a streamlined medical necessity review process. Provider performance is monitored, and audits are conducted to ensure appropriateness of services. The protocol also includes automation of approvals for certain procedures where there is an ability to automate the elements necessary for a precertification approval.

4. Settlements with Providers

We sometimes have payment disputes with providers that get settled through one-time payments to the provider or to Aetna. We, in our discretion, may reasonably apportion those settlements to self-funded customers as claim adjustments and process those amounts through the customer's banking arrangement. We are usually able to apportion the settlements through a specific claim methodology, after considering our internal and external costs of recovery and distribution. Customers remain liable after termination of their agreement for their portion of any settlement payments arising from claims paid while their plan was active with us.

5. Overpayments

We reprocess any identified errors in plan benefit payments (other than errors we reasonably determine to be *de minimis*) and seek to recover any resulting overpayment by attempting to contact the party receiving the overpayment twice by letter, phone, or email. A customer may direct us not to seek recovery of overpayments from plan participants, in which event we will have no further responsibility with respect to those overpayments. All customers are required to cooperate with us in recovering overpayments.

When seeking recovery of overpayments from a provider, we have established the following process: if we are unable to recover the overpayment through other means, we may offset one or more future payments to that provider for services rendered to plan participants by an amount equal to the prior overpayment. We may reduce future payments to the provider (including payments made to that provider involving the same or other health and welfare plans that are administered by us) by the amount of the overpayment, and we will credit the recovered amount to the plan that overpaid the provider. If any Customer desires to opt out of our bulk overpayment recovery process, they can do so at any time by notifying us in writing. Customers do not have a right to recover overpayments directly from providers on their own unless their services agreement provides that right.

6. Submissions of Claims to Stop-Loss Carriers

Claims are sometimes received late from health care providers or the adjudication of a claim is sometimes delayed because of necessary requests by us for additional information, or other justifiable reasons. Depending on the terms of your stop-loss policy, your stop-loss carrier may

deny payment on claims that are received after the timeframe set forth in the stop loss policy. We assume no responsibility if your stop loss carrier denies payment for this reason. We encourage all of our customers to consider "run-in" or "run-out" stop loss insurance coverage to cover these circumstances in which claims are not incurred and paid within the same stop loss policy period.

7. 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 administration, medical management, credentialing and customer service. 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 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 administrative fees supporting the 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.

8. Health-Related Services Offered to Plan Participants

From time to time, we may provide your plan participants with information about health-related products or services offered by third party vendors or by Aetna itself or an Aetna affiliate. Such health-related products or services may include exercise, diet or other wellness programs. To the extent permitted by law, we may receive compensation from the vendor when your plan participants elect to purchase or use these products or services; however, no compensation is due to any customer in relation to these products or services.

9. Reporting Impermissible Disclosures

To help prevent the impermissible disclosure of plan participant information, we have adopted extensive privacy policies and procedures. Even with these strict safeguards in place, there may be instances where a plan participant's personally identifiable or protected health information may be disclosed in an impermissible manner.

When impermissible disclosures are made, we will work to identify the root cause of the issue and correct any underlying problem, regarding this as sufficient to satisfy our duty to manage and mitigate these issues on your behalf.

In the instance of disclosures that are considered privacy breaches under state or federal law as well as those that pose a risk of identity theft, we will promptly notify you.

10. Use of Data

Plan and plan participant data, which includes claim, eligibility, care management, health risk assessment, and clinical lab results, reside in Aetna's electronic data warehouse. We access claims and related data from the data warehouse for a number of mandatory and/or legally permissible purposes, including payment, health care operations, care management, reporting to governmental and other oversight agencies, public health, research and data mining activities.

In the event you request Aetna to provide plan participant data to you and/or one of your vendors or other third parties, it will be your responsibility to disclose to plan participants how and with whom their data is being shared and to obtain any required authorizations, including any authorizations required under HIPAA or other federal or state law. We may refuse to provide any data to the extent we believe disclosure of such data is not permitted or has not been properly authorized under any applicable law. We may also require the recipient to sign a non-disclosure agreement.

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 self-funded domestic plans are not in scope for GDPR. To help support operational requirements of GDPR, to the extent you determine applicable, we have an option available for members in the EU or EEA to be enrolled in Aetna International plans.

11. How We Calculate Our Fees for the National Advantage Program (NAP)

We calculate NAP fees as a percentage of what we save your plan on medical costs when we use NAP. Most NAP claims relate to out-of-network services, though "savings" may apply to certain in-network services if you participate in the Itemized Bill Review component of NAP. These savings result from: (i) utilizing contracted rates, either directly or through third party vendors, (ii) negotiating claim specific discounts, (iii) applying a recognized charge on facility claims, (iv) applying a recognized charge on professional claims based on commercially competitive payment amounts, or (v) reviewing itemized bills for inconsistencies and errors.

In many situations, "savings" means the difference between the NAP priced amount and the provider's billed charges. "Savings" are often calculated relative to billed charges for facility

services, as well as for "involuntary" out-of-network services. "Involuntary" means instances where your plan participant obtained services from a non-participating provider when a participating provider was not reasonably available. In other situations, "Savings" means the difference between the NAP priced amount and some other reference rate, such as the 80th percentile of FAIR Health or your plan's out-of-network benefit rate. This calculation methodology is often used for professional services and/or "voluntary" out-of-network services, where your plan participant could reasonably have utilized a participating provider, but instead elected to go to a non-participating provider. For claims that utilize the Itemized Bill Review component of NAP, "Savings" are calculated by comparing the in-network rate prior to the review to the reduced in-network rate.

Please refer to your contractual documents for a full description of NAP and for details on how "savings" and fees are calculated for your specific Plan.

In thinking about these fees, please note:

1. Absent NAP, your plan could be responsible to pay up to billed charges for emergency services that are not impacted by law (e.g., surprise billing laws/regulations).
2. Absent NAP, your plan participants may receive more balance bills, as NAP prevents balance billing in most situations. This includes situations when a plan participant did not have a choice to get services in-network, for example, when they get surgery in a network hospital, but anesthesiologists, radiologists or other hospital-based doctors are not in the network.
3. For plans with lower out-of-network benefits (e.g., 100% of the Medicare rate), your plan may pay less by applying the plan's benefit rate than by applying the NAP priced amount.

Additional details and any exceptions to the general savings described above are available upon request.

In addition, please note we quoted your other fees assuming we will keep part of the savings from NAP as agreed to in your Annual Renewal Package. This percentage is not included in the per-employee, per-month fees. We would have quoted higher fees for those other services if we could not expect to earn the NAP fees.

12. Third Party Vendor or Aetna Claim Wire Billing Fees

We retain a percentage of the savings or the recovery amount of self-funded customer's claims for certain programs such as the following:

- Coordination of Benefits
- Retroactive Terminations
- DRG and Implant Audits
- Hospital and Outpatient Bill Review
- Workers' Compensation
- Subrogation
- National Advantage Program (NAP)
- Third Party Claim and Code Review Program

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

Overpayment recovery and 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.

Please refer to your Fee Schedule in the Renewal Package or Letter of Understanding for the percent of savings or the recovery amount applicable to each program.

Please refer to your Fee Schedule in the Renewal Package or Letter of Understanding for additional details on the programs listed above.

13. Alternate Office Processing

In order to maintain service levels, we sometimes do workload balancing of functions from one location to another. We refer to this process as "alternative office processing." For example, alternate office processing may occur in response to a severe weather event causing excessive absenteeism in a particular location. As a result, your work may sometimes be performed at locations or in units other than those agreed upon.

14. PayFlex

PayFlex (PFS) arranges for the payment of claims from funds made available by you. You authorize PFS to issue payments from a PFS account to which you remit funds for this purpose. Any interest generated on that account will generally be at federal funds rates. Interest shall be earned on such account beginning on the date funds are transferred from the customer to the account and ending on the date the check is presented for payment, the timing of which is beyond the control of PFS. Such interest shall be used to pay the fees of the financial institution with respect to the account. To the extent the interest exceeds those fees, PFS will be entitled to retain the difference. PFS will return interest in excess of these permissible amounts to you, and you agree that you will use those amounts in accordance with applicable laws, including but not limited to the Employee Retirement Income Security Act (ERISA), where applicable.

15. Behavioral Health Charges and Practices

For Self-Funded HMO Plans Administered by Aetna

The per-member, per-month (PMPM) fee that you pay for behavioral health services for your self-funded HMO product covers claim costs and administrative costs (network development and maintenance, patient management, credentialing, and, where applicable, customer service and claims processing). Fees vary by geographic area and product selection. Fees may be updated to reflect changes in cost structure. The PMPM fee may exceed or be less than the actual claims costs and administrative expenses for your plan. Overall, these arrangements generally result in a positive margin for Aetna, and such margins are retained as compensation

for the services provided by Aetna.

Mental Health Parity Compliance

With limited exceptions, self-funded plan sponsors have the responsibility for ensuring that the design of their plan is compliant with applicable law, including the Mental Health Parity and Addiction Equity Act (MHPAEA). To remain compliant with MHPAEA a plan sponsor should complete "quantitative treatment limit" (QTL) testing, which ensures that the financial requirements of the plan (e.g. copays, coinsurance) are compliant with MHPAEA. Aetna does not complete QTL testing for self-funded plans as MHPAEA compliance is the responsibility of the self-funded plan sponsors and member cost share is an element of plan design exclusively controlled by the self-funded plan sponsor.

Additionally, MHPAEA requires parity between medical and behavioral health "non-quantitative treatment limitations" (NQTLs) (e.g. pre-certification requirements, network reimbursement). While MHPAEA compliance is the responsibility of the self-funded plan sponsor, we recognize that as it relates to NQTLs, self-funded plans often adopt our "comparability" and "stringency" NQTL analysis we've developed in supporting our fully insured plans. In response to internal and external (e.g. regulatory) review, Aetna routinely reviews our NQTL analysis for our own fully insured plans and we take reasonable and appropriate steps to try to ensure that the design of our NQTLs are compliant with MHPAEA. To the extent your plan has not customized its plan design related to Aetna's standard NQTLs, our NQTL analysis is relevant to your ongoing NQTL compliance review. While Aetna can represent that we are taking reasonable compliance measures, due to ongoing uncertainty regarding application of MHPAEA (and its related regulatory guidance), Aetna cannot guarantee that all of the plans it provides third party administration services to will, at all times, meet MHPAEA's requirements, including the NQTL requirements.

Upon request, we can provide you our NQTL comparability analysis as well as a QTL testing informational supplement that provides Aetna's standard approach to QTL testing.

16. Employer and Plan Sponsor Reporting and Compliance Requirements:

Minimum Essential Coverage Reporting

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 applicable large employers (those having employed an average of 50 or more full-time employees during the preceding calendar year) to report to the IRS information about the health care coverage they have offered and furnish applicable

statements to employees. The purpose is to allow the IRS to enforce the employer responsibility provisions.

You, as the plan sponsor are responsible for collecting and reporting the information to both the IRS and your employees pursuant to your obligations under both Sections 6055 and 6056. For the collection, you may use a combined form for your 6055 and 6056 reporting. You, as the self-funded plan sponsor, must file returns under the 6055 and 6056 requirements with the IRS 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 employees by January 31 of the year succeeding the calendar year to which the return relates.

ERISA Reporting and Disclosures

You, as the customer, employer and/or plan sponsor, are responsible for creating and distributing certain reports and disclosures required by the ERISA. These include:

- Summary plan descriptions (SPD)
- Summary of material modifications (SMM)
- Summary annual reports (SAR)

At your request, we will develop draft Summary of Benefits and Coverage (SBC) documents, subject to your review and final approval. Draft SBCs will be based on plan design information that you provided for the products or services administered under your Agreement with us, as well as any additional pharmacy or behavioral health carve out information you provide. SBCs are not required for "retiree-only plans" as defined by the Affordable Care Act (ACA) and we won't be supporting generation of SBCs for "retiree-only plans." We charge a fee for the preparation of draft SBCs.

You are responsible for reviewing and approving any SBCs with your legal counsel. We are not responsible or liable for the content or distribution of any of your SBCs, regardless of the role we have played in the preparation of the documents. The production of SBCs will not be subject to Service or Performance Guarantees.

The SBC must include statements about whether the plan or coverage provides MEC and if the coverage meets minimum value (MV) requirements. Under the ACA, MV and MEC determinations are your responsibility. We will include the MV and MEC statements in SBCs produced for plans, however, we won't make the final MV or MEC determinations. We will review the MV standard for the plans based on the MV calculator criteria provided by the Department of Health and Humans Services (HHS). We will provide the SBC in editable format, so you can update MV and MEC statements within the document to reflect your determination for each plan. We don't provide legal or tax advice, and suggest you consult with your legal and tax consultants when making determinations. We don't have responsibility or liability regarding the MV or MEC evaluation, regardless of the role we played in reviewing/producing the SBC documents.

Wellness Programs

We offer several different wellness incentives and rewards programs that you may choose from to offer to your members. We, or our third party vendor, will administer and distribute any wellness incentives or rewards earned to your members based on the programs selected under the direction and control of your plan. The wellness incentives and rewards earned through these programs may be taxable for your members. We will provide you reporting which will identify members who have each earned such wellness incentives or rewards. These reports will provide you with the data needed for any tax information reporting requirements that you determine are necessary. However, you, as the plan sponsor, are responsible for complying with all tax information reporting requirements regarding any wellness incentives or rewards earned through these programs (cash, cash equivalent, or other tangible property) and provided by us or our third party vendor to your members.

You, as the plan sponsor, are also responsible for creating and distributing certain notices and obtaining any required authorizations that may be required under applicable law, including the Health Insurance Portability and Accountability Act (HIPAA), the Age Discrimination in Employment Act (ADA) and the Genetic Information Nondiscrimination Act (GINA).

PHARMACY BENEFIT

Rebate Arrangements

Aetna's affiliate, CVS Caremark, contracts for its own account with pharmaceutical manufacturers to obtain prescription drug formulary rebates directly attributable to the utilization of certain prescription drugs by plan participants. CVS Caremark may share these rebates with Aetna. Your fee quote and agreement with Aetna will specify the extent to which these rebates are shared with you. Rebates are collected at various times during the year and disbursed to self-funded customers at regular intervals. We do not pay interest on amounts held by Aetna pending distribution.

Rebates earned through drugs administered under your medical benefit plan (rather than your pharmacy benefit plan) are not shared with you. Such amounts are retained by Aetna as compensation for Aetna's efforts in administering your benefit plans. Payments or rebates from drug manufacturers that compensate Aetna for the cost of developing and administering value-based rebate contracting arrangements when drug therapies underperform thereunder also will be retained by Aetna.

Rebate projections can be impacted by several factors, including plan changes, changes in utilization and demographics.

Other Payments

The term "rebates" referenced above does not mean or include any manufacturer administrative fees that may be paid by pharmaceutical manufacturers to cover the costs related to the reporting and administration of our agreements with the pharmaceutical

manufacturers. Such manufacturer administrative fees are not included in rebate sharing arrangements.

Aetna or CVS Caremark may also receive other payments from drug manufacturers and other organizations that are not rebates. These payments are generally for one of two purposes: (i) to compensate Aetna of CVS Caremark for bona fide services it performs, such as the analysis or provision of aggregated data; or (ii) to reimburse Aetna or CVS Caremark for the cost of various educational and other related programs, such as programs to educate physicians and plan participants about clinical guidelines, disease management and other effective therapies. These payments are not considered rebates and are not included in rebate sharing arrangements with customers.

CVS Caremark may also receive network transmission fees from its network pharmacies for services it provides for them. These amounts are not considered rebates and are not in rebate sharing arrangements. These amounts are also not considered part of the calculation of claims expense for purposes of discount guarantees.

Customers agree that the amounts described above are not compensation for services provided by either Aetna or CVS Caremark, and instead are received by Aetna in connection with network contracting, provider education and other activities Aetna conducts across its book of business. Customers further agree that the amounts described above belong exclusively to Aetna or CVS Caremark, and customers have no right to, or legal interest in, any portion of the aforesaid amounts received by Aetna or CVS Caremark.

Formulary Administration

Aetna offers several versions of formulary options to its customers. Prior to the implementation of your formulary, you agreed that you made your formulary selection as a matter of your plan design and you acknowledged that you have the sole discretion and authority to select the formulary that will be used in connection with your plan. From time to time Aetna may propose modifications to the drugs and supplies included on your formulary as a result of various factors, including market conditions, clinical information, cost and rebates. These changes generally occur quarterly, and you will receive prior notice before any such change. You have the right to elect to not implement any such addition or deletion subject to Aetna's ability to operationally administer such election and, if so, Aetna's reservation of right to make appropriate and equitable financial changes resulting therefrom as described in your pharmacy benefits agreement.

In evaluating clinically and therapeutically similar drugs to be recommended for inclusion in a formulary, Aetna reviews the costs of drugs and considers rebates negotiated between Aetna and drug manufacturers. Consequently, a drug may be included on a formulary that is more expensive than a non-formulary alternative before any rebates Aetna may receive from a drug manufacturer are taken into account. In addition, certain drugs may be chosen for formulary status because of their clinical or therapeutic advantages or level of acceptance among physicians even though they cost more than non-formulary alternatives. The net cost to a

self-funded customer for covered prescriptions will vary based on: (i) the terms of Aetna's arrangements with CVS Caremark or participating pharmacies, (ii) the amount of the plan participant's co-payment, coinsurance or deductible obligation under the terms of the plan, and (iii) the percentage, if any, of rebates to which the customer is entitled under its Agreement with Aetna. As a result, a self-funded customer 's actual claim expense per prescription for a particular formulary drug may in some circumstances be higher than for a non-formulary alternative.

In prescription plans with a deductible or copayment or coinsurance tiers, use of formulary drugs generally will result in lower costs to plan participants. However, where the prescription plan utilizes a deductible or copayments or coinsurance calculated on a percentage basis, there could be some circumstances in which a formulary drug would cost the plan participant more than a non-formulary drug because: (i) the negotiated pharmacy payment rate for the formulary drug may be more than the negotiated pharmacy payment rate for the non-formulary drug, and (ii) rebates received by Aetna from CVS Caremark are not reflected in the cost of a prescription drug obtained by a plan participant.

Benefit Plan Design

Customer acknowledges that it is responsible for determining whether products or services added by Customer to the Benefit Plan Design are compliant with the laws applicable to Customer's plan.

Choose Generics Program

Choose Generics is an option that customers may elect to encourage plan participants to receive the generic version of a medication. Under this program, plan participants can choose to obtain the brand medication at a higher than normal cost share (subject to the exceptions described in the paragraph immediately below). Such higher cost share will be equal to the brand copay plus the difference in the cost between the brand medication and its generic equivalent. The cost differential is not applied to the plan participant's deductible.

If no generic equivalent medication or corresponding maximum allowable cost (MAC) amount is available or the prescriber has written "dispense as written" on the prescription order, the cost differential described above is not applied to the plan participant's higher cost share. In some instances, a brand medication is not eligible for a corresponding MAC amount due to formulary and/or rebate contract requirements that prohibit application of "plan participant pay the difference" logic or mandate minimum copay tiers. In other instances, a brand drug may not be eligible for a corresponding MAC amount due to supply and/or pricing considerations.

Participating Retail Pharmacy Network

Aetna subcontracts the participating retail pharmacy network to its affiliate, CVS Caremark. CVS Caremark, in turn, contracts with retail pharmacies to provide customers and plan participants with access to pharmacy services, including the dispensing of prescription drugs to individuals

who receive benefits from customers for whom Aetna provides pharmacy benefit management services. The prices negotiated and paid by CVS Caremark to participating retail pharmacies vary among pharmacies in the network, and can vary from one pharmacy product, plan or network to another.

Aetna frequently enters into "lock-in" or "traditional" pricing arrangements with self-funded customers. Under these arrangements, Aetna and the customer agree upon uniform or "lock-in" prices to be paid by the customer for retail pharmacy claims. This price, which is generally reconciled on an aggregate basis over a period of time and not on a claim-by-claim basis, may exceed or be less than the amount Aetna pays CVS Caremark, for the claims. It may also exceed or be less than the amount CVS Caremark pays the retail pharmacies. Overall, lock-in pricing arrangements generally result in a positive margin for Aetna and CVS Caremark, and such margins are retained as compensation for the services provided by Aetna and CVS Caremark.

Payment rates established between Aetna and its PBM subcontractor and between Aetna's PBM subcontractor and retail pharmacies may provide for different rates of payment depending on the size of the Aetna customer. In general, lower rates are paid for customers with 300 or more employees.

Generic Drug Cost

Aetna uses different methods for establishing pricing for generic drugs or brand name drugs whose patents have expired. Often Aetna establishes a single fixed price for these drugs, referred to as the "maximum allowable cost" or MAC. Sometimes when a drug first comes off patent or is not readily available from manufacturers, Aetna continues to use pricing equivalent to brand drug pricing.

Pharmacy Discount and Dispensing Fee Financial Guarantees

From time to time, Aetna may reconcile pharmacy discount and dispensing fee financial guarantees negotiated with customers. Aetna is not obligated to pay interest on any amounts owed to customers resulting from such reconciliations.

Retail Pharmacy Audits

Aetna has engaged CVS Caremark to perform periodic on-site audits of the retail network pharmacies. These audits may result in recoupment of funds paid for invalid or incorrectly billed claims. Such recoupments are generally credited to self-funded customers, less a percentage fee paid to compensate CVS Caremark for performing the audits. However, a "lock-in" customer would not receive a credit for claims that were adjudicated at the wrong rate because the customer would pay the same "lock-in" price regardless of the amount paid to the retail pharmacy.

REFERRAL AND PRIMARY CARE SELECTION POLICIES

For Elect Choice®, Managed Choice® and Aetna Select℠ products (does not apply to open access product options).

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 plan participant obtain a referral from their primary care physician (PCP) before receiving care from other providers.

For Membership in California

Given the unique nature of the health care system in California, referral registration for plan participants in California is generally not required. The delegated model in place in California already encourages providers to make appropriate referral decisions for our plan participants.